

**Canterbury**

District Health Board

Te Poari Hauora o Waitaha

**SUMMARY ANNUAL REPORT**

1 JULY 2005 – 30 JUNE 2006





This summary annual report has been extracted from the full financial report dated 25 September 2006 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](http://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



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# CHAIRMAN'S REPORT



Syd Bradley,  
Chairman

For the second year in a row, the Canterbury District Health Board (CDHB) has met its contracted volumes and targets for the community, as agreed with the Ministry of Health. The financial year ended with a \$2.5M surplus. However, this money cannot be used for discretionary service funding. It is allocated for the early payment of settlement funding for wage increases next year, resulting from recent union negotiations. A budget deficit next year will mirror the payment, so in essence the CDHB ended the year at a break even point. This is a pleasing result and is due to sound fiscal policy setting by the Board and a satisfactory implementation of that policy by management, clinicians and support staff.

This positive result masks a fairly substantial financial overspend in hospital services. Patient volumes, purchasing new technology, consumer expectations and increasing costs are all impacting on our expenditure. There has also been a growth in demand for urgent and acute medical and surgical services. Operationally, this has resulted in a decrease in our ability to provide elective services. The CDHB has been able to offset this with some efficiency gains through careful treasury management, planning and funding initiatives and the profit from the sale of a property. However, these tend to be one-off savings and most will

not be able to be maintained. We need to reduce our costs by continuing to find smarter ways of working and investing resources at the front end of our complex services to support our staff.

It is important that we prioritise the systems and processes that enable us to match patient requirements with appropriate resources. We need to make sure that our frontline staff have the tools they need to do their job, so that we can use our population-based funding to the community's best advantage.

One of our challenges is to manage our population's needs (hospital and community) with a relatively static budget now and into the future. This has been made possible by planning our budget. Now that we have moved to a three-year funding cycle, we know ahead of time what our funding will be for the coming years. Given this knowledge, we can make a significant and highly worthwhile investment in many of the CDHB's activities. This includes implementing the Board's recently established Five Point Plan that has now been further developed in meeting a wide range of specific operational objectives involving both investment and engagement with frontline operational staff.

The role of our leaders, clinical and management, and the workforce in both primary and secondary care is vital if we are to achieve the operational objectives for the benefit of patients that our Board's Chief Executive is



CDHB award winners at New Zealand Health Innovation Awards.

striving to achieve. Together, we will ensure that we work as cost effectively and productively as possible to recognise and promote innovations that allow us to deliver best value for money to all our stakeholders.

Last year, Christchurch Women's Hospital was opened. It is an outstanding facility which is serving the community very well. This year the Stage 2 Refurbishment Plan at Burwood Hospital is nearing completion and the new Diabetes and Home Dialysis Centre is now operating on the Christchurch Hospital campus.

I would like to acknowledge the outstanding work done by Dr Karleen Edwards who acted as Chief Executive for some time between the early departure of our last Chief Executive and the arrival of our new and very experienced Chief Executive, Gordon Davies.

Gordon joined us in September from the Ministry of Health and has brought a wealth of experience to the CDHB. His management style and abilities are much appreciated by both the Board and our staff.

Thanks also to my colleagues on the Board, whose

sound governance has helped the organisation navigate the many challenges it faces. While there is much more to be achieved between both primary and secondary care on a patient journey basis, I acknowledge the strong contribution made by our primary health providers. Thanks to staff from the Ministry of Health and the Minister's office for their ongoing assistance and advice.

Finally on behalf of my Board in its role as a funder of Public Health services, my thanks to all our providers and their staff for your outstanding commitment to the people of Canterbury and the wider South Island where we provide high quality tertiary services.



Syd Bradley  
Chairman  
Canterbury District Health Board



*Gordon Davies, CEO CDHB and Syd Bradley, Chairman CDHB at the 'top off' of the Diabetes building.*

# 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.



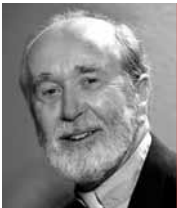
**Jo Kane** (elected) is a Waimakariri District councillor and Deputy Mayor, who believes in the basic responsibility to protect family health, and the right of wellbeing for all.



**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 Māori 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



Gordon Davies  
Chief Executive

Coming close to the end of my first year as CEO, I am pleased to report that the Canterbury District Health Board (CDHB) has shown itself to be in good heart and among the most innovative and hardworking of New Zealand's DHBs in the 2005/06 year.

One of the greatest highlights of the year was the announcement that four of the six award winners in the New Zealand Health Innovation Awards were from the CDHB. In the relatively short time that I have been here, the enthusiasm and dedication that our staff continually show in finding new and better ways of doing things for patients has thoroughly impressed me. The results in the Innovation Awards were truly inspiring, showing a stunning level of innovation in areas as diverse as mental health, blood usage and a Specialised Relative Insulin Nutrition Table (SPRINT) for use in the care of Intensive Care patients.

Launched in July 2005, the 'Improving the Patient Journey' project is also proving itself to be a leader in healthcare innovation. This year's targets have included improving patient flow through the Emergency Department,

developing a nurse initiated discharge process and piloting the benefits of having a physiotherapist located in the Emergency Department. Among its many impressive results is a significant reduction in waiting times for patients in the Emergency Department, with 83 per cent of patients now seen, treated and discharged or admitted within four hours of arriving. Although our team is striving to achieve still better results, a presentation of data recently wowed other Australasian hospitals who were eager to learn how this was done. A number of other projects have been started under the Improving the Patient Journey banner in the last year and I look forward to the significant outcomes that I believe they will generate. These projects include a Surgical Progressive Care Unit for patients requiring a high level of nursing attention, and the Acute Medical Assessment Unit which opened in June 2006 to provide patient based assessment, treatment and acute admission in a timely manner.

All those involved in the rollout of the Meningococcal B Vaccination programme in Canterbury have received well-deserved praise with impressive vaccination rates achieved on target in a comparatively short time frame for the region. In primary care this year we have also seen



Baby Sophia Burton, with Neonatal Staff Nurse Trish Graham, cuddles into one of the new polar fleece blankets donated by Kiwanis Clubs of Christchurch. At left is Rhondda Boxall of Kiwanis.



*New entrants from St James School in Aranui participating in the Fruit in Schools programme.*

the rollout of reduced fees for 45 to 65 year olds and in the wider community setting, the implementation of the CDHB's Older People's Health Strategy which will provide an integrated approach to community based services for older people, enabling them to maintain their independence for as long as possible. A recent review of CDHB's Co-ordinated Services for the Elderly (COSE) model has identified that it has directly contributed to a significant reduction in both the mortality risk for people over 65, and the risk of entry to residential care. The clear message about the harmful effects of smoking has gone out at all levels with the final step taken this year to make CDHB sites smokefree and smoking cessation initiatives have been expanded in primary care.

Our building projects have progressed on target with the new Diabetes and Home Dialysis Centre soon to be occupied, and construction of the Burwood Hospital Redevelopment due for completion in early 2007. Both of these facilities will significantly improve the delivery of services in core target areas for the CDHB. The three-year Fruit in Schools programme which has made an impressive start in Canterbury will make a different kind of contribution to the health of Canterbury people, boosting the nutrition of children in lower decile schools and encouraging them to adopt lifelong healthy eating habits. Fighting the national obesity epidemic at a local level will undoubtedly be one of our main objectives in coming years and I thank our Community and Public Health division

for the leadership they are showing in this area.

Although increased funding has been only close to inflation for the year, we have managed to significantly increase our level of health services to Canterbury people, including a substantial increase in the number of patients seen acutely at our hospitals. Our elective services have been stretched to meet demand but much work has been done in recent months to develop a sustainable system that will ensure Canterbury people most in need of elective services will be better prioritised in the future.

The CDHB has ended the financial year with a surplus thanks to a number of payments from the Ministry of Health that will not be spent until next year. This will be balanced out with a small expected deficit next year, provided plans to reduce overspending in some areas are well implemented. I would like to thank everyone involved in this year's budget process. In the coming year, managers will work with teams to ensure that the 06/07 budget is well delivered. Over expenditure will be pursued more vigorously and some budgets will need to be adjusted downward if others are overspent. This will not be an easy task with a capped budget and several services where the national prices do not yet cover actual costs. Personnel and treatment-related costs in the Hospital and Specialist Services division have, for example, contributed to significant overspending in this area. The rise in acute patients and pressure on Christchurch Hospital's Emergency Department have also been identified as areas of difficulty leading to



*A child enjoys the new therapy garden at the Champion Centre, Burwood Hospital.*

EACH DAY IN CANTERBURY  
APPROXIMATELY:

4,020 PEOPLE  
VISIT THEIR GP



*Winning team, from left: Katie Croft (Physiotherapist), Pamela Williams (chair of CDHB Quality and Patient Safety Council), Janine Griffiths (Clinical Charge Nurse EOA), Gordon Davies (CEO).*

staff pressures. Treatment related costs contribute much to the supplies overspend. Cancer drugs and cardiology (including drug eluting stents and implanted defibrillators) are the main difficulties but are needed treatments. Utilities and fuel are another problem for large institutions, as they are for ordinary New Zealanders.

Reducing expenditure at the CDHB has to be about working smarter without compromising the volume and quality of patient care. I know our current management team is committed to exploring sensible, practical and efficient models against available resources – both in primary and secondary care. At the same time, we have competing priorities for development / funding, such as specialised equipment for operating theatres and progressing with the purchase of a second MRI scanner.

As the financial year came to an end, the Board had to make plans to remove about 5000 people from the elective surgery waiting list in order to achieve compliance with the national electives policy. This policy requires that patients be seen for a first specialist assessment or treatment within six months, giving certainty to people about when they will receive health services. The removal of patients from the booking system was personally heart wrenching for many hospital staff and managers at all levels. It has however given renewed vigour to efforts to ensure that there will be no more major removals of people from the booking system. In an unprecedented level of collaboration, CDHB managers, hospital clinicians, General

Practitioners and Primary Health Organisations have been working together to create an improved system in which people are assessed for treatment more carefully at the front end of our services. All involved have worked long and hard through this process and are still looking to find better ways of doing things in the future. I would like to thank them again for what they have done and the innovations developed to help us work more effectively. I believe the systems that are being built augur well for a far better model of care in Canterbury.

The CDHB's District Strategic Plan 2006-2010, A Healthier Canterbury: Directions 2010 was signed off this year and outlines the CDHB's strategic direction for the next five years. With the calibre of our staff and community providers, I look forward with excitement to the path that the Board is following. It is becoming an even stronger, more robust organisation that will continue to raise the standard of health care delivery for everyone in Canterbury. Already, some of the projects that have commenced have started to show the power of the whole DHB-wide system to integrate care for patients.

Gordon Davies  
Chief Executive Officer

# HIGHLIGHTS AND ACHIEVEMENTS

## NEW DIABETES AND HOME DIALYSIS TRAINING CENTRE

Construction is on target for the CDHB's new Diabetes and Home Dialysis Training Centre. This purpose-built facility, costing \$5.2m, brings together for the first time under one roof the CDHB Diabetes Services, Diabetes Life Education and Diabetes Christchurch.

The four storey building offers space for meeting rooms, offices and the Diabetes Christchurch Inc shop on the ground floor, with new treatment and assessment rooms on the first floor. The second floor is reserved for diabetes administration and research, while the third floor is for the Home Dialysis Training Centre.

Diabetes Christchurch, a charity providing education and support for those suffering from diabetes, has contributed to the cost of the building.

The new building will be officially opened in early 2007.

## BURWOOD HOSPITAL REDEVELOPMENT, STAGE II

Redevelopment of Burwood Hospital is now well under way, with construction due for completion early in 2007.

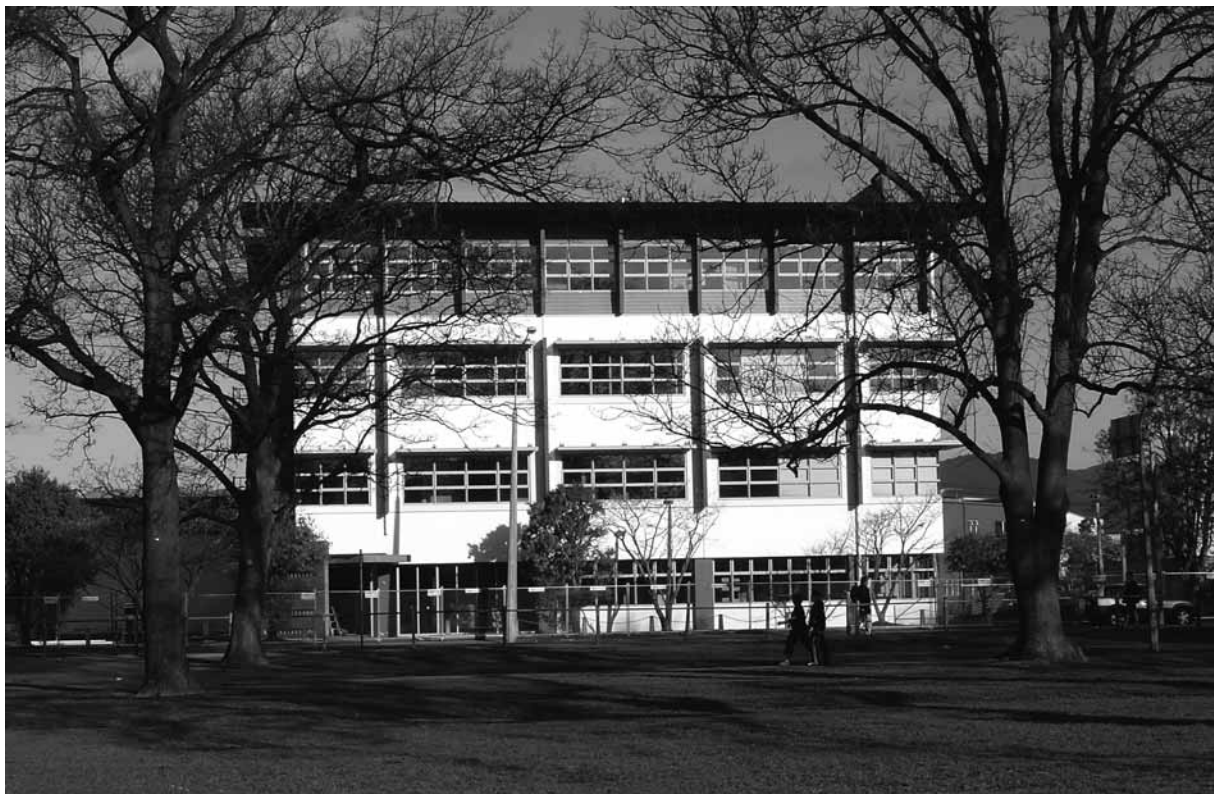
The redevelopment project includes four orthopaedic operating theatres, a theatre sterilisation unit, an admitting unit, facilities for pre-op and recovery, a 12-bed special care unit and a 30-bed surgical ward.

## INFECTION CONTROL BOOKLET LAUNCHED

This 24-page booklet was prepared for CDHB's frontline staff to give them infection control policies at their fingertips.

The infection control handbook, a first in New Zealand, is designed to fit into a uniform or shirt pocket and provide quick access to CDHB's key policies.

Infection control is fundamental to the way staff work at hospitals, both for their own health and safety and for the wellbeing of their patients.



*New Diabetes building.*

## MENINGOCOCCAL B VACCINATION PROGRAMME RESULTS

The success of the Meningococcal B Vaccination programme within Canterbury is a tribute to the hard work of Primary Health Organisations, General Practice teams and Well Child providers who achieved good results within just six months. This was a narrow timeframe when compared with other District Health Boards (DHBs) who were able to begin the vaccination programme earlier.

Overall in Canterbury, 85% of the eligible population received dose one and 79.3% received dose three of the vaccination. Of the 85% who started the programme, 93% (99,093 children and young people) completed the required three doses. This is slightly higher than the national average of 92%.

The CDHB had one of the highest rates of vaccination in New Zealand for six week to 11 month old babies. Māori and Pacific rates for dose three in the 5-17 year age group were also high – 98.2% for Pacific Island and 83.9% for Māori.

The greatest challenge in the programme came in the delivery to 18 and 19 year olds. Only 47.5% in this age group completed the programme. This low result was consistent across other DHBs.

## SMOKEFREE DHB

On 31 October 2005, all CDHB grounds, buildings and facilities became totally smokefree. Consultation on the smokefree policy began back in 2003. In 2004, special areas were designated at each site where patients and staff could smoke. These areas were removed in 2005 and CDHB patients and staff are now benefiting from a smokefree environment.

## SUPPORTCARE – IMPROVING PALLIATIVE PATIENT CARE

The CDHB's new SupportCare system has been acknowledged by the Ministry of Health for significantly improving palliative care. Launched in May 2005, SupportCare End-of-Life and SupportCare Severe Medical Illness provides patients with the best possible access to the palliative services they require. Previously, funding for residential care for patients assessed as requiring palliative care services was diagnosis-based rather than needs-based, and was essentially restricted to cancer patients. Furthermore, it was difficult for palliative care patients to access home-based services as an alternative care option.

Under the new system, patients are provided with a range of services to meet their assessed needs. Options include a residential care facility or receiving 'packages of care' in their own home. Clinical assessment criteria have been developed and now all eligible patients (hospital and community-based) have equitable access to SupportCare services. Improved internal processes are also encouraging more effective communication between clinicians, care coordinators, patients and family/whānau regarding prognosis and treatment goals.



*Baby Chrystal Thoms holds a new Patch Bear at the launch of the Patch with Love paediatric programme, supported by Aaron Mauger from the Crusaders. The programme is organised by the Surgical Research Trust and sponsored by Pumpkin Patch. Every child under seven who requires an operation will receive a Patch with Love bear which they can take home.*

## Canterbury

District Health Board

Te Poari Hauora o Waitaha

## Infection Control Service

### Staff Policy Handbook

NAME:



*Dr Paul Gee and Barb Nelson with the Vocera devices – a winner at the CDHB Quality and Innovation Awards.*

### CDHB QUALITY AND PATIENT SAFETY COUNCIL

The Quality and Patient Safety Council was established in 2002 as part of CDHB's commitment to improving its health care services. The Council promotes quality improvements, information sharing and best practices throughout the DHB.

Its representatives come from the whole spectrum of health care, from general practice and community based services, to hospital and specialist services and the Christchurch School of Medicine.

The Council developed the CDHB Quality Strategic Plan 2004-2006 which provides the framework for a health care system that is focused on consumer needs and strives for continuous improvement. The Quality Strategic Plan has ten initiatives grouped into five goal areas and a work programme monitors the Council's progress against each of these five goals.

In the last 12 months, the Council has completed a stocktake of quality activities and reporting within community based services. A questionnaire was circulated to community providers and their feedback has helped the Council to gain a better understanding of what quality initiatives are already being undertaken in the community sector.

The Council has also been working to identify and develop Quality Clinical Indicators for the CDHB's four highlighted disease priority areas. Initial indicators for

Diabetes and Cardiovascular Disease have been agreed and reports are being developed. Work continues on indicators for Respiratory Disease and Cancer.

### CDHB QUALITY AND INNOVATION AWARDS

The CDHB Quality and Innovation Awards are sponsored by the Quality and Safety Council. They were first introduced in 2003 and are designed to recognise and publicly acknowledge the excellent quality, innovation and improvement initiatives generated by CDHB staff and community based services.

In the last three years, a total of 48 projects have been entered in the annual CDHB Quality and Innovation Awards and many have gone on to enjoy success at national and international levels, such as the New Zealand Health Innovation Awards.

In 2005, the Awards attracted 16 projects across three categories:

- 1) Clinical/Diagnostic: Community Based Services
- 2) Clinical/Diagnostic: Hospital and Specialist Service
- 3) Systems Improvement

The 'Supreme Award' winner and winner of the 'Clinical/Diagnostic: Hospital and Specialist Service' category was a project that reviewed red blood cell use at Christchurch Hospital in order to minimise wastage.

The 'Clinical/Diagnostic: Community Based Services' category was won by a project that looked at the use of

screening tools to identify and examine the possible presence of mental illness and suicide risk in new prison admissions.

In the 'Systems Improvement' category, the winning project piloted the use of the Vocera paging system to improve communication within the busy Emergency Department at Christchurch Hospital.

### NEW ZEALAND HEALTH INNOVATION AWARDS

The New Zealand Health Innovation Awards Ceremony, held on 29 June 2006 in Wellington, was once again an opportunity for the CDHB to showcase some of its leading health initiatives. Of the 25 finalists, six projects were from Canterbury, including the overall 'Supreme Award' winner – the SPRINT protocol for tight glycaemic control in critically ill patients.

The SPRINT system (Specialised Relative Insulin Nutrition Tables), which also won the Small Innovation Award (1-20 people) involves a simple spinning cardboard wheel that tells a nurse quickly and accurately how much insulin to administer and how much food to allow a patient, depending on their body size and latest blood-sugar reading. It is estimated the system could save more than 150 lives and \$3 million every year in New Zealand through better controlled diabetes in intensive care patients. SPRINT

EACH DAY IN CANTERBURY  
APPROXIMATELY:

267 PEOPLE ARE ADMITTED TO A  
PUBLIC HOSPITAL – 7 ARE AGED  
BETWEEN 10-14 YEARS WHILE 24  
ARE AGED 85 OR OVER

is a joint project between engineering staff and research students at Canterbury University and the Department of Intensive Care Medicine at Christchurch Hospital.

The winner of the 'Process Improvement' category was a project that looked at mental health screening in a women's prison. This project also won the 'Clinical/Diagnostic: Community Based Services' category at the 2005 CDHB Quality and Innovation Awards.

The CDHB was also awarded a Highly Commended in the 'Process Improvement' category with its blood usage project – 'Red blood cells making a little go a long way'.



The SPRINT team accepts the Supreme Award at the NZ Health Innovation Awards dinner (from left to right): Aaron Le Compte, Geoff Shaw, Geoff Chase, Tim Lonergan. Absent: Mike Willacy.

# OUR STRATEGIC OBJECTIVES

As part of its District Strategic Plan, A Healthier Canterbury: Directions 2010, the Canterbury District Health Board (CDHB) identified strategic 'Health Gain' priorities for the coming five years.

There are three population priorities:

- Child and Youth Health
- Older Person's Health
- Māori Health

There are two service priorities:

- Primary Health
- Disease Prevention and Management

The CDHB has also identified four disease priorities:

- Cancer
- Cardiovascular (heart) disease
- Diabetes
- Respiratory disease

These priorities are based on a Health Needs Assessment for the Canterbury district (completed in 2004), key government health strategies such as the NZ Health Strategy, Māori Health Strategy and the NZ Disability Strategy, and on feedback received during consultation on the CDHB's District Strategic Plan.



*Christchurch Hospital radiographer Tim Fogarty explains x-rays to Christ's College student Anthony Bell.*



*Christine Morris with PhD student So Young Moon (right), who is researching the genetic basis of chronic lymphocytic leukaemia.*



*Children celebrating Push Play Day – an initiative launched by SPARC and supported by DHBs to get young and old more active.*

# CHILD AND YOUTH HEALTH

In Canterbury, 28% of the population is aged 0-19 years. Of these, 77% identify as European, 11% Māori, 3% Pacific Island and 6% Asian. While the European child and teenage population rate is projected to decrease by 2021, population increases are expected for Māori, Pacific Island and Asian children and teenagers.

The CDHB's Child Health and Disability Action Plan / Mahere o te Hauora Tamariki me te Hauatanga (2004-2007 and beyond) is now in its third year of implementation. The focus continues to be on initiatives that meet the plan's ten priorities for improving children's health in Canterbury:

- Access to services
- Child health information
- Hearing
- Immunisation
- Injury prevention
- Mental health
- Nutrition and physical activity
- Oral health
- Parenting
- Smokefree environments



Children from Rangiora Borough School getting fit with 'Jump Jam'.

## PROMOTING HEALTHY LIFESTYLES

Over the last 12 months, the CDHB's Community and Public Health Team, Hauora Mātauraka and other community providers have put a lot of effort into promoting nutrition, physical activity and smokefree environments to Canterbury's children and young people. The Fruit in Schools programme is just one example, with ten schools from low socio-economic areas in Christchurch now taking part. Every child at these schools receives a piece of fruit every school day for three years. In return, participating schools agree to develop school-wide approaches to promote healthy eating, physical activity, sun protection and smokefree environments.

The Fruit in Schools initiative aims to promote health and wellbeing in primary school communities by establishing the groundwork for healthy eating and living patterns. It is a joint venture developed by the Ministry of Health, Ministry of Education, Sport and Recreation NZ (SPARC), the National Health Foundation, the Cancer Society, NZ Principals' Federation, NZ School Trustees' Association, District Health Boards and Regional Sports Trusts.

## IMMUNISATION

The Meningococcal B vaccination programme officially ended 30 June 2006, with more than three million Meningococcal B doses delivered nationally. In Canterbury 85% of the eligible population received dose one and 79.3% received all three doses of the vaccine.

The Meningococcal B vaccination programme provided an opportunity to roll out the National Immunisation Register (NIR). The NIR is a means of tracking a child so that, no matter where they might move within the country, all their immunisations will be recorded. In November 2006, the NIR was extended in Canterbury to include all newborn babies. The information provided by the NIR helps the CDHB to develop and measure its immunisation strategies as it works towards raising its coverage to reach the Ministry of Health target of 95%.

## EARLY START PROGRAMME EVALUATION

The five year evaluation of Christchurch's Early Start home visitation programme is now complete, with research

showing that it is one of the best programmes of its kind. Early Start was developed by the CDHB and a consortium of other community organisations to provide an intensive, home-based family support system that meets the needs of high-risk families and their children. Findings from the study showed that programme benefits were similar for Māori and non-Māori, with few detectable differences in outcomes. Specifically, the results suggest that mainstream programmes can be just as beneficial to Māori, provided these programmes are sufficiently sensitive to issues relating to Māori. Early Start invested in cultural training for all its workers, employed Māori staff and consulted widely with Kaumātua in order to create a programme that was culturally appropriate.

## YOUTH HEALTH

This year the CDHB has been developing its Youth Plan. While the plan is still in draft, three directions have been confirmed:

- *To provide a safer, more supportive environment for young people.* This involves improving school-based health services and access to primary care services. The CDHB is also looking to improve its links with youth health providers and other community services.
- *To show a measurable improvement in young people's mental health.* Currently the CDHB provides an extensive range of mental health services for children and young people and works closely with non-government organisations to provide youth respite and community support services. The plan aims to strengthen these links with other mental health service providers in order to improve accessibility and responsiveness. Improved management of suicide prevention and services for young people with drug

and alcohol problems will also be a focus.

- *To show a measurable improvement in young people's physical health.* This includes improvements in oral health, a reduction in sexually transmitted infections and unintentional pregnancies, lower rates of obesity among young people and an emphasis on more physical activity. Reducing smoking, alcohol consumption and illicit drug use are also priorities, as is improved management of young people with chronic or complex medical conditions.

The CDHB's Youth Plan is due for release in January 2007.

Also during the year the CDHB signed a Memorandum of Understanding (MoU) with the Collaborative for Research and Training in Youth Health and Development Trust. The Collaborative Trust's vision is to create a centre to promote and enhance the health and development of young people through research and education. The MoU formalises ongoing collaboration between the CDHB and the Trust.

Another MoU was signed with Auckland Uni Services Ltd, an umbrella organisation for the University of Auckland and the Paediatric Society of New Zealand, to take part in the New Zealand Child and Youth Epidemiology Study. The three year project aims to provide high quality child and youth health information to those working in the health sector. The first report is due in February 2007.

Increasingly, Christchurch is becoming a major paediatric centre in New Zealand, with additional demands placed on tertiary services to provide care for much of the South Island. The challenge for the CDHB is to balance these needs against those of its local population. In the year ahead, the CDHB will continue to improve its links with primary health care providers to encourage a team approach to the management of child and youth health.



Dr Sue Bagshaw and Gordon Davies signing the MoU, formalising ongoing collaboration between the CDHB and the Collaborative for Research and Training in Youth Health and Development Trust.

# OLDER PERSON'S HEALTH

Canterbury is faced with the challenges of an aging population – by 2021 nearly 20% of the region's population will be over 65. People over the age of 75 and those in the last year of their life consume significant health resources, which is why Canterbury District Health Board (CDHB) is putting plans in place now to meet population needs in the future.

The CDHB has developed a comprehensive Older People's Health Strategy – *Healthy Aging, Integrated Support*. The strategy is in line with the Ministry of Health's Older People's Strategy and aims to:

- Balance demand with funding
- Enhance community based services
- Strengthen primary care
- Foster an holistic model of care in the community
- Build on existing foundations
- Identify and promote greater efficiencies
- Reduce Emergency Department admissions
- Promote integration of services

Implementing the Older People's Health Strategy over the last 12 months has resulted in the following initiatives:

- Further development of home care packages as an alternative to residential care.
- An evaluation of entry criteria and access points to residential care.
- A review of community day support options, with plans to increase capacity for general and dementia stand-alone day activity centres.
- An increase in hospital dementia and respite care capacity.
- Transitioning of rest home beds to hospital level in order to meet service levels where the need is greatest.
- A map of service location, type and demographics which will help to improve planning for additional older people's services.
- An evaluation tool to measure progress against the goals and actions of the Older People's Health Strategy.
- A database that incorporates client claim processing, patient information and detailed analysis to identify entry, exit and length of stay trends in residential care.

## COMPLEX WOUND CARE FOR AGED RESIDENTIAL CARE FACILITIES

At the beginning of 2006, the CDHB, together with the Nurse Maude Association and Healthcare New Zealand, launched an initiative to improve access to complex wound care for subsidised residents in aged residential care facilities. The two year pilot project, a first in New Zealand, will also focus on mentoring registered nurses within residential care facilities to give them the confidence and knowledge to treat patients themselves.

While a full evaluation will be conducted, it is anticipated that this project will result in fewer residents developing pressure ulcers and other complex wounds. Improved wound management will also mean fewer admissions to secondary care.

## INTERNATIONAL RESIDENT ASSESSMENT INSTRUMENT – HOME CARE (INTERRAI-HC)

The two year trial of geriatric assessment tool, InterRAI-HC, was successfully completed within the proposed timeframe and budget, and is now approved for wider use within CDHB's Older People's Health Service. The InterRAI-HC system aims to improve coordinated clinical assessment by avoiding duplication and accidental omissions, and ensuring there is one integrated plan for each patient. It is an objective, standardised tool that helps to identify patient issues and suggests further actions. Taken as a whole, the information captured by the system also provides insight into the health needs of Canterbury's ageing population.

## ASPIRE RESEARCH PROJECT

The CDHB recently took part in the Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) pilot – a research project funded by the Ministry of Health to compare the Coordinator of Services for the Elderly (COSE) model of care with the existing Needs Assessment/Service Coordination model.

The COSE model works closely with General Practice to match services with needs. Results from the research, now available on the Ministry of Health's website, indicate that COSE is more successful in reducing the number of people entering residential care.



EACH DAY IN CANTERBURY  
APPROXIMATELY:

200 PEOPLE ARE SEEN IN THE  
EMERGENCY DEPARTMENT

#### HEALTHY EATING, HEALTHY AGEING NUTRITION INITIATIVE

A needs assessment completed by the CDHB identified that living alone and cooking for one is a key social and environmental factor associated with poor dietary intake in old age. It also highlighted a lack of written nutrition resources for older people.

In response to this assessment, and in conjunction with the Partnership Health Canterbury Primary Health Organisation (PHO), seven nutrition information pamphlets and a recipe book were developed during the year. The pamphlets cover topics such as healthy eating, shopping and cooking for one, fluid intake and how to gain weight.

The recipe book, entitled *Cooking for Older People: Easy Recipes for One or Two*, was made available free to older people living independently in the community who are at risk of poor nutrition.

The recipe book proved to be very popular and all 1000 copies from the initial print run were distributed. It has since been reprinted and is now available nationally for \$10 plus postage and handling.

The initiative has also secured additional funding from the Ministry of Health to continue its work on improving nutrition in older people living within the community and identified to be at risk.

#### MĀORI HEALTH WORKING FOR OLDER PEOPLE'S HEALTH SERVICE

CDHB's Older People's Health Service initiated a pilot to explore the need for a Māori health worker within the service, with particular emphasis on Māori admitted to inpatient units. This project proved successful and culminated in Te Huanui, the Māori Health Plan for older people. A Māori health worker has now been employed.

# MĀORI HEALTH

Māori health is a strategic priority for both the government and the CDHB. Around 34,000 Māori live in Canterbury, making it the ninth largest Māori population in New Zealand. In line with national trends, Māori living in Canterbury have, on average, the poorest health status of any group in the region.

The CDHB continues to make good progress implementing and completing projects that support its Whakamahere Hauora Māori ki Waitaha, Māori Health Plan. The plan, developed in 2002, has five directional priorities:

- **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

The Māori Health team at Christchurch Hospital is one example of an ongoing project that addresses several of these directions. Established nearly three years ago, the team has a Kaitiaki (guardian) currently working with Paediatrics to facilitate relationships and achieve better health outcomes for Māori patients. This year, two more Kaitiaki have been appointed to work in the Emergency Department, Oncology, Sexual Health and the Mortuary – service areas that require certain cultural protocols. The role of the Kaitiaki is to guide and support Māori through the hospital system, helping to improve both access to services and patient outcomes.

During the year Ranga Hauora staff at Burwood Hospital held a two day, marae-based Hauora Māori wānanga for clinical staff. The cultural awareness programme taught and assisted staff at Burwood to understand how Māori views and values can impact on their clinical practice.

## MĀORI MENTAL HEALTH

An orientation programme to coordinate and integrate Māori mental health providers was recently developed for new staff by Te Korowai Hinengaro Oranga ki Waitaha. Te Korowai is a Canterbury mental health provider network made up of the following organisations, many of whom are contracted to deliver community based mental

health services:

- Purapura Whetu Trust
- Te Awa o te Ora
- T Kakakura Trust
- Te Rito Arahi
- Te Tai o Marokura (Kaikoura)
- Te Toiora Arotake
- He Oranga Pounamu (Ngai Tahu)
- He Waka Tapu
- Te Korowai Atawhai (Hillmorton Hospital)
- Hauora Mātauraka
- STOP Trust

The new orientation programme provides recruits with a comprehensive introduction to the Māori Mental Health provider community in Canterbury and helps foster collaboration between the different providers. Eleven participants attended the first orientation programme, held over two days in July 2005. The programme is now a regular event and will run twice a year.

Te Korowai Hinengaro Oranga ki Waitahi has also contracted an external trainer to offer governance training to its provider network. Funded by the Ministry of Health's Māori Provider Development Scheme, the training is designed for Boards of Trustees and Managers, and covers topics from self analysis and strategic planning to financial management.

Fourteen people attended the first workshop in November 2005. Subsequent workshops will be delivered in 2006.

## SMOKEFREE

Smoking has been identified as a major issue for Canterbury Māori. Approximately 39% of Māori smoke and that number rises to more than 50% for Māori women aged 20 to 24 years. About 31% of Māori deaths are attributed to tobacco use.

Aukati Kaipapa is a smoking cessation service that provides free nicotine replacement therapy to people that want to quit smoking. The programme is open to all but specifically targets Māori women and their families. In what is an excellent example of collaboration with a Primary Health Organisation (PHO) to improve health gain within a high needs population, Partnership Health PHO recently

agreed to fund another quit coach to work with existing quit coaches from Community and Public Health's Māori Health Team, Hauora Mātauraḡa.

Hauora Mātauraḡa and Te Hotu Manawa Māori are working together to implement a smokefree marae campaign. In June 2006, Te Rangimarie Marae became the first smokefree marae in Canterbury, while Rehua and Rapaki marae have established designated smoking areas as a transition to becoming completely smokefree.

Smokefree Canterbury, a coalition of smokefree providers including community and public health, and Hauora Mātauraḡa, has also initiated an Auahi Kore pilot project in Hornby, aimed at reducing youth smoking. Māori youth typically begin smoking as early as 11 and 12 years old. The project focuses on reaching youth through whanau to promote healthy lifestyles by being smokefree.

### PANDEMIC PLANNING

To ensure the Māori community is suitably prepared for an influenza pandemic, Hauora Mātauraḡa has developed a presentation called '*Are our whānau ready? Are you ready?*' Presentations are being given to Ngāi Tahu papatipu rūnanga, Te Rūnanga o Ngā Maata Waka, Te Rūnaka Ki Otautahi, taura-here and other key Māori organisations. As well as emphasising the importance of being prepared, the presentation also looks at issues such as hui, dealing with tupāpaku (the deceased) and tangihanga (funerals) during a pandemic.

### TE HERENGA HAUORA O TE WAKA A MĀUI

The South Island Māori Managers Network, known as Te Herenga Hauora o Te Waka a Māui, is managing a number of projects to support Māori service provision in Canterbury.

These include:

- Te Waipounamu Māori Health Workforce Development Plan 2005-2010 – this is in the final stages of consultation and will be presented to Māori health service providers at the Hui Whakapiripiri Ratonga at Waikawa Marae, Picton in November 2006.
- Te Waipounamu Māori health training and education opportunities directory – this has been developed and is currently being distributed to Māori providers.
- A review of the Māori Provider Development Scheme (MPDS) in Te Waipounamu – this is now complete and will be released subject to discussions with the Te Kete Hauora at the Ministry of Health.

### NEW KAUMĀTUA

CDHB is pleased to welcome the Reverend Maurice Gray as the DHB's new Kaumātua. Reverend Maurice Gray is a highly respected and well known Kaumātua, both in Canterbury and nationally. He is available on an on-call basis.



Tug of War at the 11th annual Māori Sports Festival.

# PRIMARY HEALTH ORGANISATIONS (PHOs)

Since 2002, changes have been made to the way primary healthcare is funded and delivered in New Zealand. As part of the Ministry of Health's Primary Health Care Strategy, Primary Health Organisations (PHOs) have been created to help deliver primary health care services to the community. These services include initiatives to improve and maintain the health of the population, as well as first line services to restore people's health when they are unwell.

PHOs are not-for-profit organisations funded by DHBs. While membership is voluntary, primary health care practitioners and providers are encouraged to join. PHOs are also required to involve their communities in their governing processes.

CDHB funds five PHOs to deliver primary health care services to the region. Here the chairs of the PHOs talk about the year's highlights and achievements.

## PARTNERSHIP HEALTH CANTERBURY – TE KEI O TE WAKA PHO

Partnership Health Canterbury is New Zealand's largest PHO, with an enrolled population of just over 341,000, including more than 19,500 Māori and 7,000 Pacific people. Geographically, its population takes into account most of Christchurch and all of Lyttelton and Selwyn.

We work in partnership with our communities and more than 100 General Practices and other health centres to improve the health and well-being of the people enrolled with us.

The Meningococcal B vaccination campaign was one of Partnership Health's major projects over the last year. We are pleased to report that more than 80% of the under five year olds registered with Partnership Health are now fully vaccinated. We have also exceeded the Ministry of Health's target for babies aged between 0 and 11 months – 94% have started the immunisation programme.

We have continued to expand our smoking cessation initiatives. The PEGS (Preparation, Education, Giving Up and Stay Smokefree) programme developed by Pegasus Health General Practitioners has now been extended to all of our General Practices. More than 2,300 people were enrolled in the programme in the 2005/6 year, which has an average quit rate of between 22% and 33%.

We are working with CDHB's Māori Health Team, Hauora Mātauraka on their Aukati Kai Paipa programme to help Māori women to stop smoking. The average quit rate is 30% and our involvement has enabled the programme to expand its coverage in Canterbury.

Partnership Health is also involved in a pilot programme for people who, while in hospital, signal an intention to give up smoking. We help to ensure that they receive the support they need, once they are back in the community.

Physical activity and nutrition remain a core focus of our health promotion activities. We have expanded the National Heart Foundation's Healthy Heart Award programme to more early childhood centres across the region, with 94 centres now enrolled in the scheme. We have commissioned Sport Canterbury to undertake research into identifying the barriers for young females to exercise and we have been involved in the development of the CDHB's very successful recipe book, *Cooking for Older People: Easy Recipes for One or Two*, designed for older people.

We are also currently leading a 30 month project called CATINC (Community Action to Improve Nutritional Capacity), a joint venture between other PHOs in the region, the CDHB and the Ministry of Health. CATINC focuses on creating environments that support healthy nutrition and easy access to healthy food.

Establishing a Community Grants scheme was another key achievement for us during the year. To date we have awarded nine grants to community groups to help them deliver initiatives that promote healthy lifestyles.

Nearly 4,000 people have enrolled in CarePlus, a programme for people with high health needs. We also have more than 360 people enrolled in the Services to Improve Access programme, which is designed to ensure Māori, Pacific Island and low-income people in Canterbury are accessing the health services they need.

We are currently piloting PATHS, a programme to coordinate health services for those people receiving sickness or invalid benefits who would like to return to work. In the past year, 104 people have voluntarily enrolled in the programme and 17% have progressed into either part or full-time employment, or are working with a Supported Employment Agency.

In the coming year, our focus will be on mental health, child health and the care of people with chronic ongoing illness. We will also begin to implement our three year Māori health plan and will be investing resources into building up our workforce.

**Michael McEvedy**  
Chair

## CHRISTCHURCH PHO

The Christchurch PHO was established 1 October 2005, making it the region's newest PHO. It has an enrolled population of 25,271 who are serviced by 18 general practitioners and 63 practice nurses from five general practices:

- Casebrook Surgery
- Radius Linwood
- Moorhouse Medical Centre
- Riccarton Clinic
- University of Canterbury Student Health

In our first few months of operating, we focused on our role in the community and how we can deliver primary care programmes that meet the population's needs without duplicating services already being delivered.

During this period, we consulted widely with our General Practice teams, various community groups and other non-government organisation health providers to help establish where we should concentrate our efforts. Feedback from this consultation, and from a recently completed community consultation questionnaire, has highlighted the need to target Well Men and Well Women checks, extended consultations for mental health issues and Māori youth sexual health.

One of our core functions as a PHO is to reduce inequalities in primary health care access and delivery, particularly for Māori, Pacific Island and low income people. In order to prioritise funding of Services to Improve Access (SIA) and health promotion initiatives, we need to have accurate information about the people who are enrolled with us. Recording ethnicity data has therefore been a priority for our general practices this year, and we now have ethnicity data for 89.5% of our enrolled population.

In line with Government requirements, we have developed a Māori Health Plan to address inequalities and barriers to care for Māori. As part of the consultation process we held two hui – the first at Koukourarata Marae and the second at Christchurch Polytechnic Institute of Technology (CPIT). Our Māori Health Plan is now before the CDHB, for its consideration, and we have agreed to allocate one third of our Health Promotion and SIA funding to Māori health initiatives.

We have also implemented CarePlus, the national programme to help manage the health needs of people who have two or more chronic conditions. Eligible patients receive individualised care plans and subsidised visits to their General Practice team as international research shows that coordinating the care of individuals with ongoing illness can significantly improve their quality of life.

Our focus for the coming year is to establish closer working relationships with health providers and our community as we strive to provide appropriate and accessible health care for our enrolled population.

**Stephen Brown**  
Chair

## CANTERBURY COMMUNITY PHO

Canterbury Community PHO is funded to deliver affordable and accessible primary health care to low income and high health need groups. It is the region's smallest PHO with fewer than 6,000 people enrolled, over 50% of whom are Māori, Pacific Island, refugees, or reside in deprivation five or above areas of Christchurch.

Immunisation has been a major health promotion initiative for us during the last 12 months. The Meningococcal B vaccination programme was a significant project as we worked towards achieving Government targets for coverage. More than 71% of the under five year olds in our enrolled population have now received all three doses of the vaccination. Influenza vaccination was another key focus, with 61% of our over 65 year old population receiving their flu shot last winter.

We also achieved Cold Chain Accreditation (CCA) in November 2005. Through careful management of vaccine stocks in cold chain, the CCA process minimises the levels of vaccine wastage and helps ensure the effectiveness of vaccines.

We are working alongside other PHOs in Canterbury to implement CATINC, the initiative to support nutrition and easy access to healthy food. During the year we hosted two Community Health Days and two Men's Clinics



*Getting people active is a focus for all PHOs and the CDHB.*

to help promote healthy lifestyles and encourage preventative health practices.

As part of our requirement as a PHO to develop Services to Improve Access (SIA) initiatives, we have concentrated on projects that target young people. Under 18 year olds can visit a General Practitioner for free and we have been promoting this to the refugee communities in particular, to make them aware of the services available to them.

Following on from work we did last year to benchmark the oral health status of adolescents, we are now taking the lead on an Adolescent Oral Health Promotion project. The project involves all five Canterbury PHOs and aims to encourage youth to make the most of the free oral health services available to them.

Over the next three years, we will be making a concerted effort to implement our Māori Health Plan which covers four strategic areas:

1. Improving Māori health status
2. Finding better ways of working with Māori
3. Building relationships to determine Māori health needs
4. Workforce development and opportunities

We will also continue to roll out the Performance Management Programme to help our General Practice teams develop, evaluate and monitor their performance as they strive towards achieving best practice models of care.

**Andy Lea**  
Chair

## RURAL CANTERBURY PHO

With an enrolled population of 62,914, the Rural Canterbury PHO covers the area of Ashburton and Waimakariri District Councils and parts of Banks Peninsula. This includes the towns of Ashburton, Tinwald, Rakaia, Methven, Akaroa, Diamond Harbour, Kaiapoi, Rangiora, Woodend and Oxford. Twenty general practices with 41 general practitioners and 48 practice nurses service the area.

As with other PHOs, recording ethnicity was a priority for our general practices this year, and we now have ethnicity data for 93.5% of our enrolled population. This information will help us to make decisions on health initiatives, and has also been incorporated into our Māori Health Plan to address inequalities and barriers to care for Māori.

We are pleased to announce that our enrolled population appears to be close to the projected census figures for the region, which means we are meeting our requirement to ensure residents within our district are enrolled with a general practitioner.

In the last year we have continued to develop our relationships with various community groups and other non-government organisation health providers. We now have Memoranda of Understanding (MoU) with:

- Royal New Zealand Plunket Society
- Presbyterian Support (South Island)
- Nurse Maude

These MoUs help us to coordinate efforts and avoid duplication of services.

We have implemented CarePlus, the national initiative for people with two or more chronic conditions. This programme has had a slow start but we are now seeing a steady increase in enrolments across our district.

We have also implemented a mental health pilot that targets individuals who suffer mild to moderate mental health problems. Patients involved in the pilot are eligible for up to five free sessions of counselling and support, which can include General Practice visits. In January 2006, we employed a clinical psychologist to coordinate the project and provide supervision and clinical support to the three Brief Intervention Coordinators who started in early February. The Coordinators have spent significant time promoting this service to General Practitioners, local non-government organisations and community agencies.

At the beginning of the year we began the PHO Performance Management Programme, a Government and DHB-led initiative that aims to improve PHO performance in delivering services to their enrolled populations. As part of our commitment to meeting these performance management requirements, we have established a clinical governance group. This group, which has community, Māori, nurse and health provider representatives, will help foster teamwork and support us in our efforts to improve health outcomes for our population.

Looking to the future, we will continue to explore ways to extend our membership base and further enhance relationships with existing providers. Community consultation will also be a focus as we set the direction for service and health priorities.

**Dr Winston McKean**  
Chair

## HURUNUI KAIKOURA PHO

The Hurunui Kaikoura PHO covers an area of around 12,800 square kilometres, yet its enrolled population is only 12,700. The district also includes the towns of Kaikoura and Hanmer Springs whose many visitors place additional strain on health resources, particularly after hours.

We spent much of last year assessing how best to provide health services to our geographically dispersed population. Despite the challenges, we have reaffirmed our decision not to amalgamate with another PHO but instead remain a small, locally focused organisation. We felt it was sufficiently important for our rural community to retain its own voice rather than run the risk of losing it within a larger PHO.

In deciding to remain small, we still have unresolved funding issues as we try to make our budget stretch to meet the health needs of our community. We already have formal and informal links with other PHOs that help us run programmes we would not otherwise be able to fund.

Part of our role as a PHO is to help facilitate sustainable community health services. In a rural environment, this often means encouraging the community to become more involved in the provision of health care. Two of the six practices within the PHO are community owned and run as charitable trusts, with doctors employed on contract. This model of service may well represent the future of health care for rural communities which struggle to attract medical professionals.

Rural communities also rely heavily on the health services provided by non-government organisations (NGOs) such as Royal New Zealand Plunket Society and St John Ambulance. As well as supporting our General Practitioners, we are exploring opportunities to work more closely with these NGOs to ensure that the services they provide can be sustained.

Looking to the year ahead, we will be examining opportunities to maximise resources by working with other PHOs to implement health promotion initiatives such as a new smoking cessation programme.

**Richard Davison**  
Chair



*Physiotherapist Moira McDougall helps Timothy with his foot movements and balance at the Child Development and Therapy Centre.*

# DISEASE PREVENTION AND MANAGEMENT

Disease Prevention and Management is a 'Health Gain' service priority for the CDHB and, within this, four disease priorities are identified as requiring particular attention. The diseases, Cardiovascular, Cancer, Diabetes and Respiratory are all influenced by lifestyle choices. Public health education on the importance of healthy eating, physical activity and smoke free environments can make a difference to the rates of these diseases and the health status of the region's community as a whole.

## CARDIOVASCULAR (HEART) DISEASE

Cardiovascular disease includes coronary heart disease, other diseases of the heart and circulation, and stroke. Cardiovascular disease is the main cause of death in Canterbury, accounting for around 45% of female deaths and 41% of male deaths.

The CDHB has entered into an agreement with the National Heart Foundation, Partnership Health and Pegasus Health to undertake a home-based Heart Guide Aotearoa programme to support rehabilitation following heart attacks. It is anticipated that this programme will reduce the overall mortality rate of participants by up to 25% over one to three years. This work is ongoing.

While the CDHB funded project for local implementation of the Heart Foundation's Healthy Heart Award has now ended, the Community and Public Health team are continuing this initiative as part of their own portfolio and are still working with the Heart Foundation where possible. A Health Promoter is working with early childhood centres to encourage nutritionally healthy and physically active environments for children. Of the 49 centres working with Community and Public Health, 44 have registered for the Heart Foundation's Healthy Heart Award and 35 have achieved it.

During the year, a primary care-based cardiovascular risk assessment project was completed in Rangiora. Three general practices were audited to ascertain their current practice of screening for cardiovascular risk factors, the extent to which the information is standardised and the accessibility of the information from records.

The audit found that, while all three practices had high levels of recording information on age, smoking, cholesterol and blood pressure, their current practice for screening

for cardiovascular risk factors varied greatly. The audit also highlighted the need for additional IT support.

In the coming months, CDHB and primary health care providers will continue to roll out further stages of the Heart Guide Aotearoa programme to help provide rehabilitation for people who have suffered a heart attack.

## CANCER

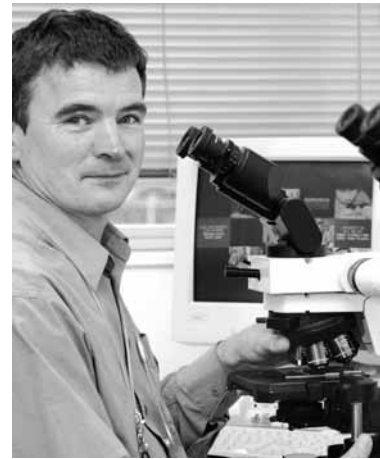
When all forms of cancer are grouped together, it is the second leading cause of death and a major cause of hospitalisation in Canterbury and New Zealand. Cancer rates in Canterbury will rise over the coming years as the region's population ages. However, due to improved treatment and early diagnosis, the risk of dying from cancer has not increased and some cancers, such as those associated with tobacco smoking, have declined.

This year CDHB has been working with other South Island DHBs on ways to implement the Government's national Cancer Control Strategy at a regional level. The Cancer Control Strategy is the first phase in the development and implementation of a comprehensive and coordinated programme to control cancer in New Zealand. South Island DHBs are in the process of establishing a Cancer Network whose steering group, made up of experts in the delivery of cancer services, will help advise on regional initiatives to meet the strategy's objectives.

One initiative already receiving funding through the Cancer Control Strategy is the Late Effects Assessment Programme (LEAP) for children and adolescents with cancer. More than 80% of young people with cancer survive and, as they transition into adulthood, many have chronic, treatment related conditions that need long term care.



*Grandparents were the focus of the 2006 Kids for Cancer Research Calendar.*



*CDHB Anatomical Pathology Department head, Martin Whitehead, examining breast cancer slides*

EACH DAY IN CANTERBURY  
APPROXIMATELY:

4,020 PEOPLE ARE  
SEEN IN GENERAL  
PRACTICE SETTINGS

The LEAP initiative was formally launched in June 2006 and a LEAP clinic has been established in Christchurch to help monitor and support children and adolescents who have completed active cancer therapy.

The Oncology Service at Christchurch Hospital also successfully sought funding through the Cancer Control Strategy for its Radiation Therapist New Graduate Integration Programme. The aim of the Graduate Programme is to enhance the practical skills of graduates, enabling them to integrate more easily without putting additional pressure on the clinical team. This six month pilot enabled the Oncology Service to employ two graduates over and above its full-time employee quota.

Cancer Control is an organised approach to reducing the burden of cancer through prevention, screening and early detection, diagnosis and treatment, support and rehabilitation, palliative care, and data collection and research. In the coming year, CDHB will implement further initiatives that meet the strategy's aim of reducing both the incidence and impact of cancer, and inequalities of care.

## DIABETES

Diabetes is estimated to cause around 1,200 deaths per year in New Zealand and managing diabetic complications (such as heart disease, blindness and kidney failure) is a significant burden for the country's health system.

According to Diabetes New Zealand, there could be as many as 31,000 people with diabetes in Canterbury.

The region has one of the highest rates of diagnosis for Type 1 diabetes in young people. Increasing rates of obesity mean that even Type II diabetes, most frequently diagnosed in adults, is now more common in Canterbury's children and youth. It is this increase in Type II diabetes, linked to poor nutrition and smoking, that is of greatest concern.

CDHB's Diabetes Centre and Community and Public Health's Diabetes Life Education team work closely together to meet diabetes screening and management targets. This year initiatives included podiatry clinics in community settings to target high-risk populations. People with diabetes can suffer from foot problems, including poor circulation, nerve damage and ulcers. The clinics offered free foot care assessments, treatments and education provided by a podiatrist. A stall was also set up at the Christchurch A & P Show in November 2005 and 300 people were provided with foot care packages.

Another initiative was CDHB's Community and Public Health Healthy Lifestyle project with Christchurch's Methodist Mission. As well as helping food bank users to gain knowledge and skills to improve their own health, the programme also assisted the Methodist Mission to become a more health-promoting employer, supplier and service to the community.

The Healthy Lifestyle project was conducted over nine weeks and the women who participated in the final assessment displayed improved fitness and a modest reduction in body mass index. As part of the programme, the Mission reviewed its policies and improved the nutritional



EACH DAY IN CANTERBURY  
APPROXIMATELY:

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215 PEOPLE ARE  
ADMITTED OR SEEN  
FOR ELECTIVE  
SURGERY



*Dr Jan Bone, and Dr Anne Marie Guiney at work on a manikin*

content of its food parcels. It also altered the food and beverages made available to staff and the public.

CDHB's new Diabetes and Home Dialysis Training Centre is all but complete and, in the coming year, Diabetes Services, Diabetes Life Education and Diabetes Christchurch (the local branch of Diabetes New Zealand) will all benefit from greatly improved administrative, education and patient facilities.

### RESPIRATORY DISEASE

The CDHB recently identified respiratory disease as one of its four main disease priorities and, as an initial step, conducted a review of work currently being undertaken to meet this priority. Findings from the research highlighted three areas within the CDHB that are involved in the management of respiratory diseases:

- Community and Public Health
- Primary Care (PHOs and NGOs with CDHB contracts)
- Secondary Care and Specialist Services

Community and Public Health, together with its Māori Health team, Hauora Mātauraka, and primary health care providers, are collaborating on a range of initiatives that include promoting smokefree environments and smoking cessation services. Community and Public Health is also working with Territorial Local Authorities and Christchurch City Council on a Healthy Housing project. The project looks for collaborative solutions to help improve air quality and create warm, dry homes for the elderly, the very young and low income groups. A research project is also underway to monitor 100 homes where there is a child diagnosed with asthma.

CDHB's Hospital and Specialist Services provide a range of services to help manage respiratory diseases. These include outreach services, diagnostic testing, pulmonary rehabilitation classes, a sleep laboratory (part of an integrated service for Obstructive Sleep Apnoea Syndrome) and the South Island's only bronchoscopy service.

In the coming year, CDHB will formalise its strategy to help manage respiratory disease in the region.

Looking to the year ahead, smoking cessation, healthy eating and physical activity to curb obesity remain a focus for the CDHB. Current trends indicate that by 2011, 29% of New Zealand's adult population will be obese. This has significant implications for rates of cardiovascular disease, Type II diabetes and some cancers. The CDHB is therefore increasing its levels of collaboration with primary health care providers and NGOs to promote population-based interventions that encourage healthy eating and increase physical exercise.

## OTHER PRIORITIES: PACIFIC PEOPLE'S HEALTH

The CDHB is one of seven DHBs with specific responsibility for addressing Pacific Health inequalities. In 2002, the Pacific Health & Disability Action Plan was released, setting the strategic direction for improving health outcomes for Pacific peoples. The priorities are:

1. Child and youth health
2. Promoting healthy lifestyles and well being
3. Primary health care and preventive services
4. Provider and workforce development
5. Promoting participation of disabled Pacific peoples
6. Health and disability information and research

The Pacific Health & Disability Action Plan was strengthened recently with the signing of a collaborative agreement between the CDHB, the Christchurch City Council, the Canterbury Development Corporation and the Ministry of Pacific Island Affairs. The agreement commits all parties to six-monthly meetings and provides the CDHB with a regular opportunity to report on how it is meeting the priorities identified in the plan.

Over the last year, the CDHB, Pacific Trust Canterbury and other community health providers were heavily involved in the Meningococcal B vaccination campaign. The Pacific Health providers worked closely with Pacific communities to

emphasise the importance of receiving all three doses of the vaccination and, as a result, 98.2% of Pacific people in the 5-17 year age group completed the full vaccination programme.

Initiatives that encourage healthy lifestyles have also been a focus for Pacific Health providers. In conjunction with Tagata Atumotu and Matua Pasifika, Pacific Trust Canterbury is running workshops on healthy eating and healthy action. Held in community halls four times a week, the workshops are designed for parents, grandparents and their children. They are proving to be very popular, with 20-50 people attending each session.

Pacific Trust Canterbury recently launched a similar nutrition and physical activities programme for Pacific youth and children in Canterbury, working with schools and language nests. A programme that focuses on reducing the numbers of Pacific people who smoke is also planned.

As part of its commitment to providing quality services, the Pacific Trust Canterbury in its Pacific Health Clinic has completed an external audit for Cornerstone Quality Accreditation from the Royal College of General Practitioners. The accreditation process is helping the Trust to review its processes for improving services.



*Daisy Jamieson gets her flu vaccination from Sjaak van den Blom, nurse at the Pacific Health Clinic, 163 Worcester Street, Christchurch*

# ORAL HEALTH

In 2005, the Government announced significant additional funding for child and adolescent dental health, with \$100 million earmarked to upgrade facilities nationally. This year a further \$40 million of operational funding was allocated to support this major reform of the country's oral health systems. The reform includes a move away from old-fashioned school dental clinics to modern community oral health services with an increased emphasis on prevention.

The new model of service involves close collaboration with a range of providers, including Māori and Pacific providers, PHOs and private dentists. It will create a community focused service and will address inequalities faced by Māori, Pacific, rural and low socio-economic populations.

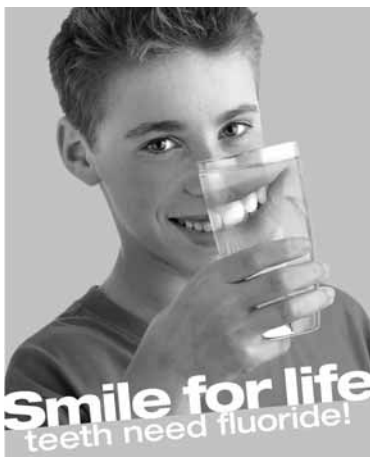
The Canterbury and South Canterbury DHBs currently spend nearly \$10 million each year to provide dental treatment for children and adolescents. Even with advancements in dental technology, the need for clinical intervention is still increasing.

In May 2006, the CDHB's Community and Public Health, and School and Community Dental Teams launched the Smile for Life oral health initiative. Funded by the Ministry of Health, Smile for Life aims to combat the epidemic of tooth decay in the region. Approximately 230,000 households, boxes and rural addresses in Canterbury and South Canterbury received a copy of the 'Smile for Life' pamphlet in their letter box, providing information on the importance of a good diet and fluoride for healthy teeth.

The CDHB has also entered into a two year agreement with the Ministry of Health to provide a PHO-based initiative to reduce the high levels of dental decay in adolescents within socially disadvantaged families. The initiative encourages collaboration between CDHB's School and Community Dental Service, oral health providers and PHOs, with Canterbury Community PHO taking the role of lead provider.

EACH DAY IN CANTERBURY  
APPROXIMATELY:

—————  
\$2.75M IS SPENT ON  
HEALTH SERVICES



*Smile for life pamphlet.*



*Lyttelton children received the Smile for Life pamphlet.*

# RURAL HEALTH

Rural Health Services are responsible for the services provided by hospitals in Ashburton, Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari. This large area has a diverse range of needs and faces the additional challenge of balancing service level expectations with what is clinically viable in a local setting.

In Ashburton, service delivery challenges, coupled with ongoing difficulties in recruiting house surgeons and senior medical staff for Ashburton Hospital, has prompted a wider review of health services for the district. Following public consultation in 2005, an integrated model of care was developed and will be implemented over the next one to three years.

The new integrated model of care aims to provide Ashburton with a safe and sustainable health service. For Ashburton Hospital this means addressing staff recruitment issues by engaging a medical officer workforce to replace house surgeons. There will also be a focus on day and short stay services, and developing local services that reduce the need for people to travel to Christchurch. For example, more visiting specialist clinics will be scheduled, and Ashburton Hospital recently received a new CT Scanner which will save an estimated 450 patients a trip to Christchurch each year.

Ashburton Hospital has also rolled out PACS, the picture archiving and communication system. PACS digitises images, eliminating the need for film and significantly improving turnaround time. Images that previously had to be couriered can now be sent electronically, arriving at their intended destination in a matter of minutes.

The integrated model of care also aims to strengthen relationships and collaboration with the primary health sector and, in particular, the PHOs. Three PHOs operate within the area covered by Rural Health Services – Partnership Health, Rural Canterbury and Hurunui Kaikoura. As well as providing primary health services (through general practices and other providers), the PHOs are involved in a number of local Health Promotion initiatives and Services to Improve Access (SIA) programmes. These include:

- A mental health pilot with the Rural Canterbury PHO that provides brief intervention for people with mild to moderate mental illness. Patients involved in the pilot are eligible for up to five free sessions of counselling



and support. The service also funds extended General Practitioner sessions.

- CarePlus, a PHO-wide initiative that monitors and supports people who have two or more chronic conditions. Eligible patients receive tailored care plans and subsidised regular visits to their general practice team. Darfield's general practice, one of the practices within the Partnership Health PHO, has been particularly proactive in identifying eligible patients and implementing CarePlus.
- The Meningococcal B vaccination programme. Hurunui Kaikoura PHO was particularly proactive, achieving over 80% vaccination rates for the under five year old age group.
- A diabetes check programme initiated by the Rural Canterbury PHO for the freezing works in Ashburton, which has a very high proportion of both Māori and Pacific staff.
- A series of cultural training sessions for practice nurses, practice managers and administration managers. The sessions are run by the Rural Canterbury PHO with the support of the Canterbury Community PHO and the CDHB Cultural Advisor in Ashburton.

In the coming year, Rural Health Services plans a similar review of health services in Kaikoura. The district's popularity as a tourist destination places its health system under pressure, particularly out of hours. In order to meet the region's ongoing needs, the current services and facilities need to be updated. As with Ashburton, this review will be undertaken in consultation with the wider community and primary health care providers.

# MENTAL HEALTH

The CDHB's Mental Health and Addiction Strategy, released in 2004, marked a shift away from tertiary and secondary health services towards a community-based system of care with increased collaboration between providers, patients and their families/whānau.

In the last 12 months CDHB's Specialist Mental Health Service (SMHS) has furthered this strategy with projects that improve access and responsiveness.

SMHS continues to focus on issues identified through a national initiative to improve patient care. Several bottlenecks have been pin-pointed within Adult Mental Health Services and work has begun to streamline the patient journey through a single point of entry. All referrals will be assessed by one team and then sent on to the appropriate service. Not only will this improve access, but it will also reduce duplication and provide for a better use of resources.

A similar single point of entry model has also been adopted by Child, Adolescent and Family Services, as part of wider changes to the unit's overall structure. Historically, child and adolescent services were grouped together with some adult services within the Family Mental Health Service. However, after a recent review, Family Mental Health's adult services were realigned into the existing Adult Mental Health Services, and the Child, Adolescent and Family Services group was established.

SMHS recently conducted a scoping exercise to establish key development issues and needs facing the Regional Forensic Service over the next five years. Information from this exercise will now help to set the strategic direction for the service.

In 2005/6 CDHB was allocated \$2.8 million additional funding through the Government's 'Blueprint for Mental Health Services in New Zealand'. The Blueprint is a national mental health planning framework that identifies necessary services for an effective mental health system. The additional funding enabled significant investment in new community mental health services for the Canterbury district including:

- Addiction treatment services for women
- Crisis and planned respite services
- Pacific child and youth mental health services
- Māori mental health services for tamariki and rangitahi

- Alcohol and other drugs advocacy and peer support
- Mental health services for older people
- Increased consultant psychiatry for maternal mental health services
- Community Support Worker Services
- Peer Support Services
- Mobile Medication Service
- Community Integration Service
- Home Rescue Services

Three of these initiatives are demonstration services – innovative new services unique to Canterbury.

- The pilot Mobile Medication Service provides targeted support to those who are acutely unwell, or have enduring mental health needs and only require assistance with taking medication.
- The 24 month Community Integration demonstration service was developed in response to feedback indicating that a shortage of community options is a barrier to people moving on from residential services. The pilot works with individuals with severe mental illness who are in existing residential or inpatient services to help facilitate their move on to more independent arrangements. By creating flexible and tailored support, this initiative is helping to ensure more people are able to access the services they require.
- The Home Rescue Service provides support to people who have a history of repeatedly losing their accommodation during periods of illness. This demonstration service provides practical support to assist people to retain their accommodation and has a strong preventative focus using advanced directives.

All demonstration services will be formally evaluated during the contract period.

# ONGOING WORK

## PANDEMIC PLANNING

In response to worldwide concerns over the H5N1 strain of influenza (commonly referred to as Bird Flu), the CDHB, together with primary health care organisations, has established a Pandemic Planning Group and developed a strategy to deal with the possibility of an influenza pandemic.

Going on historical patterns, influenza pandemics can be expected to occur, on average, three to four times each century. The current World Health Organisation position is that the H5N1 influenza virus causing high mortality rates in birds and some humans (who have had close contact with sick birds) could acquire the ability to transmit readily from human to human. If this occurs, a pandemic is likely, given that there is no natural immunity in the human population to this particular strain.

The Pandemic Planning Group is led by Dr Nigel Millar, Chief Medical Officer, and is under the coordination of Baden Ewart, General Manager of Pegasus Health. The CDHB will be the region's lead agency in a national health emergency. However, primary care services will play a key role in minimising the effects of a pandemic. Hospitals, while important, will really only be effective as back-up support to health providers in the community, who will be on the 'front line' of health care.

In the event of a pandemic there will be a two-stream approach to health services. The 'Green' stream will provide essential core health services to people not affected by influenza. People will still suffer health emergencies unrelated to the pandemic and it is important to ensure that acute health services are still available to them.

The 'Red' stream will focus on responding to the needs of people with influenza or influenza driven complications of a pre-existing illness. Community based assessment centres will be set up to treat people.

The main hospital services will be similarly split to ensure that there are, as far as possible, influenza-free areas for management of acute illness, with the remainder being allocated to care of people with influenza complications.

## IMPROVING THE PATIENT JOURNEY

Launched in July 2005, 'Improving the Patient Journey' is a long term initiative that explores ways to improve services to patients. It is led by the CDHB and involves

other service providers and Non-Government Organisations in a review of the system of care from the patient's perspective, right from the onset of illness, through the stay in hospital to recovery at home.

The key principles of the project are:

- *Lean thinking / waste minimisation* – developing processes where resources meet needs at each point
- *Whole system thinking* – viewing the process of care as a whole and not as departments
- *Constraints theory* – applying proven analysis tools to the data generated
- *Adult learning principles* – sharing the thinking and learning.

There are eight work programmes:

1. The Diagnostic Phase
2. The Emergency Department (ED)
3. The Operating Theatre
4. The After Hours Model of Care
5. The General Surgical Acute Patient Flow
6. Capacity Planning
7. The Radiology Review
8. The General Medical Programme

This work will form the basis of the CDHB's major quality and patient improvement work for the next two to three years. The aim is to identify delays that occur because of constraints in the system, so that processes can be redesigned for a smoother, more efficient journey for the patient.

The ED has been a focus over the last 12 months, with several initiatives helping to improve patient flows. New acute clinical pathways have been established, along with improved communication processes (including a colour coded queue screen) and overcrowding risk management tactics. A nurse-initiated discharge process has now been implemented in medical and surgical services and the recently opened Acute Medical Assessment Unit, made up of a team of senior doctors and nurses, is also helping to improve patient flow.

Another initiative implemented in ED is the Front Door Physio. Audits of patient activity suggested that, over an eight hour period 30-40 patients could have been referred to a physiotherapist, had one been available. Instead, the majority of these patients had to wait for extended periods

of time before being discharged without assessment, or admitted to Christchurch Hospital. By providing a physiotherapist in ED for eight hours, seven days a week, the Front Door Physio project helps to move patients through ED more quickly, reducing their length of stay and streamlining the referral process. The project also helped to reduce the number of admissions to Christchurch Hospital. After the success of its six month pilot, the Front Door Physio is now a permanent service in ED.

All these initiatives have resulted in reduced waiting times for patients in ED. Now 83% of patients are seen, treated and discharged or admitted within four hours of arriving.

An audit of the night shift model of care is now complete and its findings have prompted the establishment of a multi-disciplinary night team and a standardised handover process (that is now being piloted). A night team coordinator position has also been created.

The CDHB has started reviews of Access to Acute Theatre, and Acute Demand and After Hours Services in Primary Care. A Surgical Progressive Care Unit for patients requiring a high level of nursing attention (but who do not require intensive care) is also being developed and will open next year.

While the Improving the Patient Journey project now has strong support within the CDHB, in the coming year the focus will be on incorporating PHOs as key partners in the management of demand. To help achieve this, three new work programmes will be added to the project:

1. Health Services Planning – for the whole sector, not just hospitals.
2. Acute Demand Management – what can be done in the primary health sector to reduce the number of people needing to go to hospital.
3. Chronic Illness Management – once again, the focus is on what can be done in the primary health sector.

## PROFESSIONAL DEVELOPMENT AND RECOGNITION PROGRAMME FOR CLINICAL NURSES

A Professional Development and Recognition Programme for clinical nurses is now up and running with the Canterbury and West Coast DHBs. Developed in partnership with New Zealand Nurses Organisation (NZNO) the programme recognises and rewards nurses who demonstrate competent, proficient or expert/accomplished levels of clinical practice. The programme has also received verbal endorsement from the Nursing Council of New Zealand, which means any nurse who is successful in the programme can renew their annual practicing certificate without being subject to random audit by the Council.

Currently 22 nurses have achieved competency, 41 have achieved proficiency, 13 have achieved expert and seven have been recognised as accomplished.

## CANTERBURY HEALTH LABORATORIES

Canterbury Health Laboratories (CHL) is regarded as the premier referral medical laboratory in New Zealand. In 2005/2006 CHL completed 3.5 million tests, bringing in more than \$14M in external revenue to the CDHB (a 9% increase on the previous year). This revenue is mostly for specialist testing. CHL performs more than 1,000 different tests, around 800 of which are specialised, non-scheduled tests that are labour-intensive and require a high level of skill. Twenty three public hospitals and private laboratories around the country refer specialised tests to CHL.

The New Zealand medical laboratory sector is undergoing changes as District Health Boards examine ways to reduce or contain the costs of growth through rationalising community and hospital testing and private and public laboratories. The CDHB is currently conducting a Community Laboratory Services Review and has consulted widely with stakeholders and external experts to determine the structure of future laboratory services for the region.

## STRATEGIC HEALTH INVESTMENT FUND

The Strategic Health Investment Fund, established by the CDHB in 2002, aims to address health priorities. The availability of funds for distribution is determined annually and \$897,477 was allocated in 2005/06 on the following initiatives:

- Supporting the Acute Stroke Unit at Christchurch Hospital
- Canterbury Asthma Society's pre-school asthma programme, 'Baxter Bear'
- A community coordinator to help coordinate packages of care for older people in the community
- Deep Vein Thrombosis assessment and treatment
- The Aranui Nursing Project – a three year pilot to improve access to primary health care services in high needs areas
- A part-time Health Economist
- The Heart Foundation and Community and Public Health's Under Fives Healthy Heart Award programme
- Heart Guide Aotearoa – CDHB is one of five DHBs working with the Ministry of Health to deliver this programme
- Implementing and evaluating the InterRAI HC geriatric assessment tool
- Medication Management Project – a pilot targeting at risk patients
- Oral Health Services for the elderly
- The Pacific Trust Canterbury's Pacific Child and Family Support Service.

# STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE

1 JULY 2004 – 30 JUNE 2005



*Aranui Primary School children lining up for their Meningococcal B shot.*

# STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2004/05

All District Health Boards are required to produce three major accountability documents:

- *A District Strategic Plan* – a long-term strategic document outlining the DHB's intended direction and vision for the next five to ten years. This document is produced through a public consultation and health needs assessment process and enables the DHB to determine key priorities for focus;
- *A Statement of Intent* - a high level outline of the planned objectives and direction for the coming three year period. This document is produced for Parliament and contains the DHB's Statement of Objectives and Service Performance determining the performance targets the DHB needs to meet to achieve its long term goals outlined in its District Strategic Plan; and
- *A District Annual Plan* - a more detailed document outlining the intended actions and activity planned to progress the long-term direction and achieve the objectives outlined in the other two documents.

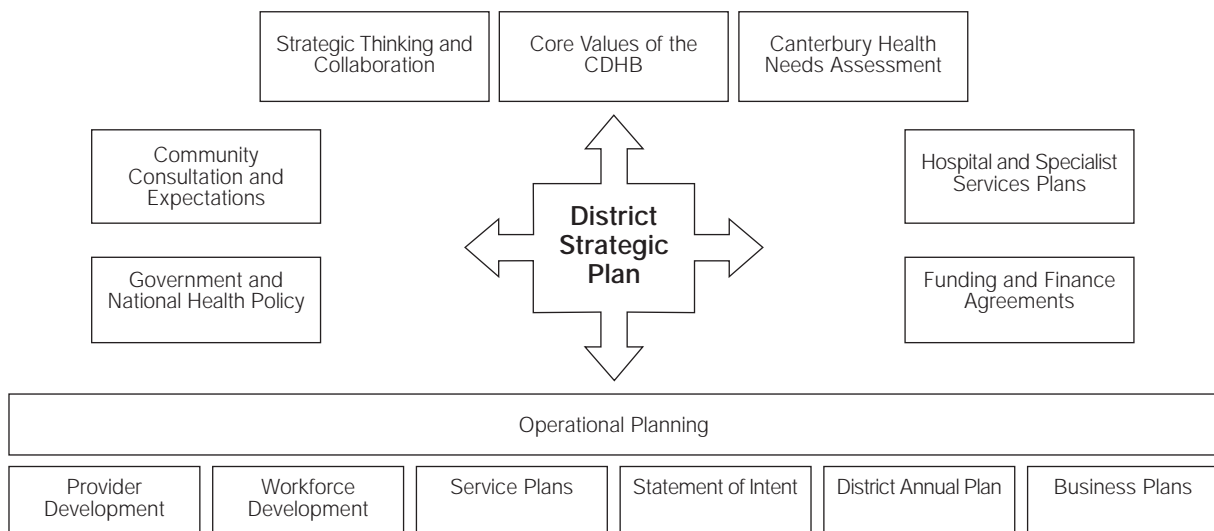
In their Statement of Intent (SOI) DHBs are required to clearly state their objectives, how these objectives are to be measured, and set the targets to be achieved. The aim of this section (*the Statement of Objectives and Service Performance*) is to demonstrate how the DHB's activities will affect its primary objective of improving the health and wellbeing of its community.

The actual performance against these measures is independently audited on an annual basis, and published in the DHB's Annual Report becoming the assessment of the DHBs non-financial performance. This is that assessment.

The measures included in this document reflect activity in the priority health areas identified in the DHB's long-term District Strategic Plan. This activity requires the DHB to find better ways of working, to develop models of service integration, develop Canterbury's health care workforce and to provide leadership in the health and disability sector.

When the CDHB updates its SOI documents it continues to develop and refine the measures for its *Statement of Objectives and Service Performance* that are appropriate to the needs of its stakeholders within government and within its community. Where possible, past performances for each measure are included, along with the 2005/2006-performance target and result to give the measurement context.

The targets provided by the DHB are based on the assumption that, notwithstanding funding and financial pressures, the DHB will be able to maintain current levels of service provision in the medium term. While the CDHB transitions to a fair share of funding under the Population Based Funding Formula the scope for service expansion is limited, therefore performance targets tend to reflect the objective of maintaining current performance levels.



## Strategic Priorities and Directions

To achieve its primary objective, to improve the health and wellbeing of people living in Canterbury, the CDHB determined to focus on achieving improved outcomes in five priority areas. These areas were identified through a health needs assessment and consultation process during the development of the DHB's five-year District Strategic Plan in 2001 Towards A Healthier Canterbury; Directions 2006. The priority areas chosen were:

- Child and Youth Health;
- Primary Health;
- Māori Health;
- Mental Health; and
- Disease Prevention and Management – focusing on Cardiovascular Disease, Diabetes and Cancer.

In addition, older person's health, elective services, hospital efficiency and effectiveness and good governance represented further areas of focus in 2005/2006.

In improving health outcomes in these priority areas, as well as in its other areas of work, the CDHB has focused its efforts around five Core Directions also chosen during the development of its District Strategic Plan in 2001:

- Improving the health status of our community - improve the health outcomes for specific groups of the Canterbury population.
- 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 healthcare 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.

### Overview of Performance

The following table provides an overview of the CDHB's performance for the 2005/2006 year. Where there is more than one performance measure for an objective, or where results are broken down by ethnicity, a tick in the box indicates a good overall result for that associated objective. For a complete breakdown of these indicators please see the full report that follows.

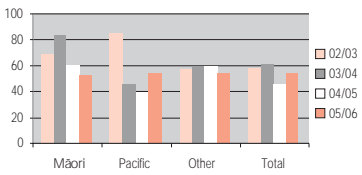
The indicators in the full report reflect the performance measures specified in the CDHB's 2005/2008 SOI (unless otherwise stated), and reflect the CDHB's District Strategic Plan priorities. The performance measurements, outlined in the Statement of Objectives and Service Performance, are loosely grouped under three output classes and these are reflected in this document:

- Funding and Performance (Strategic Plan Health Gain Priorities);
- Provider-Hospital and Specialist Services; and
- Governance.

It should be noted that the number of Pacific people in the Canterbury region is small (7254 at the 2001 Census) so the percentages shown under this ethnicity breakdown should be interpreted with caution. For some measures the results involve low numbers which may result in variability in reported results.

## 1. Funding and Performance: Strategic Plan Health Gain Priorities

### 1.1 Child and Youth Health

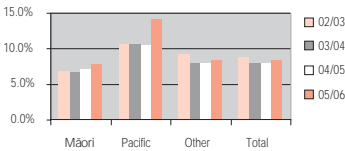
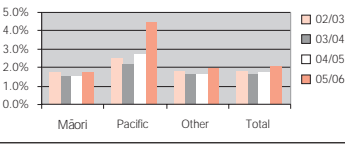
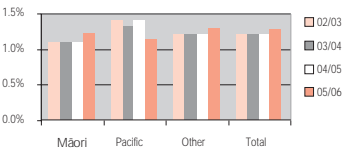
Objective:	Brief Description:			
Improved health status for Canterbury's Children and Youth.	<p>Keeping children and youth healthy gives them a better chance of becoming healthy adults. The Canterbury District Health Board (DHB) completed a Child Health and Disability Action Plan (in June 2004) to address the specific health issues of children in Canterbury. The Action Plan targets ten key priorities: access, information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments.</p> <p>It is important to note that due to the lack of fluoridation of public water supplies oral health outcomes for Canterbury children are getting worse, particularly in low decile areas. The CDHB agreed a Position Statement on fluoridation in 2003 (available on the DHB website) and is actively promoting fluoridation.</p>			
Objective 2005/06	Performance	Baseline 04/05	Target 05/06	Result 05/06
Reduced number of low birth weight babies	Measure Number of babies born in public hospital with low birth weight (rate per 1000 births). 	<ul style="list-style-type: none"> <li>• Māori 60</li> <li>• Pacific 39</li> <li>• Other 59</li> <li>• Total 45</li> </ul>	<ul style="list-style-type: none"> <li>• Māori &lt; 72</li> <li>• Pacific &lt; 44</li> <li>• Other &lt; 58</li> <li>• Total &lt; 60</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 52</li> <li>• Pacific 53</li> <li>• Other 54</li> <li>• Total 54</li> </ul>
	<p>The overall number of lower birth weight babies per 1000 births has increased on last year's levels. However, the Canterbury rate for all groups is better than the national average of 60. Pacific babies are the only ethnic group where performance is worse than target.</p>			
Minimised impact of hearing loss in children	Percentage of children passing school entry hearing tests.  <i>Early detection of hearing problems facilitates early intervention and allows the impact to be minimised.</i>	<ul style="list-style-type: none"> <li>• Māori 93%</li> <li>• Pacific 90%</li> <li>• Other 95%</li> <li>• Total 95%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 92%</li> <li>• Pacific 88%</li> <li>• Other 95%</li> <li>• Total 95%</li> </ul>	Unavailable
	<p>The National Audiology Centre is currently processing the data but figures were unavailable to the DHB at the time of preparing this report.</p>			
Improved child oral health	Average proportion of Missing or Filled teeth of year 8 children. <sup>2</sup>	Total 1.58	Total 1.6	Unavailable
	Percentage of children caries free (no fillings or holes in teeth) at age 5.	Total 51%	Total 52%	Unavailable
<p>Due to a failure in the system collecting the data associated with this measure, performance cannot be reported for 2005/06.</p>				
Implement the Meningococcal B (MeNZB) Immunisation Project	Percentage of children between 6 weeks and 5 years of age who have received their 3rd dose of the MeNZB vaccine.	N/A	Total 90%	Total 77%
	Percentage of school enrolled children who have received their 3rd dose of MeNZB vaccine.	N/A	Total 90%	Total 86%
<p>While the 90% target has not been achieved a positive trend is noted where two PHOs (including our largest PHO – with 78% of Canterbury residents enrolled) have reached 80% of under five year olds for dose three. The national benchmark for this indicator is 75.5%.</p> <p>While, again, the 90% target has not been achieved the national benchmark for this indicator is 86%. The national benchmarks for these two MeNZB indicators are particularly important in that Canterbury was the last DHB to roll-out the project and has only been running for 55 weeks while some DHB's rolled out the project six months before Canterbury.</p>				

<sup>1</sup> www.cdhb.govt.nz

<sup>2</sup> The total permanent teeth missing or filled due to holes divided by the number of children seen by school dental services during the period.

## 1.2 Primary Health

<b>Objective:</b>	<b>Brief Description:</b>
Reduced barriers to primary health care.	Reducing the barriers to good primary health care helps people stay well resulting in improved health status. During the 2005/2006 year the CDHB focused its primary care activities on the following: <ol style="list-style-type: none"> <li>1. Implementation of the government's national Primary Health Care Strategy via the ongoing development of Primary Health Organisations (PHOs) within Canterbury for those populations with the greatest barrier to Primary Care; and</li> <li>2. Implementation of the CDHB's Rural Health Services Action Plan (2002) ensuring equitable access for rural based communities.</li> </ol>

Objective 2005/06	Performance				
	Measure	Baseline 04/05	Target 05/06	Result 05/06	
PHO Development – supporting the ongoing development of PHOs within the Canterbury Region.	Services to Improve Access Plans in place in all PHOs. <i>These services aim to reduce barriers to first contact services for groups with the highest health needs.</i>	Three PHOs had Plans in place <sup>3</sup>	All five PHOs have Plans in place.	Three PHOs have Plans. One has a draft currently in consultation with its community and one PHO does not have a Plan.	
		The one PHO that has not developed a Plan is currently determining how to provide the desired services independently as the funding (to improve access) that they would receive is very low.			
	Health Promotion Plans (HPP) implemented by all PHOs.	N/A	Again three PHOs have Plans in place with the fourth PHO's Plan under way.		
	PHO Plans are consistent with CDHB health gain priority plans.	Achieved consistent focus.	PHO Plans support the DHB's health gain priorities and have been approved by the DHB.		
		• Target Achieved.			
Improved retention of Rural GPs through maintaining reasonable on-call rosters.	Percentage of GPs with a rural ranking of greater than 35 points, work no more than a one in four weekend roster (unless by choice).	100%	100%	100%	
		• Target Achieved.			
Reduce Ambulatory Sensitive Admissions.  <i>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.</i>	Reduced standardised discharge rates for ambulatory sensitive admissions 0-4 years of age, as a percentage discharged per population.  	<ul style="list-style-type: none"> <li>• Māori 7.2%</li> <li>• Pacific 10.4%</li> <li>• Other 7.8%</li> <li>• Total 7.8%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 6.5%</li> <li>• Pacific 9.0%</li> <li>• Other 7.2%</li> <li>• Total 7.2%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 7.8%</li> <li>• Pacific 14.1%</li> <li>• Other 8.3%</li> <li>• Total 8.4%</li> </ul>	
		The targets have not been achieved for any of the groupings in this age group. The CDHB's rates are also above the National Average for all groups of 7.1%.			
		Reduced standardised discharge rates for ambulatory sensitive admissions 5-14 years of age, as a percentage discharged per population.  	<ul style="list-style-type: none"> <li>• Māori 1.5%</li> <li>• Pacific 2.7%</li> <li>• Other 1.6%</li> <li>• Total 1.7%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 1.5%</li> <li>• Pacific 2.0%</li> <li>• Other 1.6%</li> <li>• Total 1.6%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 1.8%</li> <li>• Pacific 4.4%</li> <li>• Other 1.9%</li> <li>• Total 2.0%</li> </ul>
		Again targets have not been met for all groups in this age group – the National Average (for all groups) is 1.9% so the CDHB is tracking closer to the average for this indicator.			
Reduced standardised discharge rates for ambulatory sensitive admissions 15-24 years of age, as a percentage discharged per population.  	<ul style="list-style-type: none"> <li>• Māori 1.1%</li> <li>• Pacific 1.4%</li> <li>• Other 1.2%</li> <li>• Total 1.2%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 1.1%</li> <li>• Pacific 1.1%</li> <li>• Other 1.1%</li> <li>• Total 1.1%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 1.2%</li> <li>• Pacific 1.1%</li> <li>• Other 1.3%</li> <li>• Total 1.3%</li> </ul>		
While the DHB has not achieved the targets for three of the groups under this age group, the CDHB's total for all groups is better than the National Average of 1.5%.					
Note: the 65 to 74 year age group is included in the Older Person's Health section.					

<sup>3</sup> In 2004/2005 there were four PHOs established in Canterbury – at year-end 2005/2006 there were five PHOs.

### 1.3 Māori Health

<b>Objective:</b>	<b>Brief Description:</b>
Whanau Ora Māori families supported to achieve their maximum health and wellbeing.	Evidence of Māori health disparities is well known and compelling and to address these health disparities, the CDHB has developed a Māori Health Plan (July 2002), Whakamahere Hauora Māori Ki Waitaha. During the 2005/2006 year the DHB has continued to focus its efforts on the above as well as improved data quality to support future developments, and reducing health disparities for Māori. The Plan identifies a number of strategic issues, namely: <ul style="list-style-type: none"> <li>• Support of the Governments commitment to the Treaty of Waitangi;</li> <li>• Māori Participation in health planning, service provision and the workforce;</li> <li>• Effective, culturally appropriate and high quality services;</li> <li>• Monitoring of Māori health outcomes; and</li> <li>• Working across sectors.</li> </ul>

<b>Objective 2005/06</b>	<b>Performance</b>			
	<b>Measure</b>	<b>Baseline 04/05</b>	<b>Target 05/06</b>	<b>Result 05/06</b>
Monitoring of Māori health outcomes.  <i>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<sup>4</sup></i>	Improved ethnicity reporting. The percentage of discharges classified with the following ethnicity groups: Māori, Other and Not Stated.  <i>Targets are set to reduce the percentage of people classified as 'other' or 'not stated' (NS), and increase those classified as Māori.</i>	<ul style="list-style-type: none"> <li>• Māori 6.0%</li> <li>• Other 5.0%</li> <li>• NS 2.7%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori &gt;7.5%</li> <li>• Other &lt;2.5%</li> <li>• NS &lt;1.0%</li> </ul>	<ul style="list-style-type: none"> <li>• Māori 6.0%</li> <li>• Other 5.5%</li> <li>• NS 2.7%</li> </ul>
		<p>The results above do not include data from The Princess Margaret Hospital (TPMH) site as their collection is currently on a different system. This is also the pilot site for the DHB's Ethnicity Data Collection Project and the data collection results here have been more favourable with less people not stating ethnicity and more people clearly identifying 'other' ethnicities. The results for TPMH for June 2005-May 2006 were: Other 1.8% and NS 1.1%.</p> <p>This Ethnicity Data Collection Project is currently being rolled out across all Hospital and Specialist Services (HSS) sites.</p>		
Reduced health inequalities in priority areas – improving Māori service development in priority areas.	Develop an integrated health outcome and performance monitoring framework aligning the DHB's Māori Health Plan <i>Whakamahere Hauora Māori ki Waitaha</i> with the Ministry of Health (MoH) Māori Health Strategy <i>He Korowai Oranga</i> and the Māori Health Action Plan <i>Whakatataka</i> .	Draft monitoring performance framework put out for community consultation. <sup>5</sup>	Completion of monitoring framework.	A framework has not yet been completed.
		<p>Although the framework has not yet been completed, alignment of the DHB and MoH Māori Health Plans has been made with key actions being the building of quality data and the development of a framework for monitoring of Māori health outcomes over 2006/2007.</p> <p>These key actions are embedded in the revised Māori Health Plan which is awaiting Board sign-off.</p>		
	Refer to the relevant section of this document. Where data is available Māori specific targets have been provided.	CDHB has made progress in improving performance against targets set for Māori.	See ethnicity breakdowns under relevant Performance Indicators.	Refer to sections: Child 1.1 Diabetes 1.7.

<sup>4</sup> 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 Māori (measured against census population) and limits the DHB's ability to monitor health outcomes accurately.

<sup>5</sup> A similar indicator around the development of a framework for monitoring performance was used in the 2004/2005 SOI. That framework (which was developed in that year) related to a 'scorecard' means of monitoring performance against the actions within the Māori Health Plan. The framework referred here is a much more detailed and operational monitoring tool.

## 1.4 Mental Health

<b>Objective:</b>	<b>Brief Description:</b>			
Improved Health Status for Canterbury Residents who have a serious ongoing mental illness.	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 plans to continue towards implementing the Mental Health Strategy and Blueprint for Mental Health Services and on the Youth Suicide strategies and guidelines. In addition, the DHB has completed its own Mental Health and Addictions Strategic Plan, which will have its first year of implementation in 2005/2006.			
<b>Objective 2005/06</b>	<b>Performance</b>			
	<b>Measure</b>	<b>Baseline 04/05</b>	<b>Target 05/06</b>	<b>Result 05/06</b>
Mental Health Volume Delivery (Hospital and Specialist Services) <i>ensured delivery of contracted Mental Health Volumes.</i>	Actual service delivered as a percentage of the value of Hospital and Specialist Services (HSS) Mental Health funding provided <sup>6</sup> .	99% of contracted volumes delivered.	100% delivery of contracted volumes.	99% of contracted volumes were delivered.
Mental Health Service Funding: <i>expenditure is allocated to levels specified by the Mental Health "ring-fence".</i>	Total contracted funding (both HSS and Non-Government Organisations) as a percentage of the Mental Health Ring-fence Target.	100% allocation of the ring-fenced funding to providers	100% allocation of funding	100%
Improved access to Mental Health Services: <i>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.</i>	Percentage of people within each age group accessing mental health treatment and support services.  <i>These targets are set in line with estimated proportions of people with mental illnesses for each age group and ethnicity. The higher the percentage, the more people accessing services.</i>  <i>The CDHB aims to improve access to services (in line with the demographics and mental health needs of our population) therefore higher percentages are favourable.</i>	Total 0-9: 0.24% 10-14: 0.73% 15-19: 1.03% 20-64: 1.03% 65+: 0.19%	Maori 0-19 0.65% 20-64 1.31% 65+ 0.28%	Maori 0-19 0.41% 20-64 1.33% 65+ 0.31%
		Other 0-19 0.65% 20-64 1.00% 65+ 0.19%	Other 0-19 0.64% 20-64 0.98% 65+ 0.17%	
		There has been a change in groupings and no broken-down historical data is available.	Total 0-19 0.65% 20-64 1.10% 65+ 0.19%	Total 0-19 0.61% 20-64 1.00% 65+ 0.17%
The targets were generally not achieved across all age groups although there is some positives in two of the age groups for Māori. This data is collated through the Mental Health Information National Collection (MHINC) that only covers hospitals and limited NGOs. While the hospital division has not met the targets the CDHB's focus has been on community access, seeking to improve access for high-risk and high-needs groups. At this point the data from many of these community providers is not collected by the MHINC system and hence are not reflected in the above results.				

<sup>6</sup>Adjustment is made to vacant Full-time Equivalent (FTE) positions where cover has been provided.

## 1.5 Disease Prevention and Management – Cardiovascular (Heart) Disease (CVD)

<b>Objective:</b>	<b>Brief Description:</b>			
Improved cardiovascular health status –reducing the incidence of CVD and improving the quality of care.	Cardiovascular Disease (CVD) has been identified by the CDHB as a priority area for improving the health status of the people of Canterbury. The DHB developed a strategy for the management of CVD Canterbury Heart Health Strategy which has the following priorities: <ul style="list-style-type: none"> <li>• Reduce the incidence of cardiovascular disease;</li> <li>• Improve access to cardiovascular services;</li> <li>• Reduce the impact of cardiovascular disease;</li> <li>• Improve information with respect to heart health; and</li> <li>• Improve quality of care after acute events.</li> </ul>			
<b>Objective 2005/06</b>	<b>Performance</b>			
	<b>Measure</b>	<b>Baseline 04/05</b>	<b>Target 05/06</b>	<b>Result 05/06</b>
Reducing the Impact of Cardiovascular Disease.	Percentage of people with certainty who waited no more than six months for a coronary artery bypass graft.	52%	100%	45%
	Delivery of target levels of Cardiac Surgery for key procedures - Cardiac Valves and Coronary Artery Bypasses Grafts(CABG) <sup>7</sup>  <i>Cost Weighted Discharges (cwd) are a relative measure of the cost of different surgeries; ie cataract procedures have lower cwd than hip replacements</i>	3000c wd (100%)	1500c wd by 31/12/05 3000c wd by 30/06/06	1,424 cwd  2,548 (85%)
While the DHB didn't reach target, the intervention rates for July 05-March 06, show that Canterbury residents had higher rates of access to CABGs than the New Zealand average with a Standardised Discharge Ratio of 1.15. <sup>8</sup>				

	Percentage with certainty who waited for no more than six months for an angioplasty.	97%	100%	100%
		<ul style="list-style-type: none"> <li>Target Achieved.</li> </ul>		
<p>Implement the actions of the Heart Health Strategy:</p> <p>Improve heart health information – to improve ability to monitoring change and evaluation programs.</p> <p>Improve the quality of rehabilitation care after acute events.</p>	<p>Design and implement a pilot project (in primary care) that would lead to the development of a Heart Health Register for Canterbury.</p> <p>The Core Data Set is to be collected by primary and secondary providers.</p>	N/A	Core Data Set Pilot under way in at least three general practices in Rangiora.	The pilot was not run in 2005/2006.
		<p>The DHB and the Christchurch School of Medicine put in a bid for funding from the Health Research Council to run the pilot project however this was not successful. We await results of a second bid for funding. Meanwhile the DHB undertook an audit to establish the quality of data within practices with only the practice, with electronic records, providing sufficient data to develop CVD risk assessments. If funding is obtained work will be required around the use of electronic and paper-based patient records.</p>		
	<p>Trial the New Zealand Heart Manual in primary care in Canterbury – beginning with six general practices.</p> <p>The Heart Manual trial is jointly funded by the CDHB and the Heart Foundation.</p>	N/A	Heart Manual Trial under way in at least six general practices.	Trial under way with the Heart Foundation running the first training for practices in June 2006.
		<ul style="list-style-type: none"> <li>Target Achieved.</li> </ul>		

<sup>7</sup> Cardiac Valves and Coronary Bypass Grafts are counted using Diagnostic Related Groups; F03Z, F04A, F04B, F05A, F05B, F06A, F06B.

<sup>8</sup> If all DHBs were providing services at the same level they would all be at a Standardised Discharge Ratio of 1. The standardised ratio takes into account the particular sex, age, ethnicity and social deprivation mix of a DHB's population. A higher than 1 indicates that the DHB is providing more than the average rate in New Zealand. This standardised information is provided by the New Zealand Health Information Service, a Business Unit within the Ministry of Health.

#### 1.6 Disease Prevention and Management – Cancer

Objective:	Brief Description:			
Improved health status for Canterbury's residents who are at risk of developing Cancer and appropriate and timely treatment for those who do develop Cancer.	<p>Cancer has been identified by the CDHB as priority area for improving the health status of the people of Canterbury. The DHB is currently in the process of developing a local Strategy for 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 2005/2006 year.</p> <p>These measures focus on reducing the impact of Cancer rather than prevention. Cancer results for multiple causes, which limits the ability of the DHB to prevent it. However, actions such as making the CDHB smokefree and the introduction of smokefree legislation will have positive effects.</p>			
Objective 2005/06	Performance			
	Measure	Baseline 04/05	Target 05/06	Result 05/06
Reducing the impact of Cancer.	<p>Improved Access to Radiation Therapy<sup>9</sup>.</p> <p>Delay to radiotherapy is defined as the time between the specialist decision to commence radiotherapy and the start of treatment. Patients who need radiotherapy are categorised into 4 groups:            Group A - Ideally treated within 24 hours            Group B - Ideally treated within 2 weeks            Group C - Ideally treated within 4 weeks            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<sup>10</sup>.</p>	<p>Group A: 100% on time.</p> <p>Group B: 52% on time 42% wait 4-8wk 3% wait 8-12wk 3% wait 12+wks</p> <p>Group C: 79% on time 15% wait 4-8wk 2% wait 8-12wk 3% wait 12+wks</p>	<p>Group A: 100% on time.</p> <p>Group B: 100% on time.</p> <p>Group C: 95% on time 5% wait 4-8wk</p> <p>0% of patients in Groups A, B, or C wait longer than 8 weeks.</p>	<p>Group A: 100% on time.</p> <p>Group B: 65% on time 30% wait 4-8wk 4% wait 8-12wk 1% wait 12wk+</p> <p>Group C: 78% on time 20% wait 4-8 wk 2% wait 8-12 wk</p> <p>1% of all groups waited longer than 12+wks.</p>
		<p>Although the targets have not been achieved the CDHB is committed to improving wait times for Radiation Therapy and the results show improvements against the previous year.</p>		

<sup>9</sup> The CDHB intends to meet the MoH target of 100% of patients accessing radiation therapy on time, however given the ongoing international shortages of radiation therapists, the CDHB has established targets that reflect our progress towards this objective.

<sup>10</sup> 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.

## 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.	<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: health promotion, early detection, effective treatment and patient knowledge/information.</p> <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 Māori. During the 2005/06 year, the DHB primarily focused its activities on improving performance in the level of retinal (eye) screening while continuing to encourage the detection and management of Diabetes within the community<sup>11</sup>.</p>				
Objective 2005/06	Performance				
	Measure	Baseline 04/05		Target 05/06	Result 05/06
Improved Diabetes Detection: <i>Increasing the proportion of people with diabetes who receive annual diabetic reviews and the associated primary care.</i>	Increase Diabetes Annual Checks.	9,793		10,616	6142
	Increase the percentage of the expected number of people with diagnosed diabetes who have annual reviews during the year.	Māori 41% Pacific 111% <sup>12</sup> Other 84% Total 80%	Māori 80% Pacific 120% Other 87% Total 84%	Māori 24% Pacific 51% Other 51% Total 48%	
		<p>The results for all groups fell short of the targets set, with the number of annual checks undertaken falling well below that achieved in 2004. There are concerns over the accuracy of data. The DHB is working to identify alternative sources of data to inform this reporting and to clarify the number of annual checks being performed. The DHB will also review the data produced over the past several years to clarify its accuracy and to determine a way forward.</p>			
Early diagnosis and treatment of eye problems: Increase the proportion of people with diabetes having their eyes regularly screened.	Increase the percentage of people having diabetes reviews who have regular Eye Screens (in the past two years).	Māori 41% Pacific 37% Other 48% Total 48%	Māori 45% Pacific 39% Other 80% Total 75%	Māori 57% Pacific 74% Other 73% Total 72%	
		<ul style="list-style-type: none"> <li>Target Achieved for Māori and Pacific.</li> </ul> <p>While eye screening rates for Māori and Pacific look positive this data is also considered to be questionable and the reliability of the data for this indicator and will be confirmed as part of the data review.</p>			
Improved Diabetes Management: <i>Reducing the proportion of people with diabetes who have relatively poor control of their diabetes.</i>	Decrease the percentage of people having annual diabetes reviews who have poor diabetes control (HbA1c>8%).	Māori 40% Pacific 52% Other 24% Total 26%	Māori 39% Pacific 45% Other 20% Total 23%	Māori 34% Pacific 52% Other 21% Total 22%	
		<ul style="list-style-type: none"> <li>Target Achieved for Māori and in Total.</li> </ul> <p>Although case management targets may have been achieved for Māori again, these must be considered in light of the fall off in the overall number of people receiving annual checks in 2005.</p>			

<sup>11</sup>The figures presented in this section are subject to confirmation from the Local Diabetes Team (LDT) who collate the data and set targets for Canterbury on an annual basis – these figures are also set by calendar year rather than financial year.

<sup>12</sup>The higher percentage for Pacific is an anomaly caused by the LDT's belief that the estimated number of Pacific in Canterbury is too low.

## 1.8 Older Person's Health

Objective:	Brief Description:				
Maintain/improve health and independence outcomes for older Canterbury residents within available resources.	<p>Older Person's Health has been identified as an area of specific focus by the CDHB. In the 2005/2006 year the DHB completed work on its Older Person's Services Strategy Healthy Aging Integrated Support. This work contributed to the further implementation of the Health of Older People's Strategy and is aligned with the DHB's second Core Direction, Finding Better Ways of Working. As this work progresses the performance measures in this section will be revised.</p>				
Objective 2005/06	Performance				
	Measure	Baseline 04/05		Target 05/06	Result 05/06
Reduce Ambulatory Sensitive Admissions – <i>these are admissions that are potentially preventable through appropriate care and support.</i>	Reduced standardised discharge rates for Ambulatory Sensitive Admissions 65 to 75 years of age, as a percentage discharged per population.	Māori 10.4% Pacific 9.5% Other 5.5% Total 5.7%	Māori 9.0% Pacific 9.5% Other 5.5% Total 5.5%	Māori 8.0% Pacific 14.9% Other 5.4% Total 5.6%	
		<ul style="list-style-type: none"> <li>Target Achieved for Māori and Other Groups.</li> </ul> <p>The CDHB has achieved its targets for the Māori and Other groupings and the Total group rate is favourable against the national average of 6.2%.</p>			

Increase the number of older people receiving education on falls prevention – falls are a major cause of injury and ongoing disability for older people in Canterbury.	Increase the number of people referred to the Stay On Your Feet (SOYF) Home Exercise Program <i>(The SOYF Program is a collaborative inter-sectorial initiative launched to raise awareness of the risks and consequences of falls amongst the elderly and how to prevent them.)</i>	230 people referred.	250 people referred.	287 referrals.
<ul style="list-style-type: none"> <li>Target Achieved.</li> </ul>				
Develop a local DHB Strategy for Older People's Health.	During 2005/2006 the DHB will develop a specific Older People's Services Strategy and health performance measures consistent with the aims of the Strategy.	N/A.	Strategy developed, consistent with National Strategy, and Performance measures in place.	Older People's Health Services Strategy was approved in February 2006.
<ul style="list-style-type: none"> <li>Target Achieved. Implementation of the Strategy is well under-way with consistent Health Performance Measures currently under development for implementation 2006/2007.</li> </ul>				

### 1.9 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.	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 DHB intends to continue the implementation of the government's policies in relation to elective services which include: <ul style="list-style-type: none"> <li>The provision of timely access to specialist assessment and elective surgery; and</li> <li>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.</li> </ul>

Objective 2005/06	Performance			
	Measure	Baseline 04/05	Target 05/06	Result 05/06
Improved access to First Specialist Assessment (FSA) <sup>13</sup> and reduce waiting lists for FSA so that all appropriately referred patients can be assessed within appropriate timeframes.	Percentage of patients who receive their FSA within six months of referral.	94%	100%	94%
	Delivery of a level of publicly funded FSA volumes at the levels specified by contract (outlined in the DHB's District Annual Plan).	54,398 FSA completed (99%)	27,330 by 31/12/05 54,660 by 30/06/06	27,091 54,998
		Total FSAs delivered were above target levels by 338 attendances or 0.6%. There were an additional 600 FSAs delivered compared to the previous year.		
Improved certainty of treatment: <i>Provide certainty to elective surgical patients as to whether they will/will not receive access to publicly funded inpatient surgery.</i>  Provide access in a timely manner.	Percentage of patients provided with certainty of treatment receiving that treatment within six months.	87%	100%	78%
	Percentage given certainty - <i>the number of patients given certainty of treatment as a percentage of all patients receiving elective surgery during the period.</i>	65%	90%	33%
There are a number of initiatives in place to manage the patients on the booking lists. Following discussion with the MoH, plans are under way to give certainty to patients or return them to GP care. Close liaison is occurring with PHOs <sup>14</sup> .				
Surgical Volume Delivery: <i>Delivery of the level of surgery specified by contract.</i>	Case Weighted Discharges (CWD) delivered as specified in the DHB District Annual Plan <sup>15</sup> .	34,074 cwd delivered year-end (within 0.8% of target).	17,900cwd by 31/12/05 35,825cwd by 30/06/06	18,857 36,981
		<ul style="list-style-type: none"> <li>Target Achieved. The CDHB delivered 1156 cwnds over contract and 2907 additional cwnds than the previous year.</li> </ul>		

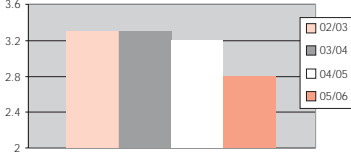
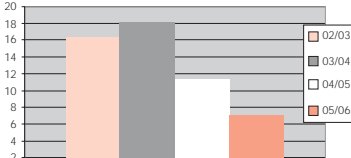
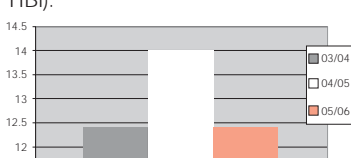
<sup>13</sup>A FSA is the first appointment a patient has with a specialist following referral.

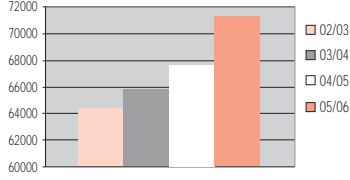
<sup>14</sup>Over the past twelve months the MoH's Elective Services Patient Flow Indicators (ESPIs) Policy has not been properly introduced by the CDHB and has affected results. This policy is now being introduced across all services.

<sup>15</sup>CWD are a relative measure of the cost of different types of surgery- eg cataract procedures have a lower cost weight than hip replacements.

## 2 Provider Hospital and Specialist Service Measures

### 2.1 Hospital Safety and Effectiveness

Objective:	Brief Description:			
The CDHB aims to be an efficient and effective provider and maximise the health status of Canterbury's residents within the available resources.	The DHB 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 2005/06	Performance			
	Measure	Baseline 04/05	Target 05/06	Result 05/06
Improved performance as a Good employer. <i>Promote a good working environment, open, inclusive and transparent and foster partnerships between staff, and between staff and management.</i>	Sick Leave Rate (as per Hospital Benchmarking Indicator (HBI)). <sup>16</sup> 	3.2% of contracted hours.	3.2% of contracted hours or less.	2.8% of contracted hours. • Target Achieved.
	Work Place Injuries per 1,000,000 hours (as per HBI). 	11.2 per million hours.	14 per million hours or less.	6.9 per million hours. • Target Achieved.
	Staff Retention and Turnover (as per HBI). 	14.0% turnover.	13% turnover.	12.4% turnover. • Target Achieved.
Patient Satisfaction – Percentage of Good and Very Good responses from Satisfaction Surveys.	Inpatient – Overall Satisfaction (HBI).	90%	Greater than 90%.	89% This target has been only missed by 0.7% and the DHB is pleased with the consistent patient satisfaction results.
	Outpatient – Overall Satisfaction (HBI).	90%	Greater than 90%.	91% • Target Achieved.
Improved Quality. Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals.	Maintain accreditation at the following divisions: • Rural Hospitals; • Older Persons and Rehabilitation; • Medical and Surgical Services; • Women's and Children's; and • Mental Health Services.	All facilities accredited.	100% of facilities maintain current accreditation status.	Maintained accreditation status. • Target Achieved.
Maintain appropriate levels of Clinical Quality within CDHB Hospitals.	Hospital Acquired Bacteraemia Rate. <sup>17</sup>	0.13	0.15 or less	0.16 The results against this indicator are slightly over the target set. Review and close monitoring of this indicator will continue through the hospital infection control program.
	Patient Falls <sup>18</sup> (causing moderate or serious injury).	Historical Data not available.	0.10 or less. <sup>19</sup>	0.02 • Target Achieved.
	IV Medication Error Rate per 1000 inpatient days. <sup>20</sup>	1.8	2.5 or more	1.5 Work continues with initiatives such as the 0800 event reporting that will facilitate an increase in the reporting of these types of incidents.

Objective 2005/06	Performance			
	Measure	Baseline 04/05	Target 05/06	Result 05/06
Monitor levels of attendance at Christchurch Hospital's Emergency Department.	Number of attendances at the Christchurch Hospital Emergency Department (ED). 	67,599	No target set, included for information purposes only.	71,279
Reduce wait times for people attending Christchurch Hospital's ED.	Percentage of people seen in ED within expected wait time by triage level. Triage 1 should be attended to immediately Triage 2 within 10 mins Triage 3 within 30 mins	Triage 1 98% Triage 2 50% Triage 3 44%	Triage 1 100% Triage 2 80% Triage 3 70%	Triage 1 100% Triage 2 45% Triage 3 46%
		While the targets have not been met over 3600 more people attended the ED in this past 2005/2006 year than in the previous year. The CDHB is working through an Acute Demand Review to improve ED wait times and reduce acute demand.		

<sup>16</sup> Hospital Benchmark Indicators are national MoH indicators used to measure national performance between DHB's.

<sup>17</sup> This indicator excludes data from the HSS Mental Health Division.

<sup>18</sup> The patient falls indicator has historically included all or total patient falls including many minor events, which cause little or no harm. While useful as a means to understand patterns of circumstances associated with falls, and therefore to drive quality improvement, it does not relate directly to the harm caused by falls, the overall rate being influenced more by reporting practices. For these reasons the DHB has changed the indicator to include only those falls associated with moderate or serious injury to provide a direct measure of injury caused by falls.

<sup>19</sup> The new patient falls indicator is a patient falls rate and is not per 1000 inpatient days as incorrectly indicated in the 2005/2008 SOI document. The Fall Rate is defined as the number of patient falls causing moderate or serious injury against the number of Inpatient Day Equivalents - these are the sum of the total inpatients days plus half the total daypatients, where; an inpatient day is when a patient is admitted for treatment and is present at the midnight census (no exclusions); a day patient is when a health care user is admitted for health care with a stay of 0 days regardless of intent at time of admission (no exclusions).

<sup>20</sup> This measure is derived from incidence reports and the level of harm reported is unusually low in comparison with formal studies of adverse drug events. The DHB wishes to set a target to increase the rate of reported errors in line with its policy of 'no blame' incident reporting emphasising the responsibility of staff to report error and the intention to deal with it in a non-punitive way. This also reflects a recommendation from the Institute of Healthcare Improvement that increasing the level of reporting is an essential step in reducing overall harm. The targets are therefore set to increase each year and are seen as minimum. As this is a new measure, targets will be confirmed after the 2005/2006 result.

### 3 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 2005/06	Performance			
	Measure	Baseline 04/05	Target 05/06	Result 05/06
Manage expenditure (including external providers) within available funding.	DHB expenditure on health services is within the funding it receives and that its operating result, after interest, depreciation and capital charge, is breakeven.	Net operating result = \$0.361m consolidated surplus	Breakeven or better.	\$2.861 million consolidated surplus.
		While the DHB is showing a \$2.861m consolidated surplus for the 2005/2006 year this relates to MoH advances for PSA settlement. Excluding these advances the DHB's position is a small surplus of around \$0.5 million.		
District Strategic Plan developed within set time frame.	Complete public consultation of draft Strategic Plan and present the draft Plan to the MoH as per required timeframes.	All milestones and targets met.	First draft 29/07/05 second draft 03/10/05.	First draft 29/07/05, second draft 19/10/05.
		<ul style="list-style-type: none"> <li>Target Achieved (second draft timeframe changed by MoH to 19/10/05 – complied with by the CDHB)</li> </ul>		
Governance Training <i>Good Governance requires training and support, particularly for members new to governance.</i>	Board members (new and existing) have received Governance training and Treaty of Waitangi training.	N/A	Governance and Treaty training available for all Board members.	Governance Training has been provided.
		Explicit Treaty of Waitangi (or cultural training) will take place in 2007.		

Objective 2005/06	Performance			
	Measure	Baseline 04/05	Target 05/06	Result 05/06
Governance Training <i>Good Governance requires training and support, particularly for members new to governance.</i>	A training register is established and maintained as required by the New Zealand Public Health and Disability Act 2000.	N/A	Registered established and maintained.	Training Register in place.
	• Target Achieved			
Clinical Governance Board	The DHB has established a Clinical Governance Board who are currently working on the development of a clinical governance framework model for the CDHB.	N/A	CDHB model of operation in place.	Board established. A model under development.
	• Target Achieved A Clinical Governance Framework is progressing with a number of options currently under consideration.			
Maintain quality of services contracted to NGO providers.	Contract Managers maintain ongoing working relationships with providers, monitoring service provision, making site visits and requiring monthly or quarterly monitoring reports.	N/A	Maintain provider monitoring processes.	Processes are in place and regular contact is maintained with providers.
	• Target Achieved			
	Regular routine audits are carried out and issues based audits are undertaken where process indicates it is appropriate.	N/A	Maintain annual audit plan processes.	The CDHB maintained its annual audit processes.
	• Target Achieved. 39 regular and two issues based audits were undertaken over the 2005/2006-year.			
The CDHB leads a provider quality network which is an information sharing forum on quality related issues.		N/A	Continuation of this quality forum.	Joint Provider Forums held.
		• Target Achieved		

#### 4. 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
<b>Revenue</b>					
MoH Revenue	932,035	3,333	582,548	(545,341)	972,575
Patient Related Revenue			31,224		31,224
Other			19,843		19,843
<b>Total Revenue</b>	932,035	3,333	633,615	(545,341)	1,023,642
<b>Expenditure</b>					
Personnel		2,225	404,621		406,846
Depreciation		16	47,356		47,372
Interest			4,936		4,936
Capital Charge			15,076		15,076
Other	927,001	1,127	163,764	(545,341)	546,551
<b>Total Expenditure</b>	927,001	3,368	635,753	(545,341)	1,020,781
<b>Net Surplus/(Deficit)</b>	<b>5,034</b>	<b>(35)</b>	<b>(2,138)</b>	<b>-</b>	<b>2,861</b>

# SUMMARY OF FINANCIAL STATEMENTS

1 JULY 2004 – 30 JUNE 2005

This summary financial report has been extracted from the full financial report dated 25 September 2006 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](http://www.cdhb.govt.nz)



*'Hospital Helping Hands' volunteers Kate McBeath and Lyn Hay taking the shop trolley around the ward.*

## STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2006

	Group			Parent	
	Actual 30/06/06 \$'000	Budget 30/06/06 \$'000	Actual 30/06/05 \$'000	Actual 30/06/06 \$'000	Actual 30/06/05 \$'000
<b>OPERATING REVENUE</b>					
Ministry of Health Revenue	972,575	953,435	900,187	964,726	893,545
Patient Related Revenue	31,224	27,670	27,851	31,661	27,795
Other Revenue	19,843	11,470	14,550	18,499	13,268
<b>TOTAL REVENUE</b>	<b>1,023,642</b>	<b>992,575</b>	<b>942,588</b>	<b>1,014,886</b>	<b>934,608</b>
<b>OPERATING EXPENSES</b>					
Employee Costs	406,846	380,322	369,683	399,201	362,441
Treatment Related Costs	109,289	102,285	98,947	112,310	102,148
External Service Providers	381,660	388,073	353,053	381,660	353,053
Depreciation	47,372	39,063	39,519	46,386	38,570
Interest Expense	4,936	6,143	4,183	4,957	4,183
Other Expenses	55,602	53,459	55,062	53,047	52,489
<b>TOTAL OPERATING EXPENSES</b>	<b>1,005,705</b>	<b>969,345</b>	<b>920,447</b>	<b>997,561</b>	<b>912,884</b>
<b>OPERATING SURPLUS BEFORE CAPITAL CHARGE</b>	<b>17,937</b>	<b>23,230</b>	<b>22,141</b>	<b>17,325</b>	<b>21,724</b>
Capital Charge Expense	(15,076)	(23,230)	(21,862)	(15,076)	(21,862)
<b>Surplus / (DEFICIT) BEFORE TAXATION</b>	<b>2,861</b>	<b>-</b>	<b>279</b>	<b>2,249</b>	<b>(138)</b>
Tax Benefit / (Expense)	-	-	82	-	-
<b>NET SURPLUS / (DEFICIT) FOR THE YEAR</b>	<b>2,861</b>	<b>-</b>	<b>361</b>	<b>2,249</b>	<b>(138)</b>

## STATEMENT OF MOVEMENTS IN EQUITY FOR THE YEAR ENDED 30 JUNE 2006

Notes	Group			Parent	
	Actual 30/06/06 \$'000	Budget 30/06/06 \$'000	Actual 30/06/05 \$'000	Actual 30/06/06 \$'000	Actual 30/06/05 \$'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD:	199,705	199,344	199,344	198,603	198,741
TOTAL RECOGNISED REVENUES AND EXPENSES:					
Net surplus / (deficit) for the period	2,861	-	361	2,249	(138)
Revaluation of Property	106,760	-	-	106,760	-
	109,621	-	361	109,009	(138)
OTHER MOVEMENTS					
Contribution from/(back to) Crown 5	(22,000)	-	-	(22,000)	-
<b>TOTAL EQUITY AT END OF THE PERIOD</b>	<b>287,326</b>	<b>199,344</b>	<b>199,705</b>	<b>285,612</b>	<b>198,603</b>

## STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2006

		Group			Parent	
		Actual as at 30/06/06 \$'000	Budget as at 30/06/06 \$'000	Actual as at 30/06/05 \$'000	Actual as at 30/06/06 \$'000	Actual as at 30/06/05 \$'000
<b>CROWN EQUITY</b>						
General Funds	5	126,174	148,079	148,174	126,312	148,312
Revaluation Reserve	5	184,477	77,717	77,717	184,477	77,717
Retained Earnings	5	(31,435)	(34,952)	(34,591)	(33,170)	(35,734)
Trust Reserve	5	8,110	8,500	8,405	7,993	8,308
<b>TOTAL EQUITY</b>		<b>287,326</b>	<b>199,344</b>	<b>199,705</b>	<b>285,612</b>	<b>198,603</b>
<b>REPRESENTED BY:</b>						
<b>CURRENT ASSETS</b>						
Cash and Bank		12,838	(2,702)	10,109	12,270	9,682
Receivables and Prepayments	3	25,391	17,500	16,341	24,898	15,795
Stocks	4	7,196	7,000	6,594	7,133	6,543
<b>TOTAL CURRENT ASSETS</b>		<b>45,425</b>	<b>21,798</b>	<b>33,044</b>	<b>44,301</b>	<b>32,020</b>
<b>CURRENT LIABILITIES</b>						
Creditors and Accruals		74,456	74,017	74,361	74,028	74,215
Owing to the Ministry of Health		3,738	5,819	7,371	3,738	7,371
Staff Entitlements due within 1 year	8	48,919	54,000	44,389	48,157	43,554
Provisions due within 1 year	9	29,217	-	22,540	29,189	22,540
<b>TOTAL CURRENT LIABILITIES</b>		<b>156,330</b>	<b>133,836</b>	<b>148,661</b>	<b>155,112</b>	<b>147,680</b>
<b>NET WORKING CAPITAL</b>		<b>(110,905)</b>	<b>(112,038)</b>	<b>(115,617)</b>	<b>(110,811)</b>	<b>(115,660)</b>
<b>NON CURRENT ASSETS</b>						
Investments	12	375	292	311	1,187	1,829
Fixed Assets	11	466,145	396,501	382,467	463,364	379,665
Surplus Property		11,760	11,760	9,300	11,760	9,300
Restricted Assets	6	8,110	7,779	8,405	7,993	8,308
<b>TOTAL NON CURRENT ASSETS</b>		<b>486,390</b>	<b>416,332</b>	<b>400,483</b>	<b>484,304</b>	<b>399,102</b>
<b>NON CURRENT LIABILITIES</b>						
Provisions	9	9,509	4,950	6,511	9,231	6,189
Loans repayable after 1 year	10	78,650	100,000	78,650	78,650	78,650
<b>TOTAL NON CURRENT LIABILITIES</b>		<b>88,159</b>	<b>104,950</b>	<b>85,161</b>	<b>87,881</b>	<b>84,839</b>
<b>NET ASSETS</b>		<b>287,326</b>	<b>199,344</b>	<b>199,705</b>	<b>285,612</b>	<b>198,603</b>

## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2006

	Group			Parent	
	Actual 30/06/06 \$'000	Budget 30/06/06 \$'000	Actual 30/06/05 \$'000	Actual 30/06/06 \$'000	Actual 30/06/05 \$'000
<b>CASH FLOW FROM OPERATING ACTIVITIES</b>					
Cash was provided from:					
Receipts from Ministry of Health	963,919	953,435	905,739	956,024	898,843
Other Receipts	44,340	34,968	46,670	43,348	45,590
Interest Received	3,102	172	1,268	3,187	1,384
	1,011,361	988,575	953,677	1,002,559	945,817
Cash was applied to:					
Payments to Employees	392,601	380,322	354,144	384,907	347,012
Payments to Suppliers	549,811	543,801	498,730	550,503	499,337
Interest Paid	4,928	6,143	4,023	4,949	4,023
Capital Charge	19,955	23,230	20,301	19,955	20,301
GST - net	(3,557)	-	1,934	(3,546)	1,949
	963,738	953,496	879,132	956,768	872,622
<b>NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES</b>	<b>47,623</b>	<b>35,079</b>	<b>74,545</b>	<b>45,791</b>	<b>73,195</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>					
Cash was provided from:					
Sale of Assets	6,650	9,750	70	6,650	70
Decrease in Investments	231	-	-	957	-
	6,881	9,750	70	7,607	70
Cash was applied to:					
Increase in Investments & Restricted Assets	-	-	645	-	489
Purchase of Assets	29,775	44,200	47,076	28,810	45,698
	29,775	44,200	47,721	28,810	46,187
<b>NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES</b>	<b>(22,894)</b>	<b>(34,450)</b>	<b>(47,651)</b>	<b>(21,203)</b>	<b>(46,117)</b>
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>					
Cash was provided from:					
Loans Raised	-	3,000	-	-	-
	-	3,000	-	-	-
Cash was applied to:					
Loans Repaid	-	-	15,950	-	15,950
Equity repaid to Crown	22,000	-	-	22,000	-
	22,000	-	15,950	22,000	15,950
<b>NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES</b>	<b>(22,000)</b>	<b>3,000</b>	<b>(15,950)</b>	<b>(22,000)</b>	<b>(15,950)</b>
Overall Increase/(Decrease) in Cash Held	2,729	3,629	10,944	2,588	11,128
Opening Cash Balance	10,109	(6,331)	(835)	9,682	(1,446)
<b>CLOSING CASH BALANCE</b>	<b>12,838</b>	<b>(2,702)</b>	<b>10,109</b>	<b>12,270</b>	<b>9,682</b>

# GLOSSARY OF TERMS

<b>Accreditation</b>	Achievement against a national system of standards.
<b>Acute Care</b>	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
<b>Ambulatory Sensitive Admissions</b>	Admissions that are potentially preventable by appropriate effective and efficient primary care, preventive or therapeutic programmes.
<b>Angioplasty</b>	An Angioplasty is a non-invasive procedure where a balloon-tipped catheter is inflated inside a diseased blood vessel. As the balloon is inflated, the vessel opens further allowing for improved flow of blood.
<b>Audit</b>	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation.
<b>Bacteraemia</b>	Hospital Acquired Bacteraemia rate measures the number of hospital acquired blood stream infections as a proportion of the number of inpatients.
<b>Certainty</b>	When the DHB gives a patient a commitment to treat within six months, this patient has certainty. This commitment can be given either through a certainty letter (promise of surgery date within six months) or being direct booked for treatment (given date for surgery directly).
<b>CABG - Coronary Artery Bypass Graft</b>	A surgical procedure which involves replacing diseased (narrowed) coronary arteries with veins obtained from the patients lower extremities. During this procedure the patient is placed on a heart bypass machine (heart-lung machine) to allow the surgeon adequate time to perform surgery on the resting (non-beating) heart.
<b>CWD - Case Weighted Discharges</b>	This is a relative measure of the cost of different types of surgery. For example cataract surgery has a lower cost weight than hip replacement surgery.
<b>ESPIs - Elective Services Patient</b>	
<b>Flow Indicators</b>	The ESPIs have been developed by the Ministry of Health to assess whether or not DHBs are on the right track with the government policies on elective services.
<b>FSA --First Specialist Assessment</b>	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
<b>FTE - Full Time Equivalent</b>	Full Time Equivalent means an Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
<b>Governance</b>	Governance, as executed by the DHB Board, is strategic oversight of the management of the DHB to ensure it delivers on its fundamental objective of working within allocated resources to improve, promote and protect the health of a defined population, and to promote the independence of people with disabilities within a defined population
<b>HBI - Hospital Benchmark Indicator</b>	Indicators of national DHB performance established and monitored by the Ministry of Health.
<b>Health Inequalities</b>	Difference in health relative to the local community or wider society to which an individual, family or group belongs.
<b>HbA1c</b>	Haemoglobin A1c; also known as glycated haemoglobin. The level of HbA1c reflects the average blood glucose level over the past 3 months.
<b>Mental Health Blueprint Funding</b>	Blueprint funding is allocated by Government to work to ensure the development of mental health services for the 3% of the total New Zealand population with moderate to severe mental illness. Service development is based on the service

	levels set out in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).
<b>Mental Health Ringfence</b>	The application of a ringfence policy for mental health services has been an important factor in ensuring progress with implementation of the Blueprint. The ringfence policy serves the purpose of ensuring money allocated to mental health is used for that purpose and that service expansion is real and not eroded by demographic and price pressures.
<b>MeNZB - Meningococcal B</b>	Meningococcal disease is a bacterial infection. It causes severe illnesses including meningitis (an infection of membranes that cover the brain) and septicaemia (a serious infection in the blood). There are several different strains of bacteria which cause meningococcal disease including A, B and C.
<b>MHINC - Mental Health Information National Collection</b>	The national database of mental health information held by the New Zealand Health Information Service (NZHIS) to support policy formation, monitoring and research.
<b>NGO - Non-Government Organisation</b>	NGOs include independent community and iwi/Maori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders. Some organisations identify closer with other categories, for example third sector organisations, voluntary organisations, community organisation etc, rather than under an NGO category. For the purposes of this definition an "NGO" includes all these types of organisations.
<b>NHI – National Health Index</b>	The NHI is a system used by public hospitals and other health and disability support services to assign an alphanumeric identifier (the NHI number) to service users for clinical and administrative purposes. The main purpose of a NHI number is to identify you and ensure your information is correctly associated with your clinical record. Most people know the NHI number as their hospital number; it is the number on clinical notes and on hospital identity bracelets. The NHI holds information on names and addresses, ethnicity, gender, date of birth and New Zealand resident status.
<b>PHO - Primary Health Organisation</b>	A new development in service delivery, PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
<b>Radiation Therapy</b>	Radiation therapy is the branch of medicine that deals with the management of cancers by radiation. Commonly treated cancers are breast, lung, rectum and prostate. Radiation is often given in addition to other forms of cancer treatment, such as chemotherapy, surgery and hormonal therapy. Radiation oncology services require close linkages with medical oncology, palliative care and most surgical and medical subspecialties.
<b>Standardised Discharge Ratio</b>	If all DHBs were providing services at the same level they would all be at a Standardised Discharge Ratio of 1. The standardised ratio takes into account the particular sex, age, ethnicity and social deprivation mix of a DHB's population. A higher than 1 indicates that the DHB is providing more than the average rate in New Zealand a rate less than 1 indicates that the DHB is providing less than the average rate in New Zealand. This standardised information is provided by the New Zealand Health Information Service, a Business Unit within the Ministry of Health.
<b>Triage Levels - Emergency Department</b>	Patients coming into the Emergency Department (ED) are triaged upon presentation into one of five categories (on the Australasian Triage Scale). Patients requiring immediate treatment are triaged as level 1, those needing treatment within 10 minutes are level 2, within 30 minutes are level 3. Patients may be re-triaged to a different category as the assessment and treatment process develops and particularly in response to significant changes in physiological status. Staff and other resources should be deployed so that treatment acuity thresholds are achieved progressively.

# 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 (Deputy Chair)

## 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  
Peter Ballantyne  
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  
Tuari Potiki  
Jo Kane  
Laurence Malcolm  
John Musgrove  
Alison Wilkie  
Syd Bradley (ex officio)  
Neville Fagerlund (ex officio)  
David Morrell (ex officio)

## CHIEF EXECUTIVE

Gordon Davies

## EXECUTIVE MANAGEMENT TEAM

Gordon Davies (Chair)  
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 Māori and Pacific Health)  
Dr Nigel Millar (Chief Medical Officer)  
Michele Hider (Communications Manager)  
Jock Muir (General Manager Hospital & Specialist Service)  
Lynn Smillie (Group Manager Human Resources)  
Wei Yoon (General Manager Finance)

## REGISTERED OFFICE

The Princess Margaret Hospital  
Cashmere Road  
P.O. Box 1600  
Christchurch

## AUDITOR

Audit New Zealand on behalf of the Auditor General

## BANKERS

Westpac  
Bank of New Zealand

**Canterbury**

District Health Board

Te Poari Hauora o Waitaha