Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

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16 October 2020

9(2)(a) [redacted]

[redacted]

[redacted]

RE Official information request CDHB 10450

I refer to your email dated 15 October 2020 requesting the following information under the Official Information Act from the Canterbury DHB. Specifically:

1. **Copies of all annual reports from financial year 2001/2002 to financial year 2007/2008.**

Please find attached the Canterbury DHB Annual Reports as requested:

Appendix 1	**-**	**6 months to 30 June 2001**
Appendix 2	**-**	**2001/2002**
Appendix 3	**-**	**2002/2003**
Appendix 4	**-**	**2003/2004**
Appendix 5	**-**	**2004/2005**
Appendix 6	**-**	**2005/2006**
Appendix 7	**-**	**2006/2007**
Appendix 8	**-**	**2007/2008**

I trust this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

APPENDIX 1

Canterbury DHB

Report for the Six Months ended 30 June 2001

Table of Contents

DIRECTORY

Board Members

Syd Bradley - Chair
Dr David Kerr - Deputy Chair
Graham Heenan
Philip Bagshaw
Mick Ozimek
Api Talemaitoga
Olive Webb
Paul White
Alison Wilkie
Marty Braithwaite

Acting Chief Executive Officer

Chai Chuah (to 30 June 2001)

Chief Executive Officer

Jean O'Callaghan (from 2 July 2001)

Registered Office

4th Floor
Avon House
10 Oxford Terrace
Christchurch

Auditor

Audit New Zealand on behalf of the Office of the Controller and Auditor-General

Banker

WestpacTrust
Bank of New Zealand

BOARD'S REPORT

To the members, on the affairs of the Board for the six months ended 30 June 2001

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based District Health Board, which provides Health and Disability Support Services, principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the six month period, the Group made a net deficit of $127,000 (budgeted surplus $241,000).

BOARD FEES

Board fees paid, or due and payable, to board members for services during the period, are as follows:

	Board Fees Period ended 30.06.01 $'000	Committee Fees to Board Members $'000
Syd Bradley	21	1
Graham Heenan	10	3
Dr David Kerr	12	3
Philip Bagshaw	10	2
Mick Ozimek	10	1
Api Talemaitoga	10	1
Olive Webb	10	1
Paul White	10	3
Alison Wilkie	10	3
Marty Braithwaite	8	2
	111	20

The limit of Board fees authorised for the six months ended 30.06.01 were $114,000.

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the period are as follows:

	Period ended 30.06.01 $'000
G Coyle	5
A Lomax	3
E Stratford	3
G Heenan	5
W Bellew	1
A Urlwin	5
	22

BOARD MEMBERS' INTEREST

The board members have declared their interest in the following transactions with the DHB during the period:

PARENT COMPANY

Syd Bradley	Deputy Chair of New Zealand Post Limited
Graham Heenan	Chair of Canterbury Laundry Limited Chair of CLS Properties Limited
Dr David Kerr	Adviser to Health Benefits
Paul White	Director of Housing New Zealand Limited

SUBSIDIARY COMPANY

William McDonald & Jim Magee	Directors of subsidiary, Burwood Rehabilitation Limited. No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.
Chai Chuah	Director of subsidiaries, Canterbury Laundry Services Limited and CLS Properties Limited. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands (based on 6 monthly earnings being annualised) is as follows:

	30.06.01 Number
$100,000 - $110,000	53
$110,001 - $120,000	29
$120,001 - $130,000	26
$130,001 - $140,000	26
$140,001 - $150,000	29
$150,001 - $160,000	30
$160,001 - $170,000	19
$170,001 - $180,000	8
$180,001 - $190,000	1
$190,001 - $200,000	3
$200,001 - $210,000	2
$210,001 - $220,000	3
$220,001 - $230,000	1
$230,001 - $240,000	1
$240,001 - $250,000	2
$250,001 - $260,000[1]	1
$260,001 - $270,000	-
$270,001 - $280,000	1
	235

[1] Acting CEO remuneration and other benefits are included in this bracket.

Of the 235 positions identified above, 222 are predominantly clinical in nature, and 13 are management/administrative positions.

If the remuneration of part-time positions was grossed-up to an FTE basis, the total number of positions with FTE salaries of $100,000 or more would be 312, with 297 positions predominantly clinical in nature and 15 management/administrative positions.

TERMINATION PAYMENTS

Termination payments made during the 6 month period ended 30 June 2001 are as follows :

Type of Payment	Number	Amount
Redundancy payment	1	4,159
Redundancy payment	1	8,879
Redundancy payment	1	10,080
Redundancy payment	1	13,630
Redundancy payment	1	20,768
Redundancy payment	1	28,648
Redundancy payment	1	31,645
Redundancy payment	1	40,893
Redundancy payment	1	47,081
Redundancy payment	1	69,305
	10	275,088

AUDITORS

Audit New Zealand continues in office under contract to the Controller and Auditor-General who is appointed under Section 41 of the Health and Disability Services Act 1993.

For and on behalf of the Board

Board Member

Board Member

STATEMENT OF RESPONSIBILITY

Pursuant to Section 42 of the Public Finance Act 1989, we acknowledge that:

a) The preparation of financial statements of Canterbury DHB, and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems designed to give reasonable assurance as to the integrity and reliability of the financial reports for the period ended 30 June 2001, are our responsibility.

c) In our opinion, the financial statements for the 6 months under review fairly reflect the financial position and operations of Canterbury DHB.

Syd Bradley
Chair
26 October, 2001

Jean O'Callaghan
Chief Executive Officer
26 October, 2001

STATEMENT OF FINANCIAL PERFORMANCE FOR THE 6 MONTHS ENDED 30 June 2001

	Notes	Group Actual 30/06/01 $'000	Group Budget 30/06/01 $'000	Parent Actual 30/06/01 $'000
OPERATING REVENUE				
MoH Revenue		206,566	199,663	199,603
Patient Related Revenue		9,477	8,979	9,238
Other Revenue		11,735	10,784	11,044
TOTAL REVENUE		227,778	219,426	219,885
OPERATING EXPENSES				
Employee Costs		142,631	139,088	136,976
Treatment Related Costs		41,959	38,006	43,092
Depreciation		9,972	11,464	9,396
Interest Expense		3,760	4,099	3,694
Other Expenses		27,289	24,682	24,427
TOTAL OPERATING EXPENSES		225,611	217,339	217,585
OPERATING SURPLUS BEFORE CAPITAL CHARGE		2,167	2,087	2,300
MoH Revenue re Capital Charge income		5,783	6,264	5,783
Capital Charge Expense	15	(8,064)	(8,110)	(8,064)
OPERATING SURPLUS/(DEFICIT) BEFORE TAXATION	2	(114)	241	19
Tax Expense	3	(81)	-	-
OPERATING SURPLUS/(DEFICIT) AFTER TAXATION		(195)	241	19
Share of Associate Co's Surplus before Tax		116	-	116
Taxation Benefits/(Expense)		(38)	-	(38)
Share of Associate Co's Surplus after Tax		78	-	78
Minority Interest		(10)	-	-
NET SURPLUS/(DEFICIT) FOR THE PERIOD		**(127)**	**241**	**97**

This statement is to be read in conjunction with the Notes on pages 11 to 24 and the Audit Report on pages 29 to 30.

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STATEMENT OF MOVEMENTS IN EQUITY FOR THE 6 MONTHS ENDED 30 JUNE 2001

	Notes	Group Actual 30/06/01 $'000	Group Budget 30/06/01 $'000	Parent Actual 30/06/01 $'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD		-	-	-
Net Surplus/(Deficit) for the period		(127)	241	97
Total recognised revenues and expenses for the period		(127)	241	97
OTHER MOVEMENTS				
Contribution from Crown	17	156,673	144,274	156,358
TOTAL EQUITY AT END OF THE PERIOD		156,546	144,515	156,455

This statement is to be read in conjunction with the Notes on pages 11 to 24 and the Audit Report on pages 29 to 30.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2001

	Notes	Group Actual 30/06/01 $'000	Group Budget 30/06/01 $'000	Parent Actual 30/06/01 $'000
CROWN EQUITY				
General Funds	5	150,277	138,019	149,962
Retained Earnings	5	(496)	241	10
Trust Reserve	5	6,765	6,255	6,483
TOTAL EQUITY		156,546	144,515	156,455
REPRESENTED BY:				
CURRENT ASSETS				
Cash & Bank		(8,249)	(1,079)	(9,193)
Receivables and Prepayments	4	52,216	44,400	51,131
Stocks	6	6,832	7,400	6,757
TOTAL CURRENT ASSETS		50,799	50,721	48,695
CURRENT LIABILITIES				
Creditors and Accruals		26,158	33,184	25,286
Capital charge due to the Crown		8,063	-	8,063
Staff Entitlements due within 1 year	7	34,612	34,000	33,726
Loans due within 1 year	8	220	267	220
TOTAL CURRENT LIABILITIES		69,053	67,451	67,295
NET WORKING CAPITAL		(18,254)	(16,730)	(18,600)
NON CURRENT ASSETS				
Investments	11	427	448	4,230
Fixed Assets	10	271,668	265,710	266,751
Surplus Property	10	7,450	-	7,350
Restricted Assets	9	6,765	6,255	6,483
TOTAL NON CURRENT ASSETS		286,310	272,413	284,814
NON CURRENT LIABILITIES				
Staff Entitlements due after 1 year	7	2,791	3,743	2,791
Deferred Tax		45	53	
Minority Interest		26	16	
Loans repayable after 1 year	8	108,648	107,356	106,968
TOTAL NON CURRENT LIABILITIES		111,510	111,168	109,759
NET ASSETS		156,546	144,515	156,455

For and on behalf of the Board

26 October, 2001

26 October, 2001

This statement is to be read in conjunction with the Notes on pages 11 to 24 and the Audit Report on pages 29 to 30.

STATEMENT OF CASH FLOWS
FOR THE 6 MONTHS ENDED 30 JUNE 2001

	Notes	Group Actual 30/06/01 $'000	Group Budget 30/06/01 $'000	Parent Actual 30/06/01 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MoH		207,282	205,927	200,319
Other Receipts		21,181	17,382	19,837
Interest Received		125	358	298
		228,588	223,667	220,454
Cash was applied to:				
Payments to Employees		142,308	140,214	136,421
Payments to Suppliers		76,738	63,064	75,554
Interest Paid		3,849	3,062	3,773
Taxes Paid		(7)	(1,169)	-
Capital Charge		4,023	8,110	4,023
GST (net)		262	(407)	139
		227,173	212,874	219,910
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	12	1,415	10,793	544
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Sale of Assets		7	10	7
Advances & Restricted Assets		-	-	294
		7	10	301
Cash was applied to:				
Advances & Restricted Assets		392	104	-
Purchase of Assets		17,120	18,191	16,594
		17,512	18,295	16,594
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(17,505)	(18,285)	(16,293)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from :				
Loans Raised		7,367	6,013	7,367
Cash vested from Canterbury Health Limited		474	400	(811)
		7,841	6,413	6,556
Cash was applied to:				
Loans Repaid		-	-	-
		-	-	-
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		7,841	6,413	6,556
Overall Increase/(Decrease) in Cash Held		(8,249)	(1,079)	(9,193)
Opening Cash Balance		-	-	-
CLOSING CASH BALANCE		(8,249)	(1,079)	(9,193)

This statement is to be read in conjunction with the Notes on pages 11 to 24 and the Audit Report on pages 29 to 30.

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1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Public Finance Act 1989.

The group consists of Canterbury DHB, its subsidiaries Burwood Rehabilitation Limited (100% owned), Canterbury Laundry Services Limited (100% owned), CLS Properties Limited (100% owned), Brackenridge Estate Limited (100% owned), Crown Public Health Limited (76.5% owned), and associated entities, New Zealand Centre for Reproductive Medicine Limited (50% owned), Heart Surgery South Island Limited (50% owned) and South Island Shared Services Agency Limited (47% owned).

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The general accounting principles recognised as appropriate for the measurement and reporting of results and financial position on an historical cost basis, modified by the revaluation of certain fixed assets have been followed.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Revenue from contracts for services is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Limited were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of CHL. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Limited. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of Canterbury DHB
Assets acquired by the DHB since its establishment, other than those vested from Canterbury Health Limited are recorded at cost. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

iv) Depreciation

Depreciation is charged on a straight line basis so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	50
Fitout Plant and Equipment	5 - 50
Plant and Equipment	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) Goods and Services Tax

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) Donated Assets

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

vii) Stocks

Stocks are valued at the lower of cost and net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

viii) Accounts Receivable

Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

ix) Investments

The investment in the Associate Companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis.

Other investments are stated at the lower of cost and net realisable value.

Dividend income is accounted for on a cash basis. Interest income is accounted for as earned.

x) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

Canterbury DHB subsidiaries are subject to income tax. Income tax expense is charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. Deferred taxation is determined on a

comprehensive basis using the liability method. Deferred tax assets attributable to timing differences or tax bases are only recognised where there is virtual certainty of realisation.

xi) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xii) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xiii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as Finance Leases and capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiv) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xv) Provision for Staff Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, parental leave and conference leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xvi) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non current securities and advances (other than securities and advances included within cash) and any other non current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvii) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xviii) Financial Instruments

Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost or market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xix) Basis of Consolidation

The consolidated financial statements include the parent DHB and its subsidiaries. The subsidiaries are accounted for using the purchase method which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis which shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

xx) Comparative Figures

Canterbury DHB was formed on 1 January 2001 and this is its first annual report. Accordingly, there are no comparative figures for the previous year. Canterbury DHB's operations combine the functions of its predecessor Canterbury Health Limited and some of those functions previously performed by the Health Funding Authority.

D CHANGE IN ACCOUNTING POLICIES

This is the first period of operation. The accounting policies stated above have been consistently applied throughout the period and correspond to the accounting policies specified in the Statement of Intent at the beginning of the period.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating surplus is stated:

	Group 30/06/01 $'000	Parent 30/06/01 $'000
After Charging:		
Audit Fees	119	87
Board Members Fees	131	131
Director Fees	22	-
Interest Expense	3,760	3,694
Bad Debts Written Off	110	110
Increase/(Decrease) in Bad Debts Provision	(124)	(124)
Rental and Operating Lease Costs	2,069	1,409
After Crediting:		
Interest Received	125	298
Gain on Sale of Assets	7	7

3. TAXATION

The tax expense arises from the operations of subsidiary entities. The DHB itself is exempt from income tax.

	Group 30/06/01 $'000
Net Operating Surplus/(Deficit) before Taxation	(114)
Prima facie taxation @ 33%	(38)
Plus/(Less) tax effect of:	
Permanent Differences	106
Timing Differences not recognised	29
Underestimation of tax in previous year	(16)
Tax Expense	81

Permanent differences are due to results of Parent and some subsidiaries not subject to income tax.

As at 30 June 2001, a deferred tax asset of $534,000 in subsidiaries has not been recognised as there is no virtual certainty of taxable surplus in future periods. The tax effect of unrecognised timing differences is $176,000.

4. RECEIVABLES AND PREPAYMENTS

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Trade Debtors	45,887	44,817
Other Debtors	3,500	3,123
Prepayments	786	761
Tax Receivable	1,190	1,200
Amount owing by Associate	853	1,230
	52,216	51,131

5. EQUITY

GENERAL FUNDS

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Opening Balance	-	-
Equity Vested from HHS	150,277	149,962
	150,277	149,962

RETAINED EARNINGS

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Opening Balance	-	-
Operating Surplus/(Deficit)	(127)	97
Transfers from/(to) Trust Reserve	(369)	(87)
Closing Balance	(496)	10
Represented by :		
Accumulated Deficit in Parent and Subsidiary	(574)	(68)
Accumulated Surplus in Associates	78	78
	(496)	10

TRUST RESERVE

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Opening Balance	6,396	6,396
Transfers from/(to) Retained Earnings	369	87
Closing Balance	6,765	6,483

6. STOCKS

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Pharmaceutical	1,937	1,937
Surgical and Medical Supplies	3,703	3,703
Other Supplies	1,646	1,571
	7,286	7,211
Provision for Obsolescence	(454)	(454)
	6,832	6,757

Some of the stocks may be subject to restriction of title ie Romalpa Clauses. The value of stocks subject to Romalpa Clauses cannot be quantified due to the inherent difficulties in identifying stocks that are still subject to the Romalpa Clauses at year end.

7. STAFF ENTITLEMENTS

Staff Entitlements consist of:	Group 30/06/01 $'000	Parent 30/06/01 $'000
Provision for Gratuities	1,440	1,440
Provision for Long Service Leave	1,919	1,919
Annual Leave Accruals	13,251	12,531
Unpaid Days Accruals	7,474	7,474
ACC Accruals	660	660
Conference Leave Accruals	1,887	1,887
General Provisions	10,772	10,606
	37,403	36,517
Less Due Within 1 Year		
Provision for Gratuities	75	75
Provision for Long Service Leave	493	493
Annual Leave Accruals	13,251	12,531
Unpaid Days Accruals	7,474	7,474
ACC Accruals	660	660
Conference Leave Accruals	1,887	1,887
General Provisions	10,772	10,606
	34,612	33,726
Staff Entitlement Due after 1 Year	2,791	2,791

8. LOANS

Loans consist of:	Group 30/06/01 $'000	Parent 30/06/01 $'000
Commercial Loans	108,700	107,020
Finance Lease	168	168
	108,868	107,188
Repayable as follows:		
Due Within 1 Year	220	220
One to Two Years	29,148	27,468
Two to Five Years	79,500	79,500
	108,868	107,188

Facilities

The DHB has loan facilities of $75 million with WestpacTrust, $45 million with Bank of New Zealand and bonds with private institutions of $27M. WestpacTrust and Bank of New Zealand facilities expire in June 2004 while the bonds are due in June 2003.

Security

Commercial loans are secured by Deed of Negative pledge.

The finance lease is secured over the plant and equipment purchased under the lease.

Interest Rates

Weighted average interest rates on the group's borrowing for the year are as follows:

	30/06/01	30/06/01
Commercial Loans	7.66%	7.66%
Finance Lease	7.00%	7.00%
Bank Overdraft	7.35%	7.63%

9. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2001, the amount of funds received where the conditions attached have not been fulfilled is $6,765,007 for the Group and $6,483,226 for the Parent.

This is represented by:	Group 30/06/01 $'000	Parent 30/06/01 $'000
Cash at Bank	210	210
Term Deposits	3,284	3,002
Local Authorities & Government Stocks	1,801	1,501
Quoted Shares	185	185
Bonds & Stocks	1,285	1,585
Total Restricted Assets	6,765	6,483

10. FIXED ASSETS

	Group 30/06/01 $'000	Parent 30/06/01 $'000
At Cost		
Freehold land	20,824	20,824
Freehold buildings	98,902	97,184
Fitout plant and equipment	121,629	121,547
Plant and equipment	33,379	27,590
Computer equipment and software	21,277	21,277
Motor vehicles	1,310	1,192
Capital work-in-progress	9,743	9,703
At Valuation		
Freehold land	26,352	25,859
Plant and equipment	22,999	22,999
	356,415	348,175
Accumulated Depreciation		
Freehold buildings	12,452	12,300
Fitout plant and equipment	32,185	32,171
Plant and equipment	15,691	12,704
Computer equipment and software	16,429	16,429
Motor vehicles	540	470
	77,297	74,074
Net Book Value		
Freehold land	47,176	46,683
Freehold buildings	86,450	84,884
Fitout plant and equipment	89,444	89,376
Plant and equipment	40,687	37,885
Computer equipment and software	4,848	4,848
Motor vehicles	770	722
Capital work-in-progress	9,743	9,703
Reclassify to Surplus Property	(7,450)	(7,350)
	271,668	266,751

Freehold land and plant and equipment disclosed at valuation were transferred from Canterbury Health Limited. They have not yet been revalued by Canterbury DHB.

Under the terms of the Ngai Tahu Claims Settlement Act 1998, most surplus property must be first offered to Ngai Tahu. The disposal of certain properties may also be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land for Christchurch Hospital, Ashburton Hospital, Darfield Hospital and Ellesmere Hospital are held under statutory trusts.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 18 years time. This interest has not been included in the Statement of Financial Position.

The fair value of ex-Canterbury Health Limited land and buildings (including infrastructure plant and fittings) based on an independent valuation by Robertson Young Telfer on 30 June 1998 is $229,762,000 and the fair value of ex-Healthlink South Limited land and buildings based on an independent valuation by Telfer Young on 1 October 2000 is $78,100,000.

11. INVESTMENTS

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Investment in Associates	395	395
Investment in Subsidiaries	-	3,803
Other Investments	32	32
	427	4,230

INVESTMENT IN ASSOCIATES

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Share of Associates Equity Brought Forward	92	92
Share of Associates Operating Surplus	78	78
Share of Associates Equity Carried Forward	170	170
Advances	225	225
	395	395

At 30 June 2001, Associate Companies comprises :

	Percentage Interest	Balance Date
Heart Surgery South Island Limited	50	30 June
New Zealand Centre for Reproductive Medicine Limited	50	30 June
South Island Shared Services Agency Limited	47	30 June

Heart Surgery South Island Limited provides heart surgery for which Canterbury DHB invoices facility fees. New Zealand Centre for Reproductive Medicine Limited provides reproductive medicine services to private patients. South Island Shared Services Agency Limited provides support services for contracting, contract monitoring and provider audits to DHBs for their Funding arm.

INVESTMENT IN SUBSIDIARIES

	Parent 30/06/01 $'000
Equity - Burwood Rehabilitation Limited	517
Equity - CLS Properties Limited	515
Equity - Canterbury Laundry Services Limited	393
Equity - Crown Public Health Limited	1
Advances - Canterbury Laundry Services Limited	2,030
Advances - Brackenridge Estate Limited	347
	3,803

At 30 June 2001 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Laundry Services Limited	100	30 June
Burwood Rehabilitation Limited	100	30 June
CLS Properties Limited	100	30 June
Brackenridge Estate Limited	100	30 June
Crown Public Health Limited	76.5	30 June

Canterbury Laundry Services Limited provides laundry services. CLS Properties Limited is an investment company holding land and buildings that it leases to Canterbury Laundry Services Limited. Burwood Rehabilitation Limited has a 60% share in the surplus of Burwood Orthopaedic Surgical Services, a partnership which performs orthopaedic surgery for ACC and work related insurers at Burwood Hospital. Crown Public Health provides public health initiatives involving education and dissemination of information in preventative health. Brackenridge Estate Limited provides residential accommodation and ongoing care for intellectually disabled persons.

12. RECONCILIATION OF RESULTS AFTER TAX WITH NET CASHFLOW FROM OPERATING ACTIVITIES

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Net Operating Surplus/(Deficit) before Share of Associate Co's Surplus	(195)	19
Add Back Non-Cash Items:		
Depreciation	9,972	9,396
Add Back Items Classified as Investing Activity:		
Gain on Asset Sale	(7)	(7)
	9,770	9,408
Movement in Term Portion Staff Entitlement	(171)	(171)
Movement in Deferred Tax	(8)	-
Movements in Working Capital:		
Decrease/(Increase) in Receivables & Prepayments	(3,791)	(4,153)
Decrease/(Increase) in Stocks	351	340
Increase/(Decrease) in Creditors & Other Accruals	(9,271)	(9,130)
Increase/(Decrease) in Capital Charge due to Crown	4,041	4,041
Increase/(Decrease) in Staff Entitlements	494	726
Less Items in Creditors relating to Investing activities		(517)
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	1,415	544

13. COMMITMENTS

	Group 30/06/01 $'000	Parent 30/06/01 $'000
CAPITAL COMMITMENTS		
Committed At Balance Date	18,701	20,150

Capital commitments include amount approved by the Board but where contracts may not have been signed or purchase orders issued.

NON CANCELLABLE OPERATING LEASE COMMITMENTS

Accommodation Leases	8,708	3,299
Computer Leases	446	323
Vehicle Leases	786	572
	9,940	4,194
For Expenditure Within:		
1 Year	2,929	1,461
2 Years	1,817	679
3 Years and Beyond	5,194	2,054
	9,940	4,194

14. TRANSACTIONS WITH RELATED PARTIES

GOVERNMENT FUNDING

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the company.

The company enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

INTER-GROUP TRANSACTIONS

During the financial year the group had the following inter-group transactions:

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Revenue		
Facility fees from Heart Surgery South Island Limited	2,682	2,682
Interest on advance from Canterbury Laundry Services Limited	-	114
Interest on advance from Brackenridge Estate Limited	-	34
Fees from Burwood Rehabilitation Limited	-	703
Services to Crown Public Health Limited	-	303
Expenses		
Linen Services and Rentals from Canterbury Laundry Services Limited	-	1,852

Interest charged on advances (refer Note 11) to Canterbury Laundry Services Limited, are at normal borrowing rates. Other balances are at normal trading terms.

AMOUNT OUTSTANDING

The amounts outstanding for all related party transactions as at 30 June are as follows :

	Group 30/06/01 $'000	Parent 30/06/01 $'000
Amount Payable included in Creditors		
Burwood Orthopaedic Surgical Services	24	24
Amount Receivable included in Amount Owing by Associates		
Heart Surgery South Island Limited	1,230	1,230
Amount Receivable owing by Subsidiaries		
Canterbury Laundry Services Limited		40
NZ Centre for Reproductive Medicine Limited		89
Brackenridge Estate Limited		45

15. CAPITAL CHARGE

The DHB pays a capital charge monthly to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2001 was 11.0%.

16. FINANCIAL INSTRUMENTS

CREDIT RISK

Financial instruments which potentially subject the group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts.

The group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2001, the Ministry of Health owed $37.4 million and had paid 97.2 percent of the amount owing by 31 July 2001.

CURRENCY RISK

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary.

There are no foreign exchange instruments outstanding at 30 June 2001.

INTEREST RATE RISK

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities.

There is an interest rate swap for converting floating interest rate to fixed interest rate of $25 million outstanding at 30 June 2001. Market value of the swap at 30 June is a payable of $199,000.

FAIR VALUES OF FINANCIAL INSTRUMENTS

Financial instruments recorded in the financial statements have been recorded at their fair values.

10M

17. VESTING OF ASSETS

Canterbury DHB was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000. On that date, the assets and liabilities of Canterbury Health Limited were vested in Canterbury DHB at their carrying values as recorded in the books of the Hospital and Health Service. The net value of the assets vested is recognised as a capital contribution by the Crown, the owner of both Canterbury DHB and Canterbury Health Limited.

The assets and liabilities vested in the DHB were :

	Group $'000	Parent $'000
Current Assets		
Cash and Bank	474	(811)
Receivables and Prepayments	48,425	46,978
Stocks	7,183	7,097
Total Current Assets	56,082	53,264
Current Liabilities		
Creditors and Accruals	35,429	34,416
Capital Charge due to the Crown	4,022	4,022
Staff Entitlements due within 1 year	34,118	33,000
Loans due within 1 year	270	270
Total Current Liabilities	73,839	71,708
Net Working Capital	(17,757)	(18,444)
Non Current Assets		
Investments	326	4,016
Fixed Assets	264,520	259,553
Surplus Property	7,450	7,350
Restricted Assets	6,396	6,396
Total Non Current Assets	278,692	277,315
Non Current Liabilities		
Staff Entitlements due after 1 year	(2,962)	(2,962)
Deferred Tax	(53)	-
Minority Interest	(16)	-
Loans repayable after 1 year	(101,231)	(99,551)
Total Non Current Liabilities	(104,262)	(102,513)
Net Assets transferred to DHB	156,673	156,358
Comprising		
General Funds	150,277	149,962
Trust Funds	6,396	6,396

18. SEGMENTAL REPORTING

Canterbury DHB operates in the provision of Health and Disability Support Services Industry in the South Island of New Zealand. Therefore, no segmental reporting is required.

19. CONTINGENT LIABILITIES

The group has outstanding legal proceedings and disputes by third parties. The Group disputes these claims and believe that it is unlikely any material loss will eventuate.

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE

Canterbury District Health Board (DHB) came into existence on 1 January 2001, and its predecessor, Canterbury Health Limited, ceased to exist. The creation of the Canterbury DHB is the result of a major change to the structure of the New Zealand publicly funded health sector, following the enactment of the New Zealand Health and Disability Act in December 2000.

Canterbury DHB will progressively take over most of the public funding of health and disability services for the people of Canterbury by assuming many of the functions of the Health Funding Authority, which was disestablished on 1 January 2001. Canterbury DHB has also taken over the roles of Canterbury Health Limited and Healthlink South Limited, which were the Hospital and Health Service providers for the district, and also provided tertiary services to the South Island and for some services, nationally.

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000; and

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000.

The performances for the 6 months to 30 June 2001 are as follows:

Good Employer

Personnel policies adopted by Canterbury DHB to meet the objective of being a good employer include:

- commitment to the principles of Equal Employment Opportunity (EEO) : fair and equitable treatment of everyone on employment-related issues regardless of race, gender, marital status, religious belief, sexual orientation, political opinion, age, employment status or family responsibilities.
- a staff training and development policy that is consistent, equitable and effective throughout the organisation in order to enable the development of employees to meet the strategic goals of the organisation within the principles of a learning organisation.
- a remuneration policy where:
  - Canterbury DHB will pay market related rates of remuneration and provide market related conditions of employment;
  - terms and conditions of employment provide fair relativity with similar operations and industries within New Zealand;
  - within Canterbury DHB the terms and conditions of employment be fair and equitable within individual categories of employment; and
  - that work performance and contribution towards the organisation's objectives be relevant criteria for individual reward and advancement.

Funder Objectives

The objectives of Section 22 and Section 23 of the New Zealand Public Health and Disability Act 2000, other than the "good employer" obligation deal mainly with the function as a Funder. For the 6 months to 30 June 2001, Canterbury DHB did not act as a Funder. During this period, the Ministry of Health has performed the entire Funder role. The objective for Canterbury DHB during this period has been to build up its capability to act as a Funder from July 2001. It is expected that over time, commencing from 1 July 2001, the Canterbury DHB will assume responsibility for the needs analysis, health planning, prioritisation and funding of health and disability services for the population in North and Central Canterbury, a population of approximately 412,000. Responsibility for funding Disability Support Services and Public Health Services is not expected to be devolved to Canterbury DHB until July 2002.

Governance and Funder Administration

Nature and Scope

The governance function is carried out by the Board over the strategic and operational functions of Canterbury DHB as a Funder and as a Provider. The Board in making governance related decisions is advised where appropriate by three statutory committees.

Funder administration is performed by the Planning and Funding Department and supported by centralised support units which include Communication, Human Resource, Finance, Information Services, Logistics, Legal and Secretariat, Internal Audit and Risk/Quality.

The centralised support units also provide support to the Provider. This centralised approach enables Canterbury DHB to avoid duplication of resources ensuring that funding is used effectively and efficiently.

Performance

Governance and Funder Administration's performance against targets during the six months to 30 June 2001 is as follows:

Objective	Achievement
1. Establish all Board Advisory committees.	Board advisory committees established and operational at 30 June 2001.
2. Staff are appointed to all key positions in Canterbury DHB organisation structure.	Staff for key positions appointed at 30 June 2001.
3. South Island Shared Services Agency Limited established in conjunction with other South Island DHBs.	South Island Shared Services Agency Limited established and operational at 30 June 2001.
4. The capability and processes required to carry out the Funder functions are in place.	Planning and Funding Department established and resourced to perform the Funder functions. Processes implemented in conjunction with Health Benefits and Shared Services Support Group for payments to providers.
5. Plan to achieve increased integration completed.	Improved accountability structure in Elder Care Canterbury, which includes appointment of an independent Chair.
6. Memorandum of Understanding with Tangata Whenua Ngai Tahu signed.	Latest draft currently with Ngai Tahu working party.
7. Identify, investigate and implement measures to improve responsiveness to Maori, including ability to develop and contract with Maori providers.	Appointment of Maori Manager and establishment of a Maori executive group.
8. Draft Statement of Intent to Responsible Minister by 31 May 2001.	Draft Statement of Intent sent to Responsible Minister by 31 May 2001.
9. Annual Plan approved by Responsible Minister before 1 July 2001.	Draft Annual Plan sent to Responsible Minister by 1 July 2001. Ministry of Health and Treasury staff are satisfied with the draft and working with Canterbury DHB to finalise additional accountability indicators.
10. Regular hui established to gain Maori input to Maori provider development, and to achieving progress on the eight Maori health gain priority areas.	Hui undertaken quarterly.

Provider

Nature and Scope

The primary activities and functions of Canterbury DHB as a provider are:

- hospital based acute and arranged secondary and tertiary level medical and surgical services;
- a full range of general and specialist mental health services delivered from both hospital and community settings;
- physical rehabilitation healthcare services;
- disability support services, including a full range of services for older persons delivered in both hospital and community settings, and residential services for people with intellectual disability;
- a range of community health services including school and community dental services, well child services and some outreach services; and
- public health services delivery by public health nurses and services from Crown Public Health Limited (a subsidiary of Canterbury DHB).

These services are provided from a number of facilities and sites, including the following:

- Christchurch Hospital provides acute secondary and tertiary medical and surgical services, including a full range of diagnostic services, as well as teaching and research.
- Burwood Hospital provides physical rehabilitation and surgical services, and is the base for a range of community services, including well child services and some public health services.
- Christchurch Women's Hospital provides primary obstetric services and secondary and tertiary obstetric, neonatal and gynaecology services.
- Princess Margaret Hospital and the Cashmere site provide assessment, treatment and rehabilitation services for older persons, as well as psycho-geriatric services and a range of specialist mental health services.
- The Hillmorton site (formerly Sunnyside) provides a range of general and specialist adult and child mental health services,
- Brackenridge Estate Limited provides services for intellectually disabled persons.
- Canterbury DHB also provides community focused and secondary healthcare services from locations outside of Christchurch. The community services are based at hospitals located in Akaroa, Ashburton, Darfield, Ellesmere, Kaikoura, Lincoln, Oxford, Rangiora and Waikari, with secondary services being delivered at Ashburton.
- Public Health services are provided by public health nurses and Crown Public Health Limited, a subsidiary of Canterbury DHB.

These services are mainly provided to the people of the Canterbury District, but a range of tertiary services are provided to people living throughout the South Island, and for some services, to people who live throughout New Zealand.

Performance

In House Provider's performance against targets during the six months to 30 June 2001 is as follows :

Outputs	
Performance Measure and Target	**Achievement**
1. Inpatient bed days actual - 227,000	Provided 211,819 inpatient bed days
2. Inpatient discharges - 29,000	Delivered 28,966 discharges
3. Outpatient attendances - 205,500	Delivered 252,853 outpatient attendances
4. Case Weight of Surgical Discharges - 15,500	Delivered 17,374 case weights
5. Case Weight of Medical and Other Discharges - 14,500	Delivered 22,758 case weights
6. Emergency attendances - 37,500	Delivered 34,536 attendances

Outcomes	
Performance Measure and Target	**Achievement**
1. Fulfil 100% of 6 months promise letters	Achieved 96.64%.
2. Fulfil 100% waiting list guidelines set by Ministry of Health	Achieved 100%
3. Achieve 85% in overall inpatient satisfaction survey	Achieved 90.40%
4. Achieve 85% in overall outpatient satisfaction survey	Achieved 91.27%
5. Ratio of patient falls per inpatient day and 0.5 day patients are not more than 4.5.	Ratio 3.52
6. Ratio of IV and medication errors per inpatient day and 0.5 day patients is no more than 1.5	Ratio 1.36
7. Ratio of bloodstream infections per 1,000 inpatients is no more than 2.5	Ratio 0.48
8. Average length of stay, excluding longstay patients is no more than 5 days.	Achieved 5.2
9. Average number of days sickness per FTE is not more than 1.5	Average 3.02
10. Staff turnover per total FTEs is no more than 10%	Turnover 8%
11. Achieve 78% occupancy for resourced beds	Achieved 80.2%

Statement Specifying Financial Performance

	Group 30.06.01 Actual	Group 30.06.01 Target	Parent 30.06.01 Actual	Parent 30.06.01 Target
Debt / (Debt + Equity) Ratio	41%	43%	41%	42%
Debt / Equity Ratio	70%	74%	69%	73%
Equity / Total Assets	45%	45%	46%	46%
Interest Cover Ratio	3.62	3.86	3.57	3.79

Audit New Zealand

REPORT OF THE AUDIT OFFICE

TO THE READERS OF THE FINANCIAL STATEMENTS OF CANTERBURY DISTRICT HEALTH BOARD FOR THE SIX MONTH PERIOD ENDED 30 JUNE 2001

We have audited the financial statements on pages 7 to 28. The financial statements provide information about the past financial and service performance of Canterbury District Health Board and its financial position as at 30 June 2001. This information is stated in accordance with the accounting policies set out on pages 11 to 14.

Responsibilities of the District Health Board

The New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 require the District Health Board to prepare financial statements in accordance with generally accepted accounting practice which fairly reflect the financial position of Canterbury District Health Board as at 30 June 2001, the results of its operations and cash flows and the service performance achievements for the six month period ended 30 June 2001.

Auditor's Responsibilities

Section 43(1) of the Public Finance Act 1989 requires the Audit Office to audit the financial statements presented by the District Health Board. It is the responsibility of the Audit Office to express an independent opinion on the financial statements and report its opinion to you.

The Controller and Auditor-General has appointed Devan Menon, of Audit New Zealand, to undertake the audit.

Basis of Opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- the significant estimates and judgements made by the District Health Board in the preparation of the financial statements *and*
- whether the accounting policies are appropriate to Canterbury District Health Board's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with generally accepted auditing standards, including the Auditing Standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

We carried out an assurance related assignment relating to tendering processes. Other than this assignment and in our capacity as auditor acting on behalf of the Controller and Auditor-General, we have no relationship with or interests in Canterbury District Health Board.

Unqualified Opinion

We have obtained all the information and explanations we have required.

In our opinion the financial statements of Canterbury District Health Board on pages 7 to 28:

- comply with generally accepted accounting practice *and*
- fairly reflect:
  - the financial position as at 30 June 2001;
  - the results of its operations and cash flows for the six month period ended on that date; *and*
  - the service performance achievements in relation to the performance targets and other measures adopted for the six month period ended on that date.

Our audit was completed on 26 October 2001 and our unqualified opinion is expressed as at that date.

D Menon
Audit New Zealand
On behalf of the Controller and Auditor-General
Christchurch, New Zealand

APPENDIX 2

Canterbury District Health Board

Report For the Year Ended
30 June 2002

Table of Contents

DIRECTORY

Board Members

Syd Bradley - Chair
Randall Allardyce
Philip Bagshaw
Erin Baker
Robin Booth
Graham Heenan
David Morrell
Tuari Potiki
Olive Webb
Paul White
Alison Wilkie

Chief Executive Officer

Jean O'Callaghan

Registered Office

Charles Luney House
250 Oxford Tce
PO Box 1600
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

WestpacTrust
Bank of New Zealand

MISSION STATEMENT

The Canterbury DHB's mission is to improve, promote and protect the health of the people in the community and foster the well- being and independence of people with disabilities and reduce disparities.

Board Members

Syd Bradley - Chair	Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB. Syd has served on a number of boards since resigning from General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a Director of the Canterbury Health Ltd and subsequently as Director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.
Randall Allardyce	Randall Allardyce is a director of medical research at the Christchurch School of Medicine & Health Sciences and is also affiliated to the University of Canterbury. Based in Cust, Randall has headed or worked for many North Canterbury community projects and healthcare initiatives as well as the establishment of the NZ Liver Transplantation Unit, the national introduction of keyhole surgery and the new Mobile Surgical Unit.
Philip Bagshaw	Philip Bagshaw is a general surgeon at Christchurch Hospital and is an Associate Professor of Surgery at the University of Otago's Christchurch School of Medicine and Health Sciences. Philip was appointed to the academic staff there in 1981, where he teaches and does research work. Philip has already served on the Canterbury District Health Board for one year.
Erin Baker	Erin Baker is currently a councillor serving on the Christchurch City Council. Erin trained as a radiographer at Christchurch Hospital and worked in this profession both in Christchurch and overseas before becoming a professional athlete. Erin has also served on the boards of Jade Stadium Limited and Christchurch and Canterbury Marketing Limited.
Robin Booth	Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
Graham Heenan	Graham Heenan has been involved in business management for nearly 30 years, since graduating with a Bachelor of Commerce in 1972. Currently Graham is self employed, and a director of numerous companies throughout the South Island. Graham's interest in the health sector has been as a director of Canterbury Health Ltd since 1995, and of Health South Canterbury (1998-2000). His particular skills relate to governance, strategic planning, finance and marketing.

/ continued /

Board Members - continued

David Morrell

David Morrell is City Missioner in Christchurch, and has had 30 years involvement with general health and mental health through hospital chaplaincy, primarily at Christchurch Hospital during the 1970s and subsequently at the City Mission. City Missioner since 1982, David has had extensive management training, both here and in the United Kingdom.

Tuari Potiki

Tuari Potiki is of Kai Tahu, Kati Mamoe descent, belonging to the hapu of Kati Taoka and Kai Te Ruahikihiki. He has a background in Maori health and has worked extensively in the alcohol and drug, mental health, and justice sectors. Tuari is currently Social Development manager with the Ngai Tahu Development Corporation.

Olive Webb

Olive Webb is a clinical psychologist, has more than 30 years experience working in the disability sector, particularly with people with intellectual disabilities. Based in Hororata, Olive has a focus on rural health issues and delivery. She is the national Health Consultant for IHC and also consults in the Mental Health sector. Olive has served on the Canterbury District Health Board for one year.

Paul White

Paul White is from the Ngai Tupoto hapu of Te Rarawa Iwi. Paul has a 20-year background in Maori development and wide experience in the public service. He is currently a management and development consultant and professional director.
Previous to this Paul was the Chief Executive of Ngai Tahu Development Corporation where he worked for three and a half years, a Regional Director for Te Puni Kokiri in Tai Tokerau for five years, and Branch Manager for the Housing Corporation in Northland where he worked for seven years. Paul is a registered architect and has a Masters in Business Studies, he is also a board member on Housing NZ Ltd. Paul is married to Claire, who is Ngai Tahu and has three children, Tawini, Te Hau, and Kaahu.

Alison Wilkie

Alison Wilkie served on the Riccarton-Wigram Community Board for three years. Alison trained as a nurse at Christchurch Hospital and has post-graduate qualifications in health economics and public health. A life member of the Asthma Foundation and the Canterbury Asthma Society, Alison has worked as an asthma and respiratory educator and owns a small business. Alison has served on the Canterbury District Health Board for one year.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the period ended 30 June 2002.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based district health board, which provides Health and Disability Support Services, principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the year, the Group made a net deficit after capital charge of $21.6 million (budgeted deficit $20.0 million).

BOARD FEES

Board fees paid, or due payable, to Board Members for services during the period, are as follows :

	Board Fees Period ended 30/06/02 $'000	Committee Fees to Board Members Period ended 30/06/02 $'000
Syd Bradley	48	7
Randall Allardyce	13	3
Philip Bagshaw	24	5
Erin Baker	13	3
Robin Booth	13	3
Marty Braithwaite (resigned)	10	2
David Kerr (resigned)	15	3
Graham Heenan	24	8
David Morrell	13	2
Mick Ozimek (resigned)	10	2
Tahu Potiki (resigned)	4	-
Tuari Potiki	11	3
Api Talemaitoga (resigned)	10	1
Olive Webb	27	5
Paul White	24	7
Alison Wilkie	24	7
	283	61

The limit of fees authorised for the year ended 30/06/02 was $370,875. The Board Members fees paid in the six months ended 30/06/01 were $111,000 compared to the authorised limit of $114,000.

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the period are as follows:

	Year Ended 30/06/02 $'000
G Coyle	2
A Lomax	9
E Stratford	1
J Luhrs	4
C Climo	4
G Heenan	9
A Urlwin	10
	39

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the following transactions during the period:

CANTERBURY DHB

Syd Bradley	Deputy Chair of New Zealand Post Ltd
Graham Heenan	Chair of Canterbury Laundry Services Ltd. Chair of CLS Properties Ltd
Dr David Kerr	Adviser to Health Benefits Adviser to Pegasus Health Ryman Healthcare Ltd
Paul White	Director of Housing New Zealand Ltd
Randall Allardyce	Director of Breath Testing Service
Alison Wilkie	Canterbury Asthma Society
David Morrell	City Missioner in Christchurch City Mission
Erin Baker	Christchurch City Council
Robin Booth	Christchurch City Council
Api Talemaitoga	Pacific Trust Canterbury Member of Pegasus Health
Mick Ozimek	Member of Pegasus Health
Neville Fagerlund	Adviser to Pegasus Health
Fiona Pimm	South Canterbury DHB

SUBSIDIARY COMPANIES

William McDonald	Director of subsidiary, Burwood Rehabilitation Limited. No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.

Chai Chuah	Director of subsidiaries, Canterbury Laundry Services Limited and CLS Properties Limited. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Paul Numan	Director of subsidiary, Brackenridge Estate Ltd. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.

DIRECTORS' AND BOARD MEMBERS' LOANS

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensures that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

USE OF BOARD OR SUBSIDIARIES' INFORMATION

During the period, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

TERMINATION PAYMENTS

Termination payments made during the year 30 June 2002 are as follows :

Number	Amount
1	750
1	1,200
1	1,208
1	10,800
1	14,137
1	14,463
1	15,000
1	23,748
1	37,830
1	39,351
1	40,000
1	45,000
1	49,135
1	67,105
1	87,280
15	447,007

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands (for 00/01 based on 6 monthly earnings being annualised) is as follows:

	30/06/02 Number	30/06/01 Number
$100,000 - $110,000	43	53
$110,001 - $120,000	22	29
$120,001 - $130,000	24	26
$130,001 - $140,000	27	26
$140,001 - $150,000	27	29
$150,001 - $160,000	29	30
$160,001 - $170,000	21	19
$170,001 - $180,000	8	8
$180,001 - $190,000	9	1
$190,001 - $200,000	10	3
$200,001 - $210,000	1	2
$210,001 - $220,000	3	3
$220,001 - $230,000	1	1
$230,001 - $240,000	-	1
$240,001 - $250,000	-	2
$250,001 - $260,000	1	1
$270,001 - $280,000	-	1
$350,001 - $360,000[1]	1	-
	227	235

Of the 227 positions identified above, 206 are predominantly clinical and 21 positions are management/administrative. If the remuneration of part-time positions were grossed-up to an FTE basis, the total number of position with FTE salaries of $100,000 or more would be 349 with 328 positions predominantly clinical and 21 positions management/administrative.

[1] CEO remuneration and other benefits are included in this bracket.

STATUTORY DISCLOSURE

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000,

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000 and

(c) a report on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2002, for the above additional disclosure requirements:

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	**Extent objectives met**
(a) to improve, promote, and protect the health of people and communities:	Initial Regional Needs Assessment completed and discussed with wider community November 2001. CDHB workshopped Strategic Plan process with internal and external stakeholders, produced a plan, then consulted in the community about directions and priorities. Plan changed as a result of consultation. As part of this process CDHB produced initial Health Needs Assessment to inform it on health and disability of its people and community.
(b) to promote the integration of health services, especially primary and secondary health services:	Strategic Plan promotes initiatives in response to its 5 Core Directions 'Working Together' and 'Finding Better Ways of Working'.
(c) to promote effective care or support for those in need of personal health services or disability support services:	CDHB has supported initiatives that assess service gaps/effective utilisation as a way of informing service development, eg, Proposal for Change, LinkAGE Project.
(d) to promote the inclusion and participation in society and independence of people with disabilities:	CDHB has actively supported the DSA Committee and produced a Disability Strategic Action Plan which has timelines for various actions in area of employment, confirmation, participation.
(e) to reduce health disparities by improving health outcomes for Maori and other population groups:	CDHB has produced its Maori Health Action Plan, which has timelines for specific actions designed to assist in improving health outcomes for Maori.
(f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The CDHB Health Needs Assessment has identified groups in the community which have health inequalities. Strategic Plan Health Gain Priority areas (eg, Child and Youth, Maori) have been identified as part of this process.
(g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	CDHB has endeavoured to provide for service coverage for people in its community and is involved in such groups as Strengthening Families to advance interagency cooperation.
(h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	Forums such as Healthy Christchurch, Elder Care Canterbury, Maori Hui, DHBNZ, Local Diabetes Team are examples of groups the CDHB is an active participant in with a view to comprehensive service planning that will lead to health improvement.

(i)	to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	CDHB works to ensure these standards are upheld by developing policies (such as tendering policies) that comply with public sector best practice and ensuring quality is specified in all contracts.
(j)	to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	CDHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme.
(k)	To be a good employer	Various strategies and systems processes implemented but further initiatives can be developed. • Culture survey undertaken across organisation. This will assist in further identifying initiatives. • Development of cluster structure at Christchurch Hospital to facilitate greater involvement at all levels across all medical disciplines. • Harassment and Bullying Policy and training implemented to assist in providing a better working environment. • Management leadership training in place. Policies and approaches under development to provide for greater involvement of Maori and Pacific Island people in the CDHB workforce.

Section 42(3)(i): Statement of how CDHB has given effect and intends to give effect to its functions specified in section 23 (b) – (e)	
Function :	**What has been done to meet function**
(b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	• Involving stakeholders in delivery of Core Directions and health gain priority areas for CDHB Strategic Plan. • Actively involve relevant groups and individuals.
(c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):	• Continuation of written media, TV and radio work to outline general issues and priorities. • To continue to respond directly to media/personal/group enquiries. • To circulate/make available significant documents/plans for population in summary and comprehensive form either at libraries, via groups or individually.
(d) to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:	Relationships with Manawhenua Ki Waitaha; Te Runanga and Nga Maata Waka; Maori community through quarterly consultation hui and with Maori providers and other Maori community organisations.
(e) to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori:	Within the provider arm a range of Komiti for Maori staff have been established across the divisions and Te Ao Marama the CDHB wide Maori Health Group.

For and on behalf of the Board

Board Member

Board Member

STATEMENT OF RESPONSIBILITY

Pursuant to Section 42 of the Public Finance Act 1989, we acknowledge that:

a) The preparation of financial statements of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the period ended 30 June 2002, are our responsibility.

c) In our opinion, the financial statements for the year under review fairly reflect the financial position and operations of Canterbury DHB.

Syd Bradley
Chair
25 October, 2002

Jean O'Callaghan
Chief Executive Officer
25 October, 2002

STATEMENT OF FINANCIAL PERFORMANCE FOR THE PERIOD ENDED 30 June 2002

	Notes	Group			Parent	
		Actual 12 mths to 30/06/02 $'000	Budget 12 mths to 30/06/02 $'000	Actual 6 mths to 30/6/01 $'000	Actual 12 mths to 30/06/02 $'000	Actual 6 mths to 30/6/01 $'000
OPERATING REVENUE						
MoH Revenue		623,078	637,904	212,349	609,975	205,386
Patient Related Revenue		22,611	20,462	9,477	22,609	9,238
Other Revenue		9,708	11,170	11,735	9,190	11,044
TOTAL REVENUE		655,397	669,536	233,561	641,774	225,668
OPERATING EXPENSES						
Employee Costs		299,748	289,534	142,631	289,231	136,976
Treatment Related Costs		83,402	79,272	41,959	85,562	43,092
External Service Providers		195,119	219,001	-	195,119	-
Depreciation	11	20,892	23,110	9,972	19,761	9,396
Interest Expense		7,443	9,500	3,760	7,310	3,694
Other Expenses		54,244	49,856	27,289	50,477	24,427
TOTAL OPERATING EXPENSES		660,848	670,273	225,611	647,460	217,585
OPERATING SURPLUS / (DEFICIT) BEFORE CAPITAL CHARGE		(5,451)	(737)	7,950	(5,686)	8,083
Capital Charge Expense		(16,192)	(19,281)	(8,064)	(16,192)	(8,064)
OPERATING SURPLUS/(DEFICIT) BEFORE TAXATION	2	(21,643)	(20,018)	(114)	(21,878)	19
Tax (Expense)/ Benefit	3	50	-	(81)	-	-
OPERATING SURPLUS (DEFICIT) AFTER TAXATION		(21,593)	(20,018)	(195)	(21,878)	19
Share of Associate Co's Surplus before Tax		-	-	116	-	116
Taxation Benefits/(Expense)		-	-	(38)	-	(38)
Share of Associate Co's Surplus after Tax		-	-	78	-	78
Minority Interest Share of Surplus in Subsidiary		(30)	0	(10)	-	-
NET SURPLUS / (DEFICIT) FOR THE YEAR		**(21,623)**	**(20,018)**	**(127)**	**(21,878)**	**97**

This statement is to be read in conjunction with the Notes on pages 16 to 31 and the Audit Report on pages 85 to 86.

STATEMENT OF MOVEMENTS IN EQUITY FOR THE PERIOD ENDED 30 JUNE 2002

	Notes	Group			Parent	
		Actual 12mths to 30/06/02 $'000	Budget 12mths to 30/06/02 $'000	Actual 6 mths to 30/06/01 $'000	Actual 12 mths to 30/06/02 $'000	Actual 6 mths to 30/06/01 $'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD:						
Equity excluding Minority Interest		156,546	157,185	-	156,455	-
Minority Interest		26	1	-	-	-
		156,572	157,186	-	156,455	-
TOTAL RECOGNISED REVENUES AND EXPENSES:						
Net surplus / (deficit) for the period		(21,623)	(20,018)	(127)	(21,878)	97
Attributable to Minority Interest		30	-	10	-	-
		(21,593)	(20,018)	(117)	(21,878)	97
OTHER MOVEMENTS						
Contribution from Crown	17	-	19,000	156,673	-	156,358
Minority Interest Introduced	17	-	-	16	-	-
		-	19,000	156,689	-	156,358
TOTAL EQUITY AT END OF THE PERIOD:						
Equity excluding Minority Interest		134,923	156,167	156,546	134,577	156,455
Minority Interest		56	1	26	-	-
		134,979	156,168	156,572	134,577	156,455

This statement is to be read in conjunction with the Notes on pages 16 to 31 and the Audit Report on pages 85 to 86.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2002

	Notes	Group			Parent	
		Actual as at 30/06/02 $'000	Budget as at 30/06/02 $'000	Actual as at 30/06/01 $'000	Actual as at 30/06/02 $'000	Actual as at 30/06/01 $'000
CROWN EQUITY						
General Funds	5	149,824	169,301	149,824	149,962	149,962
Revaluation Reserve	5	453	453	453	-	-
Retained Earnings	5	(22,534)	(20,018)	(496)	(22,268)	10
Trust Reserve	5	7,180	6,431	6,765	6,883	6,483
Minority Interest		56	1	26	-	-
TOTAL EQUITY		134,979	156,168	156,572	134,577	156,455
REPRESENTED BY:						
CURRENT ASSETS						
Cash & Bank		(3,635)	(10,781)	(8,249)	(4,531)	(9,193)
Receivables and Prepayments	4	52,596	52,690	52,216	51,364	51,131
Stocks	6	7,331	6,858	6,832	7,276	6,757
TOTAL CURRENT ASSETS		56,292	48,767	50,799	54,109	48,695
CURRENT LIABILITIES						
Creditors and Accruals		59,192	35,062	35,967	58,468	35,185
Owing to Crown		7,834	4,125	8,063	7,834	8,063
Staff Entitlements due within 1 year	7	28,661	34,654	24,713	27,996	23,827
Loans due within 1 year	9	27,568	27,667	220	27,468	220
TOTAL CURRENT LIABILITIES		123,255	101,508	68,963	121,766	67,295
NET WORKING CAPITAL		(66,963)	(52,741)	(18,164)	(67,657)	(18,600)
NON CURRENT ASSETS						
Investments	10	466	500	427	4,032	4,230
Fixed Assets	11	269,641	279,987	271,668	264,905	266,751
Surplus Property	11	7,450	7,450	7,450	7,350	7,350
Restricted Assets	8	7,180	6,431	6,765	6,883	6,483
TOTAL NON CURRENT ASSETS		284,737	294,368	286,310	283,170	284,814
NON CURRENT LIABILITIES						
Staff Entitlements due after 1 year	7	3,636	2,962	2,791	3,636	2,791
Provision for maintenance	21	210	-	90	-	-
Deferred Tax	3	69	53	45	-	-
Loans repayable after 1 year	9	78,880	82,444	108,648	77,300	106,968
TOTAL NON CURRENT LIABILITIES		82,795	85,459	111,574	80,936	109,759
NET ASSETS		134,979	156,168	156,572	134,577	156,455

For and on behalf of the Board

25 October, 2002

25 October, 2002

This statement is to be read in conjunction with the Notes on pages 16 to 31 and the Audit Report on pages 85 to 86.

STATEMENT OF CASH FLOWS
FOR THE PERIOD ENDED 30 JUNE 2002

	Notes	Group Actual 12mths to 30/06/02 $'000	Group Budget 12mths to 30/06/02 $'000	Group Last Year 6 mths to 30/06/01 $'000	Parent Actual 12 mths to 30/06/02 $'000	Parent Last Year 6 mths to 30/06/01 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from MoH		621,518	623,904	207,282	608,550	200,319
Other Receipts		30,191	30,717	21,181	29,519	19,837
Interest Received		565	516	125	717	298
		652,274	655,137	228,588	638,786	220,454
Cash was applied to:						
Payments to Employees		293,724	289,534	142,308	283,235	136,421
Payments to Suppliers		311,060	329,461	76,738	309,438	75,554
Interest Paid		7,322	9,500	3,849	7,187	3,773
Taxes Paid / (Refunded)		(1,094)	(1,200)	(7)	(1,200)	-
Capital Charge		16,356	19,281	4,023	16,356	4,023
GST (net)		(1,322)	-	262	(1,304)	139
		626,046	646,576	227,173	613,712	219,910
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	12	26,228	8,561	1,415	25,074	544
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of Assets		579	-	7	579	7
Advances & Restricted Assets		-	-	-	-	294
		579	-	7	579	301
Cash was applied to:						
Advances & Restricted Assets		454	-	392	202	-
Purchase of Assets		19,319	31,097	17,120	18,369	16,594
		19,773	31,097	17,512	18,571	16,594
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(19,194)	(31,097)	(17,505)	(17,992)	(16,293)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from :						
Loans Raised		-	20,000	7,367	-	7,367
Cash vested from Canterbury Health Ltd		-	-	474	-	(811)
Equity contribution from the Crown		-	19,000	-	-	-
		-	39,000	7,841	-	6,556
Cash was applied to:						
Loans Repaid		2,420	19,000	-	2,420	-
		2,420	19,000	-	2,420	-
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(2,420)	20,000	7,841	(2,420)	6,556
Overall Increase/(Decrease) in Cash Held		4,614	(2,536)	(8,249)	4,662	(9,193)
Opening Cash Balance		(8,249)	(8,245)	-	(9,193)	-
CLOSING CASH BALANCE		(3,635)	(10,781)	(8,249)	(4,531)	(9,193)

This statement is to be read in conjunction with the Notes on pages 16 to 31 and the Audit Report on pages 85 to 86.

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Public Finance Act 1989.

The group consists of Canterbury DHB, its subsidiaries Burwood Rehabilitation Limited (100% owned), Canterbury Laundry Services Limited (100% owned), CLS Properties Limited (100% owned), Brackenridge Estate Limited (100% owned), Crown Public Health Limited (76.5% owned), and associated entities, New Zealand Centre for Reproductive Medicine Limited (50% owned), Heart Surgery South Island Limited (50% owned) and South Island Shared Services Agency Limited (47% owned).

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The general accounting principles recognised as appropriate for the measurement and reporting of results and financial position on an historical cost basis.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Revenue from contracts for services is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Limited were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of CHL. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Limited. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of Canterbury DHB
Assets acquired by the DHB since its establishment, other than those vested from Canterbury Health Limited are recorded at cost. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

iv) Depreciation

Depreciation is charged on a straight line basis so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	50
Fitout Plant and Equipment	5 - 50
Plant and Equipment	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) Goods and Services Tax

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) Donated Assets

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

vii) Stocks

Stocks are valued at the lower of cost and net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

viii) Accounts Receivable

Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

ix) Investments

The investment in the Associate Companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis.

Other investments are stated at the lower of cost and net realisable value.

Dividend and interest income is accounted for on an accrual basis.

x) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

Canterbury DHB subsidiaries are subject to income tax, with the exception of Brackenridge Estate Ltd. Income tax expense is charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences.

Deferred taxation is determined on a comprehensive basis using the liability method.

Deferred tax assets attributable to timing differences or tax bases are only recognised where there is virtual certainty of realisation.

xi) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xii) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xiii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as Finance Leases and capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiv) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xv) Provision for Staff Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, parental leave and conference leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xvi) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non current securities and advances (other than securities and advances included within cash) and any other non current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvii) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xviii) Financial Instruments

Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost or market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xix) Basis of Consolidation

The consolidated financial statements include the parent DHB and its subsidiaries. The subsidiaries are accounted for using the purchase method which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis which shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

xx) Comparative Figures

Canterbury DHB was formed on 1 January 2001 and its previous financial period was six months ending 30/06/01. Comparative figures are shown for that period.
The Board's operations combine the functions of the predecessor Canterbury Health Ltd and some of the functions previously performed by the Health Funding Authority.

D CHANGE IN ACCOUNTING POLICIES

The accounting policies stated above have been consistently applied throughout the period and correspond to the accounting policies specified in the Statement of Intent at the beginning of the period. There were no significant accounting policy changes from the previous financial period.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating deficit is stated:	Group		Parent	
	12 mths to 30/06/02	6 mths to 30/06/01	12 mths to 30/06/02	6 mths to 30/06/01
After Charging:	$'000	$'000	$'000	$'000
Remuneration of Auditor:				
- Audit Fees	127	119	100	87
- Other Services	-	9	-	9
Board Members Fees	344	131	344	131
Directors' Fees	39	22	-	-
Interest Expense	7,443	3,760	7,310	3,694
Bad Debts Written Off	62	110	62	110
Increase/(Decrease) in Bad Debts Provision	811	(124)	812	(124)
Write-down of investments	-	-	474	437
Rental and Operating Lease Costs	3,826	2,069	2,571	1,409
After Crediting:				
Interest Received from Investments	565	125	717	298
Gain on Disposal of Assets	125	7	125	7

3. TAXATION

The tax expense arises from the operations of subsidiary entities. The DHB itself is exempt from income tax.

	Group	
	12 mths to 30/06/02	6 mths to 30/06/01
	$'000	$'000
Net Operating Surplus/(Deficit) before Taxation	(21,643)	(114)
Prima facie taxation @ 33%	(7,142)	(38)
Plus/(Less) tax effect of:		
Permanent Differences	7,185	106
Timing Differences not recognised	(90)	29
Underestimation of tax in previous year	(3)	(16)
Tax Expense / (Benefit)	(50)	81
Comprising:		
Current Tax	(74)	89
Deferred Tax	24	(8)
	(50)	81
Deferred Tax Liability		
Opening Balance	45	53
Current Year Movement	24	(8)
Closing Balance	69	45

Permanent differences are due to results of Parent and some subsidiaries not subject to income tax.
As at 30 June 2002, a deferred tax liability of $72,000 (tax asset of $255,000 at 30/6/2001) in subsidiaries has not been recognised because those timing differences are unlikely to crystallise in foreseeable future.
The tax effect of unrecognised timing differences is $24,000 ($84,000 at 30/6/2001).

4. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Trade Debtors	11,647	8,478	10,472	7,408
Receivable from Crown	36,731	37,409	36,731	37,409
Other Debtors	3,201	3,500	3,159	3,123
Prepayments	1,017	786	1,002	761
Tax Receivable	-	1,190	-	1,200
Amount owing by Associate	-	853	-	1,230
	52,596	52,216	51,364	51,131

5. EQUITY

GENERAL FUNDS

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Opening Balance	149,824	-	149,962	-
Equity Vested from HHS	-	149,824	-	149,962
	149,824	149,824	149,962	149,962

RETAINED EARNINGS

Opening Balance	(496)	-	10	-
Operating Surplus/(Deficit)	(21,623)	(127)	(21,878)	97
Transfers from/(to) Trust Reserve	(415)	(369)	(400)	(87)
Closing Balance	(22,534)	(496)	(22,268)	10
Represented by :				
Accumulated Deficit in Parent and Subsidiary	(22,612)	(574)	(22,346)	(68)
Accumulated Surplus in Associates	78	78	78	78
	(22,534)	(496)	(22,268)	10

REVALUATION RESERVE

Opening Balance	453	453	-	-
Current Year Movement	-	-	-	-
Closing Balance	453	453	-	-

TRUST RESERVE

Opening Balance	6,765	6,396	6,483	6,396
Transfers from/(to) Retained Earnings	415	369	400	87
Closing Balance	7,180	6,765	6,883	6,483

6. STOCKS

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Pharmaceuticals	2,655	1,937	2,655	1,937
Surgical and Medical Supplies	3,569	3,703	3,569	3,703
Other Supplies	1,686	1,646	1,631	1,571
	7,910	7,286	7,855	7,211
Provision for Obsolescence	(579)	(454)	(579)	(454)
	7,331	6,832	7,276	6,757

Some of the stocks may be subject to restriction of title ie Romalpa Clauses or securities registered by suppliers under Personal Property Securities Act. The value of stocks subject to above cannot be quantified due to the inherent difficulties in identifying stocks that are still subject to the Romalpa Clauses or security registered under PPSA at year end.

7. STAFF ENTITLEMENTS

Staff Entitlements consist of:	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Provision for Gratuities	1,815	1,440	1,815	1,440
Provision for Long Service Leave	2,124	1,919	2,110	1,919
Annual Leave Accruals	17,432	13,251	16,822	12,531
Unpaid Days Accruals	3,241	7,474	3,026	7,474
ACC Accruals	2,229	660	2,189	660
Conference Leave Accruals	1,932	1,887	1,932	1,887
Other	14,654	10,772	14,619	10,606
	43,427	37,403	42,513	36,517
Less Due Within 1 Year:				
Provision for Gratuities	8	75	8	75
Provision for Long Service Leave	295	493	281	493
Annual Leave Accruals	17,432	13,251	16,822	12,531
Unpaid Days Accruals	3,241	7,474	3,026	7,474
ACC Accruals	2,229	660	2,189	660
Conference Leave Accruals	1,932	1,887	1,932	1,887
Other	14,654	10,772	14,619	10,606
	39,791	34,612	38,877	33,726
Included in Creditors and Accruals	11,130	9,899	10,881	9,899
Staff Entitlement Due Within 1 Year	28,661	24,713	27,996	23,827
Staff Entitlement Due After 1 Year	3,636	2,791	3,636	2,791

8. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2002, the amount of funds received where the conditions attached have not been fulfilled is $7,180,000 ($6,765,000 at 30/06/01).

This is represented by:

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Cash at Bank	247	210	247	210
Term Deposits	4,488	3,284	4,191	3,002
Local Authorities & Government Stocks	958	1,801	958	1,501
Quoted Shares	55	185	55	185
Bonds & Stocks	1,432	1,285	1,432	1,585
Total Restricted Assets	7,180	6,765	6,883	6,483

9. LOANS

Loans consist of:

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Commercial Loans	106,448	108,700	104,768	107,020
Finance Lease	-	168	-	168
	106,448	108,868	104,768	107,188
Repayable as follows:				
Due Within 1 Year	27,568	220	27,468	220
One to Two Years	36,580	29,148	35,000	27,468
Two to Seven Years	42,300	79,500	42,300	79,500
	106,448	108,868	104,768	107,188

Security

Commercial loans are secured by Deed of Negative Pledge.

The finance lease is secured over the plant and equipment purchased under the lease.

Interest Rates

Weighted average interest rates on the group's borrowing for the year are as follows:

	30/06/02	30/06/01	30/06/02	30/06/01
Commercial Loans	7.27%	7.66%	7.26%	7.66%
Finance Lease	7.00%	7.00%	7.00%	7.00%
Bank Overdraft	7.20%	7.35%	7.20%	7.63%

10. INVESTMENTS

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Investment in Associates	466	395	466	395
Investment in Subsidiaries	-	-	3,566	3,803
Other Investments	-	32	-	32
	466	427	4,032	4,230

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Share of Associates Equity Brought Forward	170	92	170	92
Share of Associates Operating Surplus	-	78	-	78
Share of Associates Equity Carried Forward	170	170	170	170
Advances	296	225	296	225
	466	395	466	395

At 30 June 2002, Associate Companies comprised:

	Percentage Interest	Balance Date
Heart Surgery South Island Limited	50	30 June
New Zealand Centre for Reproductive Medicine Limited	50	30 June
South Island Shared Services Agency Limited	47	30 June

New Zealand Centre for Reproductive Medicine Limited provides reproductive medicine services to private patients. South Island Shared Services Agency Limited provides support services for contracting, contract monitoring and provider audits to DHBs for their Funding arm. Heart Surgery South Island Limited provided heart surgery for which Canterbury DHB invoiced facility fees. This company is no longer a going concern following the allocation of the Ministry of Health contract directly to participating DHBs from 1 July 2002.

INVESTMENT IN SUBSIDIARIES

	Parent	
	30/06/02 $'000	30/06/01 $'000
Equity - Burwood Rehabilitation Limited	542	517
Equity - CLS Properties Limited	515	515
Equity - Canterbury Laundry Services Limited	393	393
Equity - Crown Public Health Limited	1	1
Advances - Canterbury Laundry Services Limited	2,115	2,030
Advances - Brackenridge Estate Limited	-	347
	3,566	3,803

At 30 June 2002 subsidiary companies comprise:

	Percentage Interest	Balance Date
Burwood Rehabilitation Limited	100	30 June
CLS Properties Limited	100	30 June
Canterbury Laundry Services Limited	100	30 June
Brackenridge Estate Limited	100	30 June
Crown Public Health Limited	76.5	30 June

Canterbury Laundry Services Limited provides laundry services. CLS Properties Limited is an investment company holding land and building that it leases to Canterbury Laundry Services Limited. Burwood Rehabilitation Limited has a 60% share in the surplus of Burwood Orthopaedic Surgical Services, a partnership which performs orthopaedic surgery for ACC and work related insurers at Burwood Hospital. Crown Public Health provides public health initiatives involving education and dissemination of information in preventative health. Brackenridge Estate Limited provides residential accommodation and ongoing care for intellectually disabled persons.

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
At Cost				
Freehold land	20,824	20,824	20,824	20,824
Freehold buildings	96,173	97,184	96,173	97,184
Fitout plant and equipment	125,276	121,547	124,813	121,547
Plant and equipment	38,166	33,379	32,638	27,590
Computer equipment and software	22,135	21,277	22,094	21,277
Motor vehicles	1,434	1,310	1,334	1,192
Capital work-in-progress	19,383	9,743	19,375	9,703
At Valuation				
Freehold land	26,313	26,352	25,821	25,859
Freehold buildings	1,718	1,718	-	-
Fitout plant and equipment	82	82	-	-
Plant and equipment	22,985	22,999	22,985	22,999
	374,489	356,415	366,057	348,175
Accumulated Depreciation				
Freehold buildings	14,712	12,452	14,507	12,300
Fitout plant and equipment	39,458	32,185	39,227	32,171
Plant and equipment	22,227	15,691	19,146	12,704
Computer equipment and software	20,083	16,429	20,052	16,429
Motor vehicles	918	540	870	470
	97,398	77,297	93,802	74,074
Net Book Value				
Freehold land	47,137	47,176	46,645	46,683
Freehold buildings	83,179	86,450	81,666	84,884
Fitout plant and equipment	85,900	89,444	85,586	89,376
Plant and equipment	38,924	40,687	36,477	37,885
Computer equipment and software	2,052	4,848	2,043	4,848
Motor vehicles	516	770	464	722
Capital work-in-progress	19,383	9,743	19,374	9,703
Reclassify to Surplus Property	(7,450)	(7,450)	(7,350)	(7,350)
	269,641	271,668	264,905	266,751

	Group		Parent	
	12 mths to 30/06/02 $'000	6 mths to 30/06/01 $'000	12 mths to 30/06/02 $'000	6 mths to 30/06/01 $'000
Depreciation charged during the year:				
Freehold buildings	2,269	1,081	2,212	1,024
Fitout plant and equipment	7,103	2,834	7,057	2,783
Plant and equipment	7,465	3,251	6,464	2,810
Computer equipment and software	3,644	2,643	3,629	2,628
Motor vehicles	411	163	399	151
	20,892	9,972	19,761	9,396

Freehold land and plant and equipment disclosed at valuation were transferred from Canterbury Health Limited. They have not yet been revalued by Canterbury DHB.

Under the terms of the Ngai Tahu Claims Settlement Act 1998, most surplus property must be first offered to Ngai Tahu. The disposal of certain properties may also be subject to the provisions of section 40 of the Public Works Act 1981.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 18 years time. This interest has not been included in the Statement of Financial Position.

The fair value of ex-Canterbury Health Limited land and buildings (including infrastructure plant and fittings) based on an independent valuation by Robertson Young Telfer on 30 June 1998 is $229,762,000 and the fair value of ex-Healthlink South Limited land and buildings based on an independent valuation by Telfer Young on 1 October 2000 is $78,100,000.

12. RECONCILIATION OF RESULT AFTER TAX WITH NET CASHFLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	12 mths to 30/06/02 $'000	6 mths to 30/06/01 $'000	12 mths to 30/06/02 $'000	6 mths to 30/06/01 $'000
Net Operating Surplus before Share of Associate Co's Surplus	(21,593)	(195)	(21,878)	19
Add Back Non-Cash Items:				
Depreciation	20,892	9,972	19,761	9,396
Maintenance provision	120	90	-	-
Add Back Items Classified as Investing Activity:				
Gain on Asset Sale	(125)	(7)	(125)	(7)
	(706)	9,860	(2,242)	9,408
Movement in Term Portion Staff Entitlement	845	(171)	845	(171)
Movement in Deferred Tax	24	(8)	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	(380)	(3,791)	(233)	(4,153)
Decrease/ (Incr.) in Stocks	(499)	351	(519)	340
Increase/ (Decr.) in Creditors & Other Accruals	23,225	(9,361)	23,283	(9,130)
Increase/ (Decr.) in Capital Charge due to Crown	(229)	4,041	(229)	4,041
Increase/ (Decr.) in Staff Entitlements	3,948	494	4,169	726
Less: Items in Creditors relating to investing Activities	-	-	-	(517)
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	26,228	1,415	25,074	544

13. COMMITMENTS

	Group		Parent	
	30/06/02 $'000	30/06/01 $'000	30/06/02 $'000	30/06/01 $'000
CAPITAL COMMITMENTS				
Committed at Balance Date	92,739	18,701	92,739	20,150

Capital commitments include amounts approved by the Board but where contracts may not have been signed or purchase orders issued. The highest value individual project is the new building for Christchurch Women's Hospital for which a total of $78million capital funding has been approved.

NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Lease	7,408	8,708	3,650	3,299
Computer Leases	489	446	197	323
Vehicle Leases	630	786	379	572
Other	14	-	-	-
	8,541	9,940	4,226	4,194
For Expenditure Within:				
1 Year	2,331	2,929	1,216	1,461
2 Years	1,422	1,817	829	679
3 Years and Beyond	4,788	5,194	2,181	2,054
	8,541	9,940	4,226	4,194

14. TRANSACTIONS WITH RELATED PARTIES

a) GOVERNMENT FUNDING

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the Canterbury DHB. Canterbury DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

b) INTER-GROUP TRANSACTIONS

During the financial year the group had the following inter-group transactions:

	Group		Parent	
	12 mths to 30/06/02 $'000	6 mths to 30/06/01 $'000	12 mths to 30/06/02 $'000	6 mths to 30/06/01 $'000
Revenue				
Facility fees from Heart Surgery South Island Ltd	4,058	2,682	4,058	2,682
Interest on advance and director's fees from Canterbury Laundry Services Limited	-	-	151	114
Interest on advance and service fees from Brackenridge Estate Limited	-	-	111	34
Fees from Burwood Rehabilitation Limited	-	-	1,514	703
Services to Crown Public Health Limited	-	-	520	303
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	68	-	68	-

Expenses				
Linen services and rentals from Canterbury Laundry Services Limited	-	-	3,413	1,852
Services from New Zealand Centre for Reproductive Medicine Ltd	1,314	-	1,314	-
Services from South Island Shared Services Agency Ltd	587	69	587	69

Interest charged on advances (refer Note 10) to Canterbury Laundry Services Limited, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Limited are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June are as follows :

	Group		Parent	
	30/06/02 $'000	30/06/01 $'000	30/06/02 $'000	30/06/01 $'000
Amount Payable owing to associates				
South Island Shared Services Agency Ltd	-	77	-	77
NZ Centre for Reproductive Medicine Ltd	250	-	250	-
Burwood Orthopaedic Surgical Services	300	24	300	24
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd	416	158	416	158
Heart Surgery South Island Limited	978	1,230	978	1,230
NZ Centre for Reproductive Medicine Ltd	102	89	102	89
Amount Payable owing to subsidiaries				
Canterbury Laundry Services Ltd	-	-	249	-
Burwood Rehabilitation Ltd	-	-	266	301
Amount Receivable owing by subsidiaries				
Canterbury Laundry Services Ltd – Debtor	-	-	14	40
Canterbury Laundry Services Ltd – Advance	-	-	2,130	2,030
Brackenridge Estate Ltd – Advance	-	-	999	784

c) BOARD AND COMMITTEE MEMBERS

During the financial year Canterbury DHB and its subsidiaries have purchased for the following services provided on an arm's length basis by the organisations listed below which fall within the related party definition:

	Group 30/06/02 $'000	Parent 30/06/02 $'000
Christchurch City Council	609	539
Pegasus Health (payments for 2001/02 as final amount subject to contract washup)	74,187	74,187
New Zealand Post Ltd	635	598
The Christchurch City Mission	375	375
Canterbury Asthma Society Inc	35	35
Breath Testing Services	128	128
New Zealand Housing Corporation	470	-
Pacific Trust Canterbury	595	595
Ryman Healthcare Ltd	54	54
South Canterbury DHB	3	3

Canterbury DHB and its subsidiaries have provided the following services on an arm's length basis to the organisations listed below which fall within the related party definition:

	Group 30/06/02 $'000	Parent 30/06/02 $'000
Christchurch City Council	14	-
South Canterbury DHB	91	13
Champion Centre	5	5

15. CAPITAL CHARGE

The DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2002 was 11% (11.0% for six months to 30/06/01).

16. FINANCIAL INSTRUMENTS

CREDIT RISK

Financial instruments which potentially subject the group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts.

The group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2002, the Ministry of Health owed Canterbury DHB $36.8 million ($37.4 million at 30/06/01).

CURRENCY RISK

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary.

There are no foreign exchange instruments outstanding at 30 June 2002 (30/6/2001 nil).

INTEREST RATE RISK

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities.

There are no interest rates swaps outstanding at 30 June 2002 (30/6/2001 $25 million).

FAIR VALUES OF FINANCIAL INSTRUMENTS

Financial instruments recorded in the financial statements have been recorded at their fair values.

17. VESTING OF ASSETS

Canterbury DHB was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000. On that date, the assets and liabilities of Canterbury Health Limited were vested in Canterbury DHB at their carrying values as recorded in the books of the Hospital and Health Service. The net value of the assets vested is recognised as a capital contribution by the Crown, the owner of both Canterbury DHB and Canterbury Health Limited.

18. SEGMENTAL REPORTING

Canterbury DHB operates in the provision of Health and Disability Support Services Industry in the South Island of New Zealand. Therefore, no segmental reporting is required.

19. CONTINGENT LIABILITIES

The Group has outstanding legal proceedings and disputes with third parties. The Group disputes these claims and believes that it is unlikely any material loss will eventuate (30/6/2001 nil).

20. RESIDENTS ' TRUST ACCOUNT

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Resident Trust Account Balance	582	572	349	399

Residents' Trust Account comprises bank balances representing funds managed on behalf of Residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual patients' balances. Therefore, transactions occurring during the year are not included in the Statement of Financial Performance, Financial Position or Cash Flow of Canterbury DHB.

21. PROVISIONS

	Group		Parent	
	As at 30/06/02 $'000	As at 30/06/01 $'000	As at 30/06/02 $'000	As at 30/06/01 $'000
Maintenance Provision				
Opening balance	90	-	-	-
Additional provision made during the year	120	90	-	-
Charged against provision for the year	-	-	-	-
Closing balance	210	90	-	-

The provision arises from an obligation under a lease agreement with a landlord to redecorate premises at 5 yearly intervals. The cost of this is accrued on an annual basis.

22. SUBSEQUENT EVENTS

CLS Properties Ltd will be statutorily wound up in financial year 02/03 following the transfer of its assets and liabilities to Canterbury DHB.

Crown Public Health Ltd will be statutorily wound up in financial year 02/03 following the transfer of its assets and liabilities to Canterbury DHB.

Heart Surgery South Island Ltd provided services under a Ministry of Health contract. That contract has been awarded by the Ministry of Health directly to participating DHBs as from 1st July 2002. Heart Surgery South Island Ltd will be statutorily wound up in near future.

There were no other events after 30 June 2002 which could have a material impact on the information in Canterbury DHB financial statements.

Statement of Service Performance 2001/02

The provision of a Statement of Service Performance is a new requirement for the DHB, with the establishment of appropriate measures being at an evolutionary stage. CDHB intends to further develop measures that are appropriate to the needs of our stakeholders within Parliament and the community. These measures and associated performance targets will be reflected in future Statements of Intent and reported in subsequent Statements of Service Performance.

The aim of the Statement of Intent is to demonstrate how the DHB's activities impact on the DHB's primary objective of "improving the health and wellbeing of people living in Canterbury". Measures established in the 2001-2004 Statement of Intent were defined prior to the completion of the Canterbury DHB Strategic Plan. To this end, this performance overview is presented in two sections:

- An overview of the outcomes from the strategic planning process.
- An overview of CDHB's performance against the core strategic directions for the 2001/02 year. This includes a selection of relevant indicators from the Statement of Intent 2001-2004 and additional indicators that are considered to be of interest to the Public and Parliament. These performance indicators are presented under the relevant core strategic directions.

A table containing performance statements against the measures and objective specified within the Statement of Intent 2001-2004 is included.

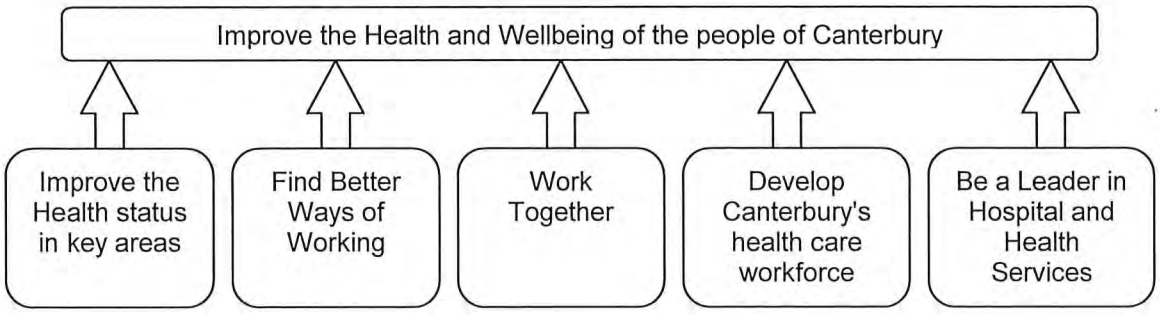
1. Strategic Planning Overview

A key outcome for CDHB during the 2001/02 year, has been the development of our strategic direction which identifies how the DHB will work over the coming years towards "Improving the Health and Wellbeing of People Living in Canterbury".

The development of the Strategic Plan reflects the first major community consultation undertaken by the DHB. Consultation on the draft plan included 47 meetings, of which 12 were public and the balance with key stakeholder groups. As a result of this community consultation the final Strategic Plan approved by the Board included priority areas as Child and Youth Health, Primary Health, Maori Health, Disease Prevention and Management [Cardiovascular (Heart) Disease, Diabetes Cancer]. Cancer and Mental Health Services were added as a result of the consultation process.

To achieve CDHB's primary objective to improve the health and well being of people living in Canterbury, the DHB intends to focus on achieving improved outcomes in these priority areas via the five core direction intervention areas:

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



2. Key 2001/02 Statement of Intent Performance Indicators.

The following indicators reflect those performance measures specified in the 2001/02 Statement of Intent which are considered the most important in terms of the DHBs strategic direction.

Objective:	*Brief Description:*
Improve the health outcomes for specific groups in our community	Within the Canterbury region: • There are a number of population groups who have lower health status than the general population of Canterbury • Likewise there are a number of chronic diseases which impact significantly on the health status of Canterbury people • The health of our Children and Young people is similar to other regions in New Zealand, however it is not as good, or improving as fast, as the health of children in other developed countries (No associated performance report for 2001/02) Interventions focused on improving the services and the way health care is provided to these groups should result over time in improvements to the health status of the people of Canterbury. Activities undertaken during the 2001/02 year have focused on understanding the current issues and developing plans that define what we should do to achieve the long term outcomes.

Target area: *Population Groups*			
Target - Outcomes	***Output 2001/02***	***Performance Measure***	***Results***
Improved health status of Canterbury's Maori Residents (Long Term)*	Produce a Maori Health Plan which identifies the appropriate actions the DHB should take to achieve the desired outcome (Short Term)	Development of a comprehensive Maori Plan.	The CDHB Maori Health Plan 2002-06 has been written to align with the CDHB strategic plan as well as *He Korowai Oranga,* the national Maori Health Strategy. This plan has been developed with local Maori and has under gone significant consultation. Local Maori and the CDHB Board have endorsed this plan. Implementation of this plan will be ongoing. Processes and progress will be reviewed annually against the established project milestones and accountabilities. Performance against this plan will be reported in future annual reports. A copy of this plan is available on request.
Improved health status of Canterbury's Pacific Island Residents (Long Term)*	Produce a Pacific Health Plan which identifies the appropriate actions the DHB should take to achieve the desired outcome (Short Term)	Development of a comprehensive Pacific Plan.	The CDHB Pacific Health Action Plan has been written to align with the CDHB strategic plan as well as the national Pacific Health & Disability Action Plan. This local action plan has been developed with input from the Pacific Island community and the Ministry of Pacific Island Affairs. The CDHB Board has endorsed this plan. Implementation of this plan will be ongoing. Performance against this plan will be reported in future annual reports. A copy of this plan is available on request.

*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

Objective:	*Brief Description:*
Find better ways of working, to get the maximum improvement in health status for our community within the available funds.	Funding for health services will always be limited. The CDHB must therefore constantly seek better ways of working to get the maximum improvement in health status for our community within the available funding. A number of key areas to improve the way we work have been identified within the strategic plan. These can be broadly grouped into a number of intermediate outcome areas, namely: • Efficiency Gains, to improve the services that can be provided within the available funding (No associated performance report for 2001/02) • Keeping people healthy via the adoption of a "Wellness" strategy to keep people healthy. This would include addressing issues such as improving access to primary care services and disease prevention.

Target area: *Keeping People Healthy*			
Target - Outcomes	***Output 2001/02***	***Performance Measures***	***Results***
Improved access to, and quality of primary health care for Rural Canterbury Residents (Long Term)*	Develop a Rural Health Strategy which covers improving access to services, quality of service and workforce planning (Short Term)	Development of a comprehensive Rural Health Plan.	The CDHB Rural Health Plan has been written to align with the CDHB strategic plan and the national Primary Care Strategy. This plan has been developed with input from the rural local bodies, rural practitioners and rural health advocates. The CDHB Board has endorsed this plan. Implementation of this plan will be ongoing. Performance against this plan will be reported in future annual reports. A copy of this plan is available on request.

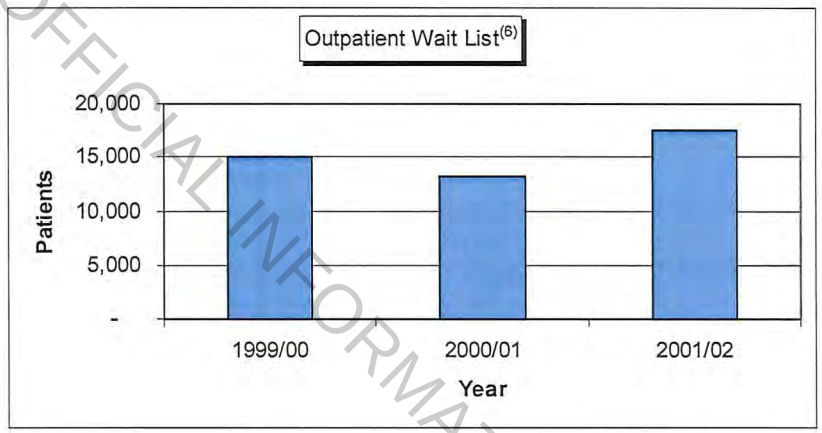
*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

Objective:	*Brief Description:*
Work together - to ensure the right service is provided at the right time to obtain the maximum possible health gains for our community.	Work together to ensure the right service is provided at the right time to ensure the maximum possible health gains are made for our community. To improve the way we work together CDHB believes that interventions are required in four broad areas: • Information, to ensure that health care providers' have access to appropriate information to support the provision of services. (No associated performance report for 2001/02) • Integration of services to provide a clear continuum of care. • Communicate and consult with our community and patients about health issues and developments and access to services. (See Strategic Plan overview) • Elective Services.

Target area: *Integration of Services*

Target - Outcomes	***Output 2001/02***	***Performance Measures***	***Results***
Improved coordination and integration to ensure the provision of a seamless services to the elderly (Long Term)*	Continue to support the Elder Care Canterbury project in its objective of integrating and improving health services for older people. (Short Term)*	Establish infrastructure to support projects within the DHB. Evaluate existing projects.*	The key results in establishing the required infrastructure has been: • Employment of a project facilitator • Development of a new model in the form of a project forum to enhance community involvement in the project • The successful pilot of the Coordinator of Services for the Elderly (COSE). This is an excellent integration project, which moves coordination of services from the hospital setting to the community by attaching COSEs to GP practices. It has been extremely well received by all involved.
	Develop the role of lead DHB with regard to defining and implementing the integrated continuum of care and the proposed devolution of age-related disability support services funding to the DHBs. (Short Term)*	Establish infrastructure to support the devolvement of funding for older person's health services from the MoH.*	The key results in establishing the required infrastructure to support devolution of funding have been: • Employment of a project manager • The establishment of a steering group representing a broad spectrum of the sector to guide the project and assist the DHB to achieve its aims • Assisting the Ministry of Health, in conjunction with Northland DHB, to develop capability criteria for all DHBs to ensure they are able to manage the devolved funding • Work on defining the integrated continuum of care, identified gaps and barriers to implementing the continuum and identified solutions.

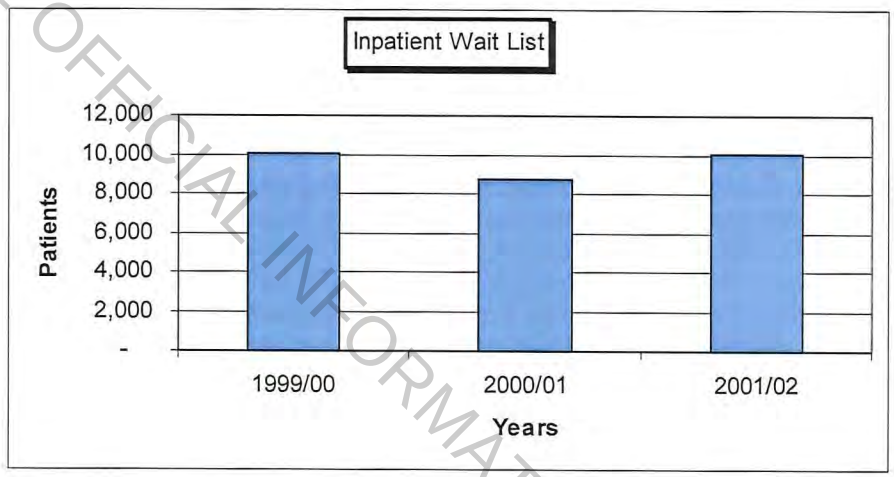
*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

Target area: Elective Services			
Target - Outcomes	***Output 2001/02***	***Performance Measures***	***Results***
Reduced waiting lists for first specialist assessments to a level where all appropriately referred patients can be assessed within appropriate timeframes. (Medium Term)*	Improve access to first specialist assessments. (Medium Term)*	100% of patients receive their first specialist appointment within six months	CDHB has continued to seek to achieve this level of performance. To date this has not however been achieved. Of the new patients seen during the year, 90% were seen within 6 months. At the end of the year there were some 6,943 patients who we had not seen who had waited longer than 6 months. This reflects approximately 2¼-months work at current activity levels. A number of specialities performed near[1] this target, namely Cardiology, Diabetes Endocrinology, Infectious Diseases, Paediatric Medicine, Paediatric Surgery, Renal Medicine, Thoracic Surgery, Haematology, Neurosurgery, Oncology and Vascular Surgery. Specialities not performing at this target include Dermatology, Endoscopy, Otolaryngology, Gastroenterology, General Medicine, General Surgery, Gynaecology, Neurology, Ophthalmology, Orthopaedics, Pain Management, Plastics, Respiratory, Rheumatology and Urology..
			

[1] Near target is defined as >95% of patients seen within 6 months and the number waiting longer than 6 months at the end of the period being <4% of annual throughput which is equivalent to 2 weeks activity

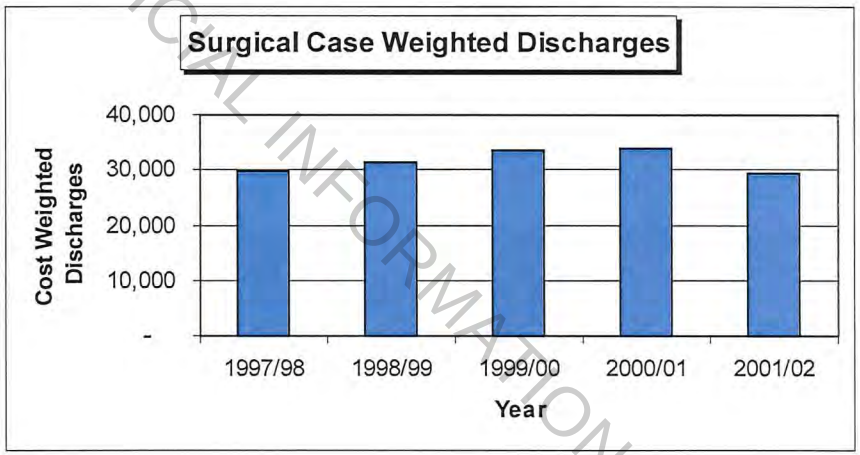
[6] Outpatient Waiting List excludes endoscopies

*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

Target area: Elective Services			
Target - Outcomes	***Output 2001/02***	***Performance Measures***	***Results***
Provide patients with certainty that they will receive/not receive access to publicly funded inpatient surgery. Provide timely access for those offered surgery. (Medium Term)*	Reduce waiting times for those patients offered publicly funded inpatient surgery (Medium Term)*	100% of patients receive publicly funded surgery within six months	CDHB provides patients with two levels of certainty for publicly funded treatment, namely, "definite" cases, who are offered certainty of treatment within 6 months and "probable" cases who are considered likely to receive publicly funded treatment within 12 months. Quarterly performance for those patients provided certainty of treatment within 6 months varied from 91% to 97% of patients receiving treatment within 6 months. Quarterly performance for those patients who were considered likely to receive treatment within 12 months has also varied. In quarter 2, 70% of these patients received treatment with the 6-month target wait time, in quarter 3, 68%, while in quarter 4 only 33% received treatment within the 6-month target. [2] The first quarter was not reported. This lower than planned performance has in part resulted from the industrial action.
			

[2] Noted that these statistics do not include Christchurch Women's Hospital due to information issues that prevent these measures from being calculated.

*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

Target area: Elective Services			
Target - Outcomes	***Output 2001/02***	***Performance Measures***	***Results***
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, ill health or incapacity (Long Term)	Deliver the level of inpatient surgery funded by the Ministry of Health. (Short Term)* (Note – this output has been used as proxy for this outcome)	100% of Ministry of Health funded surgical volumes are delivered.*	Surgical case-weighted volumes (discharges) delivered during the 2001/02 year were below the target level of delivery. Otolaryngology has delivered its funded case-weighted volumes. Ophthalmology and Dental have delivered near their funded case-weighted volumes. The remaining specialities have under delivered against the funded case-weighted volumes by the following percentages: General Surgery 7% Cardiothoracic 49% Gynaecology 11% Neurosurgery 7% Orthopaedic 19% Paediatric Surgery 16% Plastic & Burns 9% Urology 7% This lower than planned performance has in part resulted from the industrial action and shortages of Anaesthetists and Anaesthetic Technicians.
			

*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

Objective:	*Brief Description:*
Develop Canterbury's health care workforce - to ensure that we have the appropriate workforce to meet the health needs of the people of Canterbury.	To ensure that Canterbury's health workforce contributes to the health of the people of Canterbury to the maximum extent, CDHB believes that supporting the development of the health care workforce will result in improvements to the health status of the people of Canterbury. Two key areas of intervention have been identified: • Improving the relationships within the DHB to ensure we are working together to achieve common objectives. • Workforce development to support improvements in the services provided, particularly in relation to services provided to those Maori and Pacific Island communities (these areas are under development as components of the Maori and Pacific Health Plans).

***Target area**: Improving Relationships*			
Target - Outcomes	***Output 2001/02***	***Performance Measures***	***Results***
Being a good employer will ensure that Canterbury DHB provides a safe working environment, equal opportunities, culturally sensitive work place and upholds a commitment to good faith bargaining (Medium Term)	Initiate systems and processes to promote a good working environment which encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management (Medium Term)	Develop a strategy to meet DHB good employer obligations that promotes a good working environment and encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management	Various strategies and systems/processes have been implemented, but further initiatives can be developed. To date: • A Culture survey has been undertaken across the organisation. This will assist in further identifying initiatives. • Development of a cluster structure at Christchurch Hospital to facilitate greater involvement at all levels across all medical disciplines. • Harassment and bullying policy and training implemented to assist in providing a better working environment. • Management leadership training in place. Policies and approaches are under development to provide for greater involvement of Maori and Pacific Island people in the CDHB workforce.

*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

Objective:	*Brief Description:*
Be 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.	Being a leader in Hospital and Health Services to ensure the best possible care is provided to maximise the health outcomes for the people of Canterbury. Three key areas of intervention have been identified: • Quality • Regional Centre (no associated performance report for 2001/02) • Teaching Research (no associated performance report for 2001/02)

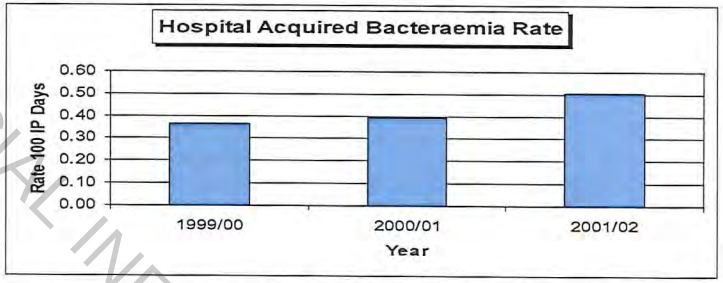
Target area: *Quality*			
Target Outcomes	***Output 2001/02***	***Performance Measures***	***Results***
Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals (Long term)*	Maintain accreditation at Ashburton, Akaroa, Waikari, Darfield, Burwood and Christchurch Women's Hospitals.*	Maintain existing accreditation status.*	Ashburton, Akaroa, Waikari, Darfield, Burwood and Christchurch Women's Hospitals are accredited with Quality Health New Zealand. During the 2001/02 year, Ashburton Hospital underwent survey by independent auditors resulting in accreditation being reconfirmed.
	Initiate accreditation process for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services.*	Initiate accreditation process.*	During the 2001/02-year, Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services entered the accreditation programme. Entering the programme required each hospital/service to establish processes and documentation that meets the requirements of the standard. Dates for accreditation surveys have not been established.
Maintain Accreditation of Support Services with International Accreditation New Zealand. (Laboratory accreditation to ISO15189 Quality Management in Medical Laboratories. Others ISO9000 series quality standards)*	Maintain accreditation for CDHB's Laboratories, Technical Services, Physiotherapy (Christchurch Hospital) and Medical Physics and Bio-engineering.*	Maintain existing accreditation status.*	During the 2001/02-year CDHB's Laboratories, Technical Services, Physiotherapy (Christchurch Hospital) and Medical Physics and Bio-engineering Services were re-surveyed to reconfirm accreditation. Accreditation was confirmed for each service

*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

<table>
<tr><td colspan="4">Target area: Quality</td></tr>
<tr><td>Target Outcomes</td><td>Output 2001/02</td><td>Performance Measures</td><td>Results</td></tr>
<tr><td rowspan="2">Maintain appropriate levels of Clinical Quality within CDHB Hospitals.*</td><td rowspan="2">Operate an effective incident reporting mechanism to monitor clinical quality.*</td><td>Patient Falls Rate[3]

(Note: Performance targets were not specified in SOI)*</td><td>Rate per 1,000 Inpatient Bed days.
<table><tr><td>1999/2000</td><td>2000/2001</td><td>2001/2002</td></tr><tr><td>3.73</td><td>3.60</td><td>3.84</td></tr></table>The inpatient fall rates have remained relatively unchanged over this 3 year period. Initiatives are planned to further reduce this rate.</td></tr>
<tr><td>IV Medication Errors[4]

(Note: Performance targets were not specified in SOI)*</td><td>Medication Errors Rate per 1,000 Inpatient Bed days
<table><tr><td>1999/2000</td><td>2000/2001</td><td>2001/2002</td></tr><tr><td>1.12</td><td>1.38</td><td>1.17</td></tr></table>The medication error rates have remained relatively unchanged over this 3 year period.</td></tr>
<tr><td></td><td></td><td>Hospital Acquired Bacteraemia Rate[5].*

(Note: Performance targets were not specified in SOI)</td><td> 

The rate is increasing and initiatives are being developed to reduce this rate.</td></tr>
</table>

[3] Note: Patient Fall rates reflect Christchurch, Burwood and Ashburton Hospitals only. Data was not available for the other DHB Hospitals.
[4] Note: IV Medication Error rates reflect Christchurch, Burwood and Ashburton Hospitals only. Data was not available for the other DHB Hospitals.
[5] Note: Hospital Acquired Bacteraemia rates reflect Christchurch, Burwood and Ashburton Hospitals only. Data was not available for the other DHB Hospitals.

*Target Outcomes, Outputs or Performance Measures not in the Statement of Intent

3. Summary of Revenues and Expenses by Output Class

	Funding $'000	Governance & Funding Admin $'000	Provider $'000	In House Elimination $'000	Total DHB $'000
Revenue					
MoH revenue	588,072	2,633	425,326	(392,953)	623,078
Patient Related Revenue			22,611		22,611
Other			9,708		9,708
Total Revenue	588,072	2,633	457,645	(392,953)	655,397
Expenditure					
Personnel		1,711	298,037		299,748
Depreciation			20,892		20,892
Interest & Capital Charge			23,635		23,635
Other	588,072	922	136,724	(392,953)	332,765
Total Expenditure	588,072	2,633	479,288	(392,953)	677,040
Net Surplus/(Deficit)	-	-	(21,643)	-	(21,643)

Statement of Service Performance

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
Advisory committees to provide policy & governance advice to the Board to better reflect needs of community	Appropriate process & structur in place to support committee meetings	Meetings to take place regularly and committee recommendations referred to Board	Yes	Regular meetings held (9 public meetings in 2001/02). Joint Board and community representation established. Minutes and Agendas available on internet website.
Reference groups to provide advocacy and input into Strategic Plan to better reflect needs of community	Reference group to be established and meetings held	Meetings Reference groups held and reported back to Committees	Yes	Reference group public meetings (6) held in Christchurch and Ashburton. Other groups (42) held as part of public consultation process for the District Strategic Plan. This requirement was fulfilled for 2001-02. We are currently reviewing how we engage with groups to achieve better targeting for information and therefore more informed advice to the Board.
Improving integration of health care services to ensure better health outcomes and improve the wellness of the Canterbury community	Policy and procedures put in place to facilitate better integration between health providers, consumers and other agencies influencing health outcome	Continue and improve on existing integration projects Identify services which can be improved through better integration.	Yes	In line with the New Zealand Health & Disability Strategy integration projects are in place for example, Elder Care Canterbury, Access Canterbury and LinkAGE. Others identified following an Integration Review by Business Assurance & Consultancy including the formation of a Steering Group between Primary Care and the Canterbury DHB. 79 projects were started and 43 were current at 30 June 02. The remaining were completed or reassessed as part of future service planning and development processes.

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
Community consultation is aimed at increasing community involvement in the assessment, funding of health and disability services	System and procedures are in place to inform and communicate with the community	Multi media approach set up to inform and communicate with the community. This will include, print, radio, TV, public meetings and web-site	Yes	Extensive consultation process developed around DSP. This was of nearly 10 weeks duration and resulted in over 200 submissions being received on the DSP. We have a Community Engagements and Consultation Policy document (currently being revised) and a strategy document which guided the Strategic Plan consultation. The CDHB's first major consultation process included 47 meetings, 12 of which were public and rest of which were stakeholder meetings. Meetings were minuted. In hindsight, we believe the target for this item needs to be revised to reflect consultation more than communication tasks
Maori Health is aimed at improving health status, contribute to decision making and participation in health services delivery	Improving accessibility and appropriateness of services Consultation with Maori on funding decision affecting Maori health Improving Maori participation in the health workforce	Develop a Maori Health Plan in consultation with Maori that identifies priorities for provision health services, funding of such services, and workforce planning	Yes	Completed and presented to CPHAC/HAC/DSAC in June 2002. The Plan has been shared with Maori groups during its preparation. Stocktake of Maori members of staff in CDHB undertaken. Appointment of Maori to key positions being progressed.

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
Refugee and Migrant Health is aimed at improving health status of refugee and migrant communities	Improved accessibility and appropriateness of services	Ensure Crown Public Health implement their Refugee, Asylum Seekers and Migrant plan and meet the key performance objectives of the plan	Yes	Plan being implemented. Six Month Report for MoH completed April 02 indicated satisfactory progress.
Pacific Peoples Health is aimed at improving health status and participation in health services delivery	Improving accessibility and appropriateness of services Improving Pacific Peoples participation in the health workforce	Develop a Pacific Peoples Health Plan in consultation with Pacific Peoples that identifies priorities for the provision of health services, and workforce planning	Yes	Completed and adopted by Board May 2002. During its preparation there was consultation with groups with the Pacific Peoples community and Ministry of Health.
Rural Health is aimed at improving better access and quality of service to rural communities	Initiate systems and processes to improve access, quality of services and improve workforce planning in the rural community	Develop a Rural Health Strategy which covers improving access to services, quality of service and workforce planning	Yes	Rural Health Plan completed May 02 and action plan developed. Work on implementation continues.

DHB WIDE OBJECTIVES YEAR 1

Objectives	Measurement	Target	Achieved Yes / No	Narrative Figures and Source
Teaching & research is to ensure there is ongoing commitment to high standard of teaching and research activities	Build on and further develop relationship and ties with tertiary and other teaching and research institutions	Support the University of Otago Christchurch School of Medicine, Christchurch Polytechnic and other teaching institutions by attending and providing seminars	Yes	CEO holds regular meetings with Dean of School of Medicine. He is also an ex officio member of Board and strong links have been developed between the School of Medicine and DHB.
		Develop joint agreements with the Clinical Training Agency (CTA)	Yes	A number of joint initiatives are being explored including a joint post graduate nursing department. A joint clinical skills laboratory was opened early in 2002.
		Develop funding agreements for research programmes with the University of Otago Christchurch School of Medicine and the Christchurch Polytechnic Institute of Technology	Partially	Contract agreement reached with Clinical Training Agency for 2001/02 and 2002/03. CDHB part funds Research Office of the University of Otago Christchurch School of Medicine and supports research carried out in its in-house provider. There is DHB participation in the research steering group. There was no funding agreement for research with the Christchurch Polytechnic Institute of Technology as at 30 June 02.

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
Good employer is ensure that Canterbury DHB provides a safe working environment, equal opportunities, culturally sensitive work place and upholds a commitment to good faith bargaining	Initiate systems and processes to promote a good working environment which encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management	Develop a strategy to meet DHB good employer obligations that promotes a good working environment and encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management	Yes	Strategies, including those below, and systems/processes implemented. Initiatives have been progressed since the industrial action, such as: • Culture survey undertaken across organisation. This will assist in further identifying initiatives. • Development of cluster structure at Christchurch Hospital to facilitate greater involvement at all levels across all medical disciplines. • Harassment and bullying policy and training implemented to assist in providing a better working environment. • Management leadership training in place. • Policies and approaches under development to provide for greater involvement of Maori and Pacific Island people in the CDHB workforce.

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
Good employer continued				▪ Cultural awareness training in place. ▪ Joint working parties are meeting involving Combined Unions and CDHB management on a regular basis. Working parties include: - Superannuation - Creche/Childcare - No Contracting Out - Scoping Exercise for Clinical Nurse Specialists - Advanced Practice for Nurses - Women's Health Division - Roster patterns for Older Persons and Mental Health Divisions. - Regular meetings held with Combined Union Group to discuss key issues and to ensure a 'no surprises' approach. - Formation of a staff group to advise the Chief Executive on initiatives to improve the working environment. - HR process and policies in place to ensure staff have equal opportunities.

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
The Canterbury DHB will use its best endeavours to work towards a system that will manage waiting times for elective (non-emergency) surgery to achieve compliance with the six month maximum waiting time, providing advice on progress towards to targets	a) A maximum waiting time of six months for the first specialist appointment	a) 100% of patients receive their first specialist appointment within six months	No	CDHB has continued to achieve this level of performance. To date this has not been achieved. Of the new patients seen during the year, 90% were seen within 6 months. At the end of the year there were some 6943 patients who we had not seen who had waited longer than 6 months. This reflects approximately 2¼ months work at current activity levels. A number of specialties are performing near this target, namely Cardiology, Diabetes, Endocrinology, Infectious Diseases, Paediatric, Medicine, Paediatric Surgery, Renal Medicine, Thoracic Surgery, Haemotology and Vascular Surgery.[1]

[1] A number of services are however delivering near this target. During the 4th quarter Cardiology, Diabetes, Endocrinology, General Medicine, Haematology, Infectious Diseases, Neurosurgery, Paediatric Medicine, Paediatric Surgery, Nephrology and Cardiothoracic have more than 90% of first specialist assessments seen within 6 months

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
	b) A maximum waiting time for surgery of six months for patients who are offered publicly funded treatment	b) 100% of patients receive publicly funded surgery within six months	No	CDHB provides patients with two levels of certainty for publicly funded treatment, namely, "definite" cases, who are offered certainty of treatment within 6 months and "probable" cases who are considered likely to receive publicly funded treatment within 12 months. Quarterly performance for those patients provided certainty of treatment within 6 months varied from 91% to 97% of patients receiving treatment within 6 months. Quarterly performance for those patients who were considered likely to receive treatment within 12 months has also varied. In quarter 2, 70% of patients receiving treatment within[2] the 6 month target wait time, in quarter 3 68%, while in quarter 4 only 33% received treatment within the 6 month target. The first quarter was not reported.

[2] It should be noted that the above statistics do not include Christchurch Womens Hospital due to information issues that prevent these measures from being calculated.

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
	c) 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, ill health or incapacity	d) 100% of patients [3] receive elective surgery before they reach a state of unreasonable distress, ill health or incapacity	No	Measurement against this indicator is not considered possible, however CDHB believes that performance against the targets contained within our funding agreement with the Ministry of Health act as an appropriate proxy. Based on this proxy CDHB has not achieved this target. Surgical case-weighted volumes delivered during the 2001/02 year are below the target level of delivery. Otolaryngology has delivered its funded case-weighted volumes. Ophthalmology and Dental have delivered near (within 30 cwd) their funded case-weighted. The remaining specialities have under delivered against the funded case-weighted volumes as follows: General Surgery 7% Cardiothoracic 49% Gynaecology 11% Neurosurgery 7% Orthopaedic 19% Paediatric Surgery 16% Plastic & Burns 9% Urology 7% This lower than planned performance has in part resulted from on-going industrial action and shortages of Anaesthetists and Anaesthetic Technicians.

[3] Please note this indicator is similar to that reported within the Statement of Service Performance narrative included in this report on page 38.

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
Compliance with the Disability Strategy through the development of a Disability Action Plan	Initiate system and processes to implement the Action Plan	The Action Plan be in place and communicated to stakeholders and staff by June 2002.	Yes	Completed and adopted by Board October 2001. Action Plan shared with providers and consumers at various meetings. Action Plan activity assessment provided March 2002.
The Canterbury DHB will carry out election for the Board in conjunction with the Local Territorial Authorities	System and processes in place to ensure the community is appropriately informed of the election process	Election held in October 2001	Yes	Media and relevant public relations work completed. Members elected and orientated to Board processes; allocated to Subcommittees and information then shared with a number of forums/publications with the community.

FUNDING FUNCTION OBJECTIVES				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and source**
Objective 1 To be an effective funder of Health and Disability Services for the population of Canterbury.	Canterbury DHB will initiate a comprehensive health needs assessment in relation to the people of Canterbury which will guide future funding decision-making processes and strategic planning.	Canterbury DHB will initiate an analysis of the current and future health needs of the resident population of the Canterbury and will share this information with the community.	Yes	Completed Health Needs Assessment November 2001. Refinement continues around priority areas of work and towards a final version by June 2004.
	Canterbury DHB will develop and implement a principle-based prioritisation framework as a basis for making rational, consistent and transparent decisions about which services should be funded.	Review existing models for prioritisation, develop or refine a framework for Canterbury DHB, share information with the community and the Board on the proposed process.	Yes	Completed May 2002 and adopted by Board. Consulted on as part of District Strategic Plan process. Awaiting publication as part of Strategic Plan (publication expected November 02).

DHB WIDE OBJECTIVES YEAR 1				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and Source**
Objective 2 Canterbury DHB will seek ways to improve public knowledge and share information about existing and planned publicly funded health and disability support services.	Canterbury DHB will develop and consult on a 5-10 year Strategic Plan that outlines the strategic direction for health and disability support services and is based on the NZ Health Strategy.	Develop needs analysis, development of strategic plan and consultation with community.	Yes	DSP Completed May 2002. Awaiting final sign off by Ministry of Health. Expected November 2002. Consultation Policy and Strategy developed and approved by Board November 2001and actioned as part of DSP consultation process.
Objective 3 The Canterbury DHB will fund quality health services.	The Canterbury DHB will develop processes to ensure that service delivery is monitored against the requirements of service contracts and are delivered in line with quality standards.	Canterbury DHB will develop a work plan that identifies robust processes to improve the monitoring of service delivery, routine auditing plans, processes for ad hoc and issues based audits and opportunities to move towards a greater quality improvement focus within the health sector.	Yes	In 2001/02 standards and processes developed as part of setting up a new system. Audit plans prepared and implemented. Major area for 2001/02 was audit of Mental Health Service contracts.
	Contract reporting requirements will be reviewed and recommendations for improvements for new contracts will be implemented.	Reporting requirements for new contracts and contracts being renegotiated over the 2001/02 year will be reviewed and any recommendations implemented.	Yes	Reporting requirements process being reviewed as contracts re-negotiated eg collection of ethnicity data/service volumes.

CHRISTCHURCH HOSPITAL
Organisational Infrastructure:

1) **To implement an organisation structure that supports the principles of:**
   - **clinical governance**
   - **effective risk management**
   - **aligning accountability with responsibility**
   - **devolved decision-making**
   - **adding value through multi-disciplinary teamwork**
   - **responsiveness to patient's needs**
2) **To imbed organisational processes that support these principles.**

Measurement	Target	Achieved Yes / No	Narrative Figures and source
Review the organisational service infrastructure to ensure that the development and maintenance of a multi-disciplinary team based approach to patient care is enhanced.	Completed March 02	Yes	The review was completed March 2002 and resulted in the restructuring of clinical services into service clusters headed by medical/nursing partnerships. This new structure, along with further devolution of responsibility to clinical leaders will help create the environment necessary to enhance the delivery of patient care.
To implement multi-disciplinary care planning tools, including clinical pathways in accordance with the accreditation programme.	June 02	Partially	Generic clinical pathway and care planning tools have been developed. Pilot implementation is under way and progressive implementation across the hospital is expected to start in September 02.

CHRISTCHURCH HOSPITAL			
Measurement	**Target**	**Achieved Yes / No**	**Narrative Figures and source**
To ensure there are effective and comprehensive pathways for clinical input into clinical risk management processes to ensure a hospital wide overview is achieved.	Staged improvements & Implementation.	Ongoing	Following the above restructure we have identified as a priority the need to set up a Clinical Governance Framework and set of processes to manage risk. The development of a Clinical Risk Management Plan is the first step. In preparation we have achieved the following during the past year: ▪ Expanded membership of the Divisional Management Group. ▪ Updated and issued a revised Christchurch Hospital Campus Policies and Procedures Manual (Nov 01). ▪ Established a "Clinical Skills Laboratory" (June 02) that provides for a systematic approach (DHB wide) for teaching core clinical activities. ▪ All new job descriptions for Department Chiefs and Nursing Directors now include a focus on Clinical Risk Management. ▪ The Risk Events Management (REM) database is now operational and provides better information, reporting and trend identification. ▪ Reviewed and improved existing practices in a structured way (NZ/AUS Standard 4360) in preparation for Accreditation.

CHRISTCHURCH HOSPITAL			
Measurement	**Target**	**Achieved Yes / No**	**Narrative Figures and source**
To achieve the specified milestones in the Accreditation Preparation Plan.	Various	No	The original plan had an unrealistic assessment of the resources required to achieve accreditation by 2002. Additional resources have now been approved and a new draft plan prepared with a more realistic target date of August 2004. A core foundation of quality already exists with areas of excellence. This will be built on with progressive implementation of the new plan.
To implement clinical audit processes consistent with the clinical audit implementation plan.	June 02	Yes	The target of 2002 considered inappropriate as the clinical audit plan has a number of initiatives with different deadlines and all of these are progressive. Hence this measurement is ongoing. The milestones to date in our clinical audit plan have been achieved. These include a baseline audit, consultation workshops and the establishment of a hospital-wide Clinical Audit Committee. The focus has shifted to education about audit and use of available resources from the development of a computerised system. Work will continue to set consistent standards for clinical audit across specialties.

CHRISTCHURCH HOSPITAL			
Measurement	**Target**	**Achieved Yes / No**	**Narrative Figures and source**
To implement the 14 sub-projects of the Theatre Review so as to improve patient satisfaction and increase the effectiveness and efficiency of patient care.	June 02	Partially	Policy and procedures for booking clerks completed and incorporated in the Nov 01 revision of the Christchurch Hospital Campus Policy and Procedures manual (Volume A). Pre-admission project – flow charts completed. Pilot will commence in August Day Surgery and holding bay will not be completed until new Day Surgery/Womens Hospital is completed. Pre-Op and post-op documentation completed. Staff education and training needs programme completed. Patient Management System – theatre model, enhancements project completed TSSU planning – part of Womens Hospital development.
To implement Canterbury DHB policies on integration with other providers including primary health care providers and NGOs to ensure better health outcomes for the community.	ongoing	Yes	Consultation with local GPs is well embedded in hospital activities. This includes joint projects, the implementation of referral guidelines and waiting list initiatives. Current contract negotiations have temporarily soured working relationships with Pegasus Health however we are looking forward to their re-engagement in these activities.

CHRISTCHURCH HOSPITAL

Measurement	Target	Achieved Yes / No	Narrative Figures and source
To enhance the interface between the acute hospital and the rehabilitation services at TPMH and Burwood Hospital through targeted project activity.	June 02	Yes	Communication protocols established with regular minuted meetings taking place to help exchange of information. The aim is to bring about alignment of services between hospitals.

CHRISTCHURCH HOSPITAL
Spending Wisely
To manage expenditure consistent with the expectations of the CDHB funding allocation.

Measurement	Target	Achieved Yes / No	Narrative Figures and source
To implement a Clinical Review Panel to ensure that all new high cost therapies are assessed for evidence of patient benefit and meet agreed health economic criteria.	July 01	Yes	The Clinical Review Panel was set up in July 2001. Since then it has established assessment criteria and undertaken several reviews.
Implement Picture Archiving and Communications System (PACS) radiology to eliminate imaging duplication and lost time.	June 02	Yes	PACs Stage 1 has been implemented in Radiology and Emergency Department 30 July 01.

CHRISTCHURCH HOSPITAL
Service Delivery
i) To ensure that demand for acute non-deferrable services is met;
ii) To deliver elective surgery and First Specialist Assessments consistent with the expectations of the Ministry of Health Funding Envelope.

Measurement	Target	Achieved Yes / No	Narrative Figures and source
To work collaboratively with hospital and community providers to ensure that sufficient capacity exists to manage peaks in acute service demand, with a particular emphasis on winter.	ongoing	Yes	Processes for planning and consultation are well established with local primary care providers. As are the internal responses including increasing staffing levels and the opening of additional beds. "Winter Planning" forms part of this objective whereby we coordinate our activities with PMH and meet with community groups including Electricity suppliers, CCC, Primary Carers. Minutes are available.
To monitor the achievement of certainty for patients requiring elective surgery on an ongoing basis.	July 01	Partially	An implementation plan was presented to the Hospital Advisory Committee in July 02. This plan received approval in principle to implement the Ministry of Health strategy on waiting list management.
To maintain an active investment in the GP Liaison initiative.	Ongoing	Yes	Monthly meetings are held with GPs involving hospital clinicians and management. Four GP's currently work on site.
To work collaboratively with primary care to ensure that referral guidelines for elective services are implemented.	July 01	Yes	General Manager and Operations Manager are members of steering committee with primary care. The MOH put out the referral guidelines.

CHRISTCHURCH HOSPITAL
Health Strategy Goals
To integrate the Government's Health Goals and Priorities into service delivery.

Measurement	Target	Achieved Yes / No	Narrative Figures and sources
Embed the outcomes of the Diabetes disease management project.	Ongoing	Yes	Awaiting CDHB Action Plan. A draft has been prepared and presented to the CDHB Executive Management Team (EMT).
To actively participate in the Asthma Disease Management Project and implement associated evidence based guidelines.	Dec 01	No	Awaiting clarification from funder.
To work with the MOH to implement the recommendations of the MOH national working parties in Radiation Oncology, Haematology and Medical Oncology.	Dec 01 Ongoing	Partially	A clinical service plan and implementation pathway has been developed. Radiation Oncology – Capex: CT Simulator and associated requirements. Verbal approval. Medical Oncology/Haematology – high cost drugs – agreed process and access. Palliative Care increase staff resources – RMO 1.0FTE, CNS 1.0FTE. Med Oncology 4th FTE Jan 03. Brachytherapy is implemented in clinical.
To work with the MOH to implement the South Island Paediatric Oncology strategy.	Dec 01	No	As part of the implementation plan a clinical service review has been undertaken setting out the requirements for compliance including the provision of improved facilities and centralisation. Funding has been designated for 2002/03. The target for this should be ongoing as a number of processes need to come together to implement the Strategy over the next 1-3 years.
To undertake a review of Child Health Services in the provider arm of CDHB to establish a comprehensive vision for the future of CDHB owned Child Health Services.	June 02	Yes	A clinical service review has been completed, setting out strategic objectives, which has been accepted by CDHB management.

CHRISTCHURCH HOSPITAL
Hospital Planning
Ensure the asset infrastructure meets the projected service capability requirements over the next decade

Measurement	Target	Achieved Yes / No	Narrative Figures and source
To undertake a comprehensive facility audit and ten year facility planning process for the campus.	June 02	No	The first attempt at achieving this failed to provide a satisfactory outcome. A fresh approach is now being planned and scheduled to begin in September 2002. Completion now expected by May 2005 in line with the completion of the new Womens Hospital. The review has been expanded to be Canterbury DHB wide.

OLDER PERSONS HEALTH

Objective	Measurement	Target	Achieved Yes / No	Narrative Figures and source
To develop professional leadership, clinical expertise amongst staff and empower them in the management of change	Workforce plan is actioned • Education/training plan includes collaborative approaches to expertise and resources	June 2002	Yes	Plan for management level completed. Professional Development Committee developed and functioning. Unit Managers, Senior Clinical Practitioners, Director of Nursing Practice developing workforce plans.
	Professional accountability models operate for each profession - Staff competency levels are defined.	June 2002	Yes	Competency levels defined. Job descriptions reviewed to reflect models, currently in draft.
To ensure patients are provided with quality health services and care that are seamless and culturally appropriate	Total length of stay across the organisation's sites/services is measured and information used to adapt service delivery as necessary.	June 2002	Yes	Length of Stay is collected and monitored three monthly by Length of Stay Committee. LOS has decreased by approximately 1 day over the last year. Trends are monitored, statistics collated and distributed to all clinical areas and management; it is used in service development work. Unit Managers and Clinical Director take responsibility for challenging increased Length of Stay.

OLDER PERSONS HEALTH				
Objective	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and source**
	Accreditation is achieved	June 2003	Partially	Accreditation is planned to be achieved by October 2004 and current year objectives have been met. All services are currently completing the Service Provision Framework, a process which will help the service in preparing for Quality Health Accreditation (an external quality peer review process).
	Care pathways and length of stay are defined and managed	June 2002	Yes	Predicted Length of Stay determined – Length of Stay Committee (set up July 01) monitors and identifies areas requiring action.
	Treatment/care plans are multidisciplinary	June 2002	Yes	A multi-disciplinary approach to care delivery is in place. Integrated clinical notes trial currently underway. Audits of treatment/care plans are in place by topic on a monthly basis eg Stroke.
	Culturally safe care is provided and audited against an agreed framework	June 2002	Partially	Advisory service provided by Te Korowai Atawhai Service. Ongoing consultation with Iwi held in June to assist with improving in this area. Currently working towards developing an agreed framework.

OLDER PERSONS HEALTH

Objective	Measurement	Target	Achieved Yes / No	Narrative Figures and source
To develop organisational structures and teams that encourages shared values and strong partnerships.	Clear decision making on professional and line management issues.	June 2002	Yes	The General Manager and Clinical Director work in a partnership model. Professional advisors are in place for all professional disciplines who report to the General Manager. The clinical service has a Clinical Management Board whose purpose is to improve clinical input into decision making for the Older Persons Health Service and to enhance the partnership between health professionals and management.
	Decision making structures reflect best use of the talents and resources of Older Persons Health employees.	June 2002	Yes	Clinical Management Board used as a decision making structure to ensure clinical input into decision making. Joint management decisions between General Manager and Clinical Director. General Manager meets with Management Team and Senior Clinical Practitioners of all professions on a formal basis. New structure implemented in 2002 to support decision making.

OLDER PERSONS HEALTH

Objective	Measurement	Target	Achieved Yes / No	Narrative Figures and source
To continue to influence health and social policy so that the needs and expectations of older people remain central to service development and delivery.	Strategic planning has consumer input.	June 2002 and ongoing	Yes	Strategic Plan currently out for consultation with staff, next stage is to distribute to Consumer Participation Group for feedback. The Clinical Management Board has agreed to include a consumer as a member.
	Support and participate in the work of the Ministry to review and advocate for older people by participating in national health committee reviews.	June 2002 and ongoing	Yes	Various clinical input into many Ministry review work such as Health of Older Peoples Strategy. Views of the clinical staff are often sought by the Ministry of Health. CDHB will be a lead DHB for the devolution of funding for care of the elderly, this project is called LinkAGE.
	Support research that enhances outcomes for older people.	June 2002 and ongoing	Yes	Chair of Gerontology (joint position with University) in place. Actively involved in research: ⇨ Medical eg, Paper on natural course of recovery of dysphagia – accepted for publication in Dysphagia Journal – Assoc. Professsor Tim Wilkinson. ⇨ Physiotherapy, eg, Involved in Doctoral Research by Sue Lord. ⇨ Speech Language Therapy, eg Involved in a controlled trial Focusing on outcomes of Rehabilitation Programming for Neurogenic Dysphagia. Continued involvement with external groups, eg primary care, NGOs, consumer groups through: ⇨ Elder Care Canterbury Forums ⇨ Influenza Campaign ⇨ Discharge Planning ⇨ Stay on your Feet ⇨ Medication Management ⇨ Elder Friendly

OLDER PERSONS HEALTH				
	Target		**Achieved Yes / No**	**Narrative Figures and source**
	Intersectorial integration is achieved. • Elder Care Canterbury initiatives are encouraged and supported within resource allocation	June 2002 and ongoing	Yes	Staff involvement in Elder Care Canterbury (ECC) continues to be supported. Staff from CDHB in-house provider attend various stakeholder groups and planning groups involved in such things as medication review, and elderly friendly hospitals. Some of these groups are short term, other groups go for several months. Administrative support to the ECC Project provided from The Princess Margaret Hospital. (0.3FTE staff member).

MENTAL HEALTH DIVISION				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Gain advantages of Healthlinks (clinical information system.)	Percentage of documents on the system	100% Review 3/02	Partially	Mental Health Division has moved from a paper based clinical information system to an electronic system. All the planned clinical documents are on the Healthlinks system and accessible. Usage is continually increasing.
Begin co-ordinated workforce projects for South Island as part of delivery 4 years of National Plan.	(Projects delivered on time and within budget)	Project management	No	Ministry of Health has delayed implementation of policy on workforce projects Child and Youth Placement project has commenced and is achieving its objective of providing exposure to Acute Child & Youth Psychiatry Mental Health Division is funding Allied Health Preceptorship Programme aimed at assisting new Allied Health Professionals transition into clinical practice Proposals have been sent to MOH workforce planning project for: - Nursing Transition Programme - Calming & Restraint Education - Treatment of Personality Disorders

MENTAL HEALTH DIVISION				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Centralise recruiting	Staff vacancy numbers Turnover in nursing numbers	Maintain budgeted FTE levels at 98%	Yes	Centralised approach through Mental Health Division HR Advisor. Over the past 12 months the nursing turnover has been 8-9% which on national/international benchmarks is low, down from 2000/01. Staff vacancies numbers were constant across the service in 01/02.
Participate in Mental Health Classification and outcome study	Clinical buy in attained	Data integrity 100% Project completed on time and within budget 6/02	No	Participation in this project was withdrawn due to a prolonged industrial situation and our inability to train staff in the tools required to undertake the assessments. Framework now in place to implement programme for 2003/04.

MENTAL HEALTH DIVISION				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Review roles in supervised accommodation	Review recommends achievable plan for the CDHB	Review completed by 8/01	No	The review of Residential Rehab Housing services delayed due to industrial action. Discussions are continuing with Planning and Funding.
Agree and action 5 projects within Access Canterbury Agreement	Projects delivered on time within budget and to standards within agreement	Better integration with GPs	Yes Partially	The projects have been agreed and have commenced and are currently at varying stages of implementation development. These are: - Discharge Planning - Shared Care - Liaison - NZ Guidelines Group - Building NGO Relationships
Ensure South Island Mental Health Network established	✔ Established	By 9/01	Yes	This is a Planning and Funding Forum and there is representation from each DHB.
Ensure CDHB Mental Health Reference Group is established.	✔ Established	By 9/01	Yes	This group has been renamed as Mental Health District Advisory Group and the Group Manager and Managing Clinical Director CDHB Mental Health Service have membership of this forum. Meet monthly with representation from NGO, Maori, Pacific Island, Primary Care, Alcohol & Drug, Consumer/Family.

WOMEN'S HEALTH DIVISION				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Implement computerised clinical audit system.	System installed.	Installation by December 2001.	No	The computerised clinical audit system was not purchased nor installed during 01-02 due to competing financial demands and priorities. Instead we appointed .5 FTE (Midwife) to develop, support and coordinate a manual clinical audit system. The manual system has achieved the agreed number of clinical audits (24 during 01-02) including the implementation of recommendations arising from each audit. Results of audits are published quarterly. The WHD Annual Report summarises clinical audit activity-due for publication on September 6th 2002. We are now better placed and will be more discerning over our choice of computerised clinical audit system once funding is approved.
Achieve compatibility with other Board hospitals of patient management system.	All services using HOMER patient management system.	Full migration by June 2002.	No	Funding for the transfer was not available in the 01-02 year. Approval in principle has now been given with $500K held as allocated priority expenditure (02-03) and a commitment to a further $500K (03-04). A formal CAPEX proposal will now be drafted and it is expected the migration will be achieved prior to the opening of the new Womens Hospital on the Christchurch campus.

WOMEN'S HEALTH DIVISION				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Review and improve all processes of information for patients regarding their treatments.	Review completed and recommendations accepted by divisional governance group.	Report completed by December 2001.	Partially	We planned a systematic approach in line with the Accreditation Action Plan. This has been delayed by the following: ▪ additional time required for work of relocation user groups, ▪ contingency planning for industrial action and ▪ staff movement resulting in acting appointments. In the meantime we have continued with ongoing maintenance of patient information and have produced over 50 new or updated pamphlets / brochures in the 01-02 year. The Quality Team are now coordinating this work which will feed into our planned Accreditation goal.

WOMEN'S HEALTH DIVISION				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Improve cultural safety for Maori patients and clients.	Policies and guidelines in place.	Full implementation by March 2002.	Partially	Policies signed off on 27 June at Powhiri for new Womens Health Division General Manager. Key aspects include the appointment of a full time Womens Health Division Maori Health Worker to be in place by December 2002. Maori representation on interview panels for Senior Womens Health Division appointments – already occurring and greater emphasis on staff education and understanding regarding the needs of Maori, also underway via inservice, education and work of Cultural Advisory Komiti. Staff cultural training is tracked on the Division's Balanced Scorecard.
Finalise user requirements for new Women's Hospital.	Working drawings signed off by users.	100% sign off.	No	Milestones achieved as per Project Development Schedule – Site Redevelopment. Sign off from Treasury and Ministry of Health for Business Case for new hospital on 25 June 02 ensures financial support. Design sign off by User Groups (multi-disciplinary groups of health professionals with consumer involvement) was substantially complete by August 02.

RURAL AND COMMUNITY HEALTH SERVICES				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and source**
Complete a stocktake of rural health and social services (including facilities) available in rural communities of Canterbury	Information available on health and social services (including facilities) available throughout rural Canterbury	30 December 2001	Yes	Details of stocktake included in CDHB Rural Health Plan
Set up and complete consultation process to obtain the views of local authorities, communities and health providers on service issues.	Information provided and meetings with target groups	30 June 2002	Yes	Process used as part of CDHB information gathering and consultation on draft strategic Plan 'Directions 2006".

SCHOOL & COMMUNITY DENTAL SERVICE				
Objectives	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Increase the % of children receiving diagnostic radiography	Year 1	15%	Yes 24%	27,000 large film, 7,100 small films taken. Based on one set of films per child, 12,050 (24% total enrolled) children received diagnostic radiography services. 12 therapists trained in radiography during the reporting year.
Increase Pre-School enrolments	Year 1	50%	Yes	Based on 6,000 children per cohort group the pre-school group 1-4 years inclusive = 24,000. Pre-school enrolments 17,447, (72% of the eligible group) Pre-school numbers have increased by 2,835 in the 12 months up to 30 June 2002.

BURWOOD HOSPITAL				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Agree quality action plan from Quality Health accreditation survey and maintain quality focus	Draft Action Plan developed Action Plan accepted by Quality Health New Zealand.	Complete by August 2001	Yes	Draft Plan completed and accepted August 2001. This Plan being followed with 81 points to be accomplished. Quality Health New Zealand, the Accreditation agency, are to review the plan in September 2002.
Implement recommendations from accreditation process	All recommendations implemented	100% compliance by March 2002	No	To date 50% of the action points have been implemented. The Burwood Quality Committee and Steering Group use the plan at least monthly as a reference. As mentioned above Quality Health New Zealand are due to review the plan in September and following this it is expected to have the remaining action points implemented by December 2002.
Implement Stage 1 of: ▪ New Administration block ▪ New Ward	Architects complete detailed plans.	100% user sign off by June 2001	Yes	Planned completion of Stage 1 of project now due 18/11/02.
	Tender Work	Award tender by end July 2001	No	Was completed 6/9/02
	Complete works as per staged dates	Stage 1A October 2001	No	Was completed 5/2/02
		Stage 1B & C May 2002	No	1B was completed 5/7/02 1C was completed 27/9/02

BURWOOD HOSPITAL				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Implement framework for clinical governance system	Recommendations of Clinical Governances Review implemented	All processes and structure in place by April 2002.	No	A Clinical Audit Consultant has completed a review. The report has been circulated and staff have had one meeting to discuss. The plan is to arrange a workshop from which an action plan will be developed. Mortality and Morbidity meetings will also provide input. The credentialling process will be in line with that developed and used at Christchurch Public Hospital.
Develop clinical pathways	Number of clinical pathways	10 pathways developed by June 2002	No	No new Clinical Pathways have been developed due to a lack of resources. Burwood previously had a Clinical Pathways Coordinator however this position was not replaced when the incumbent left. It is expected that review of existing or development of new pathways will result in the action plan above.

BURWOOD HOSPITAL				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative Figures and sources**
Review discharge planning process	Project leader(s) identified Project plan developed Project completed	July 2001 August 2001	No Partially	This objective is also linked to the two above and delayed for the same reason. Progress will be made following the planned workshop. In the interim current discharge planning has been reviewed. The Spinal Unit is currently reviewing their discharge process in conjunction with ACC. Burwood is also involved in 4 Elder Care Canterbury projects focusing on discharges.
Maintain and enhance Ministry Of Health/Accident Compensation Corporation revenue stream	Value of current contracts	Increase in contract value	Yes	ACC revenue exceeded targets last year by 10%. The Burwood General Manager is the coordinator of an ACC project for the whole Canterbury DHB. One of the working groups of this project has a focus on revenue.

BRACKENRIDGE ESTATE LIMITED

Objectives Year 1	Measurement	Target	Achieved Yes / No	Narrative figures and Sources
Review current Policies & Procedures to ensure they meet current legislative standards and best practice guidelines.	Policies and Procedures are reviewed and updated.	10/01	Yes	Policies reviewed by senior staff with consultation and feedback from staff groups.
Undertake Business Contingency Planning process.	Policies and Procedures/Plans developed and implemented.	12/01	Yes	Policies and Procedures manual developed. Risk Management Plan in place and being actioned. Strategic plan developed and progressively being implemented.
Services provided are within financial/budgeted allocations.	Allocated budgets are adhered to.	Ongoing	No	Initial budget was based on forecasted revenue increases which did not eventuate. Negotiation with MoH continuing in 2002/03. Brackenridge managed to come in under its approved expenditure budget for the financial year ($177 000). We have implemented many cost saving initiatives and have made Brackenridge more cost effective in the areas of staffing / telecommunications especially.

BRACKENRIDGE ESTATE LIMITED

Objectives Year 1	Measurement	Target	Achieved Yes / No	Narrative figures and Sources
Determine Brackenridge Estate's strategic future in key areas of specialisation and access to new residents.	Consultation with key stakeholders undertaken. Strategic future determined.	10/01 12/01	Yes	In outlining our future direction in our Strategic Plan we have identified key areas of specialisation. We see this being with the medically fragile and challenging behaviour residents. We are working to establish greater expertise with the medically fragile and believe we are making progress. We have identified in our Strategic Plan there is scope to specialise in the provision of respite care and this is being progressed with the local Needs Assessment Service Co-ordination agency and Ministry of Health.
Enhance Clinical Practice (for example restraint minimisation, day programme development).	Clinical Practice is in line with Best Practice Guidelines and Policies and Procedures.	Ongoing	Yes	Training provided for all staff in best practise eg autism, dual diagnosis, non-violent crisis intervention and restraint. Residents plans (including day programme development) in place and regularly reviewed by caregivers, families/guardians.
Support and optimise residents' current pattern of living, including access to day programmes.	Lifestyle plans based upon 'My Goals' package are in place for all residents.	12/01	Yes	My Goals package in place for all residents (individually tailored). These ensure all residents get opportunities to gain meaningful life experiences, real work where possible via day programmes and participate in leisure time activities.

BRACKENRIDGE ESTATE LIMITED				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative figures and Sources**
Consolidate links with other community and service providers.	Effective working relationships are in situ, regular contact is maintained.	Ongoing	Yes	Relationships in place with providers eg Horizons, Hohepa Trust, AJs, Birchwood, Pembury, Alfa & Omega. Member of the National Residential Providers Group and receive support from the Templeton Welfare Group.
Strengthen current stakeholder feedback mechanisms.	Stakeholder satisfaction survey undertaken. Regular contact and consultation with residents/family/whanau/ other relevant stakeholders.	03/02 Ongoing	No	Survey replaced with two meetings (Aug01/April02) to discuss issues with positive outcomes as follows: ➢ Open communication with parents on key issues eg Swimming pool development ➢ Family/staff interaction with Christmas family BBQ ➢ Families maintained regular contact. ➢ Quarterly newsletter went out to families Parent representative on the Board.

BRACKENRIDGE ESTATE LIMITED				
Objectives Year 1	**Measurement**	**Target**	**Achieved Yes / No**	**Narrative figures and Sources**
Participate in audits, e.g. Standards and Monitoring Service	Review recommendations and requirements made implementing same where appropriate and/required.	Ongoing	Yes	Implemented recommendations from the last Standards and Monitoring Service audit as follows: ➢ Policy & Procedures Manual developed ➢ New Pharmacy contracted to dispense medication ➢ Fire Training and Fire Drills are regularly scheduled ➢ Families advised of staff changes Audit NZ recommendations as follows: ➢ CDHB property division advises on property matters. Maintenance Plan needs to be developed

GLOSSARY OF TERMS	
Accreditation	Achievement against a national system of standards.
Audit	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation.
Brachytherapy	Type of radiation therapy in which radioactive materials are placed in direct contact with the tissue being treated.
CAPEX	Capital expenditure
Cardiothoracic	Relating to the heart or chest
Community	A collective of people identified by their common values and mutual concern for the development and wellbeing of their group or geographical area.
CNS	Clinical Nurse Specialist
Cohort	Generational group as defined in demographics, statistics, or market research: "The cohort of people aged 30 to 39... were more conservative" (American Demographics).
Consultation	The process of seeking the views of individuals or groups. These include both providers and health service users.
CPHAC	Community and Public Health Advisory Community
CWD - Cost Weighted Discharges	Measure of relative patient's utilisation of resources.
Disability	Incapacity caused by congenital state, injury or age-related condition expected to last six months or more. A disability may or may not be associated with the need for assistance.
Disparity (or deprivation)	Socio-economic or health inequality or difference relative to the local community or wider society to which an individual, family or group belongs.
District Health Boards	District Health Boards are organisations being established to protect, promote and improve the health and independence of a geographically defined population. Each District Health Board will fund, provide or ensure the provision of services for its population.
DSAC	Disability Support and Advisory Committee
DSP	District Strategic Plan
EMT	Executive Management Team
Equity	Equity means fairness.
Evaluation	Assessment against a standard. Evaluations can assess both the process (of establishing a programme to deliver an outcome) and outcomes (ultimate objectives).
FTE	Full time equivalent
Funding Agreement	This is the agreement the Crown enters into with any person or entity under which the person or entity agrees to provide or arrange the provision of services in return for payment. For District Health Boards, this will include the District Health Board Annual Plan, funding schedules and the District Health Board Statement of Intent.
General Surgery	General and Vascular Surgery at Christchurch Hospital provides tertiary services to general, vascular and transplant services. Approx 60% acute workload. Treats mainly non deferrable malignant life and limb threatening disease of upper and lower gastro-intestinal system, breast, endocrine and perivascular systems, primarily malignant disease.
Goal	A high level strategic statement.
Gynaecology	Disease and hygiene of women
Health Needs	This can be either: 1) what an individual requires to achieve or maintain health; or 2) an estimation of the programmes required to improve the health of populations.

Health Needs Assessment	A process designed to establish the health requirements of a particular population.
Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.
Health Policy	A formal statement or procedure within institutions (notably government) that defines priorities and the parameters for action.
Health Status	A description and/or measurement of the health of an individual or population.
Iwi	Tribe.
LOS	Length of Stay
Medical Credentialling	Medical credentialling refers to the process of permitting an individual physician to practice in a particular hospital, clinic or other medical practice setting.
Neurosurgery	Surgery of the nervous system
Objective	Objectives state what is to be achieved and cover the range of desired outcomes to achieve a goal.
Ophthalmology	Eye surgery
Orthopaedic	Prevention or correction of injuries or disease of the skeletal system and associated muscles, joints and ligaments.
Otolaryngology	Ear, nose throat surgery
PACs	Picture Archiving and Communications System
Pacific Peoples	The population of Pacific Island ethnic origin (for example, Tongan, Niuean, Fijian, Samoan, Cook Island Maori, and Tokelauan) incorporating people of Pacific Island ethnic origin born in New Zealand as well as overseas.
Partnership	The relationship of good faith, mutual respect and understanding and shared decision making between the Crown and Maori.
Performance Indicator	A measure that shows the degree to which a strategy has been achieved.
Population Based Funding	Population based funding involves using a formula to allocate each District Health Board a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
Population Health	The health of groups, families and communities. Populations may be defined by locality, biological criteria such as age or gender, social criteria such as socio-economic status, or cultural criteria such as Whanau.
Population Health Outcomes	Used to describe a change in the health status of a population due to a planned programme or series of programmes, regardless of whether such programmes were intended to change health status.
Population Health Status	The level of health experienced by a population at a given time. This may be measured by separately identifying patterns of death and illness in a population or by means of one or more measures.
Quality Assurance	Formal process of implementing quality assessment and quality improvement in programmes to assure people that professional activities have been performed adequately.
RMO	Resident Medical Officer
Secondary Care	Specialist care that is typically provided in a hospital setting.
Strategy	A course of action to achieve targets.
Target	A specific and measurable aim relating to an objective.
Tertiary Care	Very specialised care often only provided in a smaller number of locations.
Treaty of Waitangi	New Zealand's founding document. It establishes the relationship between the Crown and Maori as tangata whenua (first peoples) and requires both the Crown and Maori to act reasonably towards each other and with utmost good faith.
Urology	Diagnosis and treatment of diseases of the urinary tract and urogenital system.
Wellness	A dimension of health beyond the absence of disease or infirmity, including social, emotional and spiritual aspects of health.
WHD	Womens Health Division

Audit New Zealand

REPORT OF THE AUDITOR-GENERAL

TO THE READERS OF THE FINANCIAL STATEMENTS OF CANTERBURY DISTRICT HEALTH BOARD AND GROUP FOR THE YEAR ENDED 30 JUNE 2002

We have audited the financial statements on pages 12 to 84. The financial statements provide information about the past financial and service performance and financial position of Canterbury District Health Board and group as at 30 June 2002. This information is stated in accordance with the accounting policies set out on pages 16 to 19.

Responsibilities of the District Health Board

The New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 require the District Health Board to prepare financial statements in accordance with generally accepted accounting practice in New Zealand that fairly reflect the financial position of Canterbury District Health Board and group as at 30 June 2002, the results of operations and cash flows and service performance achievements for the year ended on that date.

Auditor's Responsibilities

Section 15 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000 require the Auditor-General to audit the financial statements presented by the District Health Board. It is the responsibility of the Auditor-General to express an independent opinion on the financial statements and report that opinion to you.

The Auditor-General has appointed K J Boddy, of Audit New Zealand, to undertake the audit.

Basis of Opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- the significant estimates and judgements made by the District Health Board in the preparation of the financial statements; and
- whether the accounting policies are appropriate to Canterbury District Health Board and group's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with the Auditing Standards published by the Auditor-General, which incorporate the Auditing Standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

Other than in our capacity as auditor acting on behalf of the Auditor-General, we have no relationship with or interests in Canterbury District Health Board or any of its subsidiaries.

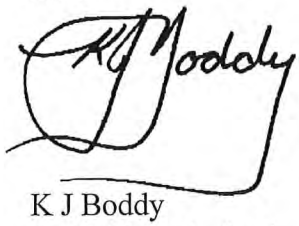
Unqualified Opinion

We have obtained all the information and explanations we have required.

In our opinion the financial statements of Canterbury District Health Board and group on pages 12 to 84:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - Canterbury District Health Board and group's financial position as at 30 June 2002;
  - the results of operations and cash flows for the year ended on that date; and
  - the service performance achievements in relation to the performance targets and other measures adopted for the year ended on that date.

Our audit was completed on 25 October 2002 and our unqualified opinion is expressed as at that date.



K J Boddy
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

Matters Relating to the Electronic Presentation of the Audited Financial Statements

This audit report relates to the financial statements of Canterbury District Health Board for the year ended 30 June 2002 included on the Canterbury District Health Board's web-site. The Canterbury District Health Board is responsible for the maintenance and integrity of the Canterbury District Health Board's web site. We have not been engaged to report on the integrity of the Canterbury District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information which may have bee hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 25 October 2002 to confirm the information included in the audited financial statements presented on this web site.

Legislation in New Zealand governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

APPENDIX 3

Canterbury District Health Board

Report For the Year Ended
30 June 2003

Table of Contents

DIRECTORY

Board Members

Syd Bradley - Chair
Randall Allardyce
Philip Bagshaw
Erin Baker (resigned effective 23 May 2003)
Robin Booth
Graham Heenan
David Morrell
Tuari Potiki (resigned effective 31 August 2003)
Olive Webb
Paul White (resigned effective 30 September 2003)
Alison Wilkie

Chief Executive

Jean O'Callaghan

Registered Office

Charles Luney House
250 Oxford Terrace
PO Box 1600
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

WestpacTrust
Bank of New Zealand

MISSION STATEMENT

The Canterbury DHB's mission is to improve, promote and protect the health of the people in the community and foster the well-being and independence of people with disabilities and reduce disparities.

BOARD MEMBERS

Syd Bradley - Chair

Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB and DHBNZ. Syd has served on a number of boards since resigning from General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services.
Syd is interested in adding value through the development and application of management systems that measure performance against standards.

Randall Allardyce

Randall Allardyce is a director of medical research at the Christchurch School of Medicine & Health Sciences and is also affiliated to the University of Canterbury. Based in Cust, Randall has headed or worked for many North Canterbury community projects and healthcare initiatives as well as the establishment of the NZ Liver Transplantation Unit, the national introduction of keyhole surgery and the new Mobile Surgical Unit.

Philip Bagshaw

Philip Bagshaw is a general surgeon at Christchurch Hospital and is an Associate Professor of Surgery at the University of Otago's Christchurch School of Medicine and Health Sciences. Philip was appointed to the academic staff there in 1981, where he teaches and does research work.

Erin Baker

Erin Baker has previously served as a councillor on the Christchurch City Council. Erin trained as a radiographer at Christchurch Hospital and worked in this profession both in Christchurch and overseas before becoming a professional athlete. Erin has also served on the boards of Jade Stadium Ltd and Christchurch and Canterbury Marketing Ltd. Erin resigned from the Canterbury DHB effective 23 May 2003.

Robin Booth

Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.

Graham Heenan

Graham Heenan has been involved in business management for nearly 30 years, since graduating with a Bachelor of Commerce in 1972. Currently Graham is self employed, and a director of numerous companies throughout the South Island. Graham's interest in the health sector has been as a director of Canterbury Health Ltd since 1995 and Health South Canterbury (1998-2000) and is currently the Chair of Canterbury Laundry Ltd and South Island Shared Services Ltd. His particular skills relate to governance, strategic planning, finance and marketing.

/ continued /

BOARD MEMBERS - continued

David Morrell

David Morrell is City Missioner in Christchurch, and has had 30 years involvement with general health and mental health through hospital chaplaincy, primarily at Christchurch Hospital during the 1970s, and subsequently at the City Mission. City Missioner since 1982, David has had extensive management training, both here and in the United Kingdom

Tuari Potiki

Tuari Potiki is of Kai Tahu, Kati Mamoe descent, belonging to the hapu of Kati Taoka and Kai Te Ruahikihiki. He has a background in Maori health and has worked extensively in the alcohol and drug, mental health, and justice sectors. Tuari is currently Social Development manager with the Ngai Tahu Development Corporation. Tuari resigned effective 31 August 2003.

Olive Webb

Olive Webb is a clinical psychologist and has more than 30 years experience working in the disability sector, particularly with people with intellectual disabilities. Based in Hororata, Olive has a focus on rural health issues and delivery. She provides clinical consultancy to IHC, is an advisor to Richmond Fellowship and also consults in the Mental Health sector.

Paul White

Paul White is from the Ngai Tupoto hapu of Te Rarawa Iwi. Paul has a 20-year background in Maori development and wide experience in the public service. He is currently a management and development consultant and professional director. Previous to this, Paul was the Chief Executive of Ngai Tahu Development Corporation, where he worked for three and a half years, a Regional Director for Te Puni Kokiri in Tai Tokerau for five years, and Branch Manager for the Housing Corporation in Northland where he worked for seven years. Paul is a registered architect and has a Masters in Business Studies. He is also a board member of Housing NZ Ltd. Paul resigned effective 30 September 2003.

Alison Wilkie

Alison Wilkie served on the Riccarton-Wigram Community Board for three years. Alison trained as a nurse at Christchurch Hospital and has post-graduate qualifications in health economics and public health. A life member of the Asthma Foundation and the Canterbury Asthma Society Inc, Alison has worked as an asthma and respiratory educator and owns a small business.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the period ended 30 June 2003.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based district health board, which provides Health and Disability Support Services, principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB recorded a net deficit of $10.4 million against a budgeted deficit of $11.5 million (2001/02 actual deficit - $21.6 million).

BOARD FEES

Board fees paid, or due payable, to Board Members for services during the period, were as follows:

	Board Fees Period ended 30/06/03 $'000	Committee Fees to Board Members Period ended 30/06/03 $'000
Syd Bradley	48	7
Randall Allardyce	24	4
Philip Bagshaw	24	3
Erin Baker	20	2
Robin Booth	24	3
Graham Heenan	24	5
David Morrell	24	5
Tuari Potiki	24	4
Olive Webb	29	4
Paul White	24	2
Alison Wilkie	24	5
	289	**44**

Total fees paid for the year were $333,000 (2001/02 - $344,000). The limit of fees authorised for the year ended 30 June 2003 was $371,250 (2001/02 - $370,875).

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the period were as follows:

	Year Ended 30/06/03 $'000
A Lomax	3
G Heenan	9
A Urlwin	10
	22

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the following transactions during the period:

CANTERBURY DHB

Syd Bradley	Chair - DHBNZ Observer - Pharmac Board Deputy Chair - New Zealand Post Ltd
Graham Heenan	Chair - Canterbury Laundry Services Ltd Group Chair - South Island Shared Services Agency Ltd
Dr David Kerr	Adviser - Health Benefits Adviser - Pegasus Health Chairman - Ryman Healthcare Ltd
Paul White	Director - Housing New Zealand Ltd
Randall Allardyce	Director - Breath Testing Service
David Morrell	City Missioner - Christchurch City Mission
Erin Baker	Councillor - Christchurch City Council
Api Talemaitoga	Vice Chair - Pacific Trust Canterbury Member - Pegasus Health
Mick Ozimek	Member - Pegasus Health
Neville Fagerlund	Adviser - Pegasus Health
Fiona Pimm	Board Member - South Canterbury DHB CEO - He Oranga Pounamu Charitable Trust

SUBSIDIARY AND ASSOCIATED COMPANIES

Chai Chuah (resigned July 2002)	Director of subsidiary, Canterbury Laundry Services Limited. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Garth Bateup	Director of subsidiaries Brackenridge Estate Limited and Canterbury Laundry Services Limited. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Kate Rawlings	Director of subsidiary, Burwood Rehabilitation Limited (wound up on 3 June 2003). No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.
Michael Hundleby (resigned December 2002)	Director of associate company, New Zealand Centre for Reproductive Medicine Limited. No directors fees or any other benefits were received from the associate company except as an employee of Canterbury DHB.
Paul Numan	Director of subsidiary, Brackenridge Estate Limited. No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.
Wei Yoon	Director of subsidiary, Burwood Rehabilitation Limited (wound up on 3 June 2003) and director of associate company New Zealand Centre for Reproductive Medicine Limited. No directors fees or any other benefits were received from the subsidiary or associate companies except as an employee of Canterbury DHB.
William McDonald (resigned December 2002)	Director of subsidiary, Burwood Rehabilitation Limited (wound up on 3 June 2003). No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.

DIRECTORS' AND BOARD MEMBERS' LOANS

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensures that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

USE OF BOARD OR SUBSIDIARIES' INFORMATION

During the period, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place eg: amounts for redundancy (based on length of service), and payment in lieu of notice etc.

Of the total payments listed of $643,802, the amounts required to be paid pursuant to the terms of employment contracts totalled $389,802, with the remaining balance comprising negotiated settlements with 14 of the 17 former employees.

Number of Employees	TOTAL $
1	1,000
1	1,000
1	5,000
1	9,000
1	10,000
1	11,000
1	12,159
1	12,159
1	16,000
1	22,883
1	23,336
1	58,636
1	74,877
1	78,186
1	80,000
1	99,028
1	129,538
17	$643,802

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands is as follows:

	30/06/03 Number	30/06/02 Number
$100,000 - $110,000	50	43
$110,001 - $120,000	36	22
$120,001 - $130,000	17	24
$130,001 - $140,000	24	27
$140,001 - $150,000	29	27
$150,001 - $160,000	21	29
$160,001 - $170,000	23	21
$170,001 - $180,000	24	8
$180,001 - $190,000	12	9
$190,001 - $200,000	5	10
$200,001 - $210,000	4	1
$210,001 - $220,000	5	3
$220,001 - $230,000	4	1
$250,001 - $260,000	1	1
$270,001 - $280,000	1	-
$350,001 - $360,000	-	1
$400,011 - $410,000[1]	1	-
	257	227

Of the 257 positions identified above, 237 (2001/02 - 206) were predominantly clinical and 20 (2001/02 - 21) positions were management/administrative. If the remuneration of part-time positions was grossed-up to an FTE basis, the total number of positions with FTE salaries of $100,000 or more would be 340 with 319 (2001/02 - 328) positions predominantly clinical and 20 (2001/02 - 21) positions management/administrative.

[1] CEO remuneration and other benefits are included in this bracket. The 30 June 2003 paid amount included $30,000 relating to the 2001/02 year.

STATUTORY DISCLOSURE

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000,

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000 and

(c) a report on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2003, for the above additional disclosure requirements:

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	**Extent objectives met**
(a) to improve, promote, and protect the health of people and communities:	The CDHB developed and consulted on its initial health needs assessment with the wider community in November 2001. The CDHB also workshopped development of the Strategic Plan with internal and external stakeholders, produced a plan, then consulted in the community about directions and priorities. The Plan changed as a result of this consultation. In addition this clearly identified health priorities. To implement this Plan, strategies have been developed to address all key health goals. CDHB funds and delivers a range of services from health promotion and protection services, primary care to specialist tertiary services to meet the needs of our population.
(b) to promote the integration of health services, especially primary and secondary health services:	The CDHB Strategic Plan promotes initiatives in response to its Core Directions which include 'Working Together' and 'Finding Better Ways of Working'. Specific strategies to integrate service delivery have emerged through the priority health areas. A number of successful projects with primary care providers and non government organisations are underway. Examples are Integration projects such as the Elder Care Canterbury Project, Access Canterbury, Stay on Your Feet, Working Together for Winter and Christchurch Hospital's acute demand project which all involve different parts of the health sector and the community working collaboratively to improve health outcomes for people in Canterbury.
(c) to promote effective care or support for those in need of personal health services or disability support services:	The CDHB has supported initiatives that assess service gaps/effective utilisation as a way of informing service development, eg, The LinkAGE Project for an integrated continuum of care for older people. Contracts with providers have clear expectations of the service to be delivered, standards expected and reporting and monitoring mechanism. Quality initiatives are in place and a quality council has been initiated to encourage a number of continuous improvement in service delivery.

(d)	to promote the inclusion and participation in society and independence of people with disabilities:	The CDHB has actively supported the Disability Support Advisory Committee which advises on issues for people with disabilities. The CDHB has produced a Disability Strategic Action Plan which has timelines for various actions in areas of health. All new building developments are assessed for meeting the needs of people with disabilities.
(e)	to reduce health disparities by improving health outcomes for Maori and other population groups:	The CDHB has produced and implemented its Maori Health Action Plan, which has timelines for specific actions designed to assist in improving health outcomes for Maori. The Maori Health Action Plan implementation has resulted in improved services (e.g. Te Whare Mahana) and greater numbers of Maori staff within generic health services. Some specific initiatives such as increasing the hours of the Maori health nurse in the diabetes centre have been implemented in some areas. Access has been improved for Pacific peoples with the opening of an inner city health clinic. The CDHB has supported the Ministry of Health in allocation of the Maori Provider development fund.
(f)	to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The CDHB Health Needs Assessment has identified groups in the community, which have health inequalities. Strategic Plan Health Gain Priority areas (eg, Child and Youth, Maori) have been identified as part of this process. For example, the development of primary health organisation in Canterbury will have a focus on reducing inequalities. The CDHB has promoted and supported the Ministry of Health funding for inequalities with two providers in Canterbury.
(g)	to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The CDHB has endeavoured to provide for services to meet the identified health needs for the people in its community and is involved in such groups as Strengthening Families and Healthy Christchurch to advance interagency cooperation. The CDHB has completed an assessment of health needs in our community and has used an active consultation process to enable participation in decision making.
(h)	to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	Forums such as Healthy Christchurch, Elder Care Canterbury, Maori Hui, DHBNZ, Local Diabetes Team are examples of groups the CDHB is an active participant of with a view to comprehensive service planning that will lead to health improvement. The CDHB has engaged in an active consultation process through formal consultation processes (e.g. for the strategic plan) as well as sector representation on project steering groups.

(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	The CDHB has established a Quality and Patient Safety Council and a Clinical Advisory Committee to provide advice to the CEO on quality issues and a forum for the wider DHB (community providers and operating division) to discuss quality issues and thereby facilitate ongoing improvement of the quality of health delivered to the population served by the CDHB. The CDHB has also developed procedures and policies that comply with public sector best practice to ensure quality standards are specified in contracts.
(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	CDHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme.
(k) To be a good employer	Various strategies and systems processes have been implemented but further initiatives are being developed. • A Culture survey is undertaken across the organisation. This will assist in further identifying initiatives. • Development of cluster structure at Christchurch Hospital to facilitate greater involvement at all levels across all medical disciplines. • Harassment and Bullying Policy and training implemented to assist in providing a better working environment. • Disability Strategy action plan implemented. • Management leadership training in place. Policies and approaches under development to provide for greater involvement of Maori and Pacific Island people in the CDHB workforce.

Section 42(3)(i): Statement of how CDHB has given effect and intends to give effect to its functions specified in section 23 (b) – (e)	
Function :	**What has been done to meet function**
(b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	• The CDHB has involved stakeholders in delivery of Core Directions and health gain priority areas for CDHB Strategic Plan. • The CDHB actively involves relevant groups and individuals In planning specific service areas. • Joint arrangements are being developed for the provision of orthopaedic and cardiac surgery services. • The CDHB works with the Ministry of Health in a number of joint/collaborative ways such as Public (Population) Health shared decision making; and the allocation of the Maori and Pacific Health development fund.

(c)	to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):	• The CDHB uses a variety of written media, TV and radio work to outline general issues and priorities and the community. • The CDHB will continue to respond directly to media / personal / group enquiries. • To circulate / make available significant documents / plans for population in summary and comprehensive form either at libraries, via groups or individually. • Involvement of sector representatives in steering groups leading the planning for health services. • The CDHB has developed a website which includes communtiy based health information. • The CDHB continues to provide health promotion services funded by the MoH.
(d)	to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:	Relationships with Manawhenua Ki Waitaha; Te Runanga and Nga Maata Waka; continue to develop. Maori community hui are held quarterly and regular meetings with Maori providers and other Maori community organisations.
(e)	to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori:	Within the provider arm a range of Komiti for Maori staff have been established across the divisions and Te Ao Marama the CDHB wide Maori Health Group. The CDHB Maori Health Plan identifies capacity and capability as key issues to address. Regular hui are held to share information. Canterbury DHB actively supported and managed the implementation of the Ministry of Health's funding for Maori Provider Development. The Canterbury DHB has also continued to support the Maori and Pacific Peoples Leadership Programme locally.

For and on behalf of the Board

Syd Bradley
Chair
24 October, 2003

Graham Heenan
Board Member
24 October, 2003

STATEMENT OF RESPONSIBILITY

Pursuant to Section 42 of the Public Finance Act 1989, we acknowledge that:

a) The preparation of financial statements of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the period ended 30 June 2003, are our responsibility.

c) In our opinion, the financial statements for the year under review fairly reflect the financial position and operations of Canterbury DHB.

Syd Bradley
Chair
24 October, 2003

Jean O'Callaghan
Chief Executive Officer
24 October, 2003

STATEMENT OF FINANCIAL PERFORMANCE FOR THE PERIOD ENDED 30 JUNE 2003

	Notes	Group			Parent	
		Actual 30/06/03 $'000	Budget 30/06/03 $'000	Actual 30/6/02 $'000	Actual 30/06/03 $'000	Actual 30/6/02 $'000
OPERATING REVENUE						
MoH Revenue		671,819	670,944	623,078	665,642	609,975
Patient Related Revenue		21,951	20,563	22,611	21,366	22,609
Other Revenue		11,616	8,808	9,708	10,919	9,190
TOTAL REVENUE		705,386	700,315	655,397	697,927	641,774
OPERATING EXPENSES						
Employee Costs		321,932	315,066	299,748	315,514	289,231
Treatment Related Costs		90,435	82,155	83,402	93,487	85,562
External Service Providers[2]		206,452	213,939	195,119	206,452	195,119
Depreciation	11	21,295	23,487	20,892	20,189	19,761
Interest Expense		6,623	7,896	7,443	6,618	7,310
Other Expenses		54,682	52,872	54,244	51,823	50,477
TOTAL OPERATING EXPENSES		701,419	695,415	660,848	694,083	647,460
OPERATING SURPLUS / (DEFICIT) BEFORE CAPITAL CHARGE		3,967	4,900	(5,451)	3,844	(5,686)
Capital Charge Expense		(14,395)	(16,400)	(16,192)	(14,395)	(16,192)
OPERATING SURPLUS/(DEFICIT) BEFORE TAXATION	2	(10,428)	(11,500)	(21,643)	(10,551)	(21,878)
Tax (Expense)/ Benefit	3	23	-	50	-	-
OPERATING SURPLUS (DEFICIT) AFTER TAXATION		(10,405)	(11,500)	(21,593)	(10,551)	(21,878)
Minority Interest Share of Surplus in Subsidiary		-	-	(30)	-	-
NET SURPLUS / (DEFICIT) FOR THE YEAR		**(10,405)**	**(11,500)**	**(21,623)**	**(10,551)**	**(21,878)**

[2] The budget included some national/regional contract expenditure which has subsequently been transferred back to other DHBs.

STATEMENT OF MOVEMENTS IN EQUITY FOR THE PERIOD ENDED 30 JUNE 2003

	Notes	Group			Parent	
		Actual 30/06/03 $'000	Budget 30/06/03 $'000	Actual 30/06/02 $'000	Actual 30/06/03 $'000	Actual 30/06/02 $'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD:						
Equity excluding Minority Interest		134,923	134,923	156,546	134,577	156,455
Minority Interest		56	56	26	-	-
		134,979	134,979	156,572	134,577	156,455
Revenue reserves from subsidiaries which were amalgamated during the year		-	-	-	215	-
		134,979	134,979	156,752	134,792	156,455
TOTAL RECOGNISED REVENUES AND EXPENSES:						
Net surplus / (deficit) for the period		(10,405)	(11,500)	(21,623)	(10,551)	(21,878)
Attributable to Minority Interest		-	-	30	-	-
Revaluation of Fixed Assets	5	77,717	-	-	77,717	-
		67,312	(11,500)	(21,593)	67,166	(21,878)
OTHER MOVEMENTS						
Contribution from Crown		9,350	25,000	-	9,350	-
Minority Interest amalgamated		(56)	-	-	-	-
		9,294	25,000	-	9,350	-
TOTAL EQUITY AT END OF THE PERIOD:						
Equity excluding Minority Interest		211,585	148,423	134,923	211,308	134,577
Minority Interest		-	56	56	-	-
TOTAL EQUITY		**211,585**	**148,479**	**134,979**	**211,308**	**134,577**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2003

	Notes	Group			Parent	
		Actual as at 30/06/03 $'000	Budget as at 30/06/03 $'000	Actual as at 30/06/02 $'000	Actual as at 30/06/03 $'000	Actual as at 30/06/02 $'000
CROWN EQUITY						
General Funds	5	159,174	174,824	149,824	159,312	149,962
Revaluation Reserve	5	77,717	453	453	77,717	-
Retained Earnings	5	(32,700)	(34,034)	(22,534)	(32,800)	(22,268)
Trust Reserve	5	7,394	7,180	7,180	7,079	6,883
Minority Interest		-	56	56	-	-
TOTAL EQUITY		**211,585**	**148,479**	**134,979**	**211,308**	**134,577**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & Bank	9	(4,295)	155	(3,635)	(4,637)	(4,531)
Receivables and Prepayments	4	57,149	52,017	52,596	55,502	51,364
Stocks	6	6,920	7,331	7,331	6,861	7,276
TOTAL CURRENT ASSETS		59,774	59,503	56,292	57,726	54,109
CURRENT LIABILITIES						
Creditors and Accruals		85,998	49,335	59,192	85,591	58,468
Owing to Crown		3,670	4,234	7,834	3,670	7,834
Staff Entitlements due within 1 year	7	28,507	35,000	28,661	28,152	27,996
Loans due within 1 year	9	99,380	120,000	27,568	99,380	27,468
TOTAL CURRENT LIABILITIES		217,555	208,569	123,255	216,793	121,766
NET WORKING CAPITAL		(157,781)	(149,066)	(66,963)	(159,067)	(67,657)
NON CURRENT ASSETS						
Investments	10	378	466	466	3,783	4,032
Fixed Assets	11	355,863	288,154	269,641	353,484	264,905
Surplus Property	11	10,300	7,450	7,450	10,300	7,350
Restricted Assets	8	7,394	7,180	7,180	7,079	6,883
TOTAL NON CURRENT ASSETS		373,935	303,250	284,737	374,646	283,170
NON CURRENT LIABILITIES						
Staff Entitlements due after 1 year	7	4,271	3,636	3,636	4,271	3,636
Provision for maintenance	20	220	-	210	-	-
Deferred Tax	3	78	69	69	-	-
Loans repayable after 1 year	9	-	2,000	78,880	-	77,300
TOTAL NON CURRENT LIABILITIES		4,569	5,705	82,795	4,271	80,936
NET ASSETS		**211,585**	**148,479**	**134,979**	**211,308**	**134,577**

For and on behalf of the Board

Syd Bradley
Chair
24 October, 2003

Graham Heenan
Board Member
24 October, 2003

STATEMENT OF CASH FLOWS
FOR THE PERIOD ENDED 30 JUNE 2003

	Notes	Group Actual 30/06/03 $'000	Group Budget 30/06/03 $'000	Group Actual 30/06/02 $'000	Parent Actual 30/06/03 $'000	Parent Actual 30/06/02 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from MoH		660,112	671,744	621,518	655,488	608,550
Other Receipts		39,402	29,150	30,191	37,540	29,519
Interest Received		682	483	565	909	717
		700,196	701,377	652,274	693,937	638,786
Cash was applied to:						
Payments to Employees		319,589	308,727	293,724	313,321	283,235
Payments to Suppliers		324,365	359,033	311,060	324,822	309,438
Interest Paid		6,416	8,379	7,322	6,411	7,187
Taxes Paid / (Refunded)		27	-	(1,094)	53	(1,200)
Capital Charge		18,559	20,000	16,356	18,559	16,356
GST (net)		1,293	-	(1,322)	1,312	(1,304)
		670,249	696,139	626,046	664,478	613,712
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	12	29,947	5,238	26,228	29,459	25,074
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of Assets		24	-	579	23	579
Decrease in Investments		81	-	-	789	-
		105	-	579	812	579
Cash was applied to:						
Increase in Investments & Restricted Assets		207	-	454	611	202
Purchase of Assets		32,787	42,000	19,319	32,048	18,369
		32,994	42,000	19,773	32,659	18,571
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(32,889)	(42,000)	(19,194)	(31,847)	(17,992)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		-	42,968	-	-	-
Equity contribution from the Crown		9,350	25,000		9,350	
		9,350	67,968	-	9,350	-
Cash was applied to:						
Loans Repaid		7,068	27,416	2,420	7,068	2,420
		7,068	27,416	2,420	7,068	2,420
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		2,282	40,552	(2,420)	2,282	(2,420)
Overall Increase/(Decrease) in Cash Held		(660)	3,790	4,614	(106)	4,662
Opening Cash Balance		(3,635)	(3,635)	(8,249)	(4,531)	(9,193)
CLOSING CASH BALANCE		**(4,295)**	**155**	**(3,635)**	**(4,637)**	**(4,531)**

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Public Finance Act 1989.

The group currently consists of Canterbury DHB, its subsidiaries Canterbury Laundry Services Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entities, New Zealand Centre for Reproductive Medicine Ltd (50% owned) and South Island Shared Services Agency Ltd (47% owned).

During the year ended 30 June 2003, the subsidiary companies Burwood Rehabilitation Ltd (100% owned), CLS Properties Ltd (100% owned) and Crown Public Health Ltd (76.5% owned) were amalgamated into Canterbury DHB, and the associate company Heart Surgery South Island Ltd (50% owned) was wound up.

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain fixed assets.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Revenue from Ministry of Health to the Funder arm of Cantebury DHB is recognised as revenue in the financial year. Revenue from contracts for services where funding is still the responsibility of Ministry of Health, is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of CHL. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of Canterbury DHB
Assets acquired by the DHB since its establishment are recorded at cost except for land, buildings and fitout plant and equipment that are revalued every five years. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of land, buildings and fitout plant and equipment
Land, buildings and fitout plant and equipment are revalued every five years. The fair value of land, buildings and fitout plant and equipment is determined by an independent registered valuer by reference to the highest and best use of these assets or, if sufficient market based evidence is not available, by reference to their depreciated replacement cost. Additions between revaluations are recorded at cost. The results of revaluing land, buildings and fitout plant and equipment are credited or debited to assets revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

iv) Depreciation

Depreciation is charged on a straight line basis so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	20 - 50
Leasehold Building & Fitout	3 - 20
Fitout Plant and Equipment	5 - 50
Plant and Equipment (incl pool)	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) Goods and Services Tax

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) Donated Assets

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

vii) Stocks

Stocks are valued at the lower of cost and net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

viii) Accounts Receivable
Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

ix) Investments

The investment in the Associate Companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis.

Other investments are stated at the lower of cost and net realisable value.

Dividend and interest income is accounted for on an accrual basis.

x) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

Canterbury DHB subsidiaries are subject to income tax, with the exception of Brackenridge Estate Ltd. Income tax expense is charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. Deferred taxation is determined on a comprehensive basis using the liability method. Deferred tax assets attributable to timing differences or tax bases are only recognised where there is virtual certainty of realisation.

xi) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xii) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xiii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as Finance Leases and capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiv) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xv) Provision for Staff Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, parental leave and conference leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xvi) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non current securities and advances (other than securities and advances included within cash) and any other non current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvii) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xviii) Financial Instruments

Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost or market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xix) Basis of Consolidation

The consolidated financial statements include the parent DHB and its subsidiaries. The subsidiaries are accounted for by adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis which shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

xx) Comparative Figures

Comparative figures for the previous period include the results of operations of subsidiary companies CLS Properties Ltd and Crown Public Health Ltd in the Group results only. These companies were amalgamated into Canterbury DHB during the year ended 30 June 2003, and accordingly now form part of the parent entity's results.

D CHANGE IN ACCOUNTING POLICIES

The Crown's policy is to revalue land, buildings and fitout plant and equipment. In order to meet Crown's policy, the Board has changed its accounting policy for the revaluation of land, buildings and fitout plant and equipment. The Board has revalued its land, buildings and fitout plant and equipment at fair value which has been determined by reference to the highest and best use of these assets or, if sufficient market-based evidence is not available, by reference to their depreciated replacement cost. The previous policy had been to disclose land, buildings and fitout plant and equipment at cost. The effect of this is to increase the value of land and buildings by $77,717,000.

There were no other significant accounting policy changes from the previous financial period. The accounting policies stated above have been consistently applied throughout the period and correspond to the accounting policies specified in the Statement of Intent at the beginning of the period.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating deficit is stated:	Group		Parent	
	30/06/03 $'000	30/06/02 $'000	30/06/03 $'000	30/06/02 $'000
After Charging:				
Remuneration of Auditor:				
- Audit Fees	120	127	101	100
- Other Services	23	-	23	-
Board Members Fees	333	344	333	344
Directors' Fees	22	39	-	-
Interest Expense	6,623	7,443	6,618	7,310
Bad Debts Written Off	130	62	130	62
Increase/(Decrease) in Bad Debts Provision	745	811	745	812
Write-down (reversal of write down) of investments	-	-	(595)	474
Rental and Operating Lease Costs	4,017	3,826	3,452	2,571
After Crediting:				
Interest Received from Investments	682	565	909	717
Gain (loss) on Disposal of Assets	(85)	125	(86)	125

3. TAXATION

The tax expense arises from the operations of subsidiary entities. The DHB itself is exempt from income tax.

	Group	
	30/06/03 $'000	30/06/02 $'000
Net Operating Surplus/(Deficit) before Taxation	(10,428)	(21,643)
Prima facie taxation @ 33%	(3,441)	(7,142)
Plus/(Less) tax effect of:		
Permanent Differences	3,418	7,185
Timing Differences not recognised	-	(90)
Underestimation of tax in previous year	-	(3)
Tax Expense / (Benefit)	(23)	(50)
Comprising:		
Current Tax	(32)	(74)
Deferred Tax	9	24
	(23)	(50)
Deferred Tax Liability		
Opening Balance	69	45
Current Year Movement	9	24
Closing Balance	78	69

Permanent differences are due to results of the Parent and Brackenridge Estate Ltd not being subject to income tax.

4. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Trade Debtors	6,822	11,647	6,781	10,472
Receivable from Crown	48,438	36,731	46,885	36,731
Other Debtors	1,594	3,201	1,550	3,159
Prepayments	295	1,017	286	1,002
	57,149	52,596	55,502	51,364

5. EQUITY

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
GENERAL FUNDS				
Opening Balance	149,824	149,824	149,962	149,962
Equity contribution from Crown	9,350	-	9,350	-
	159,174	149,824	159,312	149,962
RETAINED EARNINGS				
Opening Balance	(22,534)	(496)	(22,268)	10
Revenue reserves from amalgamated subsidiaries	-	-	215	-
Adjustment on amalgamation of CLS Properties	453	-	-	-
Operating Surplus/(Deficit)	(10,405)	(21,623)	(10,551)	(21,878)
Transfers from/(to) Trust Reserve	(214)	(415)	(196)	(400)
Closing Balance	(32,700)	(22,534)	(32,800)	(22,268)
Represented by :				
Accumulated Deficit in Parent and Subsidiary	(32,778)	(22,612)	(32,878)	(22,346)
Accumulated Surplus in Associates	78	78	78	78
	(32,700)	(22,534)	(32,800)	(22,268)
REVALUATION RESERVE				
Opening Balance	453	453	-	-
Adjustment on amalgamation of CLS Properties	(453)	-	-	-
Current Year Movement	77,717	-	77,717	-
Closing Balance	77,717	453	77,717	-
Represented by:				
Revaluation of land	27,531	63	27,531	-
Revaluation of freehold buildings	656		656	-
Revaluation of fitout plant and equipment	48,540	390	48,540	-
Revaluation of reversionary interest in buildings	990	-	990	-
	77,717	453	77,717	-
TRUST RESERVE				
Opening Balance	7,180	6,765	6,883	6,483
Transfers from/(to) Retained Earnings	214	415	196	400
Closing Balance	7,394	7,180	7,079	6,883

During the year ended 30 June 2003, Canterbury Laundry Services Property Ltd and Crown Public Health Ltd were wound up and their assets and liabilities amalgamated into Canterbury DHB. Their revenue reserves of $29,000 and $186,000 were amalgamated into Canterbury DHB revenue reserves.

6. STOCKS

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Pharmaceuticals	1,914	2,655	1,914	2,655
Surgical and Medical Supplies	3,703	3,569	3,703	3,569
Other Supplies	1,875	1,686	1,816	1,631
	7,492	7,910	7,433	7,855
Provision for Obsolescence	(572)	(579)	(572)	(579)
	6,920	7,331	6,861	7,276

Some of the stocks may be subject to restriction of title ie Romalpa Clauses or securities registered by suppliers under Personal Property Securities Act. The value of stocks subject to above cannot be quantified due to the inherent difficulties in identifying stocks that are still subject to the Romalpa Clauses or security registered under PPSA at year end.

7. STAFF ENTITLEMENTS

Staff Entitlements consist of:	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Provision for Gratuities	2,209	1,815	2,209	1,815
Provision for Long Service Leave	2,652	2,124	2,638	2,110
Annual Leave Accruals	18,760	17,432	18,417	16,822
Unpaid Days Accruals	4,504	3,241	4,356	3,026
ACC Accruals	(948)	2,229	(977)	2,189
Conference Leave Accruals	2,764	1,932	2,764	1,932
Other	15,826	14,654	15,758	14,619
	45,767	43,427	45,165	42,513
Less Due Within 1 Year:				
Provision for Gratuities	72	8	72	8
Provision for Long Service Leave	518	295	504	281
Annual Leave Accruals	18,760	17,432	18,417	16,822
Unpaid Days Accruals	4,504	3,241	4,356	3,026
ACC Accruals	(948)	2,229	(977)	2,189
Conference Leave Accruals	2,764	1,932	2,764	1,932
Other	15,826	14,654	15,758	14,619
	41,496	39,791	40,894	38,877
Included in Creditors and Accruals	12,989	11,130	12,742	10,881
Staff Entitlement Due Within 1 Year	28,507	28,661	28,152	27,996
Staff Entitlement Due After 1 Year	4,271	3,636	4,271	3,636

8. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2003, the amount of funds received where the conditions attached have not been fulfilled is $7,394,000 ($7,180,000 at 30 June 2002).

This is represented by:	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Cash at Bank	177	247	177	247
Term Deposits	4,625	4,488	4,310	4,191
Local Authorities & Government Stocks	710	958	710	958
Quoted Shares	55	55	55	55
Bonds & Stocks	1,827	1,432	1,827	1,432
Total Restricted Assets	7,394	7,180	7,079	6,883

9. LOANS AND BANK OVERDRAFT

Loans consist of:	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Commercial Loans	99,380	106,448	99,380	104,768
Finance Lease	-	-	-	-
	99,380	106,448	99,380	104,768
Repayable as follows:				
Due Within 1 Year	99,380	27,568	99,380	27,468
One to Two Years	-	78,880	-	77,300
	99,380	106,448	99,380	104,768

The bank overdraft facility available totals $2,000,000 for the parent and $2,250,000 for the group.

Security
Canterbury DHB commercial loans and the overdraft facilities are secured by Deed of Negative Pledge which requires the Board to comply with certain covenants such as limitations on borrowings, interest cover and working capital ratio. The Brackenridge Estate Ltd overdraft facility is secured by a registered first and exclusive debenture over the company's assets, undertakings and uncalled capital.

Interest Rates
Weighted average interest rates on the group's borrowing for the year are as follows:

	Group		Parent	
	30/06/03	30/06/02	30/06/03	30/06/02
Commercial Loans	5.92%	7.27%	5.92%	7.26%
Finance Lease	0.00%	7.00%	0.00%	7.00%
Bank Overdraft	7.30%	7.20%	7.30%	7.20%

10. INVESTMENTS

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Investment in Associates	378	466	378	466
Investment in Subsidiaries	-	-	3,405	3,566
	378	466	3,783	4,032

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Share of Associates Equity Brought Forward	170	170	170	170
Capital distribution on winding up (HSSIL)	(2)	-	(2)	-
Share of Associates Operating Surplus	-	-	-	-
Share of Associates Equity Carried Forward	168	170	168	170
Advances	210	296	210	296
	378	466	378	466

At 30 June 2003, Associate Companies comprised:

	Percentage Interest	Balance Date
New Zealand Centre for Reproductive Medicine Ltd	50	30 June
South Island Shared Services Agency Ltd	47	30 June

New Zealand Centre for Reproductive Medicine Ltd provides reproductive medicine services to private and publicly funded patients.
South Island Shared Services Agency Ltd provides support services for contracting, contract monitoring and provider audits to DHBs for their Funding arm.
Heart Surgery South Island Ltd used to provide heart surgery for which Canterbury DHB invoiced facility fees. That company ceased trading on 1 July 2002 following the allocation of the Ministry of Health contract directly to participating DHBs, and has been wound up.

INVESTMENT IN SUBSIDIARIES

	Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000
Equity - Burwood Rehabilitation Ltd	-	542
Equity - CLS Properties Ltd	-	515
Equity - Canterbury Laundry Services Ltd	393	393
Equity - Crown Public Health Ltd	-	1
Advances - Canterbury Laundry Services Ltd	2,001	2,115
Advances - Brackenridge Estate Ltd	1,011	-
	3,405	3,566

At 30 June 2003 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Laundry Services Ltd	100%	30 June
Brackenridge Estate Ltd	100%	30 June

Canterbury Laundry Services Ltd provides laundry services. Brackenridge Estate Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

During the year, CLS Properties Ltd, Burwood Rehabilitation Ltd and Crown Public Health were wound up and their assets and liabilities were amalgamated into Canterbury DHB.

As a result of winding up of Burwood Rehabilitation Ltd, Canterbury DHB now directly holds a 60% share in the surplus of Burwood Orthopaedic Surgical Services, a partnership which performs orthopaedic surgery for ACC and work related insurers at Burwood Hospital.

Canterbury DHB appoints both directors of Canterbury Laundry Services Ltd. The company provides services predominantly to Canterbury DHB, and Canterbury DHB has control over the objectives of the company.

Canterbury DHB appoints two out of five directors of Brackenridge Estate Ltd. Its control over the company is exercised through these directors and the provision of financial support and administrative services by Canterbury DHB.

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
At Cost				
Freehold land	-	20,824	-	20,824
Buildings - freehold	-	95,447	-	95,447
Leasehold Building & Fitout	3,497	3,447	3,042	2,984
Fitout plant and equipment	-	116,172	-	116,172
Plant and equipment	45,868	44,549	41,196	39,021
Computer equipment and software	27,502	22,135	27,417	22,094
Motor vehicles	2,079	1,434	1,938	1,334
Capital work-in-progress	27,349	19,383	27,349	19,375
At Valuation				
Freehold land	74,601	26,313	74,601	25,821
Buildings - freehold	85,920	1,718	85,920	-
Fitout plant & equipment	131,289	82	131,289	-
Plant and equipment	24,791	22,985	24,791	22,985
Reversionary interest in buildings	990	-	990	-
	423,886	374,489	418,533	366,057
Accumulated Depreciation				
Buildings - freehold	-	14,650	-	14,445
Leasehold Building & Fitout	579	363	318	142
Fitout plant and equipment	-	34,200	-	34,190
Plant and equipment	32,640	27,184	30,036	24,103
Computer equipment and software	23,452	20,083	23,409	20,052
Motor vehicles	1,052	918	986	870
	57,723	97,398	54,749	93,802

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Net Book Value				
Freehold land	74,601	47,137	74,601	46,645
Buildings - freehold	85,920	82,515	85,920	81,002
Leasehold Building & Fitout	2,918	3,084	2,724	2,842
Fitout plant and equipment	131,289	82,054	131,289	81,982
Plant and equipment	38,019	40,350	35,951	37,903
Computer equipment and software	4,050	2,052	4,008	2,043
Motor vehicles	1,027	516	952	464
Capital work-in-progress	27,349	19,383	27,349	19,374
Reversionary interest in buildings	990	-	990	-
Reclassify to Surplus Property	(10,300)	(7,450)	(10,300)	(7,350)
	355,863	269,641	353,484	264,905
Depreciation charged during the year:				
Buildings - freehold	2,235	2,247	2,235	2,190
Leasehold Building & Fitout	216	181	176	141
Fitout plant and equipment	6,795	6,667	6,781	6,661
Plant and equipment	8,564	7,742	7,547	6,741
Computer equipment and software	3,345	3,644	3,328	3,629
Motor vehicles	140	411	122	399
	21,295	20,892	20,189	19,761

Canterbury DHB has revalued its land, buildings and fitout plant and equipment as at 30 June 2003. The revaluation was carried out by the independent registered valuers Telfer Young and resulted in the net increases in the value of land ($27,531,000), freehold buildings ($670,000), fitout plant and equipment ($48,526,000) and reversionary interest in a car park building ($990,000). This increase has been recognised in the Revaluation Reserve. The total fair value of Canterbury DHB's land and buildings including fitout as at 30 June 2003 was $294,728,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 17 years time. This interest has not been included in the Statement of Financial Position, other than the June 2003 revaluation effect of $990,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

Property surplus to requirements as at 30 June 2003 included land at Hillmorton, Templeton and Hanmer Springs hospital sites, and two sites in central Christchurch.

Under the terms of the Ngai Tahu Claims Settlement Act 1998, most surplus property must be first offered to Ngai Tahu. The disposal of certain properties may also be subject to the provisions of section 40 of the Public Works Act 1981.

12. RECONCILIATION OF NET SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH FLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	30/06/03 $'000	30/06/02 $'000	30/06/03 $'000	30/06/02 $'000
Net Operating Surplus before Share of Associate	(10,405)	(21,593)	(10,551)	(21,878)
Add Back Non-Cash Items:				
Depreciation	21,295	20,892	20,189	19,761
Maintenance provision	10	120	-	-
Other non-cash items	(28)	-	27	-
Add Back Items Classified as Investing Activity:				
(Gain) / loss on Asset Sale	85	(125)	86	(125)
	10,957	(706)	9,751	(2,242)
Movement in Term Portion Staff Entitlement	635	845	635	845
Movement in Deferred Tax	9	24	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	(4,553)	(380)	(4,138)	(233)
Decrease/ (Incr.) in Stocks	411	(499)	415	(519)
Increase/ (Decr.) in Creditors & Other Accruals	26,806	23,225	27,123	23,283
Increase/ (Decr.) in Capital Charge due to Crown	(4,164)	(229)	(4,164)	(229)
Increase/ (Decr.) in Staff Entitlements	(154)	3,948	156	4,169
Add Items in Debtors relating to amalgamation of subsidiaries	-	-	777	-
Less: Items in Creditors relating to amalgamation of subsidiaries	-	-	(1,096)	-
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	29,947	26,228	29,459	25,074

13. COMMITMENTS

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
CAPITAL COMMITMENTS				
Committed at Balance Date	64,878	92,739	64,878	92,739
NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Lease	14,609	7,408	6,885	3,650
Computer Leases	197	489	197	197
Vehicle Leases	258	630	244	379
Other	11	14	-	-
	15,075	8,541	7,326	4,226
For Expenditure Within:				
1 Year	2,020	2,331	1,532	1,216
2 Years	1,660	1,422	1,187	829
3 Years and Beyond	11,395	4,788	4,607	2,181
	15,075	8,541	7,326	4,226

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are re-negotiated periodically reflecting the general principle that an on-going business relationship exists with those providers. Examples of these contracts include contracts for primary care, personal health and mental health.

There are also contracts for demand-driven items where the total expenditure is not defined in advance because it is ultimately paid to the individual consumers. Examples of this type of expenditure are pharmaceuticals, subsidy payments to rest homes and carer support relief payments.

The value of the Board's commitment relating to these contracts has not been included in the disclosure above.

Canterbury DHB has under-delivered some elective surgical volumes during 2002/03. The Board will endeavour to make up this shortfall in future years.

14. TRANSACTIONS WITH RELATED PARTIES

a) GOVERNMENT FUNDING

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the Canterbury DHB. Canterbury DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

b) INTER-GROUP TRANSACTIONS

During the financial year the group had the following inter-group transactions:

	Group		Parent	
	30/06/03 $'000	30/06/02 $'000	30/06/03 $'000	30/06/02 $'000
Revenue				
Facility fees from Heart Surgery South Island Ltd	-	4,058	-	4,058
Interest on advance and director's fees from Canterbury Laundry Services Ltd	-	-	172	151
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	129	111
Fees from Burwood Rehabilitation Ltd	-	-	-	1,514
Services to Canterbury Laundry Services Ltd	-	-	357	-
Services to Crown Public Health Ltd (prior to amalgamation with Canterbury DHB)	-	-	291	520
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	56	68	56	68
Expenses				
Linen services and rentals from Canterbury Laundry Services Ltd	-	-	3,415	3,413
Services from New Zealand Centre for Reproductive Medicine Ltd	1,042	1,314	1,042	1,314
Services from South Island Shared Services Agency Ltd	429	587	429	587

Interest charged on advances (refer Note 10) to Canterbury Laundry Services Ltd, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Ltd are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June 2003 are as follows :

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Amount Payable owing to associates				
South Island Shared Services Agency Ltd	18	-	18	-
NZ Centre for Reproductive Medicine Ltd	95	250	95	250
Burwood Orthopaedic Surgical Services	163	300	163	300
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd	264	416	264	416
Heart Surgery South Island Ltd	-	978	-	978
NZ Centre for Reproductive Medicine Ltd	4	102	4	102
Amount Payable owing to subsidiaries				
Canterbury Laundry Services Ltd	-	-	316	249
Burwood Rehabilitation Ltd	-	-	-	266
Amount Receivable owing by subsidiaries				
Canterbury Laundry Services Ltd – Debtor	-	-	32	14
Canterbury Laundry Services Ltd – Advance	-	-	2,001	2,130
Brackenridge Estate Ltd – Advance	-	-	1,326	999

c) BOARD AND COMMITTEE MEMBERS

During the financial year Canterbury DHB and its subsidiaries have purchased services provided on an arm's length basis by the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/03 $'000	30/06/02 $'000	30/06/03 $'000	30/06/02 $'000
Christchurch City Council	524	609	467	539
DHBNZ	93		93	
Pegasus Health (final amount subject to contract washup)	74,463	74,187	74,463	74,187
New Zealand Post Ltd	599	635	597	598
The Christchurch City Mission	440	375	440	375
Canterbury Asthma Society Inc	39	35	39	35
Breath Testing Services	60	128	60	128
New Zealand Housing Corporation	470	470	-	-
Pacific Trust Canterbury	650	595	650	595
He Oranga Pounamu Charitable Trust	1,321	-	1,321	-
Ryman Healthcare Ltd	30	54	30	54
South Canterbury DHB	65	3	65	3

Canterbury DHB and its subsidiaries have provided the following services on an arm's length basis to the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/03 $'000	30/06/02 $'000	30/06/03 $'000	30/06/02 $'000
Christchurch City Council	13	14	13	-
DHBNZ	10		10	
South Canterbury DHB	597	91	597	13
Champion Centre	9	5	9	5

15. CAPITAL CHARGE

Canterbury DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2003 was 11.0% (11.0% for the period ended 30 June 2002).

16. FINANCIAL INSTRUMENTS

CREDIT RISK

Financial instruments which potentially subject the group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts.

The group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2003, the Ministry of Health owed Canterbury DHB $46.9 million ($36.8 million at 30 June 2002).

CURRENCY RISK

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary.

There are no foreign exchange instruments outstanding at 30 June 2003 (30 June 2002 nil).

INTEREST RATE RISK

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities.

There are no interest rates swaps outstanding at 30 June 2003 (30 June 2002 nil).

FAIR VALUES OF FINANCIAL INSTRUMENTS

Financial instruments recorded in the financial statements have been recorded at their fair values.

17. SEGMENTAL REPORTING

Canterbury DHB operates in the provision of Health and Disability Support Services Industry in the South Island of New Zealand. Therefore, no segmental reporting is required.

18. CONTINGENCIES

Canterbury DHB has the following contingencies at year end:

Claim for a breach of intellectual property
Canterbury DHB has a claim with a third party for a breach of intellectual property. The third party has counter-claimed against Canterbury DHB.

Claim for a breach of patent rights
A third party has indicated that Canterbury DHB has breached their patent rights. This allegation is still in a very early stage and Canterbury DHB is still waiting for a legal opinion.

There were no material contingencies for disclosure in 2001/02.

19. RESIDENTS' TRUST ACCOUNT

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Resident Trust Account Balance	602	582	331	349

Residents' Trust Account comprises bank balances representing funds managed on behalf of Residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual patients' balances. Therefore, transactions occurring during the year are not included in the Statement of Financial Performance, Financial Position or Cash Flow of Canterbury DHB.

20. PROVISIONS

	Group		Parent	
	As at 30/06/03 $'000	As at 30/06/02 $'000	As at 30/06/03 $'000	As at 30/06/02 $'000
Provision for Refurbishment (Brackenridge)				
Opening balance	210	90	-	-
Additional provision made during the year	120	120	-	-
Release of surplus provision	(110)	-	-	-
Charged against provision for the year	-	-	-	-
Closing balance	220	210	-	-

The provision arises from an obligation under a lease agreement with a landlord to redecorate premises at five yearly intervals. The cost of this is accrued on an annual basis.

21. SUBSEQUENT EVENTS

There were no events after 30 June 2003 which could have a material impact on the information in Canterbury DHB's financial statements.

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2002/03

The Canterbury DHB continues to develop measures for the Statement of Service Performance that are appropriate to the needs of our stakeholders within Parliament and the community. These measures and associated performance targets will continue to be reflected in future Statements of Intent and reported in subsequent Statements of Service Performance.

The aim of the Statement of Intent is to demonstrate how the DHB's activities impact on the DHB's primary objective of "improving the health and wellbeing of people living in Canterbury". The measures included in the 2002-2005 Statement of Intent reflect activity in the priority areas identified in the Canterbury DHB Strategic Plan, "Towards a Healthier Canterbury: Directions 2006".

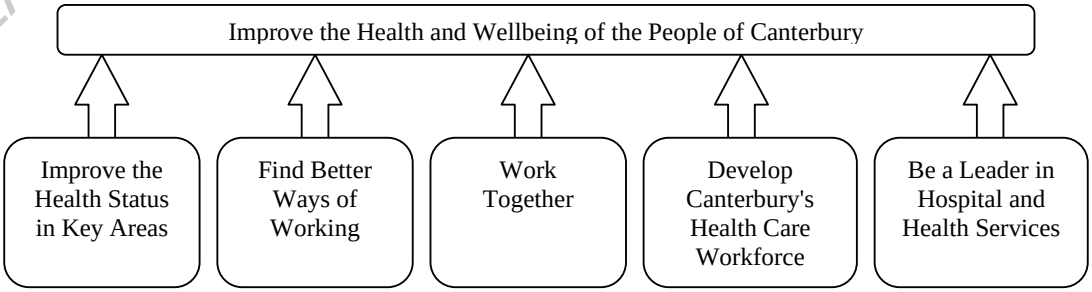
1. STRATEGIC PRIORITIES AND DIRECTIONS

To achieve CDHB's primary objective "To improve the health and wellbeing of people living in Canterbury", the Canterbury DHB is focusing on achieving improved outcomes in the following priority areas:

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

In improving health outcomes in these priority areas, as well as in our other areas of work, we are focusing our efforts on the five core directions:

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



2. SERVICE OBJECTIVES AND MEASURES

Strategic Plan Priorities

The following indicators reflect the performance measures specified in the 2002/03 Statement of Intent which reflect the Strategic Plan priorities. It should be noted that as the number of Pacific people in the Canterbury DHB district is small (7,254 at the 2001 Census) so the percentages shown below should be interpreted with caution.

2.1 Child and Youth Health

Objective:	***Brief Description:***
Improved health status for Canterbury's children and youth. (Long term)	Keeping children and youth healthy gives them a better chance of becoming healthy adults. The Canterbury DHB Child Health Strategy (March 2002) identified a range of issues. The DHB is currently in the process of developing a child health action plan to address these issues and also intends to develop a youth health action plan. As these plans are yet to be completed, it has not been possible to develop service objectives and measures, hence the relevant DHB accountabilities to the Minister of Health as outlined in the District Annual Plan, have been included as measures of our performance during the 2002/03 year. (Note: the breast feeding indicator has not been included due to data quality issues)

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Reduced number of low birth weight babies	Percentage of babies born in public hospital with low birth weight	• Māori 7.2% • Pacific 4.9% • Other 6.1% • Total 6.2%	• Māori 6.8% • Pacific 8.5% • Other 5.7% • Total 5.8%[1] It is preferable that fewer babies are born with low birth weight, hence for this indicator, lower is better. The Canterbury DHB achieved its targets for Māori and Other ethnicities and has continued to seek to achieve this target for Pacific peoples. Initiatives such as the Pacific Health Clinic should help achieve this target in the future.
Improved immunisation of Canterbury children	Percentage of children fully vaccinated by their second birthday	• Māori 75.0% • Pacific 75.0% • Other 75.0% • Total 75.0%	This was an indicator required by the Ministry of Health targets which were agreed in our District Annual Plan. However,it is difficult to gather robust information on this indicator and hence we are unable to report on it.

[1] Data is from the National Minimum Data Set, 1 July 2002 – 28 February 2003

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
Minimised impact on hearing loss in children	Percentage of children passing school entry hearing tests	• Māori 90.0% • Pacific 86.0% • Other 95.0% • Total 94.0%	• Māori 93.3% • Pacific 83.3% • Other 95.3% • Total 94.8%[2] Provisional data shows the Canterbury DHB achieved its targets for Māori and Other ethnicities and has continued to seek to achieve this target for Pacific peoples. Initiatives such as the Pacific Health Clinic should help achieve this target in the future.
Improved education and treatment of children with asthma	Repeat admission for asthma in children under the age of 5	• Māori 5.9% • Pacific 5.5% • Other 5.3% • Total 5.8%	• Māori 6.9% • Pacific 11.1% • Other 4.7% • Total 5.7%[3] It is preferable that there are fewer repeat admissions for asthma in children, hence for this indicator and the next one, lower is better. The Canterbury DHB met this target for Other ethnicities and overall and has continued to seek to achieve it for Māori and Pacific peoples.
	Repeat admission for asthma in children between the ages of 5 and 15	• Māori 5.6% • Pacific 6.4% • Other 6.0% • Total 5.8%	• Māori 0.0% • Pacific 0.0% • Other 3.5% • Total 3.0%[4] The Canterbury DHB achieved this target for all ethnicities
Improved child oral health	Mean MF score at Year 8 (Form 2). Total permanent teeth filled or missing due to caries divided by the number seen by the school dental service in the period	• Total 1.6	• 1.74 There were 9,181 permanent teeth filled for 5,281 young people giving a mean MF score of 1.74.[5] It is preferable that there are fewer permanent teeth filled or missing due to caries, hence for this indicator, lower is better. The major factor leading to the Canterbury DHB's unfavourable performance on this measure is the low proportion of Canterbury's population receiving optimally fluoridated water supplies. Another factor that may have led to an increase in filled teeth in this group is the increasing use of radiography for diagnosis of dental caries by the School and Community Dental Service. Radiography allows for earlier diagnosis of cavities and this will (at any age) lead to higher numbers of filled teeth while, paradoxically, improving health – early diagnosis leads to smaller fillings which last longer and cause fewer problems in the future.

[2] Provisional data from the National Audiology Centre, 1 July 2002 – 30 June 2003
[3] Data is from the National Minimum Data Set, 1 July 2002 – 28 February 2003
[4] Data is from the National Minimum Data Set, 1 July 2002 – 28 February 2003
[5] Data is from the Canterbury DHB Crown Funding Agreement report Quarter 3 2002/03

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
	Percentage of children caries free at age 5	• Total 53.6%	• 50% There were 2,547 children at their first publicly funded dental service after their 5th and before their 6th birthday with primary dentition free of caries, with no fillings and with no teeth missing due to caries out of a total of 5,093 children at their first publicly funded dental service. Thus the percentage of children caries free at age 5 is 50.0%[6]. As described above, the major factor leading to the Canterbury DHB's unfavourable performance on this measure is the low proportion of Canterbury's population receiving optimally fluoridated water supplies. The School and Community Dental Service continues to improve access to dental services for pre-school children and works with GP practices to achieve this. Measures for increasing the exposure to fluoride among high-risk preschool children are being investigated – these include the supply of fluoridated milk, mouth rinses and tooth brushing programmes.

[6] Data is from the Canterbury DHB Crown Funding Agreement report Quarter 3 2002/03

2.2 Primary Health

Objective:	***Brief Description:***
Reduced barriers to primary health care. (Long term)	Reducing the barriers to good primary health care ensures that people stay well resulting in improved health status. During the 2002/03 year Canterbury DHB focused its primary care activities on the following: • Implementation of the Government's primary health care strategy via the formation of Primary Healthcare Organisations (PHOs) within Canterbury for those populations with the greatest barriers to primary health care. • Implementation of Canterbury DHB's Rural Health Action Plan (May 2002). In addition to the above, measures of the effectiveness of primary health care, as per the relevant DHB accountabilities to the Minister of Health, as outlined the District Annual Plan, have been included as measures of our performance during the 2002/03 year.

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Support the establishment of 2 PHOs with the Canterbury District. (One representing rural communities and one representing lower socioeconomic groups in urban Christchurch.)	Low income urban PHO • PHO Establishment Funding application • PHO established	December 2002 1 July 2003	The first Canterbury DHB PHO, the Canterbury Community PHO started up on 1 July 2003.
	Rural PHO • PHO Establishment Funding application	July 2003	Two establishment funding applications from rural PHOs were received by July 2003. These rural PHOs are presently working towards going starting up on 1 October 2003 or 1 January 2004
Improved retention of Rural GPs: reduce onerous on-call rosters for rural GPs. Every GP with a rural ranking of 35 points or more to work no more than 1 in 4 weekends.	Percentage of GPs with a rural ranking of greater than 35 points who work no more than a 1 in 4 weekend roster (unless by choice).	• 100%	• 100% Canterbury has 32 GPs with a Rural Ranking of 35 points or more. 100% of these work no more than 1 weekend in 4, mainly due to Reasonable Roster Funding and a locum placement scheme funded jointly by Canterbury DHB and the rural general practices. In addition, many rural Canterbury GPs have used the national holiday locum scheme (NZ Locums) to allow them to take 2 or 3 weeks off during the past year.

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
Ambulatory Sensitive Admissions: Ambulatory sensitive admissions are admissions that are potentially preventable by appropriate primary care	Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age.	• Māori 7.1% • Pacific 9.8% • Other 9.7% • Total 9.8%	• Māori 6.7% • Pacific 10.6% • Other 9.1% • Total 8.8%[7] It is preferable that there are fewer ambulatory sensitive admissions, hence for this indicator and the next two, being below the target indicates better performance. Therefore since the results for Māori, Other ethnicities and overall are lower than the performance targets, the Canterbury DHB has achieved a good performance for these ethnic groups. The Canterbury DHB has continued to seek to achieve it for Pacific peoples. Initiatives such as the Pacific Health Clinic should help achieve this target in the future.
	Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age.	• Māori 1.5% • Pacific 2.8% • Other 1.9% • Total 1.9%	• Māori 1.7% • Pacific 2.5% • Other 1.8% • Total 1.8%[8] Since the results for Pacific people, Other ethnicities and overall are lower than the performance targets, the Canterbury DHB has achieved a good performance for these ethnic groups. The Canterbury DHB has continued to seek to achieve it for Māori. Continued emphasis on improving Māori access to primary care and enhanced Māori service development should help achieve this target in the future.
	Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age.	• Māori 1.1% • Pacific 1.2% • Other 1.2% • Total 1.2%	• Māori 1.1% • Pacific 1.4% • Other 1.2% • Total 1.2%[9] Since the results for Māori, Other ethnicities and overall overall are equal to the performance targets, the Canterbury DHB has achieved a good performance for these ethnic groups. . The Canterbury DHB has continued to seek to achieve it for Pacific peoples. Initiatives such as the Pacific Health Clinic should help achieve this target in the future.

[7] Data from Crown Funding Agreement Report – Quarter 4 2002/03
[8] Data from Crown Funding Agreement Report – Quarter 4 2002/03
[9] Data from Crown Funding Agreement Report – Quarter 4 2002/03

2.3 Māori Health

Objective:	*Brief Description:*
Whanau Ora *Māori families supported to achieve their maximum health and wellbeing. (Long Term)*	Evidence of Māori health disparities is well known and compelling and to address these health disparities, the Canterbury DHB has developed a Māori Health Plan (July 2002), *Whakamahere Hauora Māori Ki Waitaha.* This plan identifies a number of strategic issues, namely: • Support of the Government's commitment to the Treaty of Waitangi • Māori participation in health planning, service provision and the workforce • Effective, culturally appropriate and high quality services • Monitoring of Māori health outcomes • Working across sectors During the 2002/03 year Canterbury DHB intends to focus its efforts on acting on these directions, improving data quality to support future developments and reducing health disparities for Māori in the other DHB priority areas.

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
Monitoring of Māori health outcomes. Lack of accurate collection of ethnicity data currently is a significant barrier to achieving this objective. The DHB therefore plans to implement accurate ethnicity data collection throughout CDHB	Completion of "baseline" ethnicity data collection accuracy. Ethnicity data collection policy completed	Review completed by 30 June 2003 Policy completed 30 June 2003	The baseline Ethnicity Data Collection review has been completed across 6 provider arm divisions and 16 service areas. The policy was signed off by the Canterbury DHB Executive Management Team in June 2003. A review was undertaken in the provider arm to determine the baseline situation. An action plan has been developed to implement the recommendations made in the review; implementation will begin mid-September 2003.
Reduced health inequalities: Māori Service Development in priority areas eg. Diabetes, Cancers, Cardiovascular disease, Child Health etc	Refer to the relevant section of this document. Where data is available Māori specific targets have been provided.	See relevant Performance Indicators	Māori Health Indicators Project underway

2.4 Mental Health

Objective:	***Brief Description:***
Improved Health Status for Canterbury Residents who have a serious ongoing mental illness. (Long Term)	About 3% of New Zealanders have a serious ongoing mental illness, which requires specialist care and treatment by a range of health and social service providers. Canterbury DHB plans to continue towards implementing the Mental Health Strategy and Blueprint for Mental Health Services and the Youth Suicide strategies and guidelines. Canterbury DHB intends to develop a plan for the further implementation of these strategies.

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Mental Health Volume Delivery: Delivery of a level of publicly funded services in line with the Mental Health funding "ring-fence"	Funding weighted volumes delivered as a percentage of the value of Mental Health funding in the Canterbury DHB District Annual Plan.	• 100%	• 100% allocation of the ringfenced funding to providers There were a number of transfers of Mental Health funding between DHBs as a result of the devolution of national and regional contracts, as requested by the "receiving" DHBs. This had an impact on the level of the "ring-fence" but not on our ability to meet funding levels.
Improved access to Mental Health Services: The New Zealand Mental Health Strategy sets targets for access to treatment and support services for people of different age groups with severe mental illness.	Percentage of people within each age group accessing mental health treatment and support services	• 0-9 0.2% • 10-14 0.6% • 15-19 0.8% • 20-64 1.0% • 65+ 0.1% • **Total 0.7%**	Average annual percentages for April 2002 – March 2003 • 0-9 0.3% • 10-14 0.6% • 15-19 0.8% • 20-64 1.0% • 65+ 0.2% • Total 0.8%[10] The percentage of people within each age group accessing mental health treatment and support services was greater than or equal to each target.

[10] Data from Crown Funding Agreement Report – Quarter 4 2002/03

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
Regional Services Development: Work with South Island Mental Health Network to continue to develop Mental Health Services in the South Island	Progress agreed mental health projects:		
	- Alcohol & Drug	• Actions agreed	• South Island Alcohol and Other Drug (AOD) Service Review ◆ Consultation completed. Forums for providers at Liaison on Alcohol and Other Drugs (LOAD) meetings and specific consumer forums have been held in all DHBs except South Canterbury, including attendance by Project Manager at South Island AOD hui for Māori where review was discussed. ◆ Final face to face meeting of the Project Reference group to consider amendments in response to consultation. ◆ Amended report and service development objectives was completed for distribution to the South Island Mental Health Network on 7 July 2003.
	- Forensic		• Forensic Regional Services Development Project ◆ Governance group now teleconferencing on a fortnightly basis. ◆ Workplan implementation underway ◆ Discussion has been resumed with the Ministry of Health on obtaining additional forensic funding identified for the South Island in 2002/03
	- Workforce		• South Island Workforce Working Group ◆ Intermediate Level Training – Shared Care – West Coast and Nelson training has been completed. No feedback re evaluation yet. Formal evaluation report due at completion of training (31 July 2003). Canterbury, Otago and Southland sessions currently being organised.
	Progress Memorandum of Understanding with South Island DHBs re regional provision of psychiatric services	• Memorandum of Understanding progressed	• Yes, the Memorandum of Understanding is being progressed
CDHB Strategic Development: Complete CDHB Mental Health Strategy	Develop a CDHB Mental Health Strategy which reflects Non Governmental Organisations (NGOs), Primary Care and Provider Arm integration	• Plan completed	Plan is under development. The expected completion date is December 2003

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Service Review: Review of Residential Accommodation and Respite Care	Complete Review	• Review completed and Implementation Plan written	Implementation Plan completed. Implementation is underway across 6 areas. These are: • Improve engagement with sector • Increase Kaupapa Māori Residential Rehabilitation Services • Complete the reviews of Respite Care and Needs Assessment and Service Co-ordination • Re-provision/exit of Residential Rehabilitation Accommodation provided by the Canterbury DHB provider arm Mental Health Services • Improve integration with Primary Care • Complete, agree and implement Canterbury DHB Mental Health Strategy

2.5 Disease Prevention and Management – Cardiovascular (Heart) Disease

Objective:	***Brief Description:***
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cardiovascular disease (Long Term)	Cardiovascular disease has been identified by the Canterbury DHB as a priority area for improving the health status of the people of Canterbury. The Canterbury DHB is currently in the process of developing a strategy for the management of Cardiovascular disease in Canterbury. As this plan is yet to be completed, it has not been possible to develop service objectives and measures, hence the relevant DHB accountabilities to the Minister of Health, as outlined the District Annual Plan, have been included as measures of our performance during the 2002/03 year.

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Reducing the Impact of Cardiovascular Disease	Percentage of people with certainty who waited for no more than 6 months for coronary artery bypass graft.	• 100%	• 100% Patients were not sent letters informing them of their status until after 30 June 03
	Percentage of people with certainty who waited for no more than 6 months for an angioplasty.	• 100%	• 98.1% As at 30 June 2003, only 2 patients had waited for more than 6 months. However, both patients are "on hold" due to either personal or clinical reasons.
	Repeat admissions for acute rheumatic fever in people under 30 years of age	• Māori • Pacific • Other • Total 29.3%	• Māori 11.1% • Pacific 0.0% • Other 9.2% • Total 9.1%[11] It is preferable that there are fewer repeat admissions, hence for this indicator, lower is better. The Canterbury DHB met this performance target across all ethnic groups.

[11] Data is from National Minimum Data Set 1 July 2002 – 28 February 2003

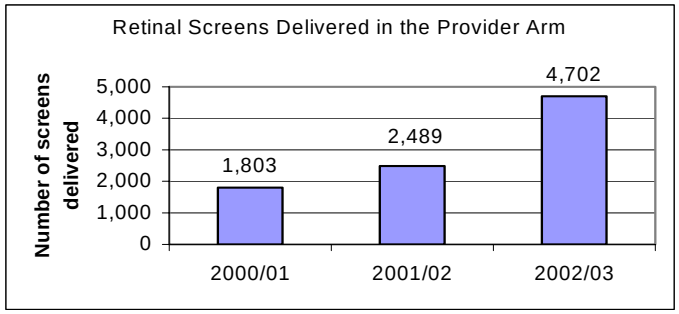
2.6 Disease Prevention and Management - Cancer

Objective:	***Brief Description:***
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cancer (Long Term)	Cancer has been identified by the Canterbury DHB as a priority area for improving the health status of the people of Canterbury. The Canterbury DHB is currently in the process of developing a strategy for the management of Cancer in Canterbury. As this plan is yet to be completed, it has not been possible to develop service objectives and measures, hence the relevant DHB accountability to the Minister of Health, as outlined the District Annual Plan, has been included as measures of our performance during the 2002/03 year.

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Reducing the impact of Cancer.	Improved Access to Radiation Therapy.		Patients who need radiotherapy are categorised into 4 groups: Group A These patients are emergencies who need urgent treatment and they are treated within 24 hours Group B Treatment for these patients is potentially curative. They are fit for radical radiation treatment and should be treated within 2 weeks Group C All other patients, including those being treated for breast and prostate cancer and for palliative treatment should be 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 The Canterbury DHB has continued to seek to achieve the target of 100% of patients being treated within 4 weeks. The reasons for delay are related mainly to resource issues with treatment capacity etc. However some delays are also due to patient preference, other co morbidities and/or treatments, the need for further tests, specific start dates for protocol reasons etc.
	Number of patients who: Started treatment on time (within 4 weeks) Waited 4 - 8 weeks Waited 8 -12 weeks Waited >12 weeks Delay to radiotherapy is defined as the time elapsing between the specialist decision to commence radiotherapy and the start of treatment	• 100% • 0% • 0% • 0%	The actual number of patients in each category was: • 64.1% 768 • 20.8% 249 • 10.7% 128 • 4.4% 53 --- --- • 100.0% 1198 NOTE: these figures do not include 118 category D patients as they all have specific start dates for protocol reasons. (Therefore this group of patients started treatment on time but not all of them started within 4 weeks.) Therefore the total patients seen is 1198 + 118 = 1316

2.7 Disease Prevention and Management - Diabetes

Objective:	***Brief Description:***
Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes (Long Term)	Diabetes has been identified by the Canterbury DHB 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, • Patient knowledge/information 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. (Refer to "Diabetes in the Canterbury DHB: Sept 2002", for a full list of priorities). During the 2002/03 year, the CDHB intends primarily to focus its activities on improving performance in the level of retinal screening while continuing to encourage the detection and management of Diabetes within the community. The Canterbury DHB has concerns about the data presented below and is of the opinion that these figures understate the numbers of people having annual diabetes reviews who had their eyes screened in the last two years.

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Early diagnosis and treatment of eye problems: Increase the proportion of people with diabetes who have had their eyes screened in the last two years	The percentage of people having annual diabetes reviews who have had their eyes screened in the last two years	• Total 65%	The Local Diabetes Team report on this target in their annual reports. For the period 1 January 2002 to 31 December 2002 they reported 41%. The target was not achieved. As outlined in the 3rd quarter Crown Funding Agreement report, the Canterbury DHB has identified Diabetes as one of its priority areas for action in the Strategic Plan (2002-2006). One of the action points to achieve population health gains in this area is to increase access to retinal screening and eye treatments. Funding for an immediate increase in volumes was provided from October 2002. Delivered volumes in the provider arm increased from 1,803 in 200/01 to 4,702 in 2002/03 as shown below and these volumes do not include screens completed in the community by optometrists and private ophthalmologists. 

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Improved Diabetes Detection: Increasing the proportion of people with diabetes who receive annual checks and the associated primary care.	The percentage of the expected number of people with diabetes in the Canterbury region who have been diagnosed with diabetes and had an annual review during the year. (Expected numbers of people with diabetes in Canterbury: • Māori 986 • Pacific 218 • Other 10,172 • Total 11,376)	• Māori 50% • Pacific 55% • Others 55% • Total 54%	• Māori 37% • Pacific 76% • Other 72% • Total 69% The Canterbury DHB has provided increased funding for primary health care and health promotion for people with diabetes and has provided increased hours for the Maori health nurse in the Diabetes Centre. This has resulted in a 45% increase in the number of people who had annual checks in the calendar year 2002 over the previous year from 5,428 to 7,830, which represents 69% of the expected number of people with diabetes according to the Ministry of Health's model. The Canterbury DHB has more than reached this target for Pacific people, other ethnicities and overall and has continued to seek to achieve it for Māori. The Canterbury DHB is committed to improving Māori access to primary care and is continuing to support the Māori and Pacific Peoples Leadership Programme. This, together with the development of Te Amorangi Richmond, improved ethnicity data collection and continuing work by Diabetes Life Education should help achieve this target in the future.
Improved Diabetes Management: Reducing the proportion of people with diabetes who have relatively poor control of their diabetes	The percentage of people having annual diabetes reviews who had poor diabetes control (HBA1c>8%)	• Māori 35% • Pacific 40% • Others 22% • Total 24%	• Māori 49% • Pacific 58% • Others 26% • Total 27% • The Canterbury DHB has continued to seek to achieve these targets but to date these have not been achieved. Again, initiatives aimed at improving Māori access to primary care and to improved knowledge about the importance of good nutrition and exercise should help the Canterbury DHB meet these targets in the future.

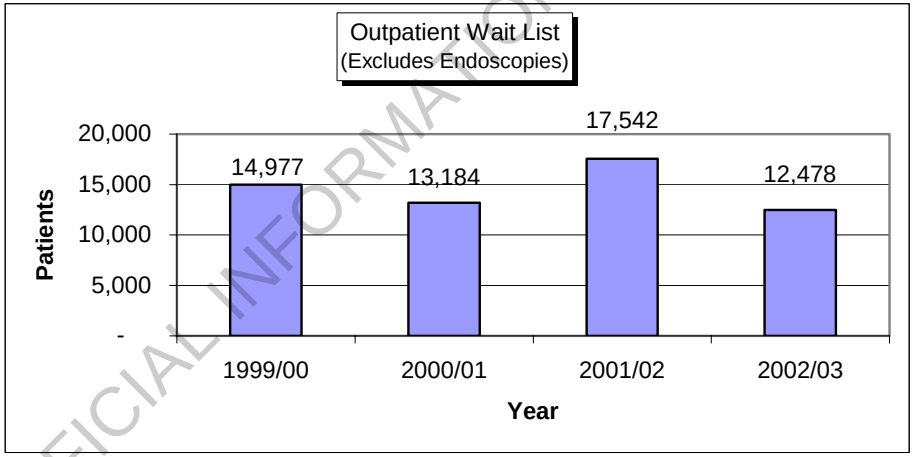
3. OTHER DHB MEASURES OF PERFORMANCE

3.1 Elective Services

Objective:	***Brief Description:***
Improved health status for Canterbury's residents via the provision of services in a timely manner within the available resources for those with the greatest level of need. (Medium Term)	Access to outpatients services and elective surgery has been an ongoing issue for Canterbury DHB. The funding and human resources available to the DHB are limited and are not sufficient to meet all of the demand for health services. We must therefore prioritise services. CDHB intends to continue the implementation of the Governments policies in relation to elective services which include: • The provision of timely access to specialist assessment and elective surgery. • The delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress, ill health.

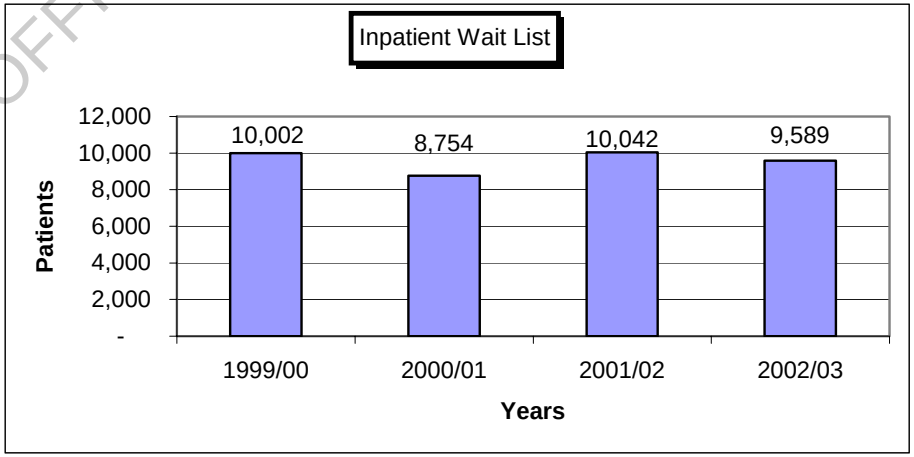
Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
***Improved access to first specialist assessment*:** Reduced waiting lists for first specialist assessments so that all appropriately referred patients can be assessed within appropriate timeframes.	Percentage of patients who receive their **first specialist assessment** within six months of referral	• 100%	• Of the new patients seen during the year, 87% waited less than 6 months. Canterbury DHB has continued to seek to achieve the target level of performance though to date this has not been achieved. At the end of the year there were 3,813 whom we had not seen who had waited longer than 6 months. This reflects approximately 1.25 months work at current activity levels. Four specialties performed near[12] this target: Dental, Oncology, Renal Medicine and Thoracic Surgery. Specialties not performing at this target were Cardiology, Cardiothoracic, Dermatology, Diabetes, Endocrinology, Endoscopy, ENT, Gastroenterology, General Medicine, General Surgery, Gynaecology, Haematology, Infectious Diseases, Neurology, Neurosurgery, Ophthalmology, Orthopaedics, Paediatric Medicine, Paediatric Surgery, Pain, Plastics, Respiratory, Rheumatology, Urology and Vascular.

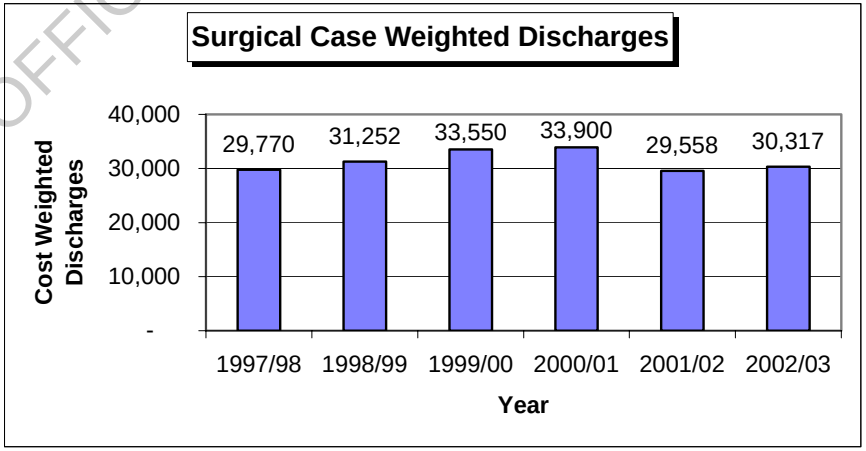
[12] Near target is defined as >95% of patients seen within 6 months and the number waiting longer than 6 months at the end of the period being <4% of annual throughput which is equivalent to 2 weeks activity

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
			 The graph above shows the numbers of people on the outpatient waiting list from 1999/00 to 2002/03. The fall in numbers from 2001/02 to 2002/03 is because the Canterbury DHB has changed the way in which it manages the waiting list.

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
Improved certainty of treatment: *Provide patients requiring* ***elective inpatient surgery*** *with certainty that they will/will not receive access to publicly funded inpatient surgery. Provide timely access for those offered surgery*.	Percentage of patients provided with certainty of treatment ("definite") that receive treatment within 6 months.	• 100%	Canterbury DHB provides patients with two levels of certainty for publicly funded treatment: "definite" cases, who are offered certainty of treatment within 6 months and "probable" cases who are considered likely to receive publicly funded treatment within 12 months. • 92% At the end of the year, 92% of patients who were provided with certainty of treatment within 6 months ("definite" cases) received treatment within 6 months[13]. Of the 8% who were not treated within 6 months 4.25% have either been treated or removed outside the 6 month time period, 3.75 % are either booked or waiting for treatment. There are a number of reasons why these people were not treated within 6 months: • The patient is awaiting a staged procedure which requires other prior treatment or investigations. • The patient has been offered dates for surgery but was unavailable or unfit at the time. • The patient is on hold awaiting further assessment or has deteriorated while waiting and requires review prior to admission. • The patient requires subspecialty or cross-service treatment requiring co-ordination of resources and post-discharge services (eg: requires bed at Burwood for post-surgery rehabilitation). The above explanations apply to a small group of patients. This group is monitored closely to ensure that their treatment is provided as soon as possible even if - as in these cases - the wait is slightly longer than 6 months. Because of these scenarios it is not possible to guarantee 100% of patients who have been given certainty will receive surgery within the timeframe because many of these factors cannot be predicted at the time of offering certainty but develop during the waiting period of 6 months.

[13] Note these statistics do not include Christchurch Women's Hospital due to information issues that prevent these measures from being calculated.

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
	Percentage of patients in active review ("probable") that receive treatment within 6 months.	60%	• 31% Of patients who were considered likely to receive treatment within 12 months ("probable" cases) 31% did not wait longer than 6 months. 1,408 Active Review patients received treatment within 6 months
			There are 943 "probable" patients and 321 "definite" patients who are overdue for surgery as at 30 June 2003. There are no patients as at 30 June 2003 who have "Expired" letters. All waiting list patients received a letter as at 28 May 2003. The inpatient waitlist numbers have remained relatively unchanged over the period 1999/00 to 2002/03.
			

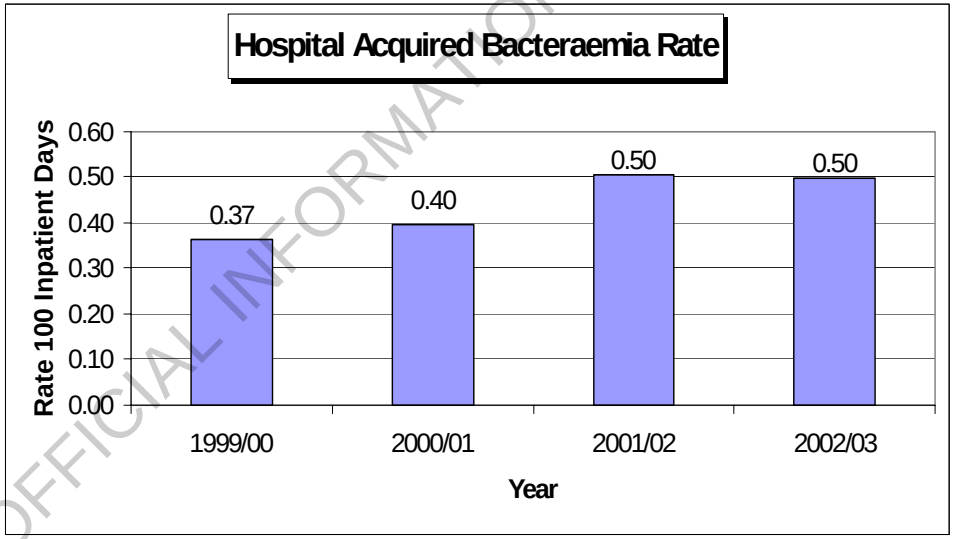
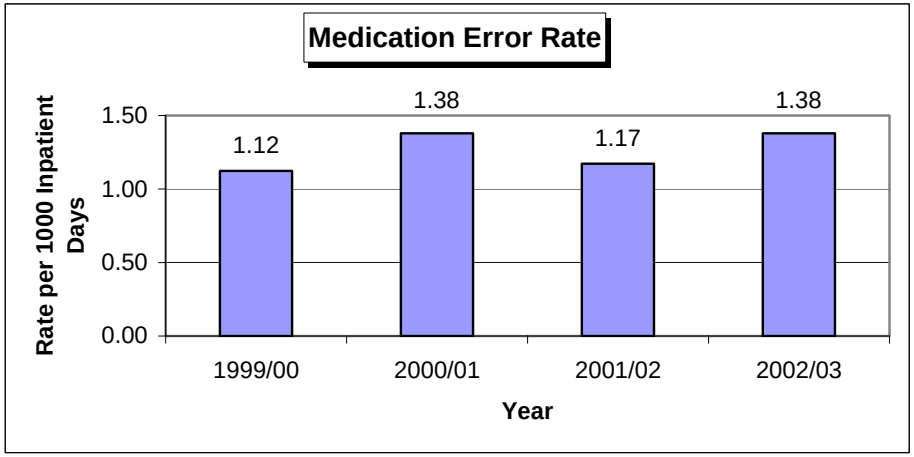
Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
Surgical Volume Delivery: Delivery of a level of publicly funded inpatient surgical volumes at the levels specified in the Canterbury DHB District Annual Plan.	Case weighted discharges delivered as a percentage of the volumes specified in the Canterbury DHB District Annual Plan.	• 100%	• 95% Surgical case-weighted volumes (discharges) delivered during the 2002/2003 year were 5% below the target level of delivery. Dental has delivered over their funded case-weighted volumes. General Surgery, Cardiothoracic, Gynaecology, Neurosurgery, Paediatric Surgery and Urology have delivered near (less than 4% below) their funded case-weighted volumes. The remaining specialities have under-delivered against the funded case-weighted volumes by the following percentages: • Otolaryngology 7% • Ophthalmology 12% • Orthopaedics 9% • Plastics & Burns 15% Case weighted discharges fell after 2000/01 because special funding which had been made available to clear waiting times finished that year.
			

3.2 Hospital Efficiency and Effectiveness

Objective:	***Brief Description:***
To be an efficient and effective provider of health services to maximise the health status of Canterbury's residents within the available resources.	The DHB is a major provider of Health Service (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 DHB must ensure that it operates in an effective and efficient manner.

Objective 2002/03	***Performance Measure***	***Performance Targets***	***Results***
Improved performance as a Good employer. Initiate systems and processes to promote a good working environment that encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management.	▪ Sick Leave Rate (As per balanced scorecard)	3.3%	The Canterbury DHB achieved this target as the sick leave rate for 2002/03 was 3.3%.
	▪ Work Place Injuries per 1,000,000 hours (As per balanced scorecard)	15	The Canterbury DHB has continued to seek to achieve this level of performance but narrowly missed achieving it this year: the number of Work Place Injuries was 16.3 per 1,000,000 hours in 2002/03. Note that the target was incorrectly recorded in the Statement of Intent as 0.15
Improved Quality. Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals. (Long term)	Maintain accreditation at Ashburton, Akaroa, Waikari, Darfield, Burwood and Christchurch Women's Hospitals.	100% of facilities maintain current accreditation status	The Canterbury DHB has achieved this target.

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
	Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services	On target for accreditation as follows: ▪ Kaikoura and Oxford first survey Nov 2003 ▪ Christchurch Survey October 2004 ▪ Mental Health and Older Persons Health Survey October 04	The Canterbury DHB is on target to achieve accreditation for these hospitals and services.
Maintain Accreditation of Support Services with International Accreditation New Zealand. (Laboratory accreditation to ISO15189 Quality Management in Medical Laboratories. Others ISO9000 series quality standards)	Maintain accreditation for CDHB's Laboratories, Technical Services, Physiotherapy (Christchurch Hospital) and Medical Physics and Bio-engineering.	▪ 100% of services maintain current accreditation status	The Canterbury DHB has achieved this target.

Objective 2002/03	*Performance Measure*	*Performance Targets*	*Results*
Maintain appropriate levels of Clinical Quality within CDHB Hospitals	Hospital Acquired Bacteraemia Rate per 100 inpatient days (Christchurch, Burwood, Womens & Ashburton Hospitals only)	• 0.50	 Initiatives developed in 2002/03 have stopped the rise of this rate.
	IV Medication Error Rate per 1000 inpatient days (Christchurch, Burwood, Womens & Ashburton Hospitals only)	• 1.38	 The IV medication error rates have remained relatively unchanged over this 4 year period.

4. SUMMARY OF REVENUES AND EXPENSES BY OUTPUT CLASS

	Funding $'000	Governance & Funding Admin $'000	Provider $'000	In House Elimination $'000	Total DHB $'000
Revenue					
MoH revenue	639,584	3,024	458,370	(429,159)	671,819
Patient Related Revenue			21,951		21,951
Other			11,616		11,616
Total Revenue	639,584	3,024	491,937	(429,159)	705,386
Expenditure					
Personnel		1,708	320,224		321,932
Depreciation		16	21,279		21,295
Interest			6,623		6,623
Capital Charge			14,395		14,395
Other	635,611	1,253	143,841	(429,159)	351,546
Total Expenditure	635,611	2,977	506,362	(429,159)	715,791
Net Surplus/(Deficit)	3,973	47	(14,425)	-	(10,405)

Note - The surplus for the Funding arm mainly relates to the volumes short delivered by the Provider arm.

GLOSSARY OF TERMS

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

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

Orthopaedic	Prevention or correction of injuries or disease of the skeletal system and associated muscles, joints and ligaments.
Otolaryngology	Ear, nose, throat surgery
PACs	Picture Archiving and Communications System
Pacific Peoples	The population of Pacific Island ethnic origin (for example, Tongan, Niuean, Fijian, Samoan, Cook Island Maori, and Tokelauan) incorporating people of Pacific Island ethnic origin born in New Zealand as well as overseas.
Partnership	The relationship of good faith, mutual respect and understanding and shared decision making between the Crown and Maori.
Performance Indicator	A measure that shows the degree to which a strategy has been achieved.
Population Based Funding (PBF)	Population based funding involves using a formula to allocate each District Health Board a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
Population Health	The health of groups, families and communities. Populations may be defined by locality, biological criteria such as age or gender, social criteria such as socio-economic status, or cultural criteria such as Whanau.
Population Health Outcomes	Used to describe a change in the health status of a population due to a planned programme or series of programmes, regardless of whether such programmes were intended to change health status.
Population Health Status	The level of health experienced by a population at a given time. This may be measured by separately identifying patterns of death and illness in a population or by means of one or more measures.
Primary Care	Primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
Quality Assurance	Formal process of implementing quality assessment and quality improvement in programmes to assure people that professional activities have been performed adequately.
RMO	Resident Medical Officer
Secondary Care	Specialist care that is typically provided in a hospital setting.
SIMHN	South Island Mental Health Network
Strategy	A course of action to achieve targets.
Target	A specific and measurable aim relating to an objective.
Tertiary Care	Very specialised care often only provided in a smaller number of locations.
Tikanga	Customary practice, rule
TLA	Territorial Local Agencies
Treaty of Waitangi	New Zealand's founding document. It establishes the relationship between the Crown and Maori as tangata whenua (first peoples) and requires both the Crown and Maori to act reasonably towards each other and with utmost good faith.
Urology	Diagnosis and treatment of diseases of the urinary tract and urogenital system.
Well-child/Tamariki ora services	Term used to describe all activities that promote health and prevent disease that are undertaken in the primary care setting for children and their families and whanau
Wellness	A dimension of health beyond the absence of disease or infirmity, including social, emotional and spiritual aspects of health.
Whanau	Family
WHD	Womens Health Division

Audit New Zealand

REPORT OF THE AUDITOR-GENERAL

TO THE READERS OF THE FINANCIAL STATEMENTS OF CANTERBURY DISTRICT HEALTH BOARD AND GROUP FOR THE YEAR ENDED 30 JUNE 2003

We have audited the financial statements on pages 15 to 62. The financial statements provide information about the past financial and service performance and financial position of Canterbury District Health Board and group as at 30 June 2003. This information is stated in accordance with the accounting policies set out on pages 19 to 23.

Responsibilities of the Board

The New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 require the District Health Board to prepare financial statements in accordance with generally accepted accounting practice in New Zealand that fairly reflect the financial position of Canterbury District Health Board and group as at 30 June 2003, the results of operations and cash flows and service performance achievements for the year ended on that date.

Auditor's responsibilities

Section 15 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000 require the Auditor-General to audit the financial statements presented by the Board. It is the responsibility of the Auditor-General to express an independent opinion on the financial statements and report that opinion to you.

The Auditor-General has appointed K J Boddy, of Audit New Zealand, to undertake the audit.

Basis of opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- the significant estimates and judgements made by the Board in the preparation of the financial statements; and
- whether the accounting policies are appropriate to Canterbury District Health Board and group's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with the Auditing Standards published by the Auditor-General, which incorporate the Auditing Standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

During the period we performed three assignments for Canterbury District Health Board. These involved an assurance related assignment relating to tendering processes, providing guidance on non financial service performance reporting requirements and delivering a seminar to Board staff on health sector issues. Other than these assignments and in our capacity as auditor acting on behalf of the Auditor-General, we have no relationship with or interests in Canterbury District Health Board or any of its subsidiaries.

Unqualified opinion

We have obtained all the information and explanations we have required.

In our opinion the financial statements of Canterbury District Health Board and group on pages 15 to 62:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - Canterbury District Health Board and group's financial position as at 30 June 2003;
  - the results of operations and cash flows for the year ended on that date; and
  - the service performance achievements in relation to the performance targets and other measures adopted for the year ended on that date.

Our audit was completed on 28 October 2003 and our unqualified opinion is expressed as at that date.

Signed

K J Boddy
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of Canterbury District Health Board (the Board) for the year ended 30 June 2003 included on the Board's website. The Board is responsible for the maintenance and integrity of the Board's website. We have not been engaged to report on the integrity of the Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

We have not been engaged to report on any other electronic versions of the Board's financial statements, and accept no responsibility for any changes that may have occurred to electronic versions of the financial statements published on other websites and/or published by other electronic means.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 28 October 2003 to confirm the information included in the audited financial statements presented on this web site.

Legislation in New Zealand governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

APPENDIX 4

Canterbury District Health Board

Report For the Year Ended 30 June 2004

Table of Contents

DIRECTORY

Board Members

Syd Bradley - Chair
Randall Allardyce
Philip Bagshaw
Robin Booth
Graham Heenan
David Morrell
Tuari Potiki (resigned effective 31 August 2003)
Olive Webb
Paul White (resigned effective 30 September 2003)
Norman Dewes (appointed 19 February 2004)
Karen Guilliland (appointed 20 November 2003)
Alison Wilkie

Chief Executive

Jean O'Callaghan

Registered Office

Charles Luney House
250 Oxford Terrace
PO Box 1600
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

WestpacTrust
Bank of New Zealand

MISSION STATEMENT

The Canterbury DHB's mission is to improve, promote and protect the health of the people in the community and foster the well-being and independence of people with disabilities and reduce disparities.

BOARD MEMBERS

Syd Bradley - Chair	Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB and DHBNZ. Syd has served on a number of boards since resigning as General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.
Randall Allardyce	Randall Allardyce is a director of medical research at the University of Otago's Christchurch School of Medicine & Health Sciences and is also affiliated to the University of Canterbury. Based in Cust, Randall has headed or worked for many North Canterbury community projects and healthcare initiatives as well as the establishment of the NZ Liver Transplantation Unit, the national introduction of keyhole surgery, and the Mobile Surgical Unit.
Philip Bagshaw	Philip Bagshaw is a general surgeon at Christchurch Hospital and is an Associate Professor of Surgery at the University of Otago's Christchurch School of Medicine & Health Sciences. Philip was appointed to the academic staff there in 1981, where he teaches and does research work.
Robin Booth	Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
David Morrell	David Morrell was City Missioner in Christchurch from 1982 to 2004 and has had over 30 years involvement with general health and mental health through hospital chaplaincy, primarily at Christchurch Hospital during the 1970s and subsequently at the City Mission. David has had extensive management training, both here and in the United Kingdom. David is also Chair of Brackenridge Estate Limited (appointed 1 June 2004).
Graham Heenan	Graham Heenan has been involved in business management for nearly 30 years, since graduating with a Bachelor of Commerce in 1972. Currently Graham is self employed, and a director of numerous companies throughout the South Island. Graham's interest in the health sector has been as a director of Canterbury Health Ltd (since 1995) and Health South Canterbury (1998-2000), and he is currently the Chair of Canterbury Laundry Service Ltd and South Island Shared Services Ltd. His particular skills relate to governance, strategic planning, finance and marketing.

/ continued /

BOARD MEMBERS - continued

Olive Webb	Olive Webb is a clinical psychologist and has more than 30 years experience working in the disability sector, particularly with people with intellectual disabilities. Based in Hororata, Olive has a focus on rural health issues and delivery. She provides clinical consultancy to IHC, is an adviser to Richmond Fellowship, and also consults in the Mental Health sector.
Alison Wilkie	Alison Wilkie served on the Riccarton-Wigram Community Board for three years. Alison trained as a nurse at Christchurch Hospital and has post-graduate qualifications in health economics and public health. A life member of the Asthma Foundation and the Canterbury Asthma Society Inc, Alison has worked as an asthma and respiratory educator and owns a small business.
Karen Guilliland	Karen Guilliland is Chief Executive of New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the Pharmac Board and Deputy Chairperson of the Health Workforce Advisory Committee.
Norman Dewes	Norm Dewes is the Chief Executive of the urban Maori authority based in Canterbury. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the period ended 30 June 2004.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based district health board, which provides Health and Disability Support Services, principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB Group recorded a net deficit of $1.241 million against a budgeted breakeven (2002/03 actual deficit - $10.4 million). Failure to meet budget was solely due to the impact of the Holidays Act 2003, which was not funded.

BOARD FEES

Board fees paid, or due payable, to Board and Committee Members for services during the period, were as follows:

	Board Fees Period ended 30/06/04 $'000	Committee Fees Period ended 30/06/04 $'000
Syd Bradley	48	5
Randall Allardyce	24	4
Philip Bagshaw	24	2
Mike Beard *	-	1
Robin Booth	24	2
Julie Barlass	-	1
Norman Dewes *	8	-
Christine Elliot *	-	1
Neville Fagerlund	-	3
Karen Guilliland *	14	1
Graham Heenan	22	4
Ruth Jones	-	1
David Kerr	-	3
Raymond Kirk	-	1
Allison Lomax *	-	1
David Morrell	24	5
Pauline O'Connor	-	1
Michael Ozimek *	-	1
Fiona Pimm	-	1
Suzanne Pitama	-	2
Tuari Potiki *	4	-
Rodney Routledge	-	2
Tim Stonhill	-	1
Apisalome Talemaitoga *	-	-
Jeanette Tarbotton	-	1
Susanne Trim	-	2
Stephanie Waterfield	-	1
Olive Webb	30	2
Gloria Weeks	-	2
Paul White *	6	-
Alison Wilkie	24	2
	252	**53**

* resigned or appointed during the year

Total fees paid for the year were $305,000 (2002/03 - $333,000). The limit of fees authorised for the year ended 30 June 2004 was $384,000 (2002/03 - $371,250).

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the period were as follows:

	Year Ended 30/06/04 $'000
Graham Heenan	9
Anne Urlwin	9
David Morrell	1
	19

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the following transactions during the period:

CANTERBURY DHB

Syd Bradley	Chair - DHBNZ Observer - Pharmac Board Deputy Chair - New Zealand Post Ltd (resigned November 2003)
Randall Allardyce	Director - Breath Testing Service Adjunct academic appointee – University of Canterbury Employee providing services to Canterbury DHB – University of Otago
Philip Bagshaw	Executive Committee Member – Council of Medical Colleges Chair – New Zealand National Board, Royal Australasian College of Surgeons Employee providing services to Canterbury DHB – University of Otago
Norman Dewes	CEO – Te Runanga O Nga Maata Waka Chairman - Te Rito Arahi Maori Alcohol, Drug and Resource Centre Board Member/Vice Chair - Canterbury Community Primary Health Organisation Director Te Amorangi Richmond Wellness Village
Neville Fagerlund	Adviser - Pegasus Health
Karen Guilliland	CEO – New Zealand College of Midwives Director – Midwifery and Maternity Provider Organisation Limited Board Member - Pharmac
Graham Heenan	Chair - Canterbury Laundry Service Ltd Chair - South Island Shared Services Agency Ltd Deputy Chair - Hanmer Springs Thermal Reserve
Dr David Kerr	Adviser - Health Benefits Adviser - Pegasus Health Chairman - Ryman Healthcare Ltd
David Morrell	City Missioner - Christchurch City Mission (retired March 2004) Chair – Brackenridge Estate Limited (appointed 1 June 2004)
Mick Ozimek	Member - Pegasus Health

Fiona Pimm	Board Member - South Canterbury DHB CEO - He Oranga Pounamu Charitable Trust
Suzanne Pitama	Employee – Department of Public Health and General Practice, University of Otago
Tuari Potiki	Employee - Ngai Tahu Development Corporation Board Member - He Oranga Pounamu
Apisalome Talemaitoga	Vice Chair - Pacific Trust Canterbury Member - Pegasus Health
Olive Webb	Clinical Consultant – Richmond Fellowship
Paul White	Director - Housing New Zealand Ltd

SUBSIDIARY AND ASSOCIATED COMPANIES

Garth Bateup	Director of subsidiaries Brackenridge Estate Limited and Canterbury Laundry Service Limited. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Paul Numan	Director of subsidiary, Brackenridge Estate Limited. No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.
Wei Yoon	Director of associate company New Zealand Centre for Reproductive Medicine Limited. No directors fees or any other benefits were received from the subsidiary or associate companies except as an employee of Canterbury DHB.

DIRECTORS' AND BOARD MEMBERS' LOANS

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensure that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

USE OF BOARD OR SUBSIDIARIES' INFORMATION

During the period, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place, eg: amounts for redundancy (based on length of service), and payment in lieu of notice etc.

Of the total payments listed of $78,907, the amounts required to be paid pursuant to the terms of employment contracts totalled $34,218, with the remaining balance comprising negotiated settlements with 2 of the 4 former employees.

Number of Employees	TOTAL $
1	7,684
1	12,000
1	15,000
1	44,223
4	**$78,907**

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands is as follows:

	30/06/04 Number	30/06/03 Number
$100,000 - $110,000	51	50
$110,001 - $120,000	41	36
$120,001 - $130,000	32	17
$130,001 - $140,000	23	24
$140,001 - $150,000	27	29
$150,001 - $160,000	29	21
$160,001 - $170,000	20	23
$170,001 - $180,000	23	24
$180,001 - $190,000	17	12
$190,001 - $200,000	14	5
$200,001 - $210,000	11	4
$210,001 - $220,000	7	5
$220,001 - $230,000	3	4
$230,001 - $240,000	2	-
$240,001 - $250,000	2	-
$250,001 - $260,000	-	1
$270,001 - $280,000	-	1
$390,001 - $400,000[1]	1	-
$400,011 - $410,000	-	1
	303	**257**

Of the 303 positions identified above, 274 (2002/03 - 237) were predominantly clinical and 29 (2002/03 - 20) positions were management/administrative.

[1] CEO remuneration and other benefits are included in this bracket.

STATUTORY DISCLOSURE

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000;

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000; and

(c) a report on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2004, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and service performance on page 35.

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	**Extent objectives met**
(a) to improve, promote, and protect the health of people and communities:	The CDHB planning in service development involves stakeholders in the primary care, secondary care, community service providers, public health groups and other government agencies, as appropriate. The CDHB funds and delivers a range of services from health promotion and protection services, primary care to specialist tertiary services to meet the needs of its population. The seven key areas of focus were He Korowai Oranga, NZ disability strategy, elective services and radiotherapy waiting times, diabetes, inequalities, primary care and a mental health blueprint.
(b) to promote the integration of health services, especially primary and secondary health services:	The CDHB has implemented a Community and Primary Health Care Plan to improve population health and improve access to primary care. The 4 Primary Health Organisations (PHOs) established by the CDHB together with public health programmes designed to meet local needs will assist in achieving this plan. The CDHB has established an integrated service planning framework, incorporating disease prevention and management and working with public health and primary care sector. This will help to address issues such as chronic diseases - respiratory and cardiac illnesses, and diabetes. The CDHB is in the process of developing a full health needs assessment policy on ethnicity information collection and improving communication between primary and secondary health sectors.
(c) to promote effective care or support for those in need of personal health services or disability support services:	The CDHB is a lead DHB in relation to older people's health. This includes working closely with the integration project, Elder Care Canterbury, to develop a continuum of care which encompasses a standardised health needs assessment tool and a cross-sectoral information-sharing policy and procedures. The CDHB's objectives include improving the health status of its population who have an ongoing mental illness, via the regional alcohol and other drug services, and by improving access to mental health services and ensuring delivery of contracted services.

(d)	to promote the inclusion and participation in society and independence of people with disabilities:	The CDHB aims to ensure it contributes to a 'non disabling' society through its actions, and the actions of the providers with whom it contracts. The CDHB has developed a Disability Strategic Action Plan (DSAP) that outlines the steps it will make to implement the NZ Disability Strategy. The DSAP involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring. All new building developments are assessed for meeting the needs of people with disabilities.
(e)	to reduce health disparities by improving health outcomes for Maori and other population groups:	The CDHB has produced and implemented its Maori Health Action Plan. The key focus of this is He Korowai Oranga and key objectives include improving ethnicity data collection, reducing health inequalities and supporting Maori health workforce development. The CDHB is continuing with the development of the Pacific People's Health Action Plan which focuses on supporting Pacific People as healthworkers, involving Pacific People in health service development and actively collecting ethnicity data.
(f)	to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The CDHB Health Needs Assessment has identified groups in the community, which have health inequalities. Strategic Plan health gain priority areas (eg, Child and Youth, Maori) have been identified as part of this process. For example, in order to reduce barriers to primary health care, the CDHB has established 4 PHOs within Canterbury that account for the enrolment of 90% of the CDHB population. Two of these PHOs represent rural communities, one represents lower socioeconomic groups in Christchurch, and the other is an urban PHO.
(g)	to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The CDHB continues to enhance relationships with the community, health providers and social agencies such as Age Concern, Child Youth and Family, Kai Tahu and the Christchurch City Council. The CDHB is also working with Territorial Local Agencies to plan for health and social services as outlined in the Local Government Act 2002.
(h)	to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	The CDHB actively participates in forums such as Healthy Christchurch, Elder Care Canterbury, Maori Hui, DHBNZ and Diabetes. Information gathered from these forums assists the service planning process. The CDHB has engaged in an active consultation through formal processes (eg for the strategic plan) and sector representation on project steering groups.

(i)	to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	The CDHB has established a Quality and Patient Safety Council and a Clinical Advisory Committee to provide advice to the CEO on quality issues, and a forum for the wider DHB (e.g. community providers) to discuss quality issues. This also facilitates ongoing quality improvement processes. The CDHB also has processes in place to maintain and improve quality including Quality Health New Zealand accreditation process for its hospitals and performance targets and measures to maintain appropriate levels of clinical quality.
(j)	to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	The CDHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme.
(k)	To be a good employer	The CDHB has established and will continue to develop relationships with its health workers and those in the community to build a workforce that meets the health and disability needs of its community. This includes addressing challenges such as staff shortages in some areas, staff needs for ongoing career development, staff participation in decision-making, and creating a family-friendly environment.

Section 42(3)(i): Statement of how CDHB has given effect and intends to give effect to its functions specified in section 23 (b) – (e)		
Function:		**What has been done to meet function**
(b)	to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	• The CDHB has involved stakeholders in delivery of Core Directions and health gain priority areas for CDHB Strategic Plan. • The CDHB actively involves relevant groups and individuals in planning specific service areas. • The CDHB has established joint arrangements with external providers for some provision of orthopaedic and cardiac surgery services. • The CDHB works with the Ministry of Health in a number of joint/collaborative ways such as Public (Population) Health shared decision making; and the allocation of the Maori and Pacific Health development fund.

(c)	to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):	• The CDHB uses a variety of written media, TV and radio work to outline general issues and priorities and the community. • The CDHB will continue to respond directly to media / personal / group enquiries. • The CDHB circulates / makes available significant documents / plans for population in summary and comprehensive form either at libraries, via groups or individually. • The CDHB involves sector representatives in steering groups leading the planning for health services. • The CDHB has developed a website, which includes community based health information. • The CDHB continues to provide health promotion services funded by the Ministry of Health.
(d)	to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:	Relationships with Manawhenua Ki Waitaha, Te Runanga and Nga Maata Waka continue to develop. Maori community hui are held quarterly and regular meetings with Maori providers and other Maori community organisations. The outcomes of these meetings are fed directly into the CDHB planning process.
(e)	to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori:	The CDHB has established Te Kahui Taumata, which includes the Kaumatua and Taua and senior Maori staff who provide Maori specific advice to the Chief Executive.

For and on behalf of the Board

Syd Bradley
Chair
8 October 2004

Graham Heenan
Board Member
8 October 2004

STATEMENT OF RESPONSIBILITY

Pursuant to Section 42 of the Public Finance Act 1989, we acknowledge that:

a) The preparation of financial statements of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the period ended 30 June 2004, are our responsibility.

c) In our opinion, the financial statements for the year under review fairly reflect the financial position and operations of Canterbury DHB.

Syd Bradley
Chair
8 October 2004

Jean O'Callaghan
Chief Executive Officer
8 October 2004

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE PERIOD ENDED 30 JUNE 2004

	Notes	Group			Parent	
		Actual 30/06/04 $'000	Budget 30/06/04 $'000	Actual 30/6/03 $'000	Actual 30/06/04 $'000	Actual 30/6/03 $'000
OPERATING REVENUE						
MoH Revenue[2]		811,362	741,162	671,819	805,320	665,642
Patient Related Revenue		24,462	22,715	21,951	23,862	21,366
Other Revenue		13,657	9,627	11,616	12,841	10,919
TOTAL REVENUE		849,481	773,504	705,386	842,023	697,927
OPERATING EXPENSES						
Employee Costs		346,910	326,656	321,932	340,029	315,514
Treatment Related Costs		90,207	89,113	90,435	93,248	93,487
External Service Providers[2]		299,921	240,864	206,452	299,921	206,452
Depreciation	11	32,652	33,831	21,295	31,663	20,189
Interest Expense		4,035	8,700	6,623	3,987	6,618
Other Expenses		53,689	50,536	54,682	51,436	51,823
TOTAL OPERATING EXPENSES		827,414	749,700	701,419	820,284	694,083
OPERATING SURPLUS BEFORE CAPITAL CHARGE		22,067	23,804	3,967	21,739	3,844
Capital Charge Expense		(23,306)	(23,804)	(14,395)	(23,306)	(14,395)
SURPLUS/(DEFICIT) BEFORE TAXATION	2	(1,239)	-	(10,428)	(1,567)	(10,551)
Tax (Expense)/ Benefit	3	(2)	-	23	-	-
NET SURPLUS / (DEFICIT) FOR THE YEAR		**(1,241)**	-	**(10,405)**	**(1,567)**	**(10,551)**

[2] The budget included some national/regional contract expenditure which has subsequently been transferred back to other DHBs. In addition DSS contracts were devolved during the year and are not reflected in the above budget.

STATEMENT OF MOVEMENTS IN EQUITY
FOR THE PERIOD ENDED 30 JUNE 2004

	Notes	Group			Parent	
		Actual 30/06/04 $'000	Budget 30/06/04 $'000	Actual 30/06/03 $'000	Actual 30/06/04 $'000	Actual 30/06/03 $'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD:						
Equity excluding Minority Interest		211,585	180,671	134,923	211,308	134,577
Minority Interest		-	56	56	-	-
		211,585	180,727	134,979	211,308	134,577
Revenue reserves from subsidiaries which were amalgamated during the year		-	-	-	-	215
		211,585	180,727	134,979	211,308	134,792
TOTAL RECOGNISED REVENUES AND EXPENSES:						
Net surplus / (deficit) for the period		(1,241)	-	(10,405)	(1,567)	(10,551)
Revaluation of Fixed Assets	5	-	-	77,717	-	77,717
		(1,241)	-	67,312	(1,567)	67,166
OTHER MOVEMENTS						
Contribution from/(back to) Crown		(11,000)	19,650	9,350	(11,000)	9,350
Minority Interest amalgamated		-	-	(56)	-	-
		(11,000)	19,650	9,294	(11,000)	9,350
TOTAL EQUITY AT END OF THE PERIOD:						
Equity excluding Minority Interest		199,344	200,321	211,585	198,741	211,308
Minority Interest		-	56	-	-	-
TOTAL EQUITY		**199,344**	**200,377**	**211,585**	**198,741**	**211,308**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2004

	Notes	Group			Parent	
		Actual as at 30/06/04 $'000	Budget as at 30/06/04 $'000	Actual as at 30/06/03 $'000	Actual as at 30/06/04 $'000	Actual as at 30/06/03 $'000
CROWN EQUITY						
General Funds	5	148,174	200,321	159,174	148,312	159,312
Revaluation Reserve	5	77,717	-	77,717	77,717	77,717
Retained Earnings	5	(34,326)	-	(32,700)	(34,740)	(32,800)
Trust Reserve	5	7,779	-	7,394	7,452	7,079
Minority Interest		-	56	-	-	-
TOTAL EQUITY		**199,344**	**200,377**	**211,585**	**198,741**	**211,308**
REPRESENTED BY:						
CURRENT ASSETS						
Receivables and Prepayments	4	27,476	50,017	57,149	27,074	55,502
Stocks	6	6,806	7,400	6,920	6,751	6,861
TOTAL CURRENT ASSETS		34,282	57,417	64,069	33,825	62,363
CURRENT LIABILITIES						
Cash & Bank	9	835	2,859	4,295	1,446	4,637
Creditors and Accruals		68,281	43,398	73,009	68,080	72,849
Owing to Crown		5,810	5,951	3,670	5,810	3,670
Staff Entitlements due within 1 year	7	38,035	39,000	32,848	37,404	32,328
Provisions due within 1 year	12	14,722	-	8,648	14,623	8,566
Loans due within 1 year	9	42,600	1,000	99,380	42,600	99,380
TOTAL CURRENT LIABILITIES		170,283	92,208	221,850	169,963	221,430
NET WORKING CAPITAL		(136,001)	(34,791)	(157,781)	(136,138)	(159,067)
NON CURRENT ASSETS						
Investments	10	292	466	378	2,196	3,783
Fixed Assets	11	375,137	347,927	355,863	372,758	353,484
Surplus Property	11	9,300	9,300	10,300	9,300	10,300
Restricted Assets	8	7,779	7,180	7,394	7,452	7,079
TOTAL NON CURRENT ASSETS		392,508	364,873	373,935	391,706	374,646
NON CURRENT LIABILITIES						
Provisions	12	5,113	3,636	4,491	4,827	4,271
Deferred Tax	3	50	69	78	-	-
Loans repayable after 1 year	9	52,000	126,000	-	52,000	-
TOTAL NON CURRENT LIABILITIES		57,163	129,705	4,569	56,827	4,271
NET ASSETS		**199,344**	**200,377**	**211,585**	**198,741**	**211,308**

For and on behalf of the Board

Syd Bradley
Chair
8 October 2004

Graham Heenan
Board Member
8 October 2004

This statement is to be read in conjunction with the Notes on pages 18 to 34 and the Audit Report on page 57.

STATEMENT OF CASH FLOWS
FOR THE PERIOD ENDED 30 JUNE 2004

	Notes	Group Actual 30/06/04 $'000	Group Budget 30/06/04 $'000	Group Actual 30/06/03 $'000	Parent Actual 30/06/04 $'000	Parent Actual 30/06/03 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from MoH		845,726	741,662	660,112	838,385	655,488
Other Receipts		32,062	31,987	39,402	30,608	37,540
Interest Received		595	355	682	682	909
		878,383	774,004	700,196	869,675	693,937
Cash was applied to:						
Payments to Employees		335,069	327,456	319,589	328,338	313,321
Payments to Suppliers		450,281	380,513	324,365	451,126	324,822
Interest Paid		4,345	8,700	6,416	4,297	6,411
Taxes Paid / (Refunded)		3	-	27	-	53
Capital Charge		21,166	21,853	18,559	21,166	18,559
GST (net)		(1,959)	-	1,293	(1,917)	1,312
		808,905	738,522	670,249	803,010	664,478
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	13	69,478	35,482	29,947	66,665	29,459
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of Assets		2,132	1,700	24	2,132	23
Decrease in Investments		-	-	81	1,214	789
		2,132	1,700	105	3,346	812
Cash was applied to:						
Increase in Investments & Restricted Assets		299	-	207	-	611
Purchase of Assets		52,071	63,650	32,787	51,040	32,048
		52,370	63,650	32,994	51,040	32,659
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(50,238)	(61,950)	(32,889)	(47,694)	(31,847)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		52,000	127,000	-	52,000	-
Equity contribution from the Crown		-	19,650	9,350	-	9,350
		52,000	146,650	9,350	52,000	9,350
Cash was applied to:						
Loans Repaid		56,780	120,000	7,068	56,780	7,068
Equity repaid to Crown		11,000	-	-	11,000	-
		67,780	120,000	7,068	67,780	7,068
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(15,780)	26,650	2,282	(15,780)	2,282
Overall Increase/(Decrease) in Cash Held		3,460	182	(660)	3,191	(106)
Opening Cash Balance		(4,295)	(3,041)	(3,635)	(4,637)	(4,531)
CLOSING CASH BALANCE		**(835)**	**(2,859)**	**(4,295)**	**(1,446)**	**(4,637)**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Public Finance Act 1989.

The group currently consists of Canterbury DHB, its subsidiaries Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entities, New Zealand Centre for Reproductive Medicine Ltd (50% owned) and South Island Shared Services Agency Ltd (47% owned).

During the year ended 30 June 2003, the subsidiary companies Burwood Rehabilitation Ltd (100% owned), CLS Properties Ltd (100% owned) and Crown Public Health Ltd (76.5% owned) were amalgamated into Canterbury DHB, and the associate company Heart Surgery South Island Ltd (50% owned) was wound up.

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain fixed assets.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Revenue from Ministry of Health to the Funder arm of Canterbury DHB is recognised as revenue in the financial year. Revenue from contracts for services where funding is still the responsibility of Ministry of Health, is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service
Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of CHL. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of Canterbnry DHB
Assets acquired by the DHB since its establishment are recorded at cost except for land, buildings and fitout plant and equipment that are revalued every five years. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of land, buildings and fitout plant and equipment
Land, buildings and fitout plant and equipment are revalued every five years. The fair value of land, buildings and fitout plant and equipment is determined by an independent registered valuer by reference to the highest and best use of these assets or, if sufficient market based evidence is not available, by reference to their depreciated replacement cost. Additions between revaluations are recorded at cost. The results of revaluing land, buildings and fitout plant and equipment are credited or debited to assets revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

iv) **Depreciation**

Depreciation is charged on a straight line basis so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	20 - 50
Leasehold Building & Fitout	3 - 20
Fitout Plant and Equipment	5 - 50
Plant and Equipment (incl pool)	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) **Goods and Services Tax**

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) **Donated Assets**

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

vii) **Stocks**

Stocks are valued at the lower of cost or net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

viii) **Accounts Receivable**

Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

ix) **Investments**

The investment in the Associate Companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis.

Other investments are stated at the lower of cost and net realisable value.

Dividend and interest income is accounted for on an accrual basis.

x) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

Canterbury DHB subsidiaries are subject to income tax, with the exception of Brackenridge Estate Ltd. Income tax expense is charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. Deferred taxation is determined on a comprehensive basis using the liability method. Deferred tax assets attributable to timing differences or tax bases are only recognised where there is virtual certainty of realisation.

xi) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xii) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xiii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as Finance Leases and capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiv) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xv) Provision for Staff Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, parental leave and conference leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xvi) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non current securities and advances (other than securities and advances included within cash) and any other non current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvii) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xviii) Financial Instruments

Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost or market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xix) Basis of Consolidation

The consolidated financial statements include the parent DHB and its subsidiaries. The subsidiaries are accounted for by adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis which shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

D CHANGE IN ACCOUNTING POLICIES

There have been no changes from the accounting policy changes adopted in the previous financial period. All policies have been applied on a basis consistent with the previous period.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating deficit is stated:	Group		Parent	
	30/06/04 $'000	30/06/03 $'000	30/06/04 $'000	30/06/03 $'000
After Charging:				
Remuneration of Auditor:				
- Audit Fees	140	120	120	101
- Other Services	-	23	-	23
Board Members Fees	252	289	252	289
Directors' Fees	19	22	-	-
Interest Expense	4,035	6,623	3,987	6,618
Bad Debts Written Off	518	130	518	130
Increase/(Decrease) in Bad Debts Provision	626	745	626	745
Write-down (reversal of write down) of investments		-	-	(595)
Rental and Operating Lease Costs	3,751	4,017	3,263	3,452
After Crediting:				
Interest Received from Investments	595	682	682	909
Gain (loss) on Disposal of Assets	1,029	(85)	1,029	(86)

3. TAXATION

The tax expense arises from the operations of subsidiary entities. The DHB itself is exempt from income tax.

	Group	
	30/06/04 $'000	30/06/03 $'000
Net Operating Surplus/(Deficit) before Taxation	(1,239)	(10,428)
Prima facie taxation @ 33%	(409)	(3,441)
Plus/(Less) tax effect of:		
Permanent Differences	411	3,418
Timing Differences not recognised	-	-
Underestimation of tax in previous year	-	-
Tax Expense / (Benefit)	2	(23)
Comprising:		
Current Tax	30	(32)
Deferred Tax	(28)	9
	2	(23)
Deferred Tax Liability		
Opening Balance	78	69
Current Year Movement	(28)	9
Closing Balance	50	78

Permanent differences are due to results of the Parent and Brackenridge Estate Ltd not being subject to income tax.

4. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Trade Debtors	10,315	6,822	10,224	6,781
Receivable from Crown	14,074	48,438	13,820	46,885
Other Debtors	2,534	1,594	2,491	1,550
Prepayments	553	295	539	286
	27,476	57,149	27,074	55,502

5. EQUITY

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
GENERAL FUNDS				
Opening Balance	159,174	149,824	159,312	149,962
Equity contribution from Crown/(Repayment)	(11,000)	9,350	(11,000)	9,350
	148,174	159,174	148,312	159,312
RETAINED EARNINGS				
Opening Balance	(32,700)	(22,534)	(32,800)	(22,268)
Revenue reserves from amalgamated subsidiaries	-	-	-	215
Adjustment on amalgamation of CLS Properties	-	453	-	-
Operating Surplus/(Deficit)	(1,241)	(10,405)	(1,567)	(10,551)
Transfers from/(to) Trust Reserve	(385)	(214)	(373)	(196)
Closing Balance	(34,326)	(32,700)	(34,740)	(32,800)
Represented by :				
Accumulated Deficit in Parent and Subsidiary	(34,404)	(32,778)	(34,818)	(32,878)
Accumulated Surplus in Associates	78	78	78	78
	(34,326)	(32,700)	(34,740)	(32,800)
REVALUATION RESERVE				
Opening Balance	77,717	453	77,717	-
Adjustment on amalgamation of CLS Properties	-	(453)	-	-
Current Year Movement	-	77,717	-	77,717
Closing Balance	77,717	77,717	77,717	77,717

Represented by:				
Revaluation of land	27,531	27,531	27,531	27,531
Revaluation of freehold buildings	656	656	656	656
Revaluation of fitout plant and equipment	48,540	48,540	48,540	48,540
Revaluation of reversionary interest in buildings	990	990	990	990
	77,717	77,717	77,717	77,717

TRUST RESERVE

Opening Balance	7,394	7,180	7,079	6,883
Transfers from/(to) Retained Earnings	385	214	373	196
Closing Balance	7,779	7,394	7,452	7,079

6. STOCKS

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Pharmaceuticals	2,226	1,914	2,226	1,914
Surgical and Medical Supplies	3,605	3,703	3,605	3,703
Other Supplies	1,689	1,875	1,634	1,816
	7,520	7,492	7,465	7,433
Provision for Obsolescence	(714)	(572)	(714)	(572)
	6,806	6,920	6,751	6,861

Some of the stocks may be subject to restriction of title ie Romalpa Clauses or securities registered by suppliers under the Personal Property Securities Act. The value of stocks subject to above cannot be quantified due to the inherent difficulties in identifying stocks that are still subject to the Romalpa Clauses or security registered under the PPSA at year end.

7. STAFF ENTITLEMENTS

Staff Entitlements consist of:

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Annual Leave Accruals	24,319	18,760	23,944	18,417
Unpaid Days Accruals	6,683	4,504	6,518	4,356
ACC Accruals	2,250	(948)	2,210	(977)
Other	4,783	10,532	4,732	10,532
Staff Entitlement Due Within 1 Year	38,035	32,848	37,404	32,328

8. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2004, the amount of funds received where the conditions attached have not been fulfilled is $7,779,000 ($7,394,000 at 30 June 2003).

This is represented by:

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Cash at Bank	416	177	416	177
Term Deposits	2,983	4,625	2,656	4,310
Local Authorities & Government Stocks	840	710	840	710
Quoted Shares	-	55	-	55
Bonds & Stocks	3,540	1,827	3,540	1,827
Total Restricted Assets	7,779	7,394	7,452	7,079

9. LOANS AND BANK OVERDRAFT

Loans consist of:

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Commercial Loans	42,600	99,380	42,600	99,380
Crown Financing Agency	52,000	-	52,000	-
	94,600	99,380	94,600	99,380
Repayable as follows:				
Due Within 1 Year	42,600	99,380	42,600	99,380
Two - Five Years	52,000	-	52,000	-
	94,600	99,380	94,600	99,380

The bank overdraft facility available totals $2,000,000 for the parent and $2,250,000 for the group.

Security

Canterbury DHB commercial loans and the overdraft facilities are secured by Deed of Negative Pledge which requires the Board to comply with certain covenants such as limitations on borrowings, interest cover and working capital ratio. The Brackenridge Estate Ltd overdraft facility is secured by a registered first and exclusive debenture over the company's assets, undertakings and uncalled capital.

Interest Rates

Weighted average interest rates on the group's borrowing for the year are as follows:

	Group		Parent	
	30/06/04	30/06/03	30/06/04	30/06/03
Commercial Loans	5.86%	5.92%	5.86%	5.92%
Crown Financing Agency	6.29%	-	6.29%	-
Bank Overdraft	7.30%	7.30%	7.30%	7.30%

10. INVESTMENTS

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Investment in Associates	292	378	292	378
Investment in Subsidiaries	-	-	1,904	3,405
	292	378	2,196	3,783

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Share of Associates Equity Brought Forward	168	170	168	170
Capital distribution on winding up (HSSIL)	-	(2)	-	(2)
Share of Associates Operating Surplus	-	-	-	-
Share of Associates Equity Carried Forward	168	168	168	168
Advances	124	210	124	210
	292	378	292	378

At 30 June 2004, Associate Companies comprised:

	Percentage Interest	Balance Date
New Zealand Centre for Reproductive Medicine Ltd	50	30 June
South Island Shared Services Agency Ltd	47	30 June

New Zealand Centre for Reproductive Medicine Ltd provides reproductive medicine services to private and publicly funded patients.
South Island Shared Services Agency Ltd provides support services for contracting, contract monitoring and provider audits to DHBs for their Funding arm.

INVESTMENT IN SUBSIDIARIES

	Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000
Equity - Canterbury Laundry Service Ltd	393	393
Advances - Canterbury Laundry Service Ltd	1,787	2,001
Equity - Brackenridge Estate Ltd	(315)	(315)
Advances - Brackenridge Estate Ltd	39	1,326
	1,904	3,405

At 30 June 2004 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Laundry Service Ltd	100%	30 June
Brackenridge Estate Ltd	100%	30 June

Canterbury Laundry Service Ltd provides laundry services. Brackenridge Estate Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

Canterbury DHB appoints both directors of Canterbury Laundry Service Ltd. The company provides services predominantly to Canterbury DHB, and Canterbury DHB has control over the objectives of the company.

Canterbury DHB appoints two out of five directors of Brackenridge Estate Ltd. Its control over the company is exercised through these directors and the provision of financial support and administrative services by Canterbury DHB.

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
At Cost				
Freehold land	-	-	-	-
Buildings - freehold	3,171	-	3,171	-
Leasehold Building & Fitout	3,042	3,497	3,042	3,042
Fitout plant and equipment	1,292	-	1,292	-
Plant and equipment	51,479	45,868	46,515	41,196
Computer equipment and software	32,837	27,502	32,837	27,417
Motor vehicles	4,075	2,079	3,590	1,938
Capital work-in-progress	60,205	27,349	60,205	27,349
At Valuation				
Freehold land	73,601	74,601	73,601	74,601
Buildings - freehold	85,920	85,920	85,920	85,920
Fitout plant & equipment	131,289	131,289	131,289	131,289
Plant and equipment	24,791	24,791	24,791	24,791
Reversionary interest in buildings	990	990	990	990
	472,692	423,886	467,243	418,533
Accumulated Depreciation				
Buildings - freehold	3,819	-	3,819	-
Leasehold Building & Fitout	329	579	329	318
Fitout plant and equipment	16,588	-	16,588	-
Plant and equipment	39,924	32,640	36,987	30,036
Computer equipment and software	26,149	23,452	26,148	23,409
Motor vehicles	1,446	1,052	1,314	986
	88,255	57,723	85,185	54,749

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Net Book Value				
Freehold land	73,601	74,601	73,601	74,601
Buildings - freehold	85,272	85,920	85,272	85,920
Leasehold Building & Fitout	2,713	2,918	2,713	2,724
Fitout plant and equipment	115,993	131,289	115,993	131,289
Plant and equipment	36,346	38,019	34,319	35,951
Computer equipment and software	6,688	4,050	6,689	4,008
Motor vehicles	2,629	1,027	2,276	952
Capital work-in-progress	60,205	27,349	60,205	27,349
Reversionary interest in buildings	990	990	990	990
Reclassify to Surplus Property	(9,300)	(10,300)	(9,300)	(10,300)
	375,137	355,863	372,758	353,484
Depreciation charged during the year:				
Buildings freehold & leasehold	3,851	2,451	3,851	2,411
Fitout plant and equipment	16,589	6,795	16,589	6,781
Plant and equipment	8,642	8,564	7,653	7,547
Computer equipment and software	3,209	3,345	3,209	3,328
Motor vehicles	361	140	361	122
	32,652	21,295	31,663	20,189

Canterbury DHB revalued its land, buildings and fitout plant and equipment as at 30 June 2003. The revaluation was carried out by the independent registered valuers Telfer Young and resulted in the net increases in the value of land ($27,531,000), freehold buildings ($670,000), fitout plant and equipment ($48,526,000) and reversionary interest in a car park building ($990,000). This increase had been recognised in the Revaluation Reserve. The total fair value of Canterbury DHB's land and buildings including fitout as at 30 June 2003 was $294,728,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 16 years time. This interest has not been included in the Statement of Financial Position, other than the June 2003 revaluation effect of $990,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

Property surplus to requirements as at 30 June 2004 included land at Hillmorton and Hanmer Springs hospital sites, and two sites in central Christchurch.

Under the terms of the Ngai Tahu Claims Settlement Act 1998, most surplus property must be first offered to Ngai Tahu. The disposal of certain properties may also be subject to the provisions of section 40 of the Public Works Act 1981.

12. PROVISIONS

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Provision due within 1 year	14,722	8,648	14,623	8,566
Provision due after 1 year	5,113	4,491	4,827	4,271
Total Provisions	19,835	13,139	19,450	12,837
Movement in Provisions				
Opening balance	13,139		12,837	
Additional provision made during the year	12,245		11,805	
Release of surplus provision	(43)		-	
Charged against provision for the year	(5,506)		(5,192)	
Closing balance	19,835		19,450	

These provisions primarily relate to staff entitlements, but also includes a refurbishment provision for Brackenridge. Staff entitlements include gratuities, long service leave, conference expenses, parental leave, and collective employment contracts pending finalisation of pay negotiations.

13. RECONCILIATION OF NET SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH FLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	30/06/04 $'000	30/06/03 $'000	30/06/04 $'000	30/06/03 $'000
Net Operating Surplus before Share of Associate Co's Surplus	(1,241)	(10,405)	(1,567)	(10,551)
Add Back Non-Cash Items:				
Depreciation	32,652	21,295	31,663	20,189
Maintenance provision	42	10	-	-
Other non-cash items		(28)	-	27
Add Back Items Classified as Investing Activity:				
(Gain) / loss on Asset Sale	(1,029)	85	(1,029)	86
	30,424	10,957	29,067	9,751
Movement in Term Portion Provisions	622	645	556	635
Movement in Deferred Tax	(28)	9	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	29,673	(4,553)	28,428	(4,138)
Decrease/ (Incr.) in Stocks	114	411	110	415
Increase/ (Decr.) in Creditors & Other Accruals	(4,728)	24,937	(4,769)	25,262
Increase/ (Decr.) in Capital Charge due to Crown	2,140	(4,164)	2,140	(4,164)
Increase/ (Decr.) in Staff Entitlements	5,187	454	5,076	834
Increase/ (Decr.) in Provisions	6,074	1,251	6,057	1,183
Add: Items in Debtors relating to amalgamation of subsidiaries	-	-	-	777
Less: Items in Creditors relating to amalgamation of subsidiaries	-	-	-	(1,096)
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	69,478	29,947	66,665	29,459

14. COMMITMENTS

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
CAPITAL COMMITMENTS				
Committed at Balance Date	53,719	64,878	53,719	64,878
NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Lease	15,977	14,609	8,736	6,885
Computer Leases	-	197	-	197
Vehicle Leases	82	258	77	244
Other	5	11	-	-
	16,064	15,075	8,813	7,326
For Expenditure Within:				
1 Year	1,695	2,020	1,217	1,532
2 Years	1,308	1,660	837	1,187
3 Years and Beyond	13,061	11,395	6,759	4,607
	16,064	15,075	8,813	7,326

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are re-negotiated periodically reflecting the general principle that an on-going business relationship exists with those providers. Examples of these contracts include contracts for primary care, personal health and mental health.

There are also contracts for demand-driven items where the total expenditure is not defined in advance because it is ultimately paid to the individual consumers. Examples of this type of expenditure are pharmaceuticals, subsidy payments to rest homes and carer support relief payments.

The value of the Board's commitment relating to these contracts has not been included in the disclosure above.

15. TRANSACTIONS WITH RELATED PARTIES

a) GOVERNMENT FUNDING

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the Canterbury DHB. Canterbury DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

b) INTER-GROUP TRANSACTIONS

During the financial year the group had the following inter-group transactions:

	Group		Parent	
	30/06/04 $'000	30/06/03 $'000	30/06/04 $'000	30/06/03 $'000
Revenue				
Interest on advance and director's fees from Canterbury Laundry Service Ltd	-	-	110	172
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	89	129
Services to Canterbury Laundry Service Ltd	-	-	603	357
Services to Crown Public Health Ltd (prior to amalgamation with Canterbury DHB)	-	-	-	291
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	57	56	57	56
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	3,425	3,415
Services from New Zealand Centre for Reproductive Medicine Ltd	1,181	1,042	1,181	1,042
Services from South Island Shared Services Agency Ltd	502	429	502	429

Interest charged on advances Canterbury Laundry Service Ltd, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Ltd are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June 2004 are as follows :

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Amount Payable owing to associates				
South Island Shared Services Agency Ltd	-	18	-	18
NZ Centre for Reproductive Medicine Ltd	-	95	-	95
Burwood Orthopaedic Surgical Services	-	163	-	163
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd	223	264	223	264
NZ Centre for Reproductive Medicine Ltd	-	4	-	4
Amount Payable owing to subsidiaries				
Canterbury Laundry Service Ltd	-	-	364	316
Amount Receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – Debtor	-	-	140	32
Canterbury Laundry Service Ltd – Advance	-	-	1,787	2,001
Brackenridge Estate Ltd – Advance	-	-	39	1,326

c) BOARD AND COMMITTEE MEMBERS

During the financial year Canterbury DHB and its subsidiaries have purchased services provided on an arm's length basis by the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/04 $'000	30/06/03 $'000	30/06/04 $'000	30/06/03 $'000
Christchurch City Council	475	524	436	467
DHBNZ	332	93	332	93
Pegasus Health	72,350	74,463	72,350	74,463
New Zealand Post Ltd	471	599	471	597
The Christchurch City Mission	448	440	448	440
Breath Testing Services	19	60	19	60
New Zealand Housing Corporation	435	470	-	-
Pacific Trust Canterbury	1,184	650	1,184	650
He Oranga Pounamu Charitable Trust	1,555	1,321	1,555	1,321
Te Amorangi Richmond Wellness Village	308	-	308	-
Te Rito Arahi Maori Alcohol Drug & Resource Centre	319	-	319	-
Windsor House	956	-	956	-
Ryman Healthcare Ltd	2,568	30	2,568	30
South Canterbury DHB	144	65	144	65
Champion Centre	6	-	6	-
Smiths City Group	12	-	12	-

Canterbury DHB and its subsidiaries have provided the following services on an arm's length basis to the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/04 $'000	30/06/03 $'000	30/06/04 $'000	30/06/03 $'000
Christchurch City Council	50	13	50	13
DHBNZ	26	10	26	10
South Canterbury DHB	2,620	597	2,620	597
Champion Centre	82	9	82	9

16. CAPITAL CHARGE

Canterbury DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2004 was 11% (11% for the period ended 30 June 2003).

17. FINANCIAL INSTRUMENTS

CREDIT RISK

Financial instruments which potentially subject the group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts.

The group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2004, the Ministry of Health owed Canterbury DHB $13.8 million ($46.9 million at 30 June 2003).

CURRENCY RISK

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary.

Forward exchange contracts amounting to US$2,000,000 and A$350,000 were outstanding at 30 June 2004 (30 June 2003 nil). The valuation of these contracts at 30 June 2004 is an unrecognised benefit of $1,000.

INTEREST RATE RISK

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities.

There are interest rates swaptions outstanding at 30 June 2004 of $37 million (30 June 2003 nil). The valuation of these contracts at 30 June 2004 is an unrecognised benefit of $0.205 million.

FAIR VALUES OF FINANCIAL INSTRUMENTS

Financial instruments recorded in the financial statements have been recorded at their fair values.

18. SEGMENTAL REPORTING

Canterbury DHB operates in the provision of Health and Disability Support Services Industry in the South Island of New Zealand. Therefore, no segmental reporting is required.

19. CONTINGENCIES

Canterbury DHB has the following contingencies at year end:

Claim for a breach of patent rights
A third party has indicated that Canterbury DHB has breached their patent rights. This allegation is being contested and the outcome is uncertain.

Claim under collective agreement
There is a claim from a union for payments around interpretation of a collective employment contract. This claim is being contested and is in the early stages of proceedings.

20. RESIDENTS' TRUST ACCOUNT

	Group		Parent	
	As at 30/06/04 $'000	As at 30/06/03 $'000	As at 30/06/04 $'000	As at 30/06/03 $'000
Residents' Trust Account Balance	682	602	364	331

Residents' Trust Account comprises bank balances representing funds managed on behalf of Residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual residents' balances. Therefore, transactions occurring during the year are not included in the Statement of Financial Performance, Financial Position or Cash Flow of Canterbury DHB.

21. SUBSEQUENT EVENTS

There were no events after 30 June 2004 which could have a material impact on the information in Canterbury DHB's financial statements.

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2003/04

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

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

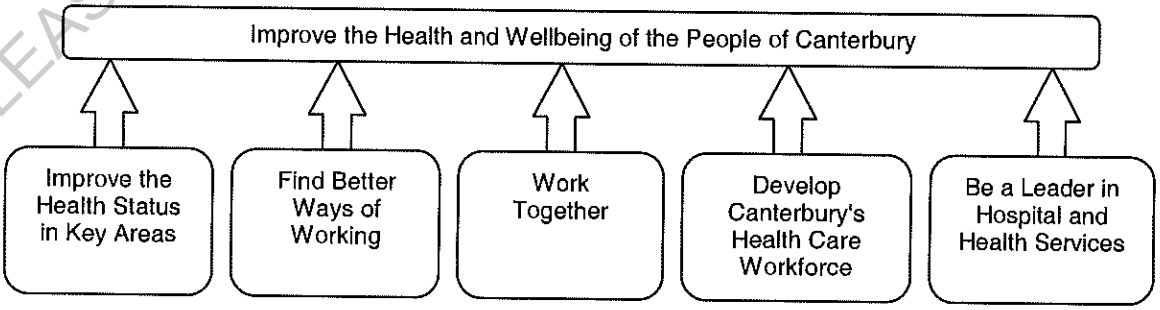
1. Strategic Priorities and Directions

To achieve CDHB's primary objective "To improve the health and wellbeing of people living in Canterbury", the Canterbury DHB is focusing on achieving improved outcomes in the following priority areas:

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

In improving health outcomes in these priority areas, as well as in our other areas of work, we are focusing our efforts on the five core directions:

- *Improving the health status of our community* - improve the health outcomes for specific groups in our community.
- *Find better ways of working* - to get the maximum improvement in health status for our community within the available funding and resources.
- *Work together* - to ensure the right service is provided at the right time to obtain the maximum possible health gains for our community.
- *Develop Canterbury's health care workforce* - to ensure that we have the appropriate workforce to meet the health needs of the people of Canterbury.
- *Be 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.



NOTE: In order to provide an overview of progress, where available, 2002/03 performance results have been included in parentheses and italics to the right of current results. In addition, for some measures the results involve low numbers which result in unreliable percentage rates. Where this is the case actual numbers have been included alongside the percentage rates to provide a more accurate picture.

1.1. Overview of Performance

The following table provides an overview of the Canterbury DHB's performance for the 2003/04 year. Where there is more than one performance measure for an objective, or where results are broken down by ethnicity in the full report on the pages that follow, a tick in the box indicates a good overall result for the associated objective.

		Objective	*Performance Measure*	*Achieved 2003/04 Target*	*Improved on 2002/03 Performance*
Strategic Plan Priorities	Child Health	Reduce the Number of Low Birth Weight Babies	Percentage of babies born in hospital with low birth weight	☑	☑
		Improved Immunisation of Canterbury Children	Percentage of children fully vaccinated by their second birthday	N/A	N/A
		Reduce Child Hearing Loss	Percentage of children passing school entry hearing tests	☑	☑
		Improved Education and Treatment of Children With Asthma	Repeat admission for asthma in children under 5 Repeat admission for asthma in children between the ages of 5 and 15	X	X
		Improve Child Oral Health	Mean MF score at Year 8 (Form 2) Percentage of children caries free at age 5	☑	☑
	Primary Health	Support the Establishment of Four PHOs	1 low income urban PHO established 2 rural PHOs established 1 urban PHO established	☑	N/A
		Improve Rural GP Retention	Percentage of GPs with a rural ranking of greater than 35 points who work no more than a 1 in 4 weekend roster	☑	N/A
		Reduce Ambulatory Sensitive Admissions	Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age	☑	☑
	Maori Health	Improve Monitoring of Maori Health	Develop an integrated health outcome and performance monitoring framework	N/A	N/A
		Reduce Health Inequalities	See relevant performance indicators including those in sections 2.1, 2.2, 2.5, and 2.7		
		Determine Performance Measures for Maori Health and Disability Outcomes	Develop baseline data and measures that link to the priority areas of diabetes, child health, and cardiovascular disease	☑	N/A
	Mental Health	100% Delivery of Contracted Volumes by the Provider-arm	100% delivery of contracted volumes	☑	N/A
		Mental Health Expenditure to be 100% of Target	100% allocation of funding	☑	N/A

		Objective	*Performance Measure*	*Achieved 2003/04 Target*	*Improved on 2002/03 Performance*
		Improved Access to Services	Percentage of people within each age group accessing mental health treatment and support services	☑	☑
	Cardio-vascular Disease	Reduce the Impact of Cardiovascular Disease	Percentage of people with certainty who waited for no more than 6 months for coronary artery bypass with grafts Delivery of target levels of cardiac surgery Percentage of people with certainty who waited for no more than 6 months for an angioplasty Repeat admissions for rheumatic fever in people under 30 years	X	☑
	Cancer	Reduce the Impact of Cancer	Improved access to radiotherapy	X	☑
	Diabetes	Earlier Diagnosis and Treatment of Eye Problems	Percentage of people having annual reviews who have had their eyes screened in the last two years	X	☑
		Improved Diabetes Monitoring	Percentage of the expected number of people with diabetes who have been diagnosed with diabetes and had an annual review during the year	X	☑
		Improved Diabetes Management	Percentage of people having annual reviews who had poor diabetes control	X	☑
Other DHB Measures of Performance	Elective Services	Improved Access to First Specialist Assessments	Percentage of patients who receive their first specialist assessment within six months of referral Delivery of a level of publicly funded first specialist assessment volumes at the levels specified in the District Annual Plan	X	☑
		Improved Certainty of Treatment	Percentage of patients with certainty who received treatment within six months	X	X
		100% Delivery of Contracted Surgical Volumes	Case weighted discharges delivered as specified in the District Annual Plan	☑	☑
	Hospital Safety and Effectiveness	Improved Performance as a Good Employer	Sick leave rate Workplace injuries Staff turnover	X	X
		Patient Satisfaction	Inpatient- overall satisfaction Outpatient- overall satisfaction	☑	X
		Improved Quality	Achieve and maintain accreditation status	☑	X
		Maintain Appropriate Levels of Clinical Quality Within CDHB Hospitals	Hospital acquired bacteraemia rate per 100 inpatient days IV medication error rate per 1000 inpatient days Patient falls per 100 inpatient days	☑	☑

2. Service Objectives and Measures

Strategic Plan Priorities

The following indicators reflect the performance measures specified in the 2003/06 Statement of Intent which reflect the Strategic Plan priorities. It should be noted that the number of Pacific people in the Canterbury DHB district is small (7,254 at the 2001 Census) so the percentages shown below should be interpreted with caution.

2.1. Child and Youth Health

Objective:	***Brief Description:***
Improved health status for Canterbury's children and youth. (Long term)	Keeping children and youth healthy gives them a better chance of becoming healthy adults. The Canterbury DHB Child Health Strategy (March 2002) identified a range of issues. The DHB is currently in the process of developing a child health action plan to address these issues and also intends to develop a youth health action plan. As these plans are yet to be completed, it has not been possible to develop service objectives and measures, hence the relevant DHB accountabilities to the Minister of Health as outlined in the District Annual Plan, have been included as measures of our performance during the 2003/04 year. (Note: the breast feeding indicator has not been included due to data quality issues)

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04***	***2002/03***
Reduced number of low birth weight babies	Percentage of babies born in public hospital with low birth weight	• Māori 7.2% • Pacific 4.9% • Other 6.1% • Total 6.2%	• Māori 8.4% • Pacific 4.5% • Other 5.9% • Total 6.1%[1] It is preferable that fewer babies are born with low birth weight, hence for this indicator, lower is better. The Canterbury DHB achieved its targets for Pacific peoples and Other ethnicities and has continued to seek to achieve this target for Māori.	*(6.8%)* *(8.5%)* *(5.7%)* *(5.8%)*
Improved immunisation of Canterbury children	Percentage of children fully vaccinated by their second birthday	• Māori 75.0% • Pacific 75.0% • Other 75.0% • Total 75.0%	This was an indicator required by the Ministry of Health targets, which were agreed in our District Annual Plan. However, given data quality issues we are unable to report accurately on it. The implementation of the National Immunisation Register over the next 2 years will improve this situation.	
Reduce numbers of children with hearing loss	Percentage of children passing school entry hearing tests	• Māori 90.0% • Pacific 86.0% • Other 95.0% • Total 94.0%	• Māori 91.6% • Pacific 86.8% • Other 95.6% • Total 95.3%[2] Provisional data shows the Canterbury DHB achieved its targets for all groups.	*(93.3%)* *(83.3%)* *(95.3%)* *(94.8%)*

[1] Data is from the National Minimum Data Set, 1 January 2003 – 31 December 2003
[2] Provisional data from the National Audiology Centre, 1 July 2003 – 30 June 2004. Data not finalised until 2005.

Objective 2003/04	*Performance Measure*	*Performance Targets*	*Results 2003/04*	*2002/03*
Improved education and treatment of children with asthma	Repeat admission for asthma in children under the age of 5	• Māori 5.9% • Pacific 5.5% • Other 5.3% • Total 5.8%	• Māori 9.8% (5 readmissions) • Pacific 13.3% (2 readmissions) • Other 7.9% (15 readmissions) • Total 8.6%[3] (22 readmissions) It is preferable that there are fewer repeat admissions for asthma in children, hence for this indicator and the next one, lower is better. The Canterbury DHB's rates for children under 5 for all groups, apart from "Total", are equivalent to the overall National rate (at a 90% confidence interval). This reflects a total of just 22 readmissions in the 12 month period from January 2003 to December 2003. Because of the low numbers involved these figures should be interpreted with caution. Initiatives underway to address asthma rates include; the implementation of the new high level Child Health Action Plan, which includes a focus on asthma, as well as funding agreements with primary care providers that focus on reducing asthma rates, and continued support of the Baxter Bear project in conjunction with the Canterbury Asthma Society.	*(6.9%)* *(11.1%)* *(4.7%)* *(5.7%)*
	Repeat admission for asthma in children between the ages of 5 and 15	• Māori 5.6% • Pacific 6.4% • Other 6.0% • Total 5.8%	• Māori 16.7% (3 readmissions) • Pacific 25.0% (1 readmission) • Other 7.0% (7 readmissions) • Total 9.0%[4] (11 readmissions) The Canterbury DHB's rates for all groups were equivalent to National rates (at a 90% confidence interval). Once again, the total number of readmissions for this age group was very low, which effects percentage rates. The initiatives described above should help achieve this target in the future.	*(0.0%)* *(0.0%)* *(3.5%)* *(3.0%)*
Improved child oral health	Mean MF score at Year 8 (Form 2). Total permanent teeth filled or missing due to holes (caries) divided by the number seen by the school dental service in the period	• Total 1.6	• 1.6 There were 8,695 permanent teeth filled for 5,308 young people giving a mean MF score of 1.6.[5] It is preferable that there are fewer permanent teeth filled or missing due to holes (caries), hence for this indicator, lower is better. The Canterbury DHB met its target for this indicator.	*(1.74)*
	Percentage of children	• Total 53.6%	• 52%	*(50%)*

[3] Data is from the National Minimum Data Set, 1 January 2003 – 31 December 2003
[4] Data is from the National Minimum Data Set, 1 January 2003 – 31 December 2003
[5] Data is from the Canterbury DHB Crown Funding Agreement report Quarter 3 2003/04 and covers the 2003 school year.

Objective 2003/04	*Performance Measure*	*Performance Targets*	*Results 2003/04* *2002/03*
	caries free (no fillings or holes in teeth) at age 5		There were 2,548 children at their first publicly funded dental service after their 5th and before their 6th birthday with primary dentition free of caries, with no fillings and with no teeth missing due to caries, out of a total of 4,901 children at their first publicly funded dental service after their 5th and before their 6th birthday. Thus the percentage of children caries free at age 5 is 52.0%[6]. Canterbury DHB has shown improved performances on this indicator since last year. The major factor impacting on the Canterbury DHB's performance on this measure is the low proportion of Canterbury's population receiving optimally fluoridated water supplies. Canterbury DHB's overall caries free rate is similar to other non-fluoridated areas. Māori and Pacific children have a lower rate of utilisation of dental services. Canterbury DHB is completed development of a high level Child Health Action Plan which will outline ways of improving access to services. As the inequality between these groups and other children is reduced, Canterbury's overall rate will increase to meet target. The Canterbury DHB is also actively promoting water fluoridation to Territorial Local Authorities through submissions to their Long Term Community Council Plans.
Improved CDHB objectives and performance measures for child health	Develop three specific child health performance measures based on implementation of the CDHB Child Health Report	• In place for 2004/05 year	The Canterbury DHB has completed its high level Child Health Plan .The development of child health performance measures is incorporated within the work done for this plan. Following this, any new performance measures could not be put in place for the 2004/05 year and have been delayed until 2005/06.

[6] Data is from the Canterbury DHB Crown Funding Agreement report Quarter 3 2003/04

2.2. Primary Health

Objective:	***Brief Description:***
Reduced barriers to primary health care. (Long term)	Reducing the barriers to good primary health care helps people stay well resulting in improved health status. During the 2003/04 year Canterbury DHB focused its primary care activities on the following: • Implementation of the Government's primary health care strategy via the formation of Primary Healthcare Organisations (PHOs) within Canterbury for those populations with the greatest barriers to primary health care. • Implementation of Canterbury DHB's Rural Health Action Plan (May 2002). In addition to the above, measures of the effectiveness of primary health care, as outlined the District Annual Plan, have been included as measures of our performance during the 2003/04 year.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04*** ***2002/03***
Support the establishment of 4 PHOs with the Canterbury District. (Two representing rural communities, one representing lower socioeconomic groups in urban Christchurch, and one other urban PHO.)	1 low income urban PHO established	• 1 July 2003	The first Canterbury DHB PHO, the Canterbury Community PHO started up on 1 July 2003. Population enrolled as at April 2004, 4731.
	2 Rural PHOs established All rural GPs working in a PHO	• By 1 October 2003 • By 1 July 2004	• Achieved 1 October 2003. Enrolled population as at April 2004; 57,149 people. • Achieved 1 January 2004. Enrolled population as at April 2004; 12,188 people.
	1 urban PHO established	• By 1 April	• Achieved 1 April 2003. Enrolled population as at April 2004; 334,675 people.
	Total Canterbury DHB population enrolled with a PHO		• 408,743 people, or 90% of the Canterbury DHB population[7], was enrolled with a PHO as at 1 April 2004
Improved retention of Rural GPs: reduce onerous on-call rosters for rural GPs. Every GP with a rural ranking of 35 points or more to work no more than 1 in 4 weekends.	Percentage of GPs with a rural ranking of greater than 35 points who work no more than a 1 in 4 weekend roster (unless by choice).	• 100%	• 100% *(100%)*

[7] Latest CDHB population projection from Statistics NZ for 2003 is 454,510 people

Objective 2003/04	*Performance Measure*	*Performance Targets*	*Results 2003/04*	*2002/03*
Reduce Ambulatory Sensitive Admissions: Ambulatory sensitive admissions are admissions that are potentially preventable by appropriate primary care. This measure provides an indication of access to and effectiveness of primary care.	Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age.	• Māori 7.1% • Pacific 9.8% • Other 9.7% • Total 9.8%	• Māori 6.6% • Pacific 10.6% • Other 7.8% • Total 7.8%[8] It is preferable that there are fewer ambulatory sensitive admissions, hence for this indicator and the next two, being below the target indicates better performance. Therefore since the results for Māori, Other ethnicities and Total are lower than the performance targets, the Canterbury DHB has achieved a good performance for these groups. The Canterbury DHB has continued to seek to achieve it for Pacific peoples. Initiatives such as the Pacific Immunisation Outreach Service (targets 0-5 years), Mother and Pepi Service (targets 0-2 years), and the Pacific Health Clinic should help achieve this target in the future.	*(6.7%)* *(10.6%)* *(9.1%)* *(8.8%)*
	Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age.	• Māori 1.5% • Pacific 2.9% • Other 1.9% • Total 1.9%	• Māori 1.5% • Pacific 2.1% • Other 1.6% • Total 1.6%[9] The results for all groups for this measure are equal to, or well below targets. Following this, the Canterbury DHB achieved a good performance for this age group.	*(1.7%)* *(2.5%)* *(1.8%)* *(1.8%)*
	Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age.	• Māori 1.1% • Pacific 1.2% • Other 1.2% • Total 1.2%	• Māori 1.1% • Pacific 1.3% • Other 1.2% • Total 1.2%[10] Since the results for Māori, Other ethnicities and overall are equal to the performance targets, the Canterbury DHB has achieved a good performance for these ethnic groups. The target for Pacific peoples showed improvement from last year and initiatives such as the Pacific Health Clinic have assisted continued progress towards achieving this target in the future.	*(1.1%)* *(1.4%)* *(1.2%)* *(1.2%)*

[8] Data is from the National Minimum Data Set, 1 January 2003 – 31 December 2003
[9] Data is from the National Minimum Data Set, 1 January 2003 – 31 December 2003
[10] Data is from the National Minimum Data Set, 1 January 2003 – 31 December 2003

2.3. Māori Health

Objective:	***Brief Description:***
Whanau Ora *Māori families supported to achieve their maximum health and wellbeing. (Long Term)*	Evidence of Māori health disparities is well known and compelling and to address these health disparities, the Canterbury DHB has developed a Māori Health Plan (July 2002), *Whakamahere Hauora Māori Ki Waitaha.* This plan identifies a number of strategic issues, namely: • Support of the Government's commitment to the Treaty of Waitangi • Māori participation in health planning, service provision and the workforce • Effective, culturally appropriate and high quality services • Monitoring of Māori health outcomes • Working across sectors During the 2003/04 year Canterbury DHB focused its efforts on acting on these directions, improving data quality to support future developments and reducing health disparities for Māori in the other DHB priority areas.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04***
Monitoring of Māori health outcomes. Lack of accurate collection of ethnicity data currently is a significant barrier to achieving this objective. The DHB therefore plans to implement accurate ethnicity data collection throughout CDHB	At the time of writing the 2003/06 SOI the 'baseline' ethnicity data collection review was not completed and the ethnicity data collection policy was still in development. (As per the 2002/03 SOI these were planned to be completed by 20 June 2003.) During the 2003/04 year Canterbury DHB intends to develop an integrated health outcome and performance monitoring framework which aligns CDHB's Maori Health Plan "Whakamahere Hauora Maori Ki Waitaha" with the MoH Strategy "He Korowai Oranga" and the Maori Health Action Plan "Whakatataka"	No target established Development of baseline data and measures	Baseline data has been captured and an audit of ethnicity data began in June 2004
Reduced health inequalities: Māori Service Development in priority areas eg. Diabetes, Cancers, Cardiovascular disease, Child Health, etc	Refer to the relevant section of this document. Where data is available Māori specific targets have been provided.	See relevant Performance Indicators	Canterbury DHB has made progress in improving performance against targets set for Maori for the following indicators; • Repeat admissions for rheumatic fever (section 2.5) • Diabetes screening and management (section 2.7) Performance for child health indicators (section 2.1) needs further improvement. This will be addressed through the implementation of CDHB's new Child Health Action Plan.

Objective 2003/04	*Performance Measure*	*Performance Targets*	*Results 2003/04*
Determine performance measure for Maori Health and Disability outcomes	Development of baseline data and measures that link to the priority areas of diabetes, child health and cardiovascular disease	Completion of baseline data and measures	Baseline data for Mental Health and Disabilities has been captured and the Child Health Action Plan has been developed.

2.4. Mental Health

Objective:	***Brief Description:***
Improved Health Status for Canterbury Residents who have a serious ongoing mental illness. (Long Term)	About 3% of New Zealanders have a serious ongoing mental illness, which requires specialist care and treatment by a range of health and social service providers. Canterbury DHB has continued towards implementing the Mental Health Strategy and Blueprint for Mental Health Services and the Youth Suicide strategies and guidelines. In June 2004 Canterbury DHB completed a plan for the further implementation of these strategies which will be implemented in 2004/05.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04*** ***2002/03***
Achieve full Mental Health Volume Delivery (Provider-Arm)	Provider Arm Mental Health volumes delivered against contract.	• 100% delivery of contracted volumes	• 99.4% of contracted volumes were delivered. *(100%)* Measurement of performance reflects the actual volume of services delivered multiplied by the relevant prices, expressed as a percentage of the total contracted funds. Note: In measuring performance, adjustment is made to vacant FTE positions where cover has been provided.
Mental Health Service Funding across all providers meets the level specified by the Mental Health funding "ring-fence"	Contracted funding as a percentage of the Mental Health Target	• 100% allocation of funding	• 100% allocation of the ring-fenced funding to providers *(100%)*
Improved access to Mental Health Services: The New Zealand Mental Health Strategy sets targets for access to treatment and support services for people of different age groups with severe mental illness.	Percentage of people within each age group accessing mental health treatment and support services	• 0-9 years 0.26% • 10-14 years 0.60% • 15-19 years 0.81% • 20-64 years 1.00% • 65+ years 0.16%	Average annual percentages for April 2003 – March 2004 • 0-9 0.24% *(0.3%)* • 10-14 0.73% *(0.6%)* • 15-19 1.03% *(0.8%)* • 20-64 1.03% *(1.0%)* • 65+ 0.19% [11] *(0.2%)* The Canterbury DHB achieved the targets for all groups apart from children 0-9 years. Higher percentages indicate greater numbers accessing services. The percentage of people within each age group accessing mental health treatment and support services was greater than or equal to each target. Canterbury DHB has developed a high level Child Health plan as well as a Mental Health Strategic plan. These two documents outline ways of improving access to services for children with mental illnesses. Note: data collection against this measure reflects those services provided by the Canterbury DHB. Data collection from other DHB funded mental health providers is being progressed. Current measurement therefore understates performance against the 3% target.

[11] Data from Crown Funding Agreement Reports – Quarters 1-4 2003/04

2.5. Disease Prevention and Management – Cardiovascular (Heart) Disease

Objective:	***Brief Description:***
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cardiovascular disease (Long Term)	Cardiovascular disease has been identified by the Canterbury DHB as a priority area for improving the health status of the people of Canterbury. The Canterbury DHB is currently in the process of developing a strategy for the management of Cardiovascular disease in Canterbury. As this plan is yet to be completed, it has not been possible to develop service objectives and measures, hence the relevant DHB accountabilities to the Minister of Health, as outlined the District Annual Plan, have been included as measures of our performance during the 2003/04 year.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04*** ***2002/03***
Reducing the Impact of Cardiovascular Disease	Percentage of people with certainty who waited for no more than 6 months for coronary artery bypass graft.	• 100%	• 58% (11 patients) During the year 19 people with certainty of treatment had a coronary bypass with grafts. Of these, 11 had surgery within 6 months, and the remaining 8 treated during the year waited on average 15 months.
	Delivery of target levels of Cardiac Surgery	• 375 cases	• 345 cases The Canterbury DHB's intervention rates for cardiac surgery are consistent with those in other regions.
	Percentage of people with certainty who waited for no more than 6 months for an angioplasty.	• 100%	• 98.9% *(98.1%)* During the year, 1 patient with certainty waited for longer than 6 months for surgery. Treatment was deferred on two occasions at the request of the patient. Treatment was provided in the first half of the year.
	Repeat admissions for acute rheumatic fever in people under 30 years of age	• Māori • Pacific • Other • Total 29.3%	• Māori 0.0% *(11.1%)* • Pacific 0.0% *(0.0%)* • Other 0.0% *(9.2%)* • Total 0.0%[12] *(9.1%)* There were no repeat admissions for acute rheumatic fever in people under 30 years of age during the period. Hence, the Canterbury DHB met this performance target across all ethnic groups.

[12] Data is from the National Minimum Data Set, 1 January 2003 – 31 December 2003

2.6. Disease Prevention and Management - Cancer

Objective:	***Brief Description:***
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cancer (Long Term)	Cancer has been identified by the Canterbury DHB as a priority area for improving the health status of the people of Canterbury. The Canterbury DHB is currently in the process of developing a strategy for the management of Cancer in Canterbury. As this plan is yet to be completed, it has not been possible to develop service objectives and measures, hence the relevant DHB accountability to the Minister of Health, as outlined the District Annual Plan, has been included as measures of our performance during the 2003/04 year.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04*** ***2002/03***
Reducing the impact of Cancer.	Improved Access to Radiation Therapy. Number of patients who: Started treatment on time (within 4 weeks) Waited 4 - 8 weeks Waited 8 -12 weeks Waited >12 weeks Delay to radiotherapy is defined as the time elapsing between the specialist decision to commence radiotherapy and the start of treatment	Improved performance during the year with target performance for the month of June (year-end) of: • 95% • 5% • 0% • 0%	The Canterbury DHB has continued to seek to achieve the goal of 100% of patients being treated within 4 weeks. The reasons for delay are related mainly to lack of suitably qualified workforce in the sector. Delays are also due to patient preference, other illnesses and/or treatments, the need for further tests, and specific start dates for protocol reasons. Percentage — Number (June 2004 only) — *(Percentages 2002/03)* 68% — 72 — *(64.1%)* 27% — 29 — *(20.8%)* 5% — 5 — *(10.7%)* 0% — 0 — *(4.4%)* 100.0% — 106 NOTE: these figures do not include 10 category D patients as they all have specific start dates for protocol reasons. Therefore this group of patients started treatment on time but not all of them started within 4 weeks. The total number of patients seen in June 2004 was 106 + 10 = 116.

2.7. Disease Prevention and Management - Diabetes

Objective:	***Brief Description:***
Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes (Long Term)	Diabetes has been identified by the Canterbury DHB 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, • Patient knowledge/information 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. (Refer to "Diabetes in the Canterbury DHB: Sept 2002", for a full list of priorities). During the 2003/04 year, the CDHB primarily focused its activities on improving performance in the level of retinal screening while continuing to encourage the detection and management of Diabetes within the community. The Canterbury DHB has concerns about the data presented below and is of the opinion that these figures understate the numbers of people having annual diabetes reviews who had their eyes screened in the last two years.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04*** ***2002/03***
Early diagnosis and treatment of eye problems: Increase the proportion of people with diabetes who have had their eyes screened in the last two years	The percentage of people having annual diabetes reviews who have had their eyes screened in the last two years	• Māori 40% • Total 49%	• 42.1% • 45% *(41.0%)* These results do not include the screening done in the community by optometrists and private ophthalmologists. The Canterbury DHB is working with the Eye Department and other community providers to find the best way to provide services and capture information.
Improved Diabetes Monitoring: Increasing the proportion of people with diabetes who receive annual checks and the associated primary care.	- The percentage of the expected number of people with diabetes who have been diagnosed with diabetes and had an annual review during the year.	• Māori 50% • Total 78%	• Māori 41.9% *(37.0%)* • Total 76.7% *(69.0%)* Canterbury DHB is working with PHOs, the Diabetes Centre, Diabetes Life Education, and the Local Diabetes Team to improve knowledge and awareness of good self-management of diabetes.

Objective 2003/04	*Performance Measure*	*Performance Targets*	*Results 2003/04* *2002/03*
	- Number of Diabetes Annual Checks	• Total 8,827	• 8,727 *(7,430)* The 2003/04 result is a significant improvement from 2002/03. There were 1,297, or 17.5%, more Annual Checks during 2003/04, which represents 11.4% of the expected number of people with diabetes according to the Ministry of Health Model. As above, Canterbury DHB is working with PHOs, the Diabetes Centre, Diabetes Life Education, and the Local Diabetes Team to improve knowledge and awareness of good self-management of diabetes.
Improved Diabetes Management: Reducing the proportion of people with diabetes who have relatively poor control of their diabetes	The percentage of people having annual diabetes reviews who had poor diabetes control (HBA1c>8%)	• Māori 35% • Total 22%	• Māori 41.9% *(49.0%)* • Total 26% *(27.0%)* The Canterbury DHB has shown improved performance against this measure compared with last year and has continued to seek to achieve these targets but to date these have not been achieved. Initiatives aimed at improving Māori access to primary care and to improved knowledge about the importance of good nutrition and exercise should help the Canterbury DHB meet these targets in the future.

3. Other DHB Measures of Performance

3.1. Elective Services

Objective:	***Brief Description:***
Improved health status for Canterbury's residents via the provision of services in a timely manner within the available resources for those with the greatest level of need. (Medium Term)	Access to outpatients services and elective surgery has been an ongoing issue for Canterbury DHB. The funding and human resources available to the DHB are limited and are not sufficient to meet all of the demand for health services. We must therefore prioritise services. CDHB intends to continue the implementation of the Governments policies in relation to elective services which include: • The provision of timely access to specialist assessment and elective surgery. • The delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress, ill health.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04*** ***2002/03***
Improved access to first specialist assessment. Reduced waiting lists for first specialist assessments so that all appropriately referred patients can be assessed within appropriate timeframes.	Percentage of patients who receive their first specialist assessment within six months of referral	• 100%	• 97.2% *(87.0%)* Of the new patients seen during the year, 95.8% waited less than 6 months, which was a significant improvement over the previous year. This reflects gains made by initiatives aimed at strengthening appropriate referral practices, such as that with the Arthritis Society. The Canterbury DHB will continue to seek to achieve the target level of performance. At the end of the year there were 1,753 people whom we had not seen who had waited longer than 6 months. This reflects approximately two weeks work at current activity levels.
	Delivery of a level of publicly funded First Specialist Assessment (FSA) volumes at the levels specified in the Canterbury DHB 2003/04 District Annual Plan	• 54,400 FSA	• 53,729 FSA The volume of FSAs delivered in 2003/04 was very close to the DAP target. When compared with 2002/03, delivery has increased by 991 FSAs or 2%. Canterbury DHB continues to develop innovative solutions to increase delivery. An example of this is the contract with Canterbury Orthopaedic Services for the provision of orthopaedic FSAs and surgery.

Objective 2003/04	*Performance Measure*	*Performance Targets*	*Results 2003/04* *2002/03*
Improved certainty of treatment: Provide certainty to elective surgical patients as to whether they will/will not receive access to publicly funded surgery. Provide access in a timely manner	Percentage of patients provided with certainty of treatment receiving treatment within 6 months	• 100%	• 84.0% *(92.0%)* Canterbury DHB provided 686 more elective surgical procedures in 2003/04 than in the previous year. In addition CDHB provided 723 more patients with certainty of treatment. Because CDHB promised more people surgery within 6 months performance against this measure has decreased. However, in terms of actual elective surgery provided CDHB's performance has improved upon performance in 2002/03.
	Percentage given certainty: The number of treated patients with certainty as a percentage of all patients receiving elective surgery during the period	• No target established- baseline data collection required	• 78.5% This figure will be used to compare and monitor performance in 2004/05.
Surgical Volume Delivery: Delivery of the level of surgery specified in the Canterbury DHB District Annual Plan	Case weighted discharges delivered as specified in the Canterbury DHB District Annual Plan (Case weighted discharges (cwd) are a relative measure of the cost of different types of surgery- eg cataract procedures have a lower cost weight than hip replacements)	• 34,245 cwd	• 34,547 cwd Canterbury DHB has exceeded the target surgical volume delivery. Note: the target was incorrectly recorded in the Statement of Intent as 32,000cwd.

3.2. Hospital Safety and Effectiveness

Objective:	***Brief Description:***
To be an efficient and effective provider of health services to maximise the health status of Canterbury's residents within the available resources.	The DHB is a major provider of Health Service (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 DHB must ensure that it operates in an effective and efficient manner.

Objective 2003/04	***Performance Measure***	***Performance Targets***	***Results 2003/04*** ***2002/03***
Improved performance as a Good employer. Initiate systems and processes to promote a good working environment that encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management.	Sick Leave Rate (As per balanced scorecard)	• 3.2% of contracted hours	• 3.3% *(3.3%)*
	Work Place Injuries per 1,000,000 hours (As per balanced scorecard)	• 17 per 1 million hours	• 18.1 *(16.3)* The Canterbury DHB is currently working towards entry into the ACC Partnership Programme. An independent audit has been conducted and is with ACC for their final decision. Date of entry into the programme is expected to be 1 October 2004.
	Staff Retention and Turnover (As per balanced scorecard)	• Less than 15% turnover	• 12.4% Target achieved.
Patient Satisfaction	Inpatient – Overall Satisfaction Percentage of good or very good responses in patient survey	• Greater than 85%	• 89% Target achieved
	Outpatient – Overall Satisfaction Percentage of good or very good responses in patient survey	• Greater than 85%	• 90% Target achieved

Objective 2003/04	Performance Measure	Performance Targets	Results 2003/04 / 2002/03
Improved Quality. Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals. (Long term)	Maintain accreditation at Ashburton, Akaroa, Waikari, Darfield, Burwood and Christchurch Women's Hospitals. Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services	100% of facilities maintain current accreditation status On target for accreditation as follows: ▪ Kaikoura and Oxford first survey Nov 2003 ▪ Christchurch Survey October 2004 ▪ Mental Health and Older Persons Health Survey October 04	The Canterbury DHB has achieved this target. The accreditation status of these facilities is as follows: • *Ashburton & Community Health Services* In December 2003, the Community Hospitals (Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari) were surveyed by Quality Health NZ for accreditation and certification. At the same time, Ashburton Hospital had a progress visit. (They were last surveyed in May 2002 by Quality Health NZ). The progress visit also involved a certification audit against the Health and Disability Sector Standards. In April 2004, Quality Health NZ confirmed certification for Ashburton & Community Health Services. • *Burwood Hospital* Burwood Hospital was surveyed by Quality Health NZ for accreditation and certification on the 27th – 29th April 2004. They are currently awaiting their results. Their first accreditation survey was in March 2001. • *Christchurch Hospital & Corporate Services* Christchurch Hospital (including Corporate Services) were surveyed by Quality Health NZ for their first accreditation survey and certification audit on 21st – 25th June 2004. They are currently awaiting their results • *Mental Health Services (MHS) & The Princess Margaret Hospital (TPMH)* The Princess Margaret Hospital and Mental Health Services combined accreditation survey and certification audit occurred during 25th – 28th May 2004. This was their first survey. They are currently awaiting their results. • *Women's Health Division (WHD)* Quality Health NZ confirmed the continued Accreditation status for Women's Health Division facilities and services. This is the second three-year Accreditation cycle successfully completed by WHD and includes the following facilities: Christchurch Women's Hospital, Rangiora Hospital, Lincoln Hospital, Lyndhurst Hospital, and the Burwood Birthing Unit (not part of the WHD at the time of the 2000 Accreditation scope). • *Laboratory and Support Services* Canterbury Laboratories has been accredited with IANZ (ISO: 15189) since 1994. They were audited last in June 2004.

Objective 2003/04	*Performance Measure*	*Performance Targets*	*Results 2003/04* *2002/03*
Maintain appropriate levels of Clinical Quality within CDHB Hospitals	Hospital Acquired Bacteraemia Rate per 100 inpatient days (Burwood, Christchurch, Womens & TPMH Hospitals) (Note: excludes Ashburton Hospital due to data collection issues)	• 0.54 infections per 100 inpatient days	• 0.12 *(0.50)* Target achieved. The Canterbury DHB has showed vast improvement on performance against this indicator and has achieved a rate far lower than that recorded in recent years.
	IV Medication Error Rate per 1000 inpatient days (Ashburton, Burwood, Christchurch, Womens and TPMH Hospitals and Mental Health Services)	• 1.5 errors per 1000 inpatient days	• 1.98 *(1.38)* The 2003/04 year reflects the first year that Older Person's Health and Mental Health Services have been included for this measure. This, in addition to better reporting, has meant that the reported error rate has increased. All incidents of medication errors with the Canterbury DHB are investigated and reviewed by divisional incident review groups.
	Patient Falls per 100 inpatient days (Ashburton, Burwood, Christchurch, Womens & TPMH Hospitals, and Mental Health Services)	• 5.6 falls per 100 inpatient days	• 5.2 Target achieved

4. Summary of Revenues and Expenses by Output Class

	Funding	Governance & Funding Admin	Provider	In-House Elimination	Total District Health Board
	$'000	$'000	$'000	$'000	$'000
Revenue					
MoH Revenue	753,584	3,267	500,876	(446,365)	811,362
Patient Related Revenue			24,462		24,462
Other		1	13,656		13,657
Total Revenue	753,584	3,268	538,994	(446,365)	849,481
Expenditure					
Personnel		1,994	344,916		346,910
Depreciation		2	32,652		32,654
Interest			4,035		4,035
Capital Charge			23,306		23,306
Other	749,814	1,202	139,166	(446,365)	443,817
Total Expenditure	749,814	3,198	544,075	(446,365)	850,722
Net Surplus/(Deficit)	3,770	70	(5,081)	-	(1,241)

5. Glossary of Terms

Accreditation	Achievement against a national system of standards.
Angioplasty	An angioplasty is a noninvasive 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.
Ambulatory Sensitive Admissions	Admissions that are potentially preventable by appropriate primary care.
Audit	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation.
Cardiac	Relating to the heart
CWD - Cost Weighted Discharges	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.
FTE	Full time equivalent
Inequality (health)	Difference in health relative to the local community or wider society to which an individual, family or group belongs.
PHO – Primary Health Organisation	Primary Health Organisations are made up of General Practitioners, nurses, and other primary health providers, and are responsible for achieving improved health outcomes for their enrolled populations.

Audit New Zealand

AUDIT REPORT

TO THE READERS OF CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2004

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, K J Boddy, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health Board and group, on his behalf, for the year ended 30 June 2004.

Unqualified opinion

In our opinion the financial statements of the Health Board and group on pages 14 to 56:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health Board and group's financial position as at 30 June 2004;
  - the results of operations and cash flows for the year ended on that date; and
  - the service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 11 October 2004, and is the date at which our opinion is expressed.

The basis of the opinion is explained below. In addition, we outline the responsibilities of the Board and the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed our audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in the opinion.

Our audit involved performing procedures to test the information presented in the financial statements. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements.

We evaluated the overall adequacy of the presentation of information in the financial statements. We obtained all the information and explanations we required to support the opinion above.

Responsibilities of the Board and the Auditor

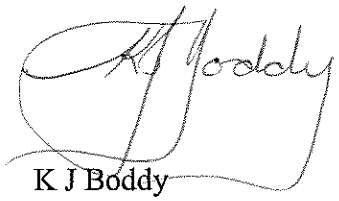
The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2004. They must also fairly reflect the results of operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

Other than the audit, we have no relationship with or interests in the Health Board or any of its subsidiaries.



K J Boddy
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

APPENDIX 5

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Canterbury District Health Board

Report For the Year Ended
30 June 2005

Table of Contents

DIRECTORY

Board Members

Syd Bradley – Chair
Robin Booth
Heather Carter (appointed 6 December 2004)
Norman Dewes
Neville Fagerlund (appointed 6 December 2004)
Karen Guilliland
Randall Allardyce (until 5 December 2004)
Alister James (appointed 6 December 2004)
Jo Kane (appointed 6 December 2004)
Laurence Malcolm (appointed 6 December 2004)
Philip Bagshaw (until 5 December 2004)
Graham Heenan (until 5 December 2004)
David Morrell
Olive Webb
Alison Wilkie (until 5 December 2004)

Chief Executive

Karleen Edwards (Interim Chief Executive Officer)

Registered Office

Charles Luney House
250 Oxford Terrace
PO Box 1600
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Westpac

MISSION STATEMENT

The Canterbury DHB's mission is to improve, promote and protect the health of the people in the community and foster the well-being and independence of people with disabilities and reduce disparities.

BOARD MEMBERS

Syd Bradley - Chair	Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB and DHBNZ. Syd has served on a number of boards since resigning as General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.
Robin Booth	Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
Heather Carter	Heather Carter is devoted to accessible and affordable health care for all New Zealanders. Heather runs LifeMasters, a personal development and workplace counselling consultancy. In addition, Heather serves on the Council of CPIT, the Federation of Graduate Women and Health Cuts Hurt (a group aimed at improving healthcare for people of Canterbury).
David Morrell	David Morrell was City Missioner in Christchurch from 1982 to 2005 and has had over 30 years involvement with general health and mental health through hospital chaplaincy, primarily at Christchurch Hospital during the 1970s and subsequently at the City Mission. David has had extensive management training, both here and in the United Kingdom. David is also Chair of Brackenridge Estate Limited.
Neville Fagerlund	Neville Fagerlund is a Chartered Accountant in Public Practice with over 25 years experience. He has provided financial and commercial advice to Pegasus Health Ltd since its inception in 1993 and advises The 24-Hour Surgery Ltd. Neville is a Director of Cambridge Clinic Ltd, a charitable company in the health arena.
Olive Webb – Deputy Chair	Olive Webb is a clinical psychologist and has more than 30 years experience working in the disability sector, particularly with people with intellectual disabilities. Based in Hororata, Olive has a focus on rural health issues and delivery. She provides clinical consultancy to IHC, is an adviser to Richmond Fellowship, and also consults in the Mental Health sector.
Alister James	Alister James is a barrister in private practice and a Board member of the Legal Services Agency. He is also the Honorary British Consul in Christchurch and spent more than 20 years in local Government as a Christchurch City Councillor. With a strong involvement in the community and voluntary sector, Alister has a particular interest in community health issues. His involvement in the pilot Youth Drug Court and the Youth Court itself has led to an interest in adolescent and alcohol and drug services.

/ continued /

BOARD MEMBERS - continued

Karen Guilliland	Karen Guilliland is Chief Executive of the New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the PHARMAC Board and Deputy Chairperson of the Health Workforce Advisory Committee.
Jo Kane	Jo Kane is a Waimakariri District Councillor and Deputy Mayor, who believes in the basic right to protect health and well being for all.
Laurence Malcolm	Laurence Malcolm is a medical graduate, Professor Emeritus and former Professor of Community Health at the Wellington School of Medicine. He currently works as a consultant in health services research and development, is a member of the Council and Executive of Age Concern Canterbury, and has been on many national and international boards and committees. He has a special interest in primary health care and the quality of clinical services.
Norman Dewes	Norm Dewes is the Chief Executive of the urban Maori authority based in Canterbury. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the year ended 30 June 2005.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based district health board, which provides Health and Disability Support Services, principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB Group recorded a net surplus of $0.361 million against a budgeted breakeven position. (2003/04 actual deficit was $1.241 million).

BOARD FEES

Board fees paid, or due payable, to Board and Committee Members for services during the year, were as follows:

	Board Fees Year ended 30/06/05 $'000	Committee Fees Year ended 30/06/05 $'000
Syd Bradley	48	3
Randall Allardyce*	10	1
Philip Bagshaw*	10	1
Robin Booth	24	1
Heather Carter*	14	2
Norman Dewes	24	2
Neville Fagerlund*	14	3
Karen Guilliland	24	3
Graham Heenan*	10	2
Alister James*	14	2
Jo Kane*	14	2
Laurence Malcolm*	14	2
David Morrell	24	5
Olive Webb	30	2
Alison Wilkie*	10	3
Julie Barlass*	-	1
Richard Buchanan*	-	-
Ruth Jones	-	1
David Kerr	-	2
Raymond Kirk*	-	1
Winston McKean*	-	1
Sandra McLean*	-	1
Christopher Mene*	-	1
John Musgrove*	-	1
Pauline O'Connor*	-	1
Fiona Pimm*	-	1
Suzanne Pitama*	-	1
Trevor Read*	-	1
Rodney Routledge*	-	1
Jeanette Tarbotton*	-	1
William Tate*	-	1
Susanne Trim*	-	1
Stephanie Waterfield*	-	-
Gloria Weeks*	-	1
	284	**52**

* resigned or appointed during the year

Total fees paid for the year were $336,000 (2003/04 - $305,000). The limit of fees authorised for the year ended 30 June 2005 was $384,000 (2003/04 - $384,000).

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the year were as follows:

	Year Ended 30/06/05 $'000
Graham Heenan	13
David Morrell	10
	23

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the Interest Register:

CANTERBURY DHB

Syd Bradley	Chair - DHBNZ Observer - PHARMAC Board Chair - Christchurch International Airport Co Limited Director - Lincoln Holding Company Ltd Director - McLean Institute Chair - Waipara Hill Wine Estate
Randall Allardyce	Adjunct academic appointee – University of Canterbury Employee providing services to Canterbury DHB – University of Otago Founder, Director and Trustee - Academy of Endosurgery, Christchurch Founder and Member of Planning and Advisory Committee - Christchurch Clinical Skills Educational Facility Member - New Zealand Liver Transplant Advisory Group to Ministry of Health Member of Advisory Board - Mobile Medical Technology (NZ) Surgical Services Limited Chief Co-ordinator, Medical Projects - Syft Technologies Limited Director - Tryst Consulting Limited Wife, Joan Allardyce, General Practitioner - Director of Student Health at the University of Canterbury
Philip Bagshaw	Chair – Council of Medical Colleges Elected Member – New Zealand National Board, Royal Australasian College of Surgeons Employee providing services to Canterbury DHB – University of Otago Founder, Director and Trustee - Academy of Endosurgery, Christchurch Member - Canterbury Medical Library Collection Review Committee Chair - Council of Medical Colleges Advisory Board Member - Mobile Surgical Services Limited Elected member - New Zealand National Board, Royal Australasian College of Surgeons Chair - New Zealand Liver Transplant Advisory Group to Ministry of Health Other various academic, clinical practice, and patient support groups and committees Red Star Films and Digital Video Productions Ltd - Shareholder Wife, Sue Bagshaw, is a medical practitioner active in areas of youth and adolescent health, sexual health and health education
Julie Barlass	Member - Ashburton District Health Committee

Robin Booth	Member - Shirley Papanui Community Board (until October 2004)
Richard Buchanan	Employee - CCS Canterbury West Coast Board Member - TimeOut Carers
Heather Carter	Council Member - Christchurch Polytechnic Institute of Technology Company Owner and Consultant - LifeMasters President - National Council of Women, Canterbury Branch
Norman Dewes	CEO – Te Runanga O Nga Maata Waka Chairman - Te Rito Arahi Maori Alcohol, Drug and Resource Centre Board Member/Vice Chair - Canterbury Community Primary Health Organisation Director - Te Amorangi Richmond Wellness Village Board Member - New Zealand Advertising Standards Authority Advisory Committee Member (Maori) - Canterbury Museum Board Member/Vice Chair - Canterbury Community Primary Health Organisation Chair - Otautahi Social Services Chair - Maori Legal Services Secretary - Te Runanga O Ngati Kahungunu ki Waitaha Council Member - Christchurch Polytechnic Institute of Technology Chair - Capital Planning and Development Committee Member - Polytechnic Midwifery Member - Canterbury Communications Trust (Broadcasting)
Neville Fagerlund	Director - Cambridge Clinic (DSAC) Limited Advisor - Pegasus After Hours Limited Advisor - Pegasus Health (Charitable) Advisor - Pegasus Health Membership Limited (and associate companies) Advisor - 24-Hour Surgery Limited
Karen Guilliland	CEO – New Zealand College of Midwives Director – Midwifery and Maternity Provider Organisation Limited Board Member - PHARMAC Member - Advisory Group to Minister of Health Member - Maternal and Newborn Information Systems Advisory Group Deputy Chair - Health Workforce Advisory Committee Consultant - Parents Centre NZ
Graham Heenan	Chair - Canterbury Laundry Service Ltd Chair - South Island Shared Services Agency Ltd Deputy Chair - Hanmer Springs Thermal Reserve
Alister James	Barrister and Youth Advocate (approved pursuant to Section 323 of the Children, Young Persons and Their Families Act 1989) Chair - Home Made Partnership Trust (Christchurch Supergrans) Honorary British Consul Member - Legal Services Agency Board (Crown Entity) Trustee - Nga Hau e Wha National Marae Trustee - Pegasus Employment and Environmental Trust (PEEPS Trust) Spouse is an employee with Community and Public Health, Canterbury District Health Board
Ruth Jones	Regional Services Co-ordinator - New Zealand CCS
David Kerr	Advisor - Pegasus Health Chairman - Ryman Healthcare Ltd Chair - Centrecare Limited General Medical Practitioner Trustee - Health Education Trust Advisor - Medical Protection Society
Ray Kirk	Director - New Zealand Health Technology Assessment Unit (NZHTA) Co-director - New Zealand Centre for Evidence-Based Research into Complementary and Alternative Medicine (ENZCAM), Department of Health

	and General Practice, Christchurch School of Medicine and Health Sciences, University of Otago
Laurence Malcolm	Consultant - Aotearoa Health Limited Member - Age Concern Canterbury, Council and Executive
Sandy McLean	Employee – Waka Tapu
Winston McKean	Panel Member - Human Rights Review Tribunal Chair - National Taskforce on Primary Health Care and PHO Development Chair - Rural Canterbury Primary Health Organisation
Chris Mene	Elected Member - Heathcote-Spreydon Community Board
David Morrell	Chair – Brackenridge Estate Limited Committee Member- Anglican Aged Care Member - Environment Canterbury, Christchurch Area Committee
John Musgrove	Board of Governors - Windsor House
Fiona Pimm	Board Member - South Canterbury DHB CEO - He Oranga Pounamu Charitable Trust Nga Hau E Wha Marae Director – Public Trust
Trevor Read	Manager, Patient Safety - ACC Establishment Programme
Rodney Routledge	Team Leader – Anglican Care
Jeanette Tarbotton	Member of Advisory Board - National Centre for Rural Health
Susanne Trim	Professional Nursing Advisor - New Zealand Nurses' Organisation Casual Employee - Nurse Maude Association
Stephanie Waterfield	Director - Smith City Group of Companies Health Consultancy
Olive Webb	Clinical Consultant – Richmond Fellowship Member - Health Practitioners Disciplinary Tribunal Health Consultant - IHC New Zealand Director - Institute of Applied Human Services Director - Access Home Health
Gloria Weeks	Secretary and Treasurer - Association of Blind Citizens, Canterbury Branch President - Disabled Person's Assembly, Christchurch Districts Member - Human Rights Commission Network Speaking Group
Alison Wilkie	Trustee - Family Help Trust Member - Pharmaceutical Society of New Zealand Inc, National Executive Board Member - Pharmaceutical Society of New Zealand Limited Trustee - Riccarton Bush Trust - Shareholder interest - Calan Healthcare

SUBSIDIARY AND ASSOCIATED COMPANIES

Garth Bateup	Director of subsidiaries Brackenridge Estate Limited and Canterbury Laundry Service Limited. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Paul Numan	Director of subsidiary, Brackenridge Estate Limited. No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.
Wei Yoon	Director of associate company New Zealand Centre for Reproductive Medicine Limited. No directors fees or any other benefits were received from the associate company except as an employee of Canterbury DHB.

DIRECTORS' AND BOARD MEMBERS' LOANS

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensure that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

USE OF BOARD OR SUBSIDIARIES' INFORMATION

During the year, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place, eg: amounts for redundancy (based on length of service), and payment in lieu of notice etc.

The total payments listed of $211,900 comprise negotiated settlements with all of the former employees.

Number of Employees	TOTAL $
1	22,013
1	22,449
1	39,438
1	128,000
4	**211,900**

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands is as follows:

	30/06/05 Number	30/06/04 Number
$100,000 - $110,000	51	51
$110,001 - $120,000	40	41
$120,001 - $130,000	28	32
$130,001 - $140,000	30	23
$140,001 - $150,000	28	27
$150,001 - $160,000	20	29
$160,001 - $170,000	24	20
$170,001 - $180,000	16	23
$180,001 - $190,000	21	17
$190,001 - $200,000	24	14
$200,001 - $210,000	20	11
$210,001 - $220,000	11	7
$220,001 - $230,000	6	3
$230,001 - $240,000	5	2
$240,001 - $250,000	2	2
$250,001 - $260,000	3	-
$260,001 - $270,000	1	-
$280,001 - $290,000	2	-
$300,001 - $310,000	1	-
$390,001 - $400,000[1]	-	1
$400,011 - $410,000[1]	1	-
	334	**303**

Of the 334 positions identified above, 304 (2003/04 - 274) were predominantly clinical and 30 (2003/04 - 29) positions were management/administrative.

[1] CEO remuneration and other benefits are included in these brackets.

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STATUTORY DISCLOSURE

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000;

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000; and

(c) a report on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2005, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 37.

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	**Extent objectives met**
(a) to improve, promote, and protect the health of people and communities:	The CDHB planning in service development involves stakeholders in the primary care, secondary care, community service providers, public health groups and other government agencies, as appropriate. The CDHB funds and delivers a range of services from health promotion and protection services, primary care to specialist tertiary services to meet the needs of its population. The seven key areas of focus were He Korowai Oranga, NZ disability strategy, elective services and radiotherapy waiting times, diabetes, inequalities, primary care and the Mental Health Blueprint.
(b) to promote the integration of health services, especially primary and secondary health services:	The CDHB is continuing to develop a Community and Primary Health Care Plan to improve population health and improve access to primary care. The four Primary Health Organisations (PHOs) established by the CDHB together with public health programmes designed to meet local needs will assist in achieving this plan. The CDHB has established an integrated service planning framework, incorporating disease prevention and management and working with the public health and primary care sectors. This will help to address issues such as chronic diseases - respiratory and cardiac illnesses, and diabetes. The CDHB has developed a full health needs assessment policy on ethnicity data collection and improving communication between primary and secondary health sectors. The CDHB is currently embarking on a project called Improving the Patient Journey. This is a major CDHB initiative to improve the quality and effectiveness of the service we provide to patients.

(c)	to promote effective care or support for those in need of personal health services or disability support services:	The CDHB is developing an Older People's Health Strategy entitled "Healthy Ageing, Integrated Support". The strategy has arisen from the CDHB's need to plan how it will fund and deliver quality services to older people within Population Based Funding and implement the Ministry of Health's Health of Older People's Strategy by 2010. The underlying objective is to maintain older people's independence for as long as possible, reduce the period and level of dependence and at the same time provide effective, integrated services when they are required.
(d)	to promote the inclusion and participation in society and independence of people with disabilities:	The CDHB aims to ensure it contributes to a 'non disabling' society through its actions, and the actions of the providers with whom it contracts. The CDHB has developed a Disability Strategic Action Plan (DSAP) that outlines the steps it is making to implement the NZ Disability Strategy. The DSAP involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring. All new building developments are assessed for meeting the needs of people with disabilities.
(e)	to reduce health disparities by improving health outcomes for Maori and other population groups:	The CDHB has produced and implemented its Maori Health Action Plan. The key focus of this is He Korowai Oranga and key objectives include improving ethnicity data collection, reducing health inequalities and supporting Maori health workforce development. The CDHB is continuing with the development of the Pacific People's Health Action Plan which focuses on supporting Pacific People as healthworkers, involving Pacific People in health service development and actively collecting ethnicity data.
(f)	to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The CDHB Health Needs Assessment has identified groups in the community, which have health inequalities. Strategic Plan health gain priority areas (eg, Child and Youth, Maori) have been identified as part of this process.
(g)	to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The CDHB continues to enhance relationships with the community, health providers and social agencies such as Age Concern, Child Youth and Family, Kai Tahu and the Christchurch City Council. The CDHB is also working with Territorial Local Authorities to plan for health and social services as outlined in the Local Government Act 2002.
(h)	to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	The CDHB actively participates in forums such as Healthy Christchurch, Elder Care Canterbury, Maori Hui, DHBNZ and Diabetes. Information gathered from these forums assists the service planning process. The CDHB has engaged in an active consultation through formal processes (eg for the strategic plan) and sector representation on project steering groups.

(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	The CDHB has established a Quality and Patient Safety Council and a Clinical Board to provide advice to the CEO on quality and clinical issues. The Quality and Patient Safety Council is a forum for the wider DHB (eg community providers) to discuss quality issues. This also facilitates ongoing quality improvement processes. The CDHB also has processes in place to maintain and improve quality including Quality Health New Zealand accreditation process for its hospitals and performance targets and measures to maintain appropriate levels of clinical quality. The Clinical Board has a strong focus on clinical governance and has a solution oriented proactive role in the setting of clinical policy and standards and encourages best practice and innovation. The Board supports the organisation's vision and values and will set a leadership role by example.
(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	The CDHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme.
(k) To be a good employer	The CDHB has established and will continue to develop relationships with its health workers and those in the community to build a workforce that meets the health and disability needs of its community. This includes addressing challenges such as staff shortages in some areas, staff needs for ongoing career development, staff participation in decision-making, and creating a family-friendly environment. In 2005 the CDHB was chosen as a finalist in the Canterbury Champion Awards (for enterprise and excellence) in the medium to large enterprise category. This category recognises the smartest provider of professional service, infrastructure or utilities.

Section 42(3)(i): Statement of how CDHB has given effect and intends to give effect to its functions specified in section 23 (b) – (e)	
Function:	**What has been done to meet function**
(b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	• The CDHB has involved stakeholders in delivery of Core Directions and health gain priority areas for the CDHB Strategic Plan. • The CDHB actively involves relevant groups and individuals in planning specific service areas. • The CDHB has established joint arrangements with external providers for some provision of orthopaedic and cardiac surgery services. • The CDHB works with the Ministry of Health in a number of joint/collaborative ways such as Public (Population) Health shared decision making; and the allocation of the Maori and Pacific Health development fund. • The CDHB continues to implement the District Strategic Plan and to develop the Strategic Plan for the next five years.

(c)	to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):	• The CDHB uses a variety of written media, TV and radio work to outline general issues and priorities and the community. • The CDHB will continue to respond directly to media / personal / group enquiries. • The CDHB circulates / makes available significant documents / plans for population in summary and comprehensive form either at libraries, via groups or individually. • The CDHB involves sector representatives in steering groups leading the planning for health services. • The CDHB has developed a website, which includes community based health information. • The CDHB continues to provide health promotion services funded by the Ministry of Health.
(d)	to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:	Relationships with Manawhenua Ki Waitaha, Te Runanga and Nga Maata Waka continue to develop. Maori community hui are held quarterly and regular meetings with Maori providers and other Maori community organisations. The outcomes of these meetings are fed directly into the CDHB planning process.
(e)	to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori:	The CDHB has established Te Kahui Taumata, which includes the Kaumatua and Taua, the Executive Director Maori and Pacific Health, and senior Maori staff who provide Maori specific advice to the Chief Executive.

For and on behalf of the Board

Syd Bradley
Chair
26 September 2005

Olive Webb
Deputy Chair
26 September 2005

STATEMENT OF RESPONSIBILITY

Pursuant to Section 42 of the Public Finance Act 1989, we acknowledge that:

a) The preparation of financial statements of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2005, are our responsibility.

c) In our opinion, the financial statements for the year under review fairly reflect the financial position and operations of Canterbury DHB.

Syd Bradley
Chair
26 September 2005

Karleen Edwards
Interim Chief Executive Officer
26 September 2005

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Group			Parent	
		Actual 30/06/05 $'000	Budget 30/06/05 $'000	Actual 30/06/04 $'000	Actual 30/06/05 $'000	Actual 30/06/04 $'000
OPERATING REVENUE						
Ministry of Health Revenue		900,187	856,333	811,362	893,545	805,320
Patient Related Revenue		27,851	24,074	24,462	27,795	23,862
Other Revenue		14,550	13,255	13,657	13,268	12,841
TOTAL REVENUE	21	942,588	893,662	849,481	934,608	842,023
OPERATING EXPENSES						
Employee Costs		369,683	353,661	346,910	362,441	340,029
Treatment Related Costs		98,947	90,436	90,207	102,148	93,248
External Service Providers		353,053	335,898	299,921	353,053	299,921
Depreciation	11	39,519	34,419	32,652	38,570	31,663
Interest Expense		4,183	5,236	4,035	4,183	3,987
Other Expenses		55,062	50,612	53,689	52,489	51,436
TOTAL OPERATING EXPENSES	21	920,447	870,262	827,414	912,884	820,284
OPERATING SURPLUS BEFORE CAPITAL CHARGE		22,141	23,400	22,067	21,724	21,739
Capital Charge Expense		(21,862)	(23,400)	(23,306)	(21,862)	(23,306)
SURPLUS/(DEFICIT) BEFORE TAXATION	2	279	-	(1,239)	(138)	(1,567)
Tax Benefit / (Expense)	3	82	-	(2)	-	-
NET SURPLUS / (DEFICIT) FOR THE YEAR		**361**	-	**(1,241)**	**(138)**	**(1,567)**

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

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

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2005

	Notes	Group			Parent	
		Actual as at 30/06/05 $'000	Budget as at 30/06/05 $'000	Actual as at 30/06/04 $'000	Actual as at 30/06/05 $'000	Actual as at 30/06/04 $'000
CROWN EQUITY						
General Funds	5	148,174	159,174	148,174	148,312	148,312
Revaluation Reserve	5	77,717	77,717	77,717	77,717	77,717
Retained Earnings	5	(34,591)	(34,200)	(34,326)	(35,734)	(34,740)
Trust Reserve	5	8,405	7,394	7,779	8,308	7,452
TOTAL EQUITY		**199,705**	**210,085**	**199,344**	**198,603**	**198,741**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and Bank	9	10,109	154	-	9,682	-
Receivables and Prepayments	4	16,341	20,488	27,476	15,795	27,074
Stocks	6	6,594	7,000	6,806	6,543	6,751
TOTAL CURRENT ASSETS		33,044	27,642	34,282	32,020	33,825
CURRENT LIABILITIES						
Bank Overdraft	9	-	-	835	-	1,446
Creditors and Accruals		74,361	69,709	68,281	74,215	68,080
Owing to the Ministry of Health		7,371	5,700	5,810	7,371	5,810
Staff Entitlements due within 1 year	7	44,389	28,500	38,035	43,554	37,404
Provisions due within 1 year	12	22,540	14,000	14,722	22,540	14,623
Loans due within 1 year	9	-	-	42,600	-	42,600
TOTAL CURRENT LIABILITIES		148,661	117,909	170,283	147,680	169,963
NET WORKING CAPITAL		(115,617)	(90,267)	(136,001)	(115,660)	(136,138)
NON CURRENT ASSETS						
Investments	10	311	378	292	1,829	2,196
Fixed Assets	11	382,467	394,051	375,137	379,665	372,758
Surplus Property		9,300	2,800	9,300	9,300	9,300
Restricted Assets	8	8,405	7,394	7,779	8,308	7,452
TOTAL NON CURRENT ASSETS		400,483	404,623	392,508	399,102	391,706
NON CURRENT LIABILITIES						
Provisions	12	6,511	4,271	5,113	6,189	4,827
Deferred Tax	3	-	-	50	-	-
Loans repayable after 1 year	9	78,650	100,000	52,000	78,650	52,000
TOTAL NON CURRENT LIABILITIES		85,161	104,271	57,163	84,839	56,827
NET ASSETS		**199,705**	**210,085**	**199,344**	**198,603**	**198,741**

For and on behalf of the Board

Syd Bradley
Chair
26 September 2005

Olive Webb
Deputy Chair
26 September 2005

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Group Actual 30/06/05 $'000	Group Budget 30/06/05 $'000	Group Actual 30/06/04 $'000	Parent Actual 30/06/05 $'000	Parent Actual 30/06/04 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		905,739	856,333	845,726	898,843	838,385
Other Receipts		46,670	35,079	32,062	45,590	30,608
Interest Received		1,268	279	595	1,384	682
		953,677	891,691	878,383	945,817	869,675
Cash was applied to:						
Payments to Employees		354,144	353,161	335,069	347,012	328,338
Payments to Suppliers		498,730	477,446	450,281	499,337	451,126
Interest Paid		4,023	5,415	4,345	4,023	4,297
Taxes Paid		-	-	3	-	-
Capital Charge		20,301	23,400	21,166	20,301	21,166
GST - net		1,934	-	(1,959)	1,949	(1,917)
		879,132	859,422	808,905	872,622	803,010
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	13	74,545	32,269	69,478	73,195	66,665
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of Assets		70	9,000	2,132	70	2,132
Decrease in Investments		-	-	-		1,214
		70	9,000	2,132	70	3,346
Cash was applied to:						
Increase in Investments & Restricted Assets		645	-	299	489	-
Purchase of Assets		47,076	61,000	52,071	45,698	51,040
		47,721	61,000	52,370	46,187	51,040
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(47,651)	(52,000)	(50,238)	(46,117)	(47,694)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		-	20,000	52,000	-	52,000
		-	20,000	52,000	-	52,000
Cash was applied to:						
Loans Repaid		15,950	-	56,780	15,950	56,780
Equity repaid to Crown		-	-	11,000	-	11,000
		15,950	-	67,780	15,950	67,780
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(15,950)	20,000	(15,780)	(15,950)	(15,780)
Overall Increase/(Decrease) in Cash Held		10,944	269	3,460	11,128	3,191
Opening Cash Balance		(835)	(115)	(4,295)	(1,446)	(4,637)
CLOSING CASH BALANCE		**10,109**	**154**	**(835)**	**9,682**	**(1,446)**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2005

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Public Finance Act 1989.

The group currently consists of Canterbury DHB, its subsidiaries Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entities, New Zealand Centre for Reproductive Medicine Ltd (50% owned) and South Island Shared Services Agency Ltd (47% owned).

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain fixed assets.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Funding for health related services received from the Ministry of Health by the Funder arm of Canterbury DHB is recognised as revenue in the financial year. Revenue from other contracts for services where funding is still the responsibility of the Ministry of Health, is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of Canterbury Health Ltd. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of Canterbury DHB

Assets acquired by the DHB since its establishment are recorded at cost except for land, buildings and fitout plant and equipment that are revalued every five years. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of land, buildings and fitout plant and equipment

Land, buildings and fitout plant and equipment are revalued every five years. The fair value of land, buildings and fitout plant and equipment is determined by an independent registered valuer by reference to the highest and best use of these assets or, if sufficient market based evidence is not available, by reference to their depreciated replacement cost. Additions between revaluations are recorded at cost. The results of revaluing land, buildings and fitout plant and equipment are credited or debited to the assets revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

Donated Assets

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

iv) Depreciation

Depreciation is charged on a straight line basis so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	20 - 50
Leasehold Building & Fitout	3 - 20
Fitout Plant and Equipment	5 - 50
Plant and Equipment (incl pool)	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) Goods and Services Tax

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) Stocks

Stocks are valued at the lower of cost and net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

vii) Accounts Receivable

Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

vii) Investments

The investment in the associate companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis.

Other investments are stated at the lower of cost and net realisable value.

Dividend and interest income is accounted for on an accrual basis.

ix) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

In prior years, Canterbury DHB subsidiaries were subject to income tax, with the exception of Brackenridge Estate Ltd. From the beginning of this financial year Canterbury Laundry Service Limited is also exempt from income tax under Section CB3 of the Income Tax Act 1994. Previously, income tax expense was charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. The tax provisions have been reversed following the tax exempt status given to Canterbury Laundry Service Limited.

x) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xi) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as finance leases and the related lease assets are capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected economic lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiii) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xiv) Provision for Staff Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, parental leave, conference leave, and sabbatical leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xv) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non current securities and advances (other than securities and advances included within cash) and any other non current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvi) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xvii) Financial Instruments

Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost and market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xviii) Basis of Consolidation

The consolidated financial statements include the parent DHB and its subsidiaries. The subsidiaries are accounted for by adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis which shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

D CHANGE IN ACCOUNTING POLICIES

There have been no changes in accounting policies during the year. All policies have been applied on a basis consistent with the previous period.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating deficit is stated:	Group		Parent	
	30/06/05 $'000	30/06/04 $'000	30/06/05 $'000	30/06/04 $'000
After Charging:				
Remuneration of Auditor:				
- Audit Fees	148	140	127	120
- Other Services	-	-	-	-
Board Members' Fees	284	252	284	252
Directors' Fees	23	19	-	-
Interest Expense	4,183	4,035	4,183	3,987
Bad Debts Written Off	589	518	589	518
Increase/(Decrease) in Bad Debts Provision	(649)	626	(649)	616
Rental and Operating Lease Costs	3,438	3,751	2,991	3,263
After Crediting:				
Interest Income	1,406	595	1,384	682
Gain (loss) on Disposal of Assets	(157)	1,029	(151)	1,029

3. TAXATION

The DHB and its subsidiaries are exempt from income tax. Tax provisions made by subsidiaries in previous years are no longer applicable and were reversed in the 2004/05 financial year.

	Group	
	30/06/05 $'000	30/06/04 $'000
Net Operating Surplus/(Deficit) before Taxation	361	(1,239)
Prima facie taxation @ 33%	-	(409)
Plus/(Less) tax effect of:		
Permanent Differences	-	411
Timing Differences not recognised	-	-
Reversal of tax in previous year	(82)	-
Tax Expense / (Benefit)	(82)	2
Comprising:		
Current Tax	(32)	30
Deferred Tax	(50)	(28)
	(82)	2
Deferred Tax Liability		
Opening Balance	50	78
Current Year Movement	(50)	(28)
Closing Balance	-	50

4. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Trade Debtors	6,644	10,315	6,540	10,224
Receivable from the Ministry of Health	8,880	14,074	8,522	13,820
Other Debtors	310	2,534	264	2,491
Prepayments	507	553	469	539
	16,341	27,476	15,795	27,074

5. EQUITY

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
GENERAL FUNDS				
Opening Balance	148,174	159,174	148,312	159,312
Equity contribution from Crown/(Repayment)	-	(11,000)	-	(11,000)
	148,174	148,174	148,312	148,312
RETAINED EARNINGS				
Opening Balance	(34,326)	(32,700)	(34,740)	(32,800)
Operating Surplus/(Deficit)	361	(1,241)	(138)	(1,567)
Transfers from/(to) Trust Reserve	(626)	(385)	(856)	(373)
Closing Balance	(34,591)	(34,326)	(35,734)	(34,740)
Represented by :				
Accumulated Deficit in Parent and Subsidiary	(34,669)	(34,404)	(35,812)	(34,818)
Accumulated Surplus in Associates	78	78	78	78
	(34,591)	(34,326)	(35,734)	(34,740)
REVALUATION RESERVE				
Opening Balance	77,717	77,717	77,717	77,717
Current Year Movement	-	-	-	-
Closing Balance	77,717	77,717	77,717	77,717

Represented by:				
Revaluation of land	27,531	27,531	27,531	27,531
Revaluation of freehold buildings	656	656	656	656
Revaluation of fitout plant and equipment	48,540	48,540	48,540	48,540
Revaluation of reversionary interest in	990	990	990	990
	77,717	77,717	77,717	77,717

TRUST RESERVE

Opening Balance	7,779	7,394	7,452	7,079
Transfers from/(to) Retained Earnings	626	385	856	373
Closing Balance	8,405	7,779	8,308	7,452

6. STOCKS

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Pharmaceuticals	2,366	2,226	2,366	2,226
Surgical and Medical Supplies	3,399	3,605	3,399	3,605
Other Supplies	1,700	1,689	1,649	1,634
	7,465	7,520	7,414	7,465
Provision for Obsolescence	(871)	(714)	(871)	(714)
	6,594	6,806	6,543	6,751

Some of the stocks may be subject to restriction of title ie Romalpa Clauses or securities registered by suppliers under the Personal Property Securities Act. The value of stocks subject to the above cannot be quantified due to the inherent difficulties in identifying stocks that are still subject to the Romalpa Clauses or security registered under the PPSA at year end.

7. STAFF ENTITLEMENTS

Staff Entitlements consist of:	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Annual Leave Accruals	27,450	24,319	26,995	23,944
Unpaid Days Accruals	8,833	6,683	8,649	6,518
ACC Accruals	2,546	2,250	2,488	2,210
Other	5,560	4,783	5,422	4,732
Staff Entitlement Due Within 1 Year	44,389	38,035	43,554	37,404

8. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2005, the amount of funds received where the conditions attached have not been fulfilled is $8,405,000 ($7,779,000 at 30 June 2004).

This is represented by:	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Cash at Bank	484	416	387	416
Term Deposits	3,291	2,983	3,291	2,656
Local Authorities & Government Stocks	870	840	870	840
Quoted Shares	-	-	-	-
Bonds & Stocks	3,760	3,540	3,760	3,540
Total Restricted Assets	8,405	7,779	8,308	7,452

9. LOANS AND BANK OVERDRAFT

Loans consist of:	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Commercial Loans	-	42,600	-	42,600
Crown Financing Agency	78,650	52,000	78,650	52,000
	78,650	94,600	78,650	94,600
Repayable as follows:				
Due Within 1 Year	-	42,600	-	42,600
Two - Five Years	78,650	52,000	78,650	52,000
	78,650	94,600	78,650	94,600

The bank overdraft facility available totals $1,000,000 for both the parent and the group.

Security
Canterbury DHB commercial loans and the overdraft facilities are secured by Deed of Negative Pledge which requires the Board to comply with certain covenants such as limitations on borrowings, interest cover and working capital ratio.

Interest Rates
Average interest rates on the group's borrowing for the year are as follows:

	Group		Parent	
	30/06/05	30/06/04	30/06/05	30/06/04
Commercial Loans	6.57%	5.86%	6.57%	5.86%
Crown Financing Agency	5.87%	6.29%	5.87%	6.29%
Bank Overdraft	8.45%	7.30%	8.45%	7.30%

10. INVESTMENTS

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Investment in Associates	311	292	311	292
Investment in Subsidiaries	-	-	1,518	1,904
	311	292	1,829	2,196

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Share of Associates Equity Brought Forward	168	168	168	168
Share of Associates Operating Surplus	-	-	-	-
Share of Associates Equity Carried Forward	168	168	168	168
Advances	143	124	143	124
	311	292	311	292

At 30 June 2005, Associate Companies comprised:

	Percentage Interest	Balance Date
New Zealand Centre for Reproductive Medicine Ltd	50	30 June
South Island Shared Services Agency Ltd	47	30 June

New Zealand Centre for Reproductive Medicine Ltd provides reproductive medicine services to private and publicly funded patients.
South Island Shared Services Agency Ltd provides support services for contracting, contract monitoring and provider audits to DHBs for their Funding arm.

INVESTMENT IN SUBSIDIARIES

	Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000
Equity - Canterbury Laundry Service Ltd	393	393
Advances - Canterbury Laundry Service Ltd	1,677	1,787
Equity - Brackenridge Estate Ltd	(315)	(315)
Advances - Brackenridge Estate Ltd	(237)	39
	1,518	1,904

At 30 June 2005 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Laundry Service Ltd	100%	30 June
Brackenridge Estate Ltd	100%	30 June

Canterbury Laundry Service Ltd provides laundry services. Brackenridge Estate Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

Canterbury DHB appoints all the directors of Canterbury Laundry Service Ltd. The company provides services predominantly to Canterbury DHB, and Canterbury DHB has control over the objectives of the company.

Canterbury DHB appoints three out of five directors of Brackenridge Estate Ltd. Its control over the company is exercised through these directors and the provision of financial support and administrative services by Canterbury DHB.

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
At Cost				
Freehold land	-	-	-	-
Buildings - freehold	29,003	3,171	29,003	3,171
Leasehold Building & Fitout	3,042	3,042	3,042	3,042
Fitout plant and equipment	29,499	1,292	29,499	1,292
Plant and equipment	87,465	51,479	82,155	46,515
Computer equipment and software	36,564	32,837	36,517	32,837
Motor vehicles	4,890	4,075	4,295	3,590
Capital work-in-progress	5,842	60,205	5,842	60,205
At Valuation				
Freehold land	64,301	64,301	64,301	64,301
Buildings - freehold	85,920	85,920	85,920	85,920
Fitout plant & equipment	131,289	131,289	131,289	131,289
Plant and equipment	24,791	24,791	24,791	24,791
Reversionary interest in buildings	990	990	990	990
	503,596	463,392	497,644	457,943
Accumulated Depreciation				
Buildings - freehold	8,071	3,819	8,071	3,819
Leasehold Building & Fitout	339	329	339	329
Fitout plant and equipment	33,370	16,588	33,370	16,588
Plant and equipment	49,290	39,924	46,379	36,987
Computer equipment and software	28,010	26,149	27,996	26,148
Motor vehicles	2,049	1,446	1,824	1,314
	121,129	88,255	117,979	85,185

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Net Book Value				
Freehold land	64,301	64,301	64,301	64,301
Buildings - freehold	106,852	85,272	106,852	85,272
Leasehold Building & Fitout	2,703	2,713	2,703	2,713
Fitout plant and equipment	127,418	115,993	127,418	115,993
Plant and equipment	62,966	36,346	60,567	34,319
Computer equipment and software	8,554	6,688	8,521	6,689
Motor vehicles	2,841	2,629	2,471	2,276
Capital work-in-progress	5,842	60,205	5,842	60,205
Reversionary interest in buildings	990	990	990	990
	382,467	375,137	379,665	372,758
Depreciation charged during the year:				
Buildings freehold & leasehold	4,262	3,851	4,262	3,851
Fitout plant and equipment	16,785	16,589	16,785	16,589
Plant and equipment	10,898	8,642	10,045	7,653
Computer equipment and software	6,928	3,209	6,853	3,209
Motor vehicles	646	361	625	361
	39,519	32,652	38,570	31,663

Canterbury DHB revalued its land, buildings and fitout plant and equipment as at 30 June 2003. The revaluation was carried out by independent registered valuers and resulted in the net increases in the value of land ($27,531,000), freehold buildings ($670,000), fitout plant and equipment ($48,526,000) and reversionary interest in a car park building ($990,000). This increase had been recognised in the Revaluation Reserve. The total fair value of Canterbury DHB's land and buildings including fitout as at 30 June 2003 was $294,728,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 2019. This interest has not been included in the Statement of Financial Position, other than the June 2003 revaluation effect of $990,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

12. PROVISIONS

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Provisions due within 1 year	22,540	14,722	22,540	14,623
Provisions due after 1 year	6,511	5,113	6,189	4,827
Total Provisions	29,051	19,835	28,729	19,450
Movement in Provisions				
Opening balance	19,835	13,139	19,450	12,837
Additional provisions made during the year	13,064	12,245	13,101	11,805
Release of surplus provisions during the year	-	(43)	-	-
Charged against provisions for the year	(3,848)	(5,506)	(3,822)	(5,192)
Closing balance	29,051	19,835	28,729	19,450

These provisions primarily relate to staff entitlements, but also includes a refurbishment provision for Brackenridge. Staff entitlements include gratuities, long service leave, conference and sabbatical leave expenses, parental leave, and collective employment contracts pending finalisation of pay negotiations.

13. RECONCILIATION OF NET SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH FLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	30/06/05 $'000	30/06/04 $'000	30/06/05 $'000	30/06/04 $'000
Net Operating Surplus before Share of Associate Co's Surplus	361	(1,241)	(138)	(1,567)
Add Back Non-Cash Items:				
Depreciation	39,519	32,652	38,570	31,663
Maintenance provision	-	42	-	-
Add Back Items Classified as Investing Activity:				
(Gain) / loss on Asset Sale	157	(1,029)	151	(1,029)
	40,037	30,424	38,583	29,067
Movement in Term Portion Provisions	1,398	622	1,362	556
Movement in Deferred Tax	(50)	(28)	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	11,135	29,673	11,279	28,428
Decrease/ (Incr.) in Stocks	212	114	208	110
Increase/ (Decr.) in Creditors & Other Accruals	6,080	(4,728)	6,135	(4,769)
Increase/ (Decr.) in Capital Charge due to Crown	1,561	2,140	1,561	2,140
Increase/ (Decr.) in Staff Entitlements	6,354	5,187	6,150	5,076
Increase/ (Decr.) in Provisions	7,818	6,074	7,917	6,057
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	74,545	69,478	73,195	66,665

14. COMMITMENTS

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
CAPITAL COMMITMENTS				
Committed at Balance Date	32,041	53,719	32,041	53,719
NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Lease	14,646	15,977	8,009	8,736
Vehicle Leases	31	82	31	77
Other	5	5	-	-
	14,682	16,064	8,040	8,813
For Expenditure Within:				
1 Year	1,633	1,695	1,169	1,217
2 Years	1,282	1,308	820	837
3 Years and Beyond	11,767	13,061	6,051	6,759
	14,682	16,064	8,040	8,813

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are re-negotiated periodically reflecting the general principle that an on-going business relationship exists with those providers. Examples of these contracts include contracts for primary care, personal health and mental health.

There are also contracts for demand-driven items where the total expenditure is not defined in advance. Examples of this type of expenditure are pharmaceuticals, subsidy payments to rest homes and carer support relief payments.

The value of the Board's commitment relating to these contracts has not been included in the disclosure above.

15. TRANSACTIONS WITH RELATED PARTIES

a) GOVERNMENT FUNDING

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the Canterbury DHB. Canterbury DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

b) INTER-GROUP TRANSACTIONS

During the financial year the group had the following inter-group transactions:

	Group		Parent	
	30/06/05 $'000	30/06/04 $'000	30/06/05 $'000	30/06/04 $'000
Revenue				
Interest on advance and director's fees from Canterbury Laundry Service Ltd	-	-	124	110
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	40	89
Services to Canterbury Laundry Service Ltd	-	-	427	603
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	57	57	57	57
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	3,349	3,425
Services from New Zealand Centre for Reproductive Medicine Ltd	1,675	1,181	1,675	1,181
Services from South Island Shared Services Agency Ltd	608	502	608	502

Interest charged on advances Canterbury Laundry Service Ltd, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Ltd are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June 2005 are as follows :

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd	143	223	143	223
Amount Payable owing to subsidiaries				
Brackenridge Estate Ltd – Advance		-	238	-
Canterbury Laundry Service Ltd		-	334	364
Amount Receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – Debtor	-	-	9	140
Canterbury Laundry Service Ltd – Advance	-	-	1,700	1,787
Brackenridge Estate Ltd – Advance	-	-	-	39

c) BOARD AND COMMITTEE MEMBERS

During the financial year Canterbury DHB and its subsidiaries have purchased services provided on an arm's length basis by the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/05 $'000	30/06/04 $'000	30/06/05 $'000	30/06/04 $'000
DHBNZ	332	332	332	332
Pegasus Health	19,350	72,350	19,350	72,350
The Christchurch City Mission	491	448	491	448
Breath Testing Services	-	19	-	19
He Oranga Pounamu Charitable Trust	588	1,555	588	1,555
Te Amorangi Richmond Wellness Village	303	308	303	308
Te Rito Arahi Maori Alcohol Drug & Resource Centre	330	319	330	319
Windsor House	1,298	956	1,298	956
Ryman Healthcare Ltd	3,572	2,568	3,572	2,568
TimeOut Carers	47	-	47	-
Cambridge Clinic (DSAC) Ltd	116	-	116	-
Canterbury Community Primary Health Organisation	723	-	723	-
Rural Canterbury Primary Health Organisation	6,631	-	6,631	-
South Canterbury DHB	1,244	144	1,244	144
Access Home Health	2,765	-	2,765	-
Otautahi Women's Welfare League	210	-	210	-
Smiths City Group	13	12	13	12

Canterbury DHB and its subsidiaries have provided the following services on an arm's length basis to the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/05 $'000	30/06/04 $'000	30/06/05 $'000	30/06/04 $'000
DHBNZ	56	26	56	26
South Canterbury DHB	10,420	2,620	10,420	2,620

16. CAPITAL CHARGE

Canterbury DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2005 was 11% (11% for the year ended 30 June 2004).

17. FINANCIAL INSTRUMENTS

CREDIT RISK

Financial instruments which potentially subject the group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts.

The group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2005, the Ministry of Health owed Canterbury DHB $8.9 million ($14.1 million at 30 June 2004).

CURRENCY RISK

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary.

Forward exchange contracts amounting to US$100,000 and A$250,000 were outstanding at 30 June 2005 (30 June 2004 US$2,000,000 and A$350,000). The valuation of these contracts at 30 June 2005 is an unrecognised loss of $1,664.

INTEREST RATE RISK

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities.

There are interest rates swap options outstanding at 30 June 2005 of $45 million (30 June 2004 $37 million). The valuation of these contracts at 30 June 2005 is an unrecognised benefit of $0.3 million.

FAIR VALUES OF FINANCIAL INSTRUMENTS

Financial instruments recorded in the financial statements have been recorded at their fair values.

18. SEGMENTAL REPORTING

Canterbury DHB operates in the provision of Health and Disability Support Services Industry in the South Island of New Zealand. Therefore, no segmental reporting is required.

19. CONTINGENCIES

Canterbury DHB has the following contingencies at year end:

Claim for a breach of patent rights
A third party has indicated that Canterbury DHB has breached their patent rights. This allegation is being contested and the outcome is uncertain.

20. RESIDENTS' TRUST ACCOUNT

	Group		Parent	
	As at 30/06/05 $'000	As at 30/06/04 $'000	As at 30/06/05 $'000	As at 30/06/04 $'000
Residents' Trust Account Balance	753	682	385	364

Residents' Trust Account comprises bank balances representing funds managed on behalf of Residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual residents' balances. Therefore, transactions occurring during the year are not included in the Statement of Financial Performance, Financial Position or Cash Flow of Canterbury DHB.

21. BUDGET VARIANCE

Additional DSS contracts were devolved during the year and are not reflected in these budgets. Additionally, the budget included some national / regional contract expenditure which has subsequently been transferred back to other DHBs.

22. SUBSEQUENT EVENTS

There were no events after 30 June 2005 which could have a material impact on the information in Canterbury DHB's financial statements.

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2004/05

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

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

1. Strategic Priorities and Directions

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

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

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

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

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

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

NOTE: *In order to provide an overview of progress, where available, 2003/04 performance results have been included in parentheses and italics to the right of current results.*

For some measures the results involve low numbers which result in unreliable percentage rates. Where this is the case 95% confidence intervals have been included alongside the percentage rates to provide a more accurate picture. Please see the glossary for an explanation of confidence intervals.

A Week in the Life of the Canterbury DHB

48,000 people visit their GP;
$1,960,000 worth of prescription items are dispensed;
$541,000 worth of laboratory tests are completed;
1,560 people are discharged from hospital, of which 1,260 were admitted acutely;
190 people access mental health services;
875 women have a cervical smear;
680 people have a free influenza vaccination;
200 people have a free diabetes check;
1,640 people have their first attendance at Outpatients;
4800 people have a follow up Outpatients attendance;
250 children have a dental check;
1,500 people attend the Emergency Department;
710 people are admitted to hospital from the Emergency Department;
280 people have elective surgery;
76 cases of infectious diseases are notified;
15 people are discharged from hospital with asthma as the principal diagnosis;
100 babies are born; and
20 people die in hospital.

1.1. Overview of Performance

The following table provides an overview of the Canterbury DHB's performance for the 2004/05 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 the 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 2004/07 Statement of Intent (unless otherwise stated), which reflect the Canterbury DHB's Strategic Plan priorities. 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 should be interpreted with caution.

Priority Area	Objective	Performance Measure	Achieved or Met Target?	Improved/maintained 2003/04 performance?
Child Health	Reduce the Number of Low Birth Weight Babies[ϕ]	Percentage of babies born in hospital with low birth weight	✓	✓
	Reduce Child Hearing Loss	Percentage of children passing school entry hearing tests	✓	✓
	Improve Child Oral Health	Mean MF score at Year 8 (Form 2)	✓	✓
		Percentage of children caries free at age 5	N	N
Primary Health	Support the Development of Four PHOs in Canterbury	Ethnicity data being collected by PHOs	✓	
		Services to Improve Access in place in all PHOs	N	
		Percentage of CDHB population enrolled with PHOs	N	
		PHO plans support CDHB health gain priority areas	✓	
	Improve Rural GP Retention	Percentage of GPs with a rural ranking of greater than 35 points who work no more than a 1 in 4 weekend roster	✓	✓
	Reduce Ambulatory Sensitive Admissions[ϕ]	Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age	N	✓
		Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age	✓	N
		Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age	N	✓
Maori Health	Improve Monitoring of Maori Health	Improved ethnicity reporting: the percentage of discharges classified as Maori, Other or not stated	N	
		Development of monitoring framework	✓	✓
	Reduce Health Inequalities	See relevant performance indicators including those in sections 2.1.1, 2.1.2, 2.1.5, and 2.1.7		
Mental Health	100% Delivery of Contracted Volumes by the Provider-arm	100% delivery of contracted volumes	N	✓
	Mental Health Expenditure to be 100% of Target	100% allocation of funding	✓	✓
	Improved Access to Services	Percentage of people within each age group accessing mental health treatment and support services	Data unavailable	Data unavailable

[ϕ] For a complete breakdown of these indicators by ethnicity please see the full report that follows

Priority Area	Objective	Performance Measure	Achieved or Met Target?	Improved/maintained 2003/04 performance?
Cardiovascular Disease	Reduce the Impact of Cardiovascular Disease	Percentage of people with certainty who waited no more than 6 months for coronary artery bypass	N	N
		Delivery of target levels of cardiac surgery	✓	
		Percentage of people with certainty who waited no more than 6 months for an angioplasty	N	N
Cancer	Reduce the Impact of Cancer	Improved access to radiotherapy	N	✓
Diabetes	Earlier Diagnosis and Treatment of Eye Problems[ϕ]	Percentage of people having annual reviews who have had their eyes screened in the last two years	N	✓
	Improved Diabetes Monitoring[ϕ]	Percentage of the expected number of people with diabetes who have been diagnosed with diabetes and had an annual review during the year	N	✓
	Improved Diabetes Management[ϕ]	Percentage of people having annual reviews who had poor diabetes control	✓	✓
Elective Services	Improved Access to First Specialist Assessments (FSA)	Percentage of patients who receive their FSA within six months of referral	N	N
		Delivery of a level of publicly funded FSA volumes at the levels specified in the DAP	N	✓
	Improved Certainty of Treatment	Percentage of patients with certainty who received treatment within six months	N	✓
		Percentage of treated patients who had been given certainty	N	N
	100% Delivery of Contracted Surgical Volumes	Case weighted discharges delivered as specified in the District Annual Plan	N	N
Hospital Safety and Effectiveness	Improved Performance as a Good Employer	Sick leave rate	✓	✓
		Workplace injuries	✓	✓
		Staff turnover	N	N
	Patient Satisfaction	Inpatient- overall satisfaction	N	✓
		Outpatient- overall satisfaction	N	✓
	Improved Quality	Achieve and maintain accreditation status	✓	✓
	Maintain Appropriate Levels of Clinical Quality Within CDHB Hospitals	Hospital acquired bacteraemia rate per 100 inpatient days	✓	N
		IV medication error rate per 1000 inpatient days	✓	✓
		Patient falls per 100 inpatient days	N	N
	Monitor levels of attendance at Christchurch Hospital's Emergency Department	Number of attendances at Christchurch Hospital's Emergency Department	67,599	65,750

[ϕ] For a complete breakdown of these indicators by ethnicity please see the full report that follows

Priority Area	Objective	Performance Measure	Achieved or Met Target?	Improved/maintained 2003/04 performance?
	Reduce wait times for people attending Christchurch Hospital's Emergency Department	Percentage of people seen within expected wait time by triage level Level 1 Level 2 Level 3	 N N N	 ☑ N N
Good Governance	Break even. Manage expenditure (including funding to 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	☑	☑

2. Service Objectives and Measures

2.1. Funding and Performance: Strategic Plan Health Priorities

2.1.1 Child and Youth Health

Objective:	***Brief Description:***
Improved health status for Canterbury's children and youth. (Long term)	Keeping children and youth healthy gives them a better chance of becoming healthy adults. The Canterbury DHB (CDHB) has developed a Child Health and Disability Action Plan to address the health issues of the children of Canterbury. The targets for 2004/05 given here come from the District Annual Plan (note: the immunisation indicator from previous years has not been included due to data quality issues).

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05***	***(95% Confidence intervals for discharge rates)***	***2003/04***
Reduced number of low birth weight babies	Percentage of babies born in public hospital with low birth weight.	• Māori < 7.0% • Pacific < 4.7% • Total < 6.0%	• Māori 6.0% • Pacific 3.9% • Total 4.5%[1]	(3.5---10.1) (1.2---10.5) (3.9---5.3)	*(8.4%)* *(4.5%)* *(6.1%)*
			It is preferable that fewer babies are born with low birth weight, hence for this indicator, lower is better. The CDHB achieved its targets for all groups.		
Minimised impact on hearing loss in children	Percentage of children passing school entry hearing tests.	• Māori 90.0% • Pacific 86.0% • Total 94.0%	• Māori 93.2% • Pacific 89.7% • Total [2] 95.2%		*(91.6%)* *(86.8%)* (95.3%)
Improved child oral health	Average proportion of Missing or Filled teeth of Form 2 (year 8) children *(Total permanent teeth missing or filled due to caries (holes) divided by the number of children seen by the school dental service in the period).*	• Total 1.6	• 1.58 There were 8,374 permanent teeth filled for 5,296 young people giving a mean MF score of 1.58.[3] It is preferable that there are fewer permanent teeth filled or missing due to holes (caries), hence for this indicator, lower is better. The CDHB achieved its target for this indicator.		*(1.6)*

[1] Data is from the National Minimum Data Set, 1 April 2004 – 31 March 2005
[2] Data is from the National Audiology Centre
[3] Data is from the Canterbury DHB Crown Funding Agreement report Quarter 3 2004/05 and covers the 2004 school year.

Objective 2004/05	*Performance Measure*	*Performance Targets*	*Results 2004/05* *(95% Confidence intervals for discharge rates)* *2003/04*
	Percentage of children caries free (no fillings or holes in teeth) at age 5.	• Total 52%	• 51% *(52%)* There were 2,418 children at their first publicly funded dental service after their 5th and before their 6th birthday with primary dentition free of caries, with no fillings and with no teeth missing due to caries, out of a total of 4,724 children at their first publicly funded dental service after their 5th and before their 6th birthday. Thus the percentage of children caries free at age 5 is 51%[4], which was marginally short of the target. A major factor impacting on the CDHB's performance on this measure is the low proportion of Canterbury's population receiving optimally fluoridated water supplies. The CDHB agreed a 'position statement' on fluoridation in 2003 and this is available on its website www.cdhb.govt.nz.

[4] Data is from the Canterbury DHB Crown Funding Agreement report Quarter 3 2004/05 and covers the 2004 school year.

2.1.2 Primary Health

Objective:	***Brief Description:***
Reduced barriers to primary health care. (Long term)	Reducing the barriers to good primary health care helps people stay well resulting in improved health status. During the 2004/05 year the Canterbury DHB focused its primary care activities on the following: • Implementation of the Government's primary health care strategy via the development of Primary Health Organisations (PHO) within Canterbury for those populations with the greatest barriers to primary health care. • Implementation of Canterbury DHB's rural health action plan of May 2002.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05 (95% Confidence intervals for discharge rates) 2003/04***
PHO Development Support the development of 4 PHOs within the Canterbury Region (two representing rural communities, one representing lower socio-economic groups in urban Christchurch and one other urban PHO).	Ethnicity data being collected by PHOs.	100% of PHO practices collecting ethnicity data by 1 April 2005	• 100% Target Achieved
	Services to improve access in place in all PHOs.	All PHOs have implemented Services to Improve Access plans by 1 January 2005	All PHOs have Services to Improve Access with the exception of Hurunui Kaikoura PHO, which serves 3% of the CDHB's population. *Note: Services to Improve Access reduce barriers to first contact services for groups with the highest health needs.*
	Percentage of CDHB population enrolled with PHOs.	95% of CDHB's census population is enrolled with PHOs by 1 July 2005	As at 1 July 2005 there were 431,878 people enrolled with a PHO. The 2005 population projection from Statistics NZ for 2005 is 459,670. Based on this 94% of CDHB's population was enrolled with a PHO as at 1 July 2005. On the basis that population projections contain a certain amount or error, it is considered that this result is equal to target.
	PHO plans support CDHB health gain priority areas.	PHO Health Promotion and Services to Improve Access plans are consistent with CDHB health gain priority plans	Target achieved. PHO Health Promotion Plans and Services focus on nutrition, physical activity, and smoking cessation. These are consistent with CDHB's health gain priority areas – Child and Youth, Maori, Primary Health, Mental Health, and Disease Management (Diabetes, CVD, Cancer).
Improved retention of Rural GPs: Maintain reasonable on-call rosters for rural GPs. Every GP with a rural ranking of 35 points or more to work no more than 1 in 4 weekends.	Percentage of GPs with a rural ranking of greater than 35 point, who work no more than a 1 in 4 weekend roster (unless by choice).	• 100%	• 100% *(100%)* Target Achieved

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***(95% Confidence intervals for discharge rates)*** ***2003/04***
Reduce Ambulatory Sensitive Admissions. Ambulatory sensitive admissions are admissions that are potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care. *(Ambulatory means hospital outpatient or GP care)*	Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age.	• Māori 6.7% • Pacific 6.7% • Total 6.7%	• Māori 7.2% (6.2---8.3) *(6.6%)* • Pacific 10.4% (8.0---13.4) *(10.6%)* • Total 7.8%[5] (7.4---8.2) *(7.8%)* The 95% confidence interval for Maori covers the range from 6.2 to 8.3, which includes the target. In addition, the rate for Pacific people involves relatively low numbers and, as can be seen from the confidence interval, the true rate may be as low as 8.0. Actions to improve performance on this indicator are embodied within the CDHB's Child Health Action Plan, Maori Health Plan, and Pacific Health Action Plan. The Child Health Action Plan lists the following 10 key child health priorities; Access to Services, Child Health Information, Hearing, Immunisation, Injury Prevention, Mental Health, Nutrition and Physical Activity, Oral Health, Parenting, and Smokefree Environments. Some specific initiatives resulting from these plans that will potentially impact on performance against this indicator are: • Pacific Immunisation Outreach Service (targets 0-5 years) • Mother and Pepi services (targets 0-2 years) • Development of a Pacific Peoples immunisation database is underway • Continued operation of a Pacific Health Clinic • Well Child/ Tamariki Ora services.

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

Objective 2004/05	*Performance Measure*	*Performance Targets*	*Results 2004/05* *(95% Confidence intervals for discharge rates)* *2003/04*
	Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age.	• Māori 1.7% • Pacific 1.7% • Total 1.7%	• Māori 1.5% (1.2---1.9) *(1.5%)* • Pacific 2.7% (1.9---3.9) *(2.1%)* • Total 1.7%[6] (1.7---1.8) *(1.6%)* The rate for Maori is better than the target and the rate for 'total' is equal to target indicating a good result for this measure. The rate for Pacific people, while higher than the target, relates to only 29 admits. The confidence interval for this group is also very wide. Actions to improve performance on this indicator are embodied within the CDHB's Child Health Action Plan and Pacific Health Action Plan. The Child Health Action Plan lists the following 10 key child health priorities; Access to Services, Child Health Information, Hearing, Immunisation, Injury Prevention, Mental Health, Nutrition and Physical Activity, Oral Health, Parenting, and Smokefree Environments Some specific initiatives resulting from these plans that will potentially impact on performance against this indicator are: • Pacific Immunisation Outreach Service (targets 0-5 years) • Mother and Pepi services (targets 0-2 years) • Development of a Pacific Peoples immunisation database is underway • Continued operation of a Pacific Health Clinic • Well Child/ Tamariki Ora services.
	Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age.	• Māori 1.1% • Pacific 1.1% • Total 1.1%	• Māori 1.1% (0.8---1.5) *(1.1%)* • Pacific 1.4% (0.8---2.4) *(1.3%)* • Total 1.2%[7] (1.1---1.3) *(1.2%)* The rate for Maori is equal to the target, while the rate for 'total' is slightly above the target. The Pacific peoples rate is higher than the target, however this the rate relates to only 24 admissions and the confidence interval for this value includes the target, as do the confidence intervals for the rates of the other three groups.

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

2.1.3 Māori Health

Objective:	***Brief Description:***
Whanau Ora *Māori families supported to achieve their maximum health and wellbeing.* *(Long Term)*	Evidence of Māori health disparities is well known and compelling and to address these health disparities, the Canterbury DHB has developed a Māori Health Plan (July 2002), *Whakamahere Hauora Māori Ki Waitaha.* This plan identifies a number of strategic issues, namely: • Support of the Governments commitment to the Treaty of Waitangi, • Māori Participation in health planning, service provision and the workforce, • Effective, culturally appropriate and high quality services, • Monitoring of Māori health outcomes, • Working across sectors. During the 2004/05 year the Canterbury 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.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05***
Monitoring of Māori health outcomes. Current collection of ethnicity data is a significant barrier to achieving this objective. The DHB therefore plans to continue to implement accurate Ethnicity Data Collection throughout CDHB.	Improved ethnicity reporting. The percentage of discharges classified with the following ethnicity groups: • Maori • Other • Not stated Improved ethnicity reporting will result in fewer people classified as 'other' or 'not stated'. Classification of people under these categories contributes to under reporting of groups such as Maori (measured against census population) and limits CDHB's ability to monitor health outcomes accurately.	Ethnicity reporting targets • Maori 7.5% • Other less than 2.5% • Not stated less than 1.0%	Percentage of discharges from CDHB hospitals with the following ethnicity reported • Maori 6.0% • Other 5.0% • Not stated 2.7% 2004/05 targets had been set aiming to reduce the percentage of people classified as 'other' or 'not stated', and increase the percentage classified as Maori. Actions to improve this result include an Ethnicity Data Implementation Plan and recent completion of the appointment of Ethnicity Data Team Leaders for each Hospital and Specialist Services division. The aim over 2005/06 is to establish Ethnicity Data Teams and to action the Implementation Plan throughout the CDHB.
Monitoring of Māori health outcomes. Continued …	During 2004/05 CDHB intended to develop an integrated health outcome and performance monitoring framework aligning its Māori Health Plan *"Whakamahere Hauora Māori Ki Waitaha"* with the MoH Māori Health Strategy *"He Korowai Oranga"* and the Māori Health Action Plan *"Whakatataka"*. Continuing work that started in 2003/04.	• Completion of monitoring framework by June 2005	A proposed monitoring performance framework was completed in May 2005 as a result of a review of CDHB Strategic Māori Health plan – Whakamahere Hauora Māori ki Waitaha. The proposed framework was taken out for consultation with the Māori community to see if it provided a clear picture of what has occurred for Māori health since 2002. Discussion occurred and support given from the community on the proviso that CDHB look to capture more disease specific information in the future.

Objective 2004/05	*Performance Measure*	*Performance Targets*	***Results 2004/05***
			The performance monitoring framework uses a scorecard that summarises CDHB's five Māori health directions and the number of short, medium and long term projects identified to progress Māori health over the next 5 years. The scorecard grades the level of progress on each project (ie: development, ongoing and completed). At this stage 42 of the 59 key projects within our current plan are under way with a remaining 17 to work on.
Reduced health inequalities: Māori Service Development in priority areas eg. Diabetes, Cancers, Cardiovascular disease, Child Health etc	Refer to the relevant section of this document. Where data is available Māori specific targets have been provided.	See relevant Performance Indicators	CDHB has made progress in improving performance against targets set for Maori for the following indicators; • Diabetes management (section 2.1.7) • Low birth weight babies (section 2.1.1) Performance for other diabetes and child health indicators needs further improvement. Child health will be addressed through the implementation of CDHB's Child Health Action Plan. The CDHB is working with PHOs, the Diabetes Centre, Community & Public Health and the Local Diabetes Team to improve knowledge and awareness of good self-management of diabetes.

2.1.4 Mental Health

Objective:	***Brief Description:***
Improved Health Status for Canterbury Residents who have a serious ongoing mental illness. (Long Term)	About 3% of New Zealanders have a serious ongoing mental illness, which requires specialist care and treatment by a range of health and social service providers. The Canterbury DHB continues towards implementing the Mental Health Strategy and Blueprint for Mental Health Services and the Youth Suicide strategies and guidelines. In addition, the Canterbury DHB has completed its own Mental Health Strategic Plan (June 2004), which has had its first year of implementation in 2004/05.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
Mental Health Volume Delivery (Hospital & Specialist Services): 100% delivery of Mental Health Volumes.	Actual funding delivered as a percentage of the value of Hospital and Specialist Services Mental Health funding in the CDHB District Annual Plan (DAP).	• 100% delivery of contracted volumes	• 99% of contracted volumes were delivered. *(99%)* Measurement of performance reflects the actual volume of services delivered multiplied by the relevant prices, expressed as a percentage of the total contracted funds. Overall CDHB performance shows a small under-delivery. This relates mainly to clinical psychologist vacancies within some Child and Youth services. Active recruitment within these areas has been ongoing and reflects a national shortage. *Note: In measuring performance, adjustment is made to vacant FTE positions where cover has been provided.*
Mental Health Service Funding: Mental Health Services Funding expenditure to the level specified by the Mental Health "ring-fence".	Contracted funding as a percentage of the Mental Health Target.	• 100% allocation of funding	• 100% allocation of the ring-fenced funding to providers *(100%)*
Improved access to Mental Health Services: The New Zealand Mental Health Strategy sets targets for access to treatment and support services for people of different age groups with severe mental illness.	Percentage of people within each age group accessing mental health treatment and support services. *Note: these targets are set in line with estimated proportions of people with mental illnesses for each age group and ethnicity. The higher the percentage is, the more people there are accessing services. The CDHB aims to improve access to services and so higher percentages are favourable.*	***Māori*** • 0-19 years: 0.50% • 20-64 years: 1.30% • 65+ years : 0.28% ***Other*** • 0-19 years : 0.65% • 20-64 years: 1.00% • 65+ years: 0.19% **Total** • 0-19 years : 0.65% • 20-64 years: 1.10% • 65+ years: 0.20%	This data is currently unavailable. Recent MHINC data submission issues mean that CDHB information needs to be resubmitted before final figures can be produced.

2.1.5 Disease Prevention and Management – Cardiovascular (Heart) Disease

Objective:	***Brief Description:***
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cardiovascular disease. (Long Term)	Cardiovascular disease has been identified by the Canterbury DHB as a priority area for improving the health status of the people of Canterbury. The Canterbury DHB developed a strategy for the management of Cardiovascular disease in Canterbury *Heart Health Strategy*. However this was completed after the objectives and measures were set for the DAP and Statement of Intent targets. Therefore the relevant accountabilities to the Minister of Health, as outlined in the DAP, along with the target level of Cardiac Surgery were used as measures of the Canterbury DHB's performance during the 2004/05 year.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
Reducing the Impact of Cardiovascular Disease.	Percentage of people with certainty who waited for no more than 6 months for coronary artery bypass graft.	• 100%	52% *(58%)*
	Delivery of target levels of Cardiac Surgery for key procedures (Cardiac Valves and Coronary Artery Bypasses with Grafts). *Note: Cardiac Valves and Coronary Bypass with Grafts are counted using the following Diagnostic Related Groups (drgs); F03Z, F04A, F04B, F05A, F05B, F06A, and F06B.*	• 1500cwd delivered by 31 December 2004 • 3000cwd delivered by June 30 2005	• 3000cwd (100%) * The Canterbury DHB met the target delivery for Cardiac surgery. The 2004/05-year reflects the first year where cardiac surgery has been funded using cwd rather than cases. *Note: Cost weighted discharges (cwd) are a relative measure of the cost of different types of surgery ie; cataract procedures have lower cwd than hip replacements.*
	Percentage of people with certainty who waited for no more than 6 months for an angioplasty.	• 100%	97% *(99%)*

2.1.6 Disease Prevention and Management - Cancer

Objective:	***Brief Description:***
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cancer. (Long Term)	Cancer has been identified by the DHB as priority area for improving the health status of the people of Canterbury. The CDHB is currently in the process of implementing the National Cancer Control Strategy Action Plan for the management of Cancer in Canterbury. When completing the DAP and Statement of Intent specific service objectives and measures were not established, hence the relevant accountability to the Minister of Health, as outlined in the DAP, were used as measures of performance during the 2004/05 year.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
Reducing the impact of Cancer.	Improved Access to Radiation Therapy. 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	Improved performance during the year with target for the month of June (year end) of: • 100% of patients in Group A started treatment on time • 100% of patients in Group B started on time • 95% of patients in Group C started on time (within 4 weeks) • 5% of patients in Group C waited 4-8 weeks • 0% of patients in Groups A, B, or C waited 8-12 weeks • 0% of patients in Groups A, B, or C waited longer than 12 weeks *Note: these targets do not include Priority 'D' patients who have combined chemotherapy and radiation treatments. The start date for radiation treatment for these patients depends on their treatment schedule.*	• 100% of Group A patients started treatment on time during 11 months of the year – with the exception of June when there were no Group A patients. (100%) • 52% of patients in Group B started on time (52%) • 79% of patients in Group C started on time (72%) • 15% of patients in Group C waited 4-8 weeks (22%) • 0% of patients in Group A waited 8-12 weeks (0%) • 3% of patients in Group B waited 8-12 weeks (0%) • 2% of patients in Group C waited 8-12 weeks (7%) • 0% of patients in Group A waited longer than 12 weeks (0%) • 3% of patients in Group B waited longer than 12 weeks (0%) • 3% of patients in Group C waited longer than 12 weeks (0%) The CDHB has continued to seek to achieve the goal of 100% of patients being treated within 4 weeks. The reasons for delay are related primarily to lack of suitably qualified workforce in the sector. Delays are also due to other illnesses and/or treatments, the need for further tests, and specific start dates for protocol reasons. *Note: these figures do not include 17 category D patients as they all have specific start dates for protocol reasons. Therefore this group of patients started treatment on time but not all of them started within 4 weeks.*

2.1.7 Disease Prevention and Management - Diabetes

Objective:	***Brief Description:***
Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes. (Long Term)	Diabetes has been identified by the Canterbury DHB 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, • Patient knowledge/information. 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 (refer Local Diabetes Team (LDT) Annual Report 2003 for a full list of priorities). During the 2004/05 year, the Canterbury DHB primarily focused its activities on improving performance in the level of retinal screening while continuing to encourage the detection and management of Diabetes within the community. The Canterbury DHB has concerns about the data presented below and is of the opinion that these figures understate the numbers of people having annual diabetes reviews who had their eyes screened in the last two years.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
Improved Diabetes Detection: Increasing the proportion of people with diabetes who receive annual checks and the associated primary care.	The percentage of the expected number of people with diagnosed diabetes who had an annual review during the year (expected numbers of people with diabetes: Māori: 1,192 Total: 12,142). Number of diabetes annual checks	Percentage receiving annual reviews during the 2004 year • Māori 80% • Total 81% **Number of annual checks during 2004** • Total 9,827	• Māori 41% *(42%)* • Total 80% *(77%)* The CDHB was very close to the target for Total but has yet to meet its target for Maori. Work continued with Maori to improve the case detection rate through providing extra hours for a Maori health nurse at the Diabetes Centre and targeted screening programmes and education provided through Community and Public Health. • 9750 (8727) Actual checks delivered
Early diagnosis and treatment of eye problems: Increase the proportion of people with diabetes who have had their eyes screened in the last two years.	The percentage of people having annual diabetes reviews who have had their eyes screened in the last two years.	• Māori 45% • Total 65%	• 41% *(42%)* • 48% *(45%)* The rate for other ethnicities has improved from 2003. Work continues with the Eye Department and other groups, including community optometrists, to provide an eye screening service that is patient centred, convenient and based in the community. This forms part of the review of the Ophthalmology Department currently underway. The CDHB is working with the LDT to address and improve the data collection and measurement process. Approximately 4500 retinal screens are provided by the CDHB each year. Over the two year period for this indicator this is approximately 9000 screens which should provide at least 88% coverage of people with diabetes in Canterbury.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
Improved Diabetes Management: Reducing the proportion of people with diabetes who have relatively poor control of their diabetes.	The percentage of people having annual diabetes reviews who had poor diabetes control (HBA1c>8%).	• Māori 40% • Total 23%	• Māori 40% (42%) • Total 24% (26%) The CDHB met the target for Maori and came very close to meeting the target for other ethnicities. Work continues with PHOs, the Diabetes Centre, Community and Public Health and the LDT to improve knowledge and awareness of good self-management of diabetes.

2.1.8 Elective Services

Objective:	***Brief Description:***
Improved health status for Canterbury's residents via the provision of services in a timely manner within the available resources for those with the greatest level of need. (Medium Term)	Access to outpatients services and elective surgery has been an ongoing issue for the Canterbury DHB. 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 Canterbury DHB intends to continue the implementation of the Governments policies in relation to elective services which include: • The provision of timely access to specialist assessment and elective surgery. • The delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress or ill health.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
Improved access to first specialist assessment: Reduced waiting lists for first specialist assessments so that all appropriately referred patients can be assessed within appropriate timeframes.	Percentage of patients who receive their First Specialist Assessment (FSA) within six months of referral. *Note: a FSA is the first appointment a patient has with a specialist following referral.*	• 100% of patients who have an FSA in 2004/05 have it within six months of referral	• 94% *(97%)* Of the new patients seen during the year, 94.2% waited less than 6 months, leaving 5.8% who waited longer than 6 months. This is slightly higher than the previous year. The CDHB will continue to seek to achieve the target level of performance. At the end of the year there were 1,676 people whom we had not seen who had waited longer than 6 months. This reflects approximately two weeks work at current activity levels.
	Delivery of a level of publicly funded FSA volumes at the levels specified in the CDHB DAP.	• 27,550 FSA completed by 31 December 2004 • 55,100 FSA completed in total by 30 June 2005	• 54,398 (99%) *(53,729)* Although the DAP target was not reached the volume of FSAs delivered in 2004/05 was very close to the target and, when compared with 2003/04, delivery has increased by 669 FSAs or 1.2%.
Improved certainty of treatment: Provide certainty to elective surgical patients as to whether they will/will not receive access to publicly funded inpatient surgery. Provide access in a timely manner.	Percentage of patients provided with certainty of treatment receiving treatment within 6 months.	• 100%	87% *(84%)*

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
	Percentage given certainty. *(The number of treated patients with certainty as a percentage of all patients receiving elective surgery during the period)*	• 90%	65% *(78%)*
Surgical Volume Delivery: Delivery of the level of surgery specified in the CDHB DAP.	Case weighted discharges delivered as specified in the CDHB DAP. *(Case weighted discharges (cwd) are a relative measure of the cost of different types of surgery- eg cataract procedures have a lower cost weight than hip replacements)*	• 17,100cwd delivered by 31 December 2004 • 34,359cwd by 30 June 2005 * *The original target in the 2004/07 SOI did not include Dental (240 cwd)	• 34,074 cwd delivered year-end *(34,547)* Delivery was very close to the target (0.8%). In addition to the volumes delivered by the provider-arm Hospital and Specialist Services, CDHB also has contracts with private providers. These include Canterbury Orthopaedic Services (1465cwd delivered in 2004/05) and St George's Hospital (215cwd of cardiac surgery). The contract with Canterbury Orthopaedic Services has made an important contribution to CDHB's performance on the Orthopaedic Initiative to increase the number of hip and knee replacements. This contract was increased to cover shortfall in provider-arm delivery.

2.2. PROVIDER HOSPITAL AND SPECIALIST SERVICE MEASURES

2.2.1 Hospital Safety and Effectiveness

Objective:	***Brief Description:***
As a leader in hospital and health care services the Canterbury DHB aims to be an efficient and effective provider and maximise the health status of Canterbury's residents within the available resources.	The Canterbury 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 Canterbury DHB must ensure that it operates in an effective and efficient manner.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** ***2003/04***
Improved performance as a Good employer. Initiate systems and processes to promote a good working environment that encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management.	Sick Leave Rate (as per balanced scorecard)	• 3.2% of contracted hours	• 3.2 *(3.3%)* Target achieved
	Work Place Injuries per 1,000,000 hours (as per balanced scorecard)	• 17 per 1 million hours	• 11.2 *(18.1)* Target achieved
	Staff Retention and Turnover (as per balanced scorecard)	• Less than 10% turnover	• 14.0% *(12.4%)* Target not achieved.
Patient Satisfaction.	Inpatient – Overall Satisfaction *(as per balanced scorecard)*	• Greater than 95%	• 90% *(89%)* The CDHB has slightly improved its levels of satisfaction from last year and produced a high level of patient satisfaction at 90%.
	Outpatient – Overall Satisfaction. *(as per balanced scorecard)*	• Greater than 95%	• 90% *(90%)* The CDHB continues to maintain a high level of patient satisfaction at 90%.

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results*** ***2004/05*** ***2003/04***
Improved Quality. Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals. (Long term)*	Maintain accreditation at Ashburton, Akaroa, Ellesmere, Waikari, Darfield, Burwood and Christchurch Women's Hospitals. Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services.	100% of facilities maintain current accreditation status Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services	The CDHB has achieved this target. The accreditation status of these facilities is as follows: • *Rural Health Services (Ashburton & Community Health Services)* Ashburton Health Services: Accreditation awarded 28th May 2002. This is their fourth 3-year accreditation having been accredited since 1993. Community Hospitals (Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari): Accreditation awarded 13th February 2004. This is the second accreditation for Akaroa, Darfield, Ellesmere and Waikari and the first for Kaikoura and Oxford. Rural Health Services are certified from March 2004 until March 2007 (3 years). • *Burwood Hospital* Burwood's second 3-year accreditation was awarded May 2004. Certified for 1 year from September 2004 until September 2005. • *Christchurch Hospital & Corporate Services* Christchurch Hospital (including Corporate Services) was surveyed by Quality Health NZ for their first accreditation survey and certification audit in June 2004. Accreditation was awarded in February 2005. Certified for 2 years from September 2004 until September 2006. Technical Services, Medical Physics and Bio-engineering were successful in re-certification against the AS/NZ Standard ISO9001: 2000. • *Mental Health Services (MHS) & The Princess Margaret Hospital (TPMH)* Accreditation awarded November 2004. The PMH Certified from September 2004 until September 2007 (3 years), MHS Certified from September 2004 until September 2006 (2 years). • *Women's Health Division (WHD)* Quality Health NZ confirmed the continued Accreditation status for Women's Health Division facilities and services. This is the second 3-year accreditation successfully completed by WHD. Certified from November 2003 until November 2005 (2 years). • *Laboratory and Support Services* Canterbury Laboratories has been accredited with IANZ (ISO: 15189) since 1994.
Maintain appropriate levels of Clinical Quality within CDHB Hospitals.	Hospital Acquired Bacteraemia Rate per 100 inpatient days.	Hospital Acquired Bacteraemia Rate per 100 inpatient days • Less than 0.2	• 0.13 *(0.12)* Target achieved *Note: performance now reflects measurement of all CDHB hospitals except Mental Health division*

Objective 2004/05	*Performance Measure*	*Performance Targets*	*Results* *2004/05* *2003/04*
	IV Medication Error Rate per 1000 inpatient days.	• Less than 1.9	• 1. 8 *(2.0)* Target achieved *Note: performance now reflects measurement of all CDHB hospitals*
	Patient Falls per 100 inpatient days.	• Less than 4.5	• 5.48 *(5.2)* The total falls rate includes many minor events, which cause little or no harm. Analysis of the total falls data set is useful as a means to understand patterns of circumstances which are associated with falls and therefore to drive quality improvement. However, it does not relate directly to the harm caused by falls, the overall rate being influenced more by reporting practices. The CDHB has been working to increase the reporting rate of falls and therefore supports an increase in overall fall numbers as a sign of increased reporting. In consideration of its increased focus on reporting falls, in future years the CDHB will include in the falls rate only those which are associated with moderate or serious injury. In this way it will provide a direct measure of injury caused by falls. *Note: performance now reflects measurement of all CDHB hospitals*
Monitor levels of attendance at Christchurch Hospital's Emergency Department.	Number of attendances.	• No target set, included for information purposes only	• 67,599 *(65,750)*
Reduce wait times for people attending Christchurch Hospital's Emergency Department.	Percentage of people seen within expected wait time by triage.	• Triage 1 100% • Triage 2 80% • Triage 3 70%	• Triage 1 98% *(93%)* • Triage 2 50% *(55%)* • Triage 3 44% *(46%)* The targets for this indicator have not been met. However, the clerical process for recording of time seen by doctor has been improved and this has resulted in the Triage 1 target being met for the last three quarters. The CDHB is currently implementing the 'Improving the Patient Journey' Project; the goal of which is to reduce unnecessary waits and delays for patients. This project includes several initiatives within the emergency department. These will assist with improved performance on this measure in 2005/06 and beyond.

2.3. GOVERNANCE

2.3.1 Good Governance

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

Objective 2004/05	***Performance Measure***	***Performance Targets***	***Results 2004/05*** / ***2003/04***
Break even. Manage expenditure (including funding to external providers) within available funding.	CDHB expenditure on health services is within the funding it receives and that its operating result, after interest, depreciation and capital charge, for 2004-05, is breakeven.	Net operating result = Breakeven or better	$0.3M *(($1.2m))* Target met. The CDHB achieved a slight surplus of $0.3M for 2004/05

3. Summary of Revenues and Expenses by Output Class

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

4. Glossary of Terms

Accreditation	Achievement against a national system of standards.
Angioplasty	An angioplasty is a noninvasive 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.
Ambulatory Sensitive Admissions	Admissions that are potentially preventable by appropriate primary care.
Audit	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation.
Bacteraemia	Hospital acquired bacteraemia rate measures the number of hospital acquired blood stream infections as a proportion of the number of inpatients.
Cardiac	Relating to the heart
Certainty	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).
Confidence Interval	The range within which we can be confident that the true value lies. A 95% confidence interval means that the probability that the interval contains the true value is 95%. The width of the confidence interval gives an indication of the variability within the sampling distribution. A narrow confidence interval indicates smaller variability, while a wide interval indicates large variability. The amount of variability, and hence the width of the interval, is greatly affected by the size of the group being sampled. This is particularly relevant when interpreting statistics for measures that are broken down by ethnicity.
CWD - Cost Weighted Discharges	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.
FTE	Full time equivalent
Inequality (health)	Difference in health relative to the local community or wider society to which an individual, family or group belongs.
PHO – Primary Health Organisation	Primary Health Organisations are made up of General Practitioners, nurses, and other primary health providers, and are responsible for achieving improved health outcomes for their enrolled populations.
Triage levels (emergency department)	Patients in the emergency department are triaged upon presentation into one of five categories on the Australasian Triage Scale according to the triageur's response to the question: "This patient should wait for medical care no longer than ... minutes". Patients requiring immediate treatment are triaged as level 1, those needing treatment within 10 minutes are level 2, within 30 minutes are level 3, within 60 minutes are level 4, and within 120 minutes are level 5. The triage of patients continues within the Emergency Department, following initial assessment and treatment. 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 from Triage Code 1 through to 5.

Audit New Zealand

AUDIT REPORT

TO THE READERS OF CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2005

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health Board and group, on his behalf, for the year ended 30 June 2005.

Unqualified opinion

In our opinion the financial statements of the Health Board and group on pages 16 to 37 and 39 to 60:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health Board and group's financial position as at 30 June 2005;
  - the results of operations and cash flows for the year ended on that date; and
  - the service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 26 September 2005, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements.

We evaluated the overall adequacy of the presentation of information in the financial statements. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2005. They must also fairly reflect the results of operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001, section 43 of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

Other than the audit, we have no relationship with or interests in the Health Board or any of its subsidiaries.

Julian Tan
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of the Canterbury District Health Board for the year ended 30 June 2005 included on the Canterbury District Health Board's web site. The Canterbury District Health Board's governing body is responsible for the maintenance and integrity of the Canterbury District Health Board's web site. We have not been engaged to report on the integrity of the Canterbury District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information that may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 26 September 2005 to confirm the information included in the audited financial statements presented on this web site.

Legislation in New Zealand governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

APPENDIX 6

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Canterbury District Health Board

Report For the Year Ended
30 June 2006

Table of Contents

DIRECTORY

Board Members

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

Chief Executive

Gordon Davies (Chief Executive Officer)

Registered Office

2nd Floor, H Block
The Princess Margaret Hospital
Cashmere Road
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Westpac Banking Corporation

MISSION STATEMENT

The Canterbury DHB's mission is to improve, promote and protect the health of the people in the community and foster the well-being and independence of people with disabilities and reduce disparities.

BOARD MEMBERS

Syd Bradley - Chair	Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB. Syd has served on a number of boards since resigning as General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.
Robin Booth	Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
Heather Carter	Heather Carter is devoted to accessible and affordable health care for all New Zealanders. Heather runs LifeMasters, a personal development and workplace counselling consultancy. In addition, Heather serves on the Council of the Christchurch Polytechnic Institute of Technology, and Health Cuts Hurt (a group aimed at improving healthcare for people of Canterbury).
David Morrell	David Morrell was City Missioner in Christchurch from 1982 to 2005 and has had over 30 years involvement with general health and mental health through hospital chaplaincy, primarily at Christchurch Hospital during the 1970s and subsequently at the City Mission. David has had extensive management training, both here and in the United Kingdom. David is also Chair of Brackenridge Estate Limited, a member of Anglican Aged Care Committee and Environment Canterbury, Christchurch Area Committee.
Neville Fagerlund	Neville Fagerlund is a Chartered Accountant in public practice with over 25 years experience. He has provided financial and commercial advice to Pegasus Health Ltd since its inception in 1993 and advises The 24-Hour Surgery Ltd. Neville is a Director of Cambridge Clinic Ltd, a charitable company in the health arena.
Olive Webb – Deputy Chair	Olive Webb is a clinical psychologist and has more than 30 years experience working in the disability sector, particularly with people with intellectual disabilities. Based in Hororata, Olive has a focus on rural health issues and delivery. She provides clinical consultancy to IHC, and also consults in the Mental Health sector. Olive is a director of Institute of Applied Human Services and Access Home Health. She is also a member of the Health Practitioners Disciplinary Tribunal.
Alister James	Alister James is a barrister in private practice and a Board member of the Legal Services Agency. He is also the Honorary British Consul in Christchurch and spent more than 20 years in local Government as a Christchurch City Councillor. Alister is a Trustee on Nga Hau e Wha National Marae and Pegasus Employment and Environmental Trust, and the Chairperson of Home Made Partnership Trust. With a strong involvement in the community and voluntary sector, Alister has a particular interest in community health issues. His involvement in the pilot Youth Drug Court and the Youth Court itself has led to an interest in adolescent and alcohol and drug services.

/ continued /

BOARD MEMBERS - continued

Karen Guilliland	Karen Guilliland is Chief Executive of the New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the PHARMAC Board. She also provides consultancy to Parents Centre NZ.
Jo Kane	Jo Kane is a Waimakariri District Councillor and Deputy Mayor, who believes in the basic right to protect health and well being for all.
Laurence Malcolm	Laurence Malcolm is a medical graduate, Professor Emeritus and former Professor of Community Health at the Wellington School of Medicine. He currently works as a consultant in health services research and development, is a member of the Council and Executive of Age Concern Canterbury, and has been on many national and international boards and committees. He has a special interest in primary health care and the quality of clinical services.
Norman Dewes	Norm Dewes is the Chief Executive of the urban Māori authority based in Canterbury (Te Runanga o Nga Maata Waka). Norm is a member of the New Zealand Advertising Standards Authority, Canterbury Museum Advisory Committee, and Canterbury Community Primary Health Organisation. He is the Chairperson of Te Rito Arahi Māori Alcohol, Drug and Resource Centre, Otautahi Social Services, Māori Legal Services and Capital Planning and Development, and is the Manager of Nga Hau e Wha National Marae. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the year ended 30 June 2006.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based district health board, which provides Health and Disability Support Services, principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB Group recorded a net surplus of $2.86 million against a budgeted breakeven position. (2004/05 result was a net surplus of $0.361 million).

BOARD FEES

Board fees paid, or due payable, to Board and Committee Members for services during the year, were as follows:

	Board Fees Year ended 30/06/06 $'000	Committee Fees Year ended 30/06/06 $'000
Syd Bradley	48	4
Olive Webb	30	4
Robin Booth	24	2
Heather Carter	24	5
Norman Dewes	24	3
Neville Fagerlund	24	3
Karen Guilliland	24	2
Alister James	24	2
Jo Kane	24	4
Laurence Malcolm	24	4
David Morrell	24	7
Peter Ballantyne*	-	1
Alison Wilkie	-	4
Richard Buchanan	-	1
Ruth Jones	-	1
David Kerr	-	3
Winston McKean	-	2
John Musgrove	-	2
Tuari Potiki*	-	1
Trevor Read	-	3
William Tate		3
	294	**61**

* appointed during the year

Total fees paid for the year were $355,000 (2004/05 - $336,000). The limit of fees authorised for the year ended 30 June 2006 was $384,000 (2004/05 - $384,000).

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the year were as follows:

	Year Ended 30/06/06 $'000	Year Ended 30/06/05 $'000
David Morrell	10	10
Graham Heenan	13	13
	23	23

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the Interest Register:

CANTERBURY DHB

Syd Bradley	Chair - Christchurch International Airport Co Limited Chair - Waipara Hill Wine Estate
Olive Webb	Member - Health Practitioners Disciplinary Tribunal Health Consultant - IHC New Zealand Director - Institute of Applied Human Services Director - Access Home Health
Heather Carter	Council Member - Christchurch Polytechnic Institute of Technology Company Owner and Consultant - LifeMasters President - National Council of Women, Canterbury Branch
Norman Dewes	CEO – Te Runanga O Nga Maata Waka Chair - Te Rito Arahi Māori Alcohol, Drug and Resource Centre Board Member/Vice Chair - Canterbury Community Primary Health Organisation Director - Te Amorangi Richmond Wellness Village Board Member - New Zealand Advertising Standards Authority Advisory Committee Member (Māori) - Canterbury Museum Chair - Otautahi Social Services Chair - Māori Legal Services Secretary - Te Runanga O Ngati Kahungunu ki Waitaha Chair - Capital Planning and Development Manager, Nga Hau e Wha, National Marae
Karen Guilliland	CEO – New Zealand College of Midwives Director – Midwifery and Maternity Provider Organisation Limited Board Member - PHARMAC Consultant - Parents Centre NZ
Neville Fagerlund	Director - Cambridge Clinic (DSAC) Limited Advisor - Pegasus After Hours Limited Advisor - Pegasus Health (Charitable) Advisor - Pegasus Health Membership Limited (and associate companies) Advisor - 24-Hour Surgery Limited
Alister James	Barrister and Youth Advocate (approved pursuant to Section 323 of the Children, Young Persons and Their Families Act 1989) Chair - Home Made Partnership Trust (Christchurch Supergrans) Honorary British Consul Member - Legal Services Agency Board (Crown Entity) Trustee - Nga Hau e Wha National Marae Trustee - Pegasus Employment and Environmental Trust (PEEPS Trust) Spouse is an employee with Community and Public Health, Canterbury District Health Board

Jo Kane	Deputy Mayor, Waimakariri District Council
Laurence Malcolm	Consultant - Aotearoa Health Limited Member - Age Concern Canterbury, Council and Executive
David Morrell	Chair – Brackenridge Estate Limited Committee Member- Anglican Aged Care Member - Environment Canterbury, Christchurch Area Committee
Ruth Jones	Regional Services Co-ordinator - New Zealand CCS
Richard Buchanan	Employee - CCS Canterbury West Coast Board Member - TimeOut Carers
David Kerr	Advisor - Pegasus Health Chairman - Ryman Healthcare Ltd Chair - Centrecare Limited General Medical Practitioner Trustee - Health Education Trust Advisor - Medical Protection Society
Winston McKean	Panel Member - Human Rights Review Tribunal Chair - National Taskforce on Primary Health Care and PHO Development Chair - Rural Canterbury Primary Health Organisation
John Musgrove	Board of Governors - Windsor House
Trevor Read	Manager, Patient Safety - ACC Establishment Programme
Alison Wilkie	Trustee - Family Help Trust Member - Pharmaceutical Society of New Zealand Inc, National Executive Board Member - Pharmaceutical Society of New Zealand Limited Trustee - Riccarton Bush Trust Shareholder interest - Calan Healthcare
Peter Ballantyne	Trust Board Member, Bishop Julius Hall of Residence Member, University of Canterbury, Audit and Risk Committee Committee Member, Anglican Aged Care Consultant – Deloitte Spouse, Claire Ballantyne is a Canterbury DHB employee
Tuari Potiki	Board Member – He Oranga Pounamu Executive Member – Drug and Alcohol Practitioners Association of NZ Spouse, Tracey is a board member of the Rural Canterbury PHO

SUBSIDIARY AND ASSOCIATED COMPANIES

Garth Bateup	Director of subsidiaries Brackenridge Estate Limited and Canterbury Laundry Service Limited. No directors fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Paul Numan	Director of subsidiary, Brackenridge Estate Limited. No directors fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.
Wei Yoon	Director of associate company New Zealand Centre for Reproductive Medicine Limited. No directors fees or any other benefits were received from the associate company except as an employee of Canterbury DHB.

DIRECTORS' AND BOARD MEMBERS' LOANS

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensure that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

USE OF BOARD OR SUBSIDIARIES' INFORMATION

During the year, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place, eg: amounts for redundancy (based on length of service), and payment in lieu of notice etc.

The total payments made by Canterbury DHB were $35,074 (2004/05 – 4 employees totalling $211,900) comprise negotiated settlements with all of the former employees.

Number of Employees	TOTAL $
1	25,574
1	4,000
2	5,500
4	**35,074**

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands is as follows:

	30/06/06 Number	30/06/05 Number
$100,000 - $110,000	77	51
$110,001 - $120,000	55	40
$120,001 - $130,000	49	28
$130,001 - $140,000	34	30
$140,001 - $150,000	26	28
$150,001 - $160,000	26	20
$160,001 - $170,000	41	24
$170,001 - $180,000	25	16
$180,001 - $190,000	16	21
$190,001 - $200,000	20	24
$200,001 - $210,000	24	20
$210,001 - $220,000	10	11
$220,001 - $230,000	7	6
$230,001 - $240,000	6	5
$240,001 - $250,000	3	2
$250,001 - $260,000	3	3
$260,001 - $270,000	2	1
$270,001 - $280,000	1	-
$280,001 - $290,000	2	2
$290,001 - $299,000	1	-
$300,001 - $310,000	-	1
$330,001 - $340,000[1]	1	-
$400,011 - $410,000[1]	-	1
	429	**334**

Of the 429 positions identified above, 397 (2004/05 - 304) were predominantly clinical and 32 (2004/05 - 30) positions were management/administrative.

[1] CEO remuneration and other benefits are included in these brackets.

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STATUTORY DISCLOSURE

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000;

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000; and

(c) a report on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2006, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 36.

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	**Extent objectives met**
(a) to improve, promote, and protect the health of people and communities:	The CDHB planning in service development involves stakeholders in the primary care, secondary care, community service providers, public health groups and other government agencies, as appropriate. The CDHB funds and delivers a range of services from health promotion and protection services, primary care to specialist tertiary services to meet the needs of its population. The key areas of focus were Child and Youth Health, Older Person's Health, Māori Health and He Korowai Oranga, Primary Health, Mental Health and the Mental Health Blueprint and the NZ Disability Strategy. Further to this the CDHB focused on the following disease priorities: Cancer, Cardiovascular Disease and Diabetes. The Minister's expectations also saw particular focus on elective services, radiotherapy waiting times, effectiveness and value for money.
(b) to promote the integration of health services, especially primary and secondary health services:	The CDHB has developed a Framework for Community and Primary Health Care to improve population health and improve access to primary care. Through consultation a number of principles were developed as the basis for funding community and primary health initiatives in Canterbury. This work will evolve and feed into the development of a framework for chronic disease management and health services planning in 2006/2007. A successful collaborative sector-based approach between the CDHB and the five Canterbury PHOs has been taken on a number of projects over the past year: ▪ The MoH has approved a joint initiative under the Cancer Control Strategy; ▪ Work on Health Promotion and Care Plus Plans is ongoing; and ▪ An Oral Health initiative has also been approved by the MoH, which will see PHOs involved in the oral health care needs of their enrolled population. The CDHB has embarked on a project called Improving the Patient Journey. This is a major CDHB initiative to improve the quality and effectiveness of the service we provide to patients. The current phase of the initiative has been focused on improving acute patient flows. Significant investment has been made on ED flow issues, establishing new acute clinical pathways and understanding the acute surgical pathways. While continuing with the work begun in 2005 the CDHB wants to ensure that the continuum of care (from population to tertiary services) is linked in a strategic response to its priority disease states. An overarching chronic disease management framework will be developed over the coming year under the CDHB's Core Direction *Finding Better Ways of Working*. This framework will address strategic work for each of the four disease priorities

	the DHB has chosen (Cancer, Cardiovascular, Diabetes and Respiratory Disease). This work will be aligned with national and regional work and will allow the DHB to look across the spectrum to develop a disease continuum with the patient as the central focus providing the right services, at the right time, in the right location and by the right provider.
(c) to promote effective care or support for those in need of personal health services or disability support services:	The CDHB has developed an Older People's Health Strategy entitled *Healthy Ageing, Integrated Support*. The underlying objective is to maintain older people's independence for as long as possible, reduce the period and level of dependence and at the same time provide effective, integrated services when they are required. Work has begun on implementing the Strategy including: ▪ Further developing home care packages looking at wrap-around review and monitoring of packages; ▪ Evaluating entry criteria and access points to residential care to best meet the needs of older people through integrated support in the community; ▪ Exploring workable models of care within other DHBs and work with providers to develop flexible, coordinated care (focusing on building medium packages of care in the community as an alternative to residential care); ▪ Reviewing community day care options and developing plans to build capacity for general and dementia stand-alone day care centres; ▪ Building hospital respite capacity to relieve the waiting list and free up more beds at this level for respite stays. Aiming to provide greater support to older people and their carers living in the community; ▪ Transitioning rest home beds to hospital level with additional hospital beds generally replacing rest home beds within existing aged residential care facilities to meet service levels where the need is greatest and maintaining provider sustainability; ▪ Working with SISSAL to create a map of service location, type and demographics in order to enhance better planning for additional older people's services; and ▪ Developing an evaluation tool to enable measurement of progress against the goals and actions of the Strategy.
(d) to promote the inclusion and participation in society and independence of people with disabilities:	The CDHB aims to ensure it contributes to a 'non disabling' society through its actions, and the actions of the providers with whom it contracts. The CDHB has developed a Disability Strategic Action Plan (DSAP) that outlines the steps it is making to implement the NZ Disability Strategy. The DSAP involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring. All new CDHB building developments are assessed for meeting the needs of people with disabilities.
(e) to reduce health disparities by improving health outcomes for Māori and other population groups:	The CDHB has produced and implemented its Māori Health Action Plan and over the past year this Plan has been reviewed up updated. The key focus of this is He Korowai Oranga and key objectives include improving ethnicity data collection, reducing health inequalities and supporting Māori health workforce development. ▪ An Ethnicity Data Collection Project has been run at a pilot site (The Princess Margaret Hospital) and is producing excellent results. This Project is being rolled-out across all the CDHB sites. ▪ A scorecard for analysing Māori and Pacific utilisation of health services has been developed as part of the updated draft Māori Health Plan. Building quality data and monitoring Māori health outcomes are key milestones of the national Māori Health Plan the CDHB is committed to implementing in 2006/2007. The CDHB is continuing with the development of the Pacific People's Health Action Plan which focuses on supporting Pacific People as healthworkers, involving Pacific People in health service development and actively collecting ethnicity data.

(f)	to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The CDHB Health Needs Assessment has identified groups in the community, which have health inequalities. Strategic Plan Health Gain Priority Areas are identified as part of this process. For the coming years the following Health Gain Priorities have been identified: Child and Youth Health, Older Person's Health, Māori Health, Primary Health, Disease Prevention and Management with a focus on Cancer, Cardiovascular, Diabetes and Respiratory Disease. Work continues with PHOs in Canterbury to reduce barriers to primary care including the financial barriers to care through the reduction of co-payments for all 18-25 year olds and 45-64 year olds. Over the next year the CDHB will work with PHOs to reduce the co-payments for the remaining age group (25-44).
(g)	to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The CDHB continues to enhance relationships with the community, health providers and social agencies such as Age Concern, Child Youth and Family, Kai Tahu and the Christchurch City Council. The CDHB is also working with Territorial Local Authorities to plan for health and social services as outlined in the Local Government Act 2002. Under its Core Direction *Working Together*, the CDHB will focus in 2006/2007 on *Sharing Responsibility for Quality Health Outcomes with Our Community*. There are a number of determinants of health which the CDHB cannot effect alone and as such we will work with local agencies TLAs and health forums to address those social determinants such as housing, income, education, transport and recreation and to develop a shared vision for improving outcomes. The CDHB will also focus on increasing the level of community action through leadership, advocacy and promotion of intersectorial engagement.
(h)	to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	The CDHB actively participates in forums such as Healthy Christchurch and information gathered from these forums assists the service planning process. The CDHB also engages in active consultation through formal processes (eg in the development of the District Strategic Plan) and sector representation on project steering groups. The CDHB's *Healthy Eating Active Living Plan* (HEAL) is in place to promote and support healthy eating and active living within DHB settings. Streams of work include: ▪ Working on the recently funded project *Community Action To Improve Nutritional Capacity*, a joint project between the CDHB and PHOs working with priority communities to change their environments and make it easier for people to eat healthily; and ▪ Progressing the SPARC-funded *Canterbury Active Communities Project* to implementation phase. The development of a sophisticated communication and social marketing campaign is under way as well as plans for supporting and building capacity for community evaluation.
(i)	to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	The CDHB has established a Quality and Patient Safety Council and a Clinical Board to provide advice to the CEO on quality and clinical issues. The Quality and Patient Safety Council is a forum for the wider DHB (eg community providers) to discuss quality issues. This also facilitates ongoing quality improvement processes. The CDHB also has processes in place to maintain and improve quality including Quality Health New Zealand accreditation process for its hospitals and performance targets and measures to maintain appropriate levels of clinical quality. The Clinical Board has a strong focus on clinical governance and has a solution oriented proactive role in the setting of clinical policy and standards and encourages best practice and innovation. The Board supports the organisation's vision and values and will set a leadership role by example.
(j)	to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	The CDHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme.

(k) To be a good employer	The CDHB has established and will continue to develop relationships with its health workers and those in the community to build a workforce that meets the health and disability needs of its community. This includes addressing challenges such as staff shortages in some areas, staff needs for ongoing career development, staff participation in decision-making, and creating a family-friendly environment.

Section 42(3)(i) – Statement of how CDHB has given effect and intends to give effect to its functions specified in section 23 (b)-(e)	
Function:	**What has been done to meet function**
(b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	• The CDHB has involved stakeholders in selection of its' Health Gain Priority Areas for the CDHB District Strategic Plan. • The CDHB actively involves relevant groups and individuals in planning specific service areas. • The CDHB has established joint arrangements with external providers for some provision of orthopaedic and cardiac surgery services. • The CDHB works with the MoH in a number of joint/collaborative ways such as Public (Population) Health shared decision making; and the allocation of the Māori and Pacific Health development funding. • The CDHB continues to implement the District Strategic Plan and to develop the Strategic Plan for the next five years.
(c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):	• The CDHB uses a variety of written media, TV and radio work to outline general issues and priorities and the community. • The CDHB will continue to respond directly to media / personal / group enquires. • The CDHB circulates and makes available significant documents and plans for its population in summary and comprehensive form either at libraries, via groups or individually and on its website. • The CDHB involves sector representatives in steering groups leading the planning for health services. • The CDHB has developed a website, which includes community based health information and its primary planning documents. • The CDHB continues to provide health promotion services funded by the MoH.
(d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:	Relationships with Manawhenua Ki Waitaha, Te Runanga and Nga Maata Waka continue to develop. Māori community hui are held quarterly and regular meetings with Māori providers and other Māori community organisations. The outcomes of these meetings are fed directly into the CDHB planning process.
(e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:	The CDHB has established Te Kahui Taumata, which includes the Taua, the Executive Director Māori and Pacific Health, and senior Māori staff who provide Māori specific advice to the Chief Executive.

For and on behalf of the Board

Syd Bradley
Chair
25 September 2006

Neville Fagerlund
Board Member
25 September 2006

STATEMENT OF RESPONSIBILITY

Pursuant to Section 42 of the Public Finance Act 1989, we acknowledge that:

a) The preparation of financial statements of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2006, are our responsibility.

c) In our opinion, the financial statements for the year under review fairly reflect the financial position and operations of Canterbury DHB.

Syd Bradley
Chair
25 September 2006

Gordon Davies
Chief Executive Officer
25 September 2006

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Group Actual 30/06/06 $'000	Group Budget 30/06/06 $'000	Group Actual 30/06/05 $'000	Parent Actual 30/06/06 $'000	Parent Actual 30/06/05 $'000
OPERATING REVENUE						
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
TOTAL REVENUE		1,023,642	992,575	942,588	1,014,886	934,608
OPERATING EXPENSES						
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	11	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
TOTAL OPERATING EXPENSES		1,005,705	969,345	920,447	997,561	912,884
OPERATING SURPLUS BEFORE CAPITAL CHARGE		17,937	23,230	22,141	17,325	21,724
Capital Charge Expense		(15,076)	(23,230)	(21,862)	(15,076)	(21,862)
SURPLUS / (DEFICIT) BEFORE TAXATION		2,861	-	279	2,249	(138)
Tax Benefit / (Expense)		-	-	82	-	-
NET SURPLUS / (DEFICIT) FOR THE YEAR	**2**	**2,861**	**-**	**361**	**2,249**	**(138)**

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

	Notes	Group Actual 30/06/06 $'000	Group Budget 30/06/06 $'000	Group Actual 30/06/05 $'000	Parent Actual 30/06/06 $'000	Parent 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)	-
				-		-
TOTAL EQUITY AT END OF THE PERIOD		**287,326**	**199,344**	**199,705**	**285,612**	**198,603**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2006

	Notes	Group Actual as at 30/06/06 $'000	Group Budget as at 30/06/06 $'000	Group Actual as at 30/06/05 $'000	Parent Actual as at 30/06/06 $'000	Parent Actual as at 30/06/05 $'000
CROWN EQUITY						
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
TOTAL EQUITY		**287,326**	**199,344**	**199,705**	**285,612**	**198,603**
REPRESENTED BY:						
CURRENT ASSETS						
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
TOTAL CURRENT ASSETS		45,425	21,798	33,044	44,301	32,020
CURRENT LIABILITIES						
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
TOTAL CURRENT LIABILITIES		156,330	133,836	148,661	155,112	147,680
NET WORKING CAPITAL		(110,905)	(112,038)	(115,617)	(110,811)	(115,660)
NON CURRENT ASSETS						
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
TOTAL NON CURRENT ASSETS		486,390	416,332	400,483	484,304	399,102
NON CURRENT LIABILITIES						
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
TOTAL NON CURRENT LIABILITIES		88,159	104,950	85,161	87,881	84,839
NET ASSETS		**287,326**	**199,344**	**199,705**	**285,612**	**198,603**

For and on behalf of the Board

Syd Bradley
Chair
25 September 2006

Neville Fagerlund
Board Member
25 September 2006

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Group Actual as at 30/06/06 $'000	Group Budget as at 30/06/06 $'000	Group Actual as at 30/06/05 $'000	Parent Actual as at 30/06/06 $'000	Parent Actual as at 30/06/05 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
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
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	13	47,623	35,079	74,545	45,791	73,195
CASH FLOWS FROM INVESTING ACTIVITIES						
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
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(22,894)	(34,450)	(47,651)	(21,203)	(46,117)
CASH FLOWS FROM FINANCING ACTIVITIES						
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
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(22,000)	3,000	(15,950)	(22,000)	(15,950)
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)
CLOSING CASH BALANCE		**12,838**	(2,702)	**10,109**	**12,270**	**9,682**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2006

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Public Finance Act 1989.

The group currently consists of Canterbury DHB, its subsidiaries Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entities, New Zealand Centre for Reproductive Medicine Ltd (50% owned) and South Island Shared Services Agency Ltd (47% owned).

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain fixed assets.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Funding for health related services received from the Ministry of Health by the Funder arm of Canterbury DHB is recognised as revenue in the financial year. Revenue from other contracts for services where funding is still the responsibility of the Ministry of Health, is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of Canterbury Health Ltd. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of Canterbury DHB

Assets acquired by the DHB since its establishment are recorded at cost except for land, buildings and fitout plant and equipment that are revalued every five years. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of land, buildings and fitout plant and equipment

Land, buildings and fitout plant and equipment are revalued every five years in accordance with FRS3. The value of land, buildings and fitout plant and equipment is determined by an independent registered valuer by reference to the highest and best use of these assets or, if sufficient market based evidence is not available, by reference to their optimised depreciated replacement cost. Additions between revaluations are recorded at cost. The results of revaluing land, buildings and fitout plant and equipment are credited or debited to the assets revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

The latest valuation was performed as at 30 June 2006 by Chris Stanley (Registered Valuer) of TelferYoung (Canterbury) Ltd.

Donated Assets

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

iv) Depreciation

Depreciation is charged on a straight line basis so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	20 - 50
Leasehold Building & Fitout	3 - 20
Fitout Plant and Equipment	5 - 50
Plant and Equipment (incl pool)	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) Goods and Services Tax

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) Stocks

Stocks are valued at the lower of cost and net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

vii) Accounts Receivable

Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

vii) Investments

The investment in the associate companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis.

Other investments are stated at the lower of cost and net realisable value.

Dividend and interest income is accounted for on an accrual basis.

ix) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CB3 of the Income Tax Act 1994.

In prior years, Canterbury DHB subsidiaries were subject to income tax, with the exception of Brackenridge Estate Ltd. From the beginning of 1 July 2004 Canterbury Laundry Service Limited is also exempt from income tax under Section CB3 of the Income Tax Act 1994. Previously, income tax expense was charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. The tax provisions have been reversed following the tax exempt status given to Canterbury Laundry Service Limited.

x) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xi) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as finance leases and the related lease assets are capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected economic lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiii) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xiv) Provision for Staff Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, parental leave, conference leave, and sabbatical leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xv) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non current securities and advances (other than securities and advances included within cash) and any other non current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvi) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xvii) Financial Instruments

Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost and market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xviii) Basis of Consolidation

The consolidated financial statements include the parent DHB and its subsidiaries. The subsidiaries are accounted for by adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis which shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

D CHANGE IN ACCOUNTING POLICIES

There have been no changes in accounting policies during the year. All policies have been applied on a basis consistent with the previous period.

Canterbury DHB's adoption of the New Zealand equivalent International Financial Reporting Standards (NZ IFRS) will be in line with government entity timeframe, effective 1 July 2007, i.e. for the 2007/08 financial year. This will require the 2006/07 financial statements to include restated NZ IFRS–compliant comparatives for the year ended 2007 and opening balances as at 1 July 2006. The DHB has been working

with representatives of the Ministry of Health and Treasury along with external advisers, to identify and quantify the impacts of NZ IFRS adoption and also to implement processes for capturing all relevant information. Our preliminary work has identified some changes will result, including the areas associated with Employee Entitlements, Derivatives, Revenue, Leases, Capital Contributions and Trust Equity. However, the full financial effects of NZ IFRS have yet to be determined or calculated. Some presentation and classification issues will arise as a result of the adoption of NZ IFRS. Some assets and liabilities may be reclassified and accordingly, some impact in the Statement of Financial Performance may be expected.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating deficit is stated:	Group		Parent	
	30/06/06 $'000	30/06/05 $'000	30/06/06 $'000	30/06/05 $'000
After Charging:				
Remuneration of Auditor:				
- Audit Fees	148	148	117	127
- Other Services	3	-	3	-
Board Members' Fees	294	284	294	284
Directors' Fees	23	23	-	-
Interest Expense	4,936	4,183	4,957	4,183
Bad Debts Written Off	408	589	408	589
Increase/(Decrease) in Bad Debts Provision	(680)	(649)	(680)	(649)
Rental and Operating Lease Costs	3,444	3,438	2,997	2,991
After Crediting:				
Interest Income	3,102	1,406	3,187	1,384
Gain (loss) on Disposal of Assets	3,625	(157)	3,625	(151)

3. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Trade Debtors	7,782	6,644	7,678	6,540
Receivable from the Ministry of Health	8,849	8,880	8,525	8,522
Other Debtors	7,859	310	7,825	264
Prepayments	901	507	870	469
	25,391	16,341	24,898	15,795

4. STOCKS

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Pharmaceuticals	2,468	2,366	2,468	2,366
Surgical and Medical Supplies	3,985	3,399	3,985	3,399
Other Supplies	1,501	1,700	1,438	1,649
	7,954	7,465	7,891	7,414
Provision for Obsolescence	(758)	(871)	(758)	(871)
	7,196	6,594	7,133	6,543

Some of the stocks may be subject to restriction of title ie Romalpa Clauses or securities registered by suppliers under the Personal Property Securities Act. The value of stocks subject to the above cannot be quantified due to the inherent difficulties in identifying stocks that are still subject to the Romalpa Clauses or security registered under the PPSA at year end.

5. EQUITY

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
GENERAL FUNDS				
Opening Balance	148,174	148,174	148,312	148,312
Equity repayment to MoH (2 cash repayments of $11m each)	(22,000)	-	(22,000)	-
	126,174	148,174	126,312	148,312
RETAINED EARNINGS				
Opening Balance	(34,591)	(34,326)	(35,734)	(34,740)
Operating Surplus/(Deficit)	2,861	361	2,249	(138)
Transfers from/(to) Trust Reserve	295	(626)	315	(856)
Closing Balance	(31,435)	(34,591)	(33,170)	(35,734)
Represented by :				
Accumulated Deficit in Parent and Subsidiary	(31,513)	(34,669)	(33,248)	(35,812)
Accumulated Surplus in Associates	78	78	78	78
	(31,435)	(34,591)	(33,170)	(35,734)
REVALUATION RESERVE				
Opening Balance	77,717	77,717	77,717	77,717
Current Year Movement	106,760	-	106,760	-
Closing Balance	184,477	77,717	184,477	77,717
Represented by:				
Revaluation of land	68,603	27,531	68,603	27,531
Revaluation of building including fitout	114,374	49,196	114,374	49,196
Revaluation of reversionary interest in	1,500	990	1,500	990
	184,477	77,717	184,477	77,717
TRUST RESERVE				
Opening Balance	8,405	7,779	8,308	7,452
Transfers from/(to) Retained Earnings	(295)	626	(315)	856
Closing Balance	8,110	8,405	7,993	8,308

6. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2006, the amount of funds received where the conditions attached have not been fulfilled is $8,110,000 ($8,405,000 at 30 June 2005).

This is represented by:

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Cash at Bank	355	484	355	387
Term Deposits	836	3,291	719	3,291
Local Authorities & Government Stocks	830	870	830	870
Bonds & Stocks	6,089	3,760	6,089	3,760
Total Restricted Assets	8,110	8,405	7,993	8,308

7. RESIDENTS' TRUST ACCOUNT

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Residents' Trust Account Balance	806	753	806	385

Residents' Trust Account comprises bank balances representing funds managed on behalf of Residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual residents' balances. Therefore, transactions occurring during the year are not included in the Statement of Financial Performance, Financial Position or Cash Flow of Canterbury DHB.

8. STAFF ENTITLEMENTS

Staff Entitlements consist of:

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Annual Leave Accruals	31,797	27,450	31,344	26,995
Unpaid Days Accruals	10,004	8,833	9,799	8,649
ACC Accruals	2,959	2,546	2,955	2,488
Other	4,159	5,560	4,059	5,422
Staff Entitlement Due Within 1 Year	48,919	44,389	48,157	43,554

9. PROVISIONS

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Provisions due within 1 year	29,217	22,540	29,189	22,540
Provisions due after 1 year	9,509	6,511	9,231	6,189
Total Provisions	38,726	29,051	38,420	28,729
Movement in Provisions				
Opening balance	29,051	19,835	28,729	19,450
Additional provisions made during the year	19,812	13,064	19,828	13,101
Charged against provisions for the year	(10,137)	(3,848)	(10,137)	(3,822)
Closing balance	38,726	29,051	38,420	28,729

These provisions primarily relate to staff entitlements, but also includes a refurbishment provision for Brackenridge. Staff entitlements include gratuities, long service leave, conference and sabbatical leave expenses, parental leave, and collective employment contracts pending finalisation of pay negotiations.

10. LOANS AND BANK OVERDRAFT

Loans consist of:	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Commercial Loans	-	-	-	-
Crown Financing Agency	78,650	78,650	78,650	78,650
	78,650	78,650	78,650	78,650
Repayable as follows:				
Due Within 1 Year	-	-	-	-
Two - Five Years	78,650	78,650	78,650	78,650
	78,650	78,650	78,650	78,650

The bank overdraft facility available totals $1,000,000 for both the parent and the group.

Security

Canterbury DHB commercial loans and the overdraft facilities are secured by Deed of Negative Pledge which requires the Board to comply with certain covenants such as limitations on borrowings, interest cover and working capital ratio.

Interest Rates

Average interest rates on the group's borrowing for the year are as follows:

	Group		Parent	
	30/06/06	30/06/05	30/06/06	30/06/05
Commercial Loans	-	6.57%	-	6.57%
Crown Financing Agency	6.24%	5.87%	6.24%	5.87%
Bank Overdraft	8.80%	8.45%	8.80%	8.45%

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
At Cost				
Buildings and Fitout Plant	-	58,502	-	58,502
Leasehold Building & Fitout	1,281	3,042	894	3,042
Plant and equipment	74,720	87,465	69,693	82,155
Computer equipment and software	40,578	36,564	40,521	36,517
Motor vehicles	4,988	4,890	4,371	4,295
Capital work-in-progress	15,841	5,842	15,727	5,842
At Valuation				
Land	99,913	64,301	99,913	64,301
Buildings and Fitout Plant	300,816	217,209	300,816	217,209
Plant and equipment	24,791	24,791	24,791	24,791
Reversionary interest in buildings	1,500	990	1,500	990
	564,428	503,596	558,226	497,644
Accumulated Depreciation				
Buildings and Fitout Plant	-	41,441	-	41,441
Leasehold Building & Fitout	891	339	808	339
Plant and equipment	58,549	49,290	55,557	46,379
Computer equipment and software	35,930	28,010	35,882	27,996
Motor vehicles	2,913	2,049	2,615	1,824
	98,283	121,129	94,862	117,979
Net Book Value				
Land	99,913	64,301	99,913	64,301
Buildings and Fitout Plant	300,816	234,270	300,816	234,270
Leasehold Building & Fitout	390	2,703	86	2,703
Plant and equipment	40,962	62,966	38,927	60,567
Computer equipment and software	4,648	8,554	4,639	8,521
Motor vehicles	2,075	2,841	1,756	2,471
Capital work-in-progress	15,841	5,842	15,727	5,842
Reversionary interest in buildings	1,500	990	1,500	990
	466,145	382,467	463,364	379,665
Depreciation charged during the year:				
Buildings and Fitout Plant & leasehold	27,585	21,047	27,548	21,047
Plant and equipment	10,860	10,898	10,050	10,045
Computer equipment and software	7,920	6,928	7,886	6,853
Motor vehicles	1,007	646	902	625
	47,372	39,519	46,386	38,570

Canterbury DHB revalued its land, buildings and fitout plant as at 30 June 2006. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of TelferYoung (Canterbury) Ltd), which is consistent with FRS3 Accounting for Property Plant & Equipment, and resulted in the net increases in the value of land ($41,072,000), buildings and fitout ($65,178,000) and reversionary interest in a car park building ($510,000). This increase had been recognised in the Revaluation Reserve. The total optimised depreciated replacement cost of Canterbury DHB's land and buildings including fitout as at 30 June 2006 was $400,729,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 2019. This interest has not been included in the Statement of Financial Position, other than the total revaluation effect of $1,500,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

12. INVESTMENTS

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Investment in Associates	375	311	375	311
Investment in Subsidiaries	-	-	812	1,518
	375	311	1,187	1,829

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Share of Associates Equity Brought Forward	168	168	168	168
Share of Associates Operating Surplus	-	-	-	-
Share of Associates Equity Carried Forward	168	168	168	168
Advances	207	143	207	143
	375	311	375	311

At 30 June 2006, Associate Companies comprised:

	Percentage Interest	Balance Date
New Zealand Centre for Reproductive Medicine Ltd	50	30 June
South Island Shared Services Agency Ltd	47	30 June

New Zealand Centre for Reproductive Medicine Ltd provides reproductive medicine services to private and publicly funded patients.
South Island Shared Services Agency Ltd provides a range of support services such as contracting, contract monitoring and provider audits on behalf of the South Island DHBs Funding arms.

INVESTMENT IN SUBSIDIARIES

	Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000
Equity - Canterbury Laundry Service Ltd	393	393
Advances - Canterbury Laundry Service Ltd	1,823	1,677
Equity - Brackenridge Estate Ltd	(87)	(315)
Advances - Brackenridge Estate Ltd	(1,317)	(237)
	812	1,518

At 30 June 2006 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Laundry Service Ltd	100%	30 June
Brackenridge Estate Ltd	100%	30 June

Canterbury Laundry Service Ltd provides laundry services. Brackenridge Estate Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

Canterbury DHB appoints all the directors of Canterbury Laundry Service Ltd. The company provides services predominantly to Canterbury DHB, and Canterbury DHB has control over the objectives of the company.

Canterbury DHB appoints three out of five directors of Brackenridge Estate Ltd. Its control over the company is exercised through these directors and the provision of financial support and administrative services by Canterbury DHB.

13 RECONCILIATION OF NET SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH FLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	30/06/06 $'000	30/06/05 $'000	30/06/06 $'000	30/06/05 $'000
Net Operating Surplus before Share of Associate Co's Surplus	2,861	361	2,249	(138)
Add Back Non-Cash Items:				
Depreciation	47,372	39,519	46,386	38,570
Add Back Items Classified as Investing Activity:				
(Gain) / loss on Asset Sale	(3,625)	157	(3,625)	151
	46,608	40,037	45,010	38,583
Movement in Term Portion Provisions	2,998	1,398	3,042	1,362
Movement in Deferred Tax	-	(50)	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	(9,050)	11,135	(9,103)	11,279
Decrease/ (Incr.) in Stocks	(602)	212	(590)	208
Increase/ (Decr.) in Creditors & Other Accruals	95	6,080	(187)	6,135
Increase/ (Decr.) in Capital Charge due to Crown	(3,633)	1,561	(3,633)	1,561
Increase/ (Decr.) in Staff Entitlements	4,530	6,354	4,603	6,150
Increase/ (Decr.) in Provisions	6,677	7,818	6,649	7,917
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	47,623	74,545	45,791	73,195

14. COMMITMENTS

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
CAPITAL COMMITMENTS				
Committed at Balance Date	31,536	32,041	30,762	32,041
NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Leases	13,901	14,646	7,725	8,009
Vehicle Leases	-	31	-	31
Other	7	5	-	-
	13,908	14,682	7,725	8,040
For Expenditure Within:				
1 Year	1,387	1,633	923	1,169
2 Years	1,151	1,282	687	820
3 Years and Beyond	11,370	11,767	6,115	6,051
	13,908	14,682	7,725	8,040

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are re-negotiated periodically reflecting the general principle that an on-going business relationship exists with those providers. Examples of these contracts include contracts for primary care, personal health and mental health.

There are also contracts for demand-driven items where the total expenditure is not defined in advance. Examples of this type of expenditure are pharmaceuticals, subsidy payments to rest homes and carer support relief payments.

The value of the Board's commitment relating to these contracts has not been included in the disclosure above.

15. TRANSACTIONS WITH RELATED PARTIES

a) GOVERNMENT FUNDING

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the Canterbury DHB. Canterbury DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

b) INTER-GROUP TRANSACTIONS

During the financial year the group had the following inter-group transactions:

	Group		Parent	
	30/06/06 $'000	30/06/05 $'000	30/06/06 $'000	30/06/05 $'000
Revenue				
Interest on advance and director's fees from Canterbury Laundry Service Ltd			138	124
Interest on advance and service fees from Brackenridge Estate Ltd			13	40
Services to Canterbury Laundry Service Ltd			478	427
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	53	57	53	57
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd			3,403	3,349
Services from New Zealand Centre for Reproductive Medicine Ltd		1,675		1,675
Services from South Island Shared Services Agency Ltd	555	608	555	608

Interest charged on advances Canterbury Laundry Service Ltd, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Ltd are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June 2006 are as follows :

	Group		Parent	
	As at 30/06/06 $'000	As at 30/06/05 $'000	As at 30/06/06 $'000	As at 30/06/05 $'000
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd (relates to expenses paid on their behalf and recharged)	207	143	207	143
Amount Payable owing to subsidiaries				
Brackenridge Estate Ltd – Advance			1,317	238
Canterbury Laundry Service Ltd			279	334
Amount Receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – Debtor			45	9
Canterbury Laundry Service Ltd – Advance			1,823	1,700

c) BOARD AND COMMITTEE MEMBERS

During the financial year Canterbury DHB and its subsidiaries have purchased services provided on an arm's length basis by the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/06 $'000	30/06/05 $'000	30/06/06 $'000	30/06/05 $'000
Pegasus Health	14,565	19,350	14,565	19,350
The Christchurch City Mission	468	491	468	491
He Oranga Pounamu Charitable Trust	171	588	171	588
Te Amorangi Richmond Wellness Village	151	303	151	303
Te Rito Arahi Māori Alcohol Drug & Resource Centre	308	330	308	330
Windsor House	1,778	1,298	1,778	1,298
Ryman Healthcare Ltd	4,985	3,572	4,985	3,572
TimeOut Carers	213	47	213	47
Canterbury Community Primary Health Organisation	796	723	796	723
Rural Canterbury Primary Health Organisation	6,450	6,631	6,450	6,631
Access Home Health	2,569	2,765	2,569	2,765
Deloitte	2	-	2	-
Otautahi Women's Welfare League	-	210	-	210

Canterbury DHB and its subsidiaries have provided the following services on an arm's length basis to the organisations listed below which fall within the related party definition:

	Group		Parent	
	30/06/06 $'000	30/06/05 $'000	30/06/06 $'000	30/06/05 $'000
Pegasus Health	127	138	127	138
The Christchurch City Mission	32	37	32	37
Christchurch Polytech	313	333	313	333

16. CAPITAL CHARGE

Canterbury DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2006 was 8% (11% for the year ended 30 June 2005).

17. FINANCIAL INSTRUMENTS

CREDIT RISK

Financial instruments which potentially subject the group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts.

The group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2006, the Ministry of Health owed Canterbury DHB $8.8 million ($8.9 million at 30 June 2005).

CURRENCY RISK

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary.

There were no forward exchange contracts outstanding at 30 June 2006 (30 June 2005 US$100,000 and A$250,000).

INTEREST RATE RISK

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities.

There are interest rates swap and options outstanding at 30 June 2006 of $46 million (30 June 2005 $45 million). The valuation of these contracts at 30 June 2006 is an unrecognised loss of $0.042 million.

FAIR VALUES OF FINANCIAL INSTRUMENTS

Financial instruments recorded in the financial statements have been recorded at their fair values.

18. SEGMENTAL REPORTING

Canterbury DHB operates in the provision of Health and Disability Support Services Industry in the South Island of New Zealand. Therefore, no segmental reporting is required.

19. CONTINGENCIES

Canterbury DHB have the following contingencies at year end:

Collective Employment Agreements negotiations

There are a number of collective employment agreements that expired before 30 June 2006. Negotiations are in progress. Industrial action had taken place and potentially there may be further industrial actions in the future. The financial impact of any additional industrial action relating to these expired collective employment agreements has not been allowed for due to the high degree of uncertainty.

(30 June 2005 – there was one contingency in relation to a claim for a breach of patent rights.)

20. BUDGET VARIANCE

Additional personal health funding for PHO and funding for settlement of the national Public Service Association (PSA) Multi Employer Collective Agreement (MECA) was devolved during the year and is not reflected in these budgets. Additionally, change in capital charge rate from 11% to 8% resulting in funding transferred back to MoH has also not been reflected in the budgets.

21. SUBSEQUENT EVENTS

There were no events after 30 June 2006 which could have a material impact on the information in Canterbury DHB's financial statements (30 June 2005 – no events).

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2005/2006

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

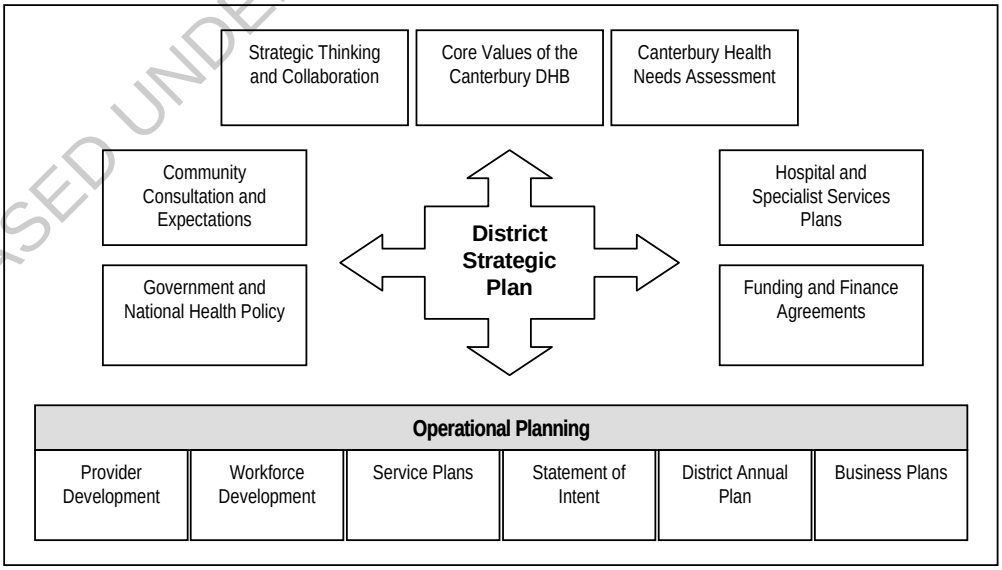
- *A District Strategic Plan* – a long-term strategic document outlining the DHB's intended direction and vision for the next five to ten years. This document is produced through a public consultation and health needs assessment process and enables the DHB to determine key priorities for focus;
- *A 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 Canterbury DHB 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 Canterbury DHB 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 Canterbury DHB 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 Canterbury DHB 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 Canterbury DHB'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 Canterbury DHB's 2005/2008 SOI (unless otherwise stated), and reflect the Canterbury DHB'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:

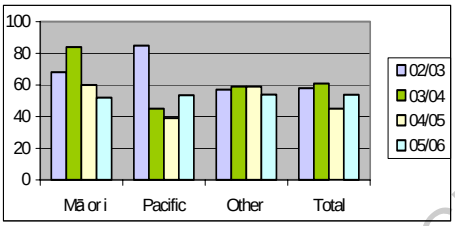
- Funding and Performance (Strategic Plan Health Gain Priorities);
- Provider-Hospital and Specialist Services; and
- Governance.

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.	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. 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 Canterbury DHB agreed a Position Statement on fluoridation in 2003 (available on the DHB website[1]) and is actively promoting fluoridation.

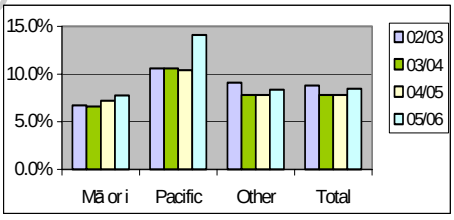
Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
Reduced number of low birth weight babies.	Number of babies born in public hospital with low birth weight (rate per 1000 births). 	Māori 60 Pacific 39 Other 59 Total 45	Māori <72 Pacific <44 Other <58 Total <60	Māori 52 Pacific 53 Other 54 Total 54
		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.		
Minimised impact of hearing loss in children.	Percentage of children passing school entry hearing tests. *Early detection of hearing problems facilitates early intervention and allows the impact to be minimised.*	Māori 93% Pacific 90% Other 95% Total 95%	Māori 92% Pacific 88% Other 95% Total 95%	Unavailable
		The National Audiology Centre is currently processing the data but figures were unavailable to the DHB at the time of preparing this report.		
Improved Child Oral Health.	Average proportion of Missing or Filled teeth of year 8 children.[2]	Total 1.58	Total 1.6	Unavailable
		Due to a failure in the system collecting the data associated with this measure, performance cannot be reported for 2005/06.		
	Percentage of children caries free (no fillings or holes in teeth) at age 5.	Total 51%	Total 52%	Unavailable
		Due to a failure in the system collecting the data associated with this measure, performance cannot be reported for 2005/06.		
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%
		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%.		
	Percentage of school enrolled children who have received their 3rd dose of MeNZB vaccine.	N/A	Total 90%	Total 86%
		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.		

[1] www.cdhb.govt.nz

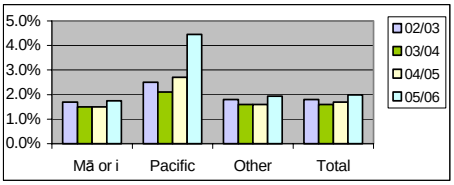
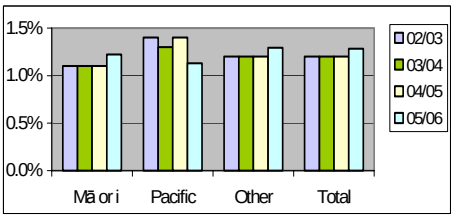
[2] The total permanent teeth missing or filled due to holes divided by the number of children seen by school dental services during the period.

1.2 Primary Health

Objective:	***Brief Description:***
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 Canterbury DHB focused its primary care activities on the following: 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 2. Implementation of the Canterbury DHB's Rural Health Services Action Plan (2002) ensuring equitable access for rural based communities.

Objective 2005/2006	***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. *These services aim to reduce barriers to first contact services for groups with the highest health needs.*	Three PHOs had Plans in place[3].	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.	
		The remaining PHO is determining how to provide desired services over geographical boundaries.		
	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. *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.*	Reduced standardised discharge rates for ambulatory sensitive admissions 0-4 years of age, as a percentage discharged per population.  	Māori 7.2% Pacific 10.4% Other 7.8% Total 7.8%	Māori 6.5% Pacific 9.0% Other 7.2% Total 7.2%	Māori 7.8% Pacific 14.1% Other 8.3% Total 8.4%
		The targets have not been achieved for any of the groupings in this age group. The Canterbury DHB's rates are also above the National Average for all groups of 7.1%.		

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

<table>
<tr><th rowspan="2">Objective 2005/2006</th><th colspan="4">Performance</th></tr>
<tr><th>Measure</th><th>Baseline 04/05</th><th>Target 05/06</th><th>Result 05/06</th></tr>
<tr><td rowspan="2">Reduce Ambulatory Sensitive Admissions.
Ambulatory sensitive admissions are admissions that are potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care.</td><td>Reduced standardised discharge rates for ambulatory sensitive admissions 5-14 years of age, as a percentage discharged per population.
 
</td><td>Māori 1.5%
Pacific 2.7%
Other 1.6%
Total 1.7%</td><td>Māori 1.5%
Pacific 2.0%
Other 1.6%
Total 1.6%</td><td>Māori 1.8%
Pacific 4.4%
Other 1.9%
Total 2.0%</td></tr>
<tr><td colspan="3">Again targets have not been met for all groups in this age group – the National Average (for all groups) is 1.9% so the Canterbury DHB is tracking closer to the average for this indicator.</td></tr>
<tr><td></td><td>Reduced standardised discharge rates for ambulatory sensitive admissions 15-24 years of age, as a percentage discharged per population.
 
</td><td>Māori 1.1%
Pacific 1.4%
Other 1.2%
Total 1.2%</td><td>Māori 1.1%
Pacific 1.1%
Other 1.1%
Total 1.1%</td><td>Māori 1.2%
Pacific 1.1%
Other 1.3%
Total 1.3%</td></tr>
<tr><td colspan="3">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%.</td></tr>
<tr><td></td><td colspan="4">Note: the 65 to 74 year age group is included in the Older Person's Health section.</td></tr>
</table>

1.3 Māori Health

Objective:	***Brief Description:***
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 Canterbury DHB 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: ▪ Support of the Governments commitment to the Treaty of Waitangi; ▪ Māori Participation in health planning, service provision and the workforce; ▪ Effective, culturally appropriate and high quality services; ▪ Monitoring of Māori health outcomes; and ▪ Working across sectors.

Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
Monitoring of Māori health outcomes. *Current collection of ethnicity data is a significant barrier to achieving this objective. The DHB therefore plans to continue to implement accurate Ethnicity Data Collection*[4].	Improved ethnicity reporting. The percentage of discharges classified with the following ethnicity groups: Māori, Other and Not stated. *Targets are set to reduce the percentage of people classified as 'other' or 'not stated' (NS), and increase those classified as Māori.*	Māori 6.0% Other 5.0% NS 2.7%	Māori >7.5% Other <2.5% NS <1.0%	Māori 6.0% Other 5.5% NS 2.7%
		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%. *This Ethnicity Data Collection Project is currently being rolled out across all Hospital and Specialist Services (HSS) sites.*		
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 *Whakamahere Hauora Māori ki Waitaha* with the Ministry of Health (MoH) Māori Health Strategy *He Korowai Oranga* and the Māori Health Action Plan *Whakatataka.*	Draft monitoring performance framework put out for community consultation.[5]	Completion of monitoring framework.	A framework has not yet been completed.
		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. *These key actions are embedded in the revised Māori Health Plan which is awaiting Board sign-off.*		
	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.

[4] 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 Maori (measured against census population) and limits the DHB's ability to monitor health outcomes accurately.

[5] 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 Maori Health Plan. The framework referred here is a much more detailed and operational monitoring tool.

1.4 Mental Health

Objective:	***Brief Description:***
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 Canterbury DHB 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.

Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
Mental Health Volume Delivery (Hospital and Specialist Services) ensured *delivery of contracted Mental Health Volumes.*	Actual service delivered as a percentage of the value of Hospital and Specialist Services (HSS) Mental Health funding provided[6].	99% of contracted volumes delivered.	100% delivery of contracted volumes.	99% of contracted volumes were delivered.
Mental Health Service Funding: *expenditure is allocated to levels specified by the Mental Health "ring-fence".*	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%
		▪ *Target Achieved.*		
Improved access to Mental Health Services: *The New Zealand Mental Health Strategy sets targets for access to treatment and support services for people of different age groups with severe mental illness.*	Percentage of people within each age group accessing mental health treatment and support services. *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.* *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.*	**Total** 0-9: 0.24% 10-14: 0.73% 15-19: 1.03% 20-64: 1.03% 65+: 0.19% *There has been a change in groupings and no broken-down historical data is available.*	***Māori*** 0-19 0.65% 20-64 1.31% 65+ 0.28% ***Other*** 0-19 0.65% 20-64 1.00% 65+ 0.19% **Total** 0-19 0.65% 20-64 1.10% 65+ 0.19%	***Māori*** 0-19 0.41% 20-64 1.33% 65+ 0.31% ***Other*** 0-19 0.64% 20-64 0.98% 65+ 0.17% **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.*		

[6] 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)

Objective: *Improved cardiovascular health status –reducing the incidence of CVD and improving the quality of care.*	***Brief Description:*** Cardiovascular Disease (CVD) has been identified by the Canterbury DHB 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: ▪ Reduce the incidence of cardiovascular disease; ▪ Improve access to cardiovascular services; ▪ Reduce the impact of cardiovascular disease; ▪ Improve information with respect to heart health; and ▪ Improve quality of care after acute events.			
Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
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%
		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 cardiology care.		
	Delivery of target levels of Cardiac Surgery for key procedures - Cardiac Valves and Coronary Artery Bypasses Grafts(CABG).[7] *Cost Weighted Discharges (cwd) are a relative measure of the cost of different surgeries; ie cataract procedures have lower cwd than hip replacements*	3000cwd (100%)	1500cwd by 31/12/05 3000cwd 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. [8]		
	Percentage with certainty who waited for no more than six months for an angioplasty.	97%	100%	100%
		▪ *Target Achieved.*		
Implement the actions of the Heart Health Strategy: Improve heart health information – *to improve ability to monitoring change and evaluation programs.*	Design and implement a pilot project (in primary care) that would lead to the development of a Heart Health Register for Canterbury. *The Core Data Set is to be collected by primary and secondary providers.*	N/A	Core Data Set Pilot under way in at least three general practices in Rangiora.	The pilot was not run in 2005/2006.
		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.		
Improve the quality of rehabilitation care after acute events.	Trial the New Zealand Heart Manual in primary care in Canterbury – beginning with six general practices. The Heart Manual trial is jointly funded by the Canterbury DHB and the Heart Foundation.	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.
		▪ *Target Achieved.*		

[7] Cardiac Valves and Coronary Bypass Grafts are counted using Diagnostic Related Groups; F03Z, F04A, F04B, F05A, F05B, F06A, F06B.

[8] 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.	Cancer has been identified by the Canterbury DHB 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. 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 Canterbury DHB smokefree and the introduction of smokefree legislation will have positive effects.

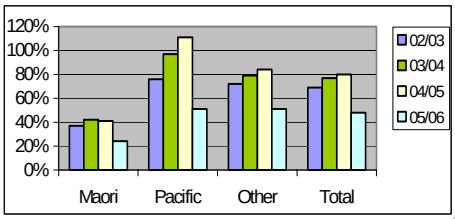
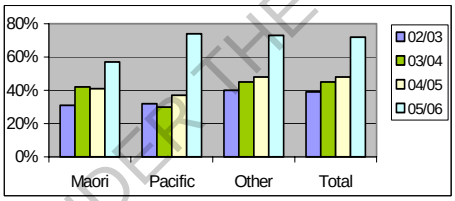
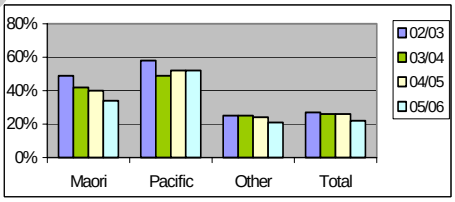
Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
Reducing the impact of Cancer.	Improved Access to Radiation Therapy. [9] Delay to radiotherapy is defined as the time between the specialist decision to commence radiotherapy and the start of 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.[10]	Group A: 100% on time. Group B: 52% on time 42% wait 4-8wk 3% wait 8-12wk 3% wait 12+wks Group C: 79% on time 15% wait 4-8wk 2% wait 8-12wk 3% wait 12+wks	Group A: 100% on time. Group B: 100% on time. Group C: 95% on time 5% wait 4-8wk 0% of patients in Groups A, B, or C wait longer than 8 weeks.	Group A: 100% on time. Group B: 65% on time 30% wait 4-8wk 4% wait 8-12wk 1% wait 12wk+ Group C: 78% on time 20% wait 4-8 wk 2% wait 8-12 wk 1% of all groups waited longer than 12+wks.
		Although the targets have not been achieved the Canterbury DHB is committed to improving wait times for Radiation Therapy and the results show improvements against the previous year.		

[9] 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 Canterbury DHB has established targets that reflect our progress towards this objective.

[10] 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

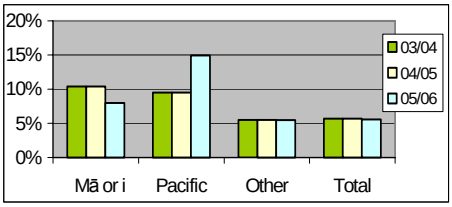
Objective: *Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes.*	***Brief Description:*** Diabetes has been identified by the Canterbury DHB as a priority area for improving the health status of the people of Canterbury. To achieve this objective a number of areas for action exist, namely: health promotion, early detection, effective treatment and patient knowledge/information. 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.[11]

Objective 2005/2006	***Performance***			
	Measure	***Baseline 2004***	***Target 2005***	***Results 2005***
Improved Diabetes Detection: *Increasing the proportion of people with diabetes who receive annual diabetic reviews and the associated primary care.*	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%[12] Other 84% Total 80%	Māori 80% Pacific 120% Other 87% Total 84%	Māori 24% Pacific 51% Other 51% Total 48%
		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.		
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%
		▪ *Target Achieved for Māori and Pacific.* *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.*		
Improved Diabetes Management: *Reducing the proportion of people with diabetes who have relatively poor control of their diabetes.*	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%
		▪ *Target Achieved for Māori and in Total.* *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.*		

[11] 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.

[12] 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: *Maintain/improve health and independence outcomes for older Canterbury residents within available resources.*	***Brief Description:*** Older Person's Health has been identified as an area of specific focus by the Canterbury DHB. 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.			
Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
Reduce Ambulatory Sensitive Admissions – *these are admissions that are potentially preventable through appropriate care and support.*	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%
		▪ *Target Achieved for Māori and Other Groups.* *The Canterbury DHB has achieved its targets for the Māori and Other groupings and the Total group rate is favourable against the national average of 6.2%.*		
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 *(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.)*	230 people referred.	250 people referred.	287 referrals.
		▪ *Target Achieved.*		
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.
		▪ *Target Achieved.* *Implementation of the Strategy is well under-way with consistent Health Performance Measures currently under development for implementation 2006/2007.*		

1.9 Elective Services

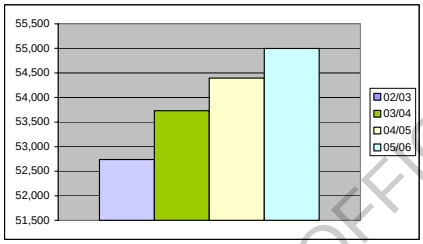
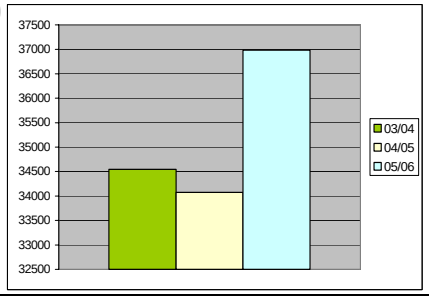
Objective:

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.

Brief Description:

Access to outpatients services and elective surgery has been an ongoing issue for the Canterbury DHB. 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:

- The provision of timely access to specialist assessment and elective surgery; and
- The delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress or ill health.

Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
Improved access to First Specialist Assessment (FSA)[13] 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%
		Areas of longer waits are in orthopaedics, gastroenterology, respiratory and rheumatology. These services have plans in place to clear the backlog.		
	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: *Provide certainty to elective surgical patients as to whether they will/will not receive access to publicly funded inpatient surgery.* Provide access in a timely manner.	Percentage of patients provided with certainty of treatment receiving that treatment within six months.	87%	100%	78%
		See below.		
	Percentage given certainty - *the number of patients given certainty of treatment as a percentage of all patients receiving elective surgery during the period.*	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. [14]		
Surgical Volume Delivery: *Delivery of the level of surgery specified by contract.*	Case Weighted Discharges (CWD) delivered as specified in the DHB District Annual Plan[15]. 	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
		▪ *Target Achieved.* *The Canterbury DHB delivered 1156 cwds over contract and 2907 additional cwds than the previous year.*		

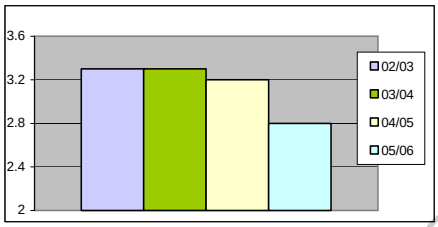
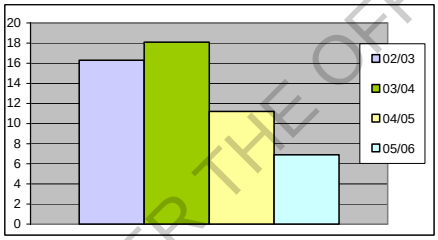
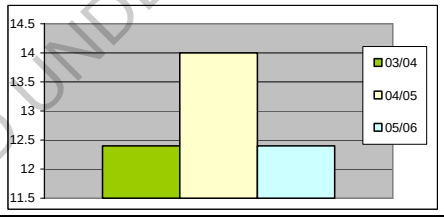
[13] A FSA is the first appointment a patient has with a specialist following referral.

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

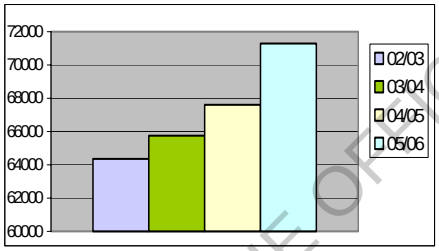
[15] CWD are a relative measure of the cost of different types of surgery- eg cataract procedures have a lower cost weight than hip replacements.

2 PROVIDER HOSPITAL AND SPECIALIST SERVICE MEASURES

2.1 Hospital Safety and Effectiveness

Objective: *The Canterbury DHB aims to be an efficient and effective provider and maximise the health status of Canterbury's residents within the available resources.*	***Brief Description:*** 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 Canterbury DHB must ensure that it operates in an effective and efficient manner.			
Objective 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
Improved performance as a Good employer. *Promote a good working environment, open, inclusive and transparent and foster partnerships between staff, and between staff and management.*	Sick Leave Rate (as per Hospital Benchmarking Indicator (HBI)).[16] 	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.*		

[16] Hospital Benchmark Indicators are national MoH indicators used to measure national performance between DHB's.

Objective 2005/2006	*Performance*			
	Measure	***Baseline 04/05***	***Target 05/06***	***Result 05/06***
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.[17]	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[18] (causing moderate or serious injury).	Historical Data not available.	0.10 or less.[19]	0.02
		▪ *Target Achieved.*		
	IV Medication Error Rate per 1000 inpatient days.[20]	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.		
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 Canterbury DHB is working through an Acute Demand Review to improve ED wait times and reduce acute demand.		

17 This indicator excludes data from the HSS Mental Health Division.

18 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.

19 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).

20 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: *To provide good governance to ensure that health services meet the needs of Canterbury people while staying within available funding.*	***Brief Description:*** The Canterbury DHB 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 2005/2006	***Performance***			
	Measure	***Baseline 04/05***	***Targets***	***Results***
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 and second draft 03/10/05.	First draft 29/07/05, second draft 19/10/05.
		▪ *Target Achieved (second draft timeframe changed by MoH to 19/10/05 – complied with by the CDHB)*		
Governance Training *Good Governance requires training and support, particularly for members new to governance.*	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.		
	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 Canterbury DHB.	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
Revenue					
MoH Revenue	932,035	3,333	582,548	(545,341)	972,575
Patient Related Revenue			31,224		31,224
Other			19,843		19,843
Total Revenue	932,035	3,333	633,615	(545,341)	1,023,642
Expenditure					
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
Total Expenditure	927,001	3,368	635,753	(545,341)	1,020,781
Net Surplus/(Deficit)	**5,034**	**(35)**	**(2,138)**	**-**	**2,861**

5 Glossary

Accreditation	Achievement against a national system of standards.
Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
Ambulatory Sensitive Admissions	Admissions that are potentially preventable by appropriate effective and efficient primary care, preventive or therapeutic programmes.
Angioplasty	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.
Audit	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation.
Bacteraemia	Hospital Acquired Bacteraemia rate measures the number of hospital acquired blood stream infections as a proportion of the number of inpatients.
Certainty	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).
CABG - Coronary Artery Bypass Graft	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.
CWD - Case Weighted Discharges	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.
ESPIs - Elective Services Patient Flow Indicators	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.
FSA –-First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
FTE - Full Time Equivalent	Full Time Equivalent means an Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
Governance	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
HBI - Hospital Benchmark Indicator	Indicators of national DHB performance established and monitored by the Ministry of Health.
Health Inequalities	Difference in health relative to the local community or wider society to which an individual, family or group belongs.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin. The level of HbA1c reflects the average blood glucose level over the past 3 months.
Mental Health Blueprint Funding	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).*
Mental Health Ringfence	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.

MeNZB - Meningococcal B	Meningococcal disease is a bacterial infection. It causes severe illnesses including meningitis (an infection of membranes that cover the brain) and septicaemia (a serious infection in the blood). There are several different strains of bacteria which cause meningococcal disease including A, B and C.
MHINC - Mental Health Information National Collection	The national database of mental health information held by the New Zealand Health Information Service (NZHIS) to support policy formation, monitoring and research.
NGO - Non-Government Organisation	NGOs include independent community and iwi/Māori 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.
NHI – National Health Index	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.
PHO - Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
Radiation Therapy	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 subspecialities.
Standardised Discharge Ratio	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.
Triage Levels - Emergency Department	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.

AUDIT REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

AUDIT REPORT

TO THE READERS OF CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2006

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health Board and group, on his behalf, for the year ended 30 June 2006.

Unqualified opinion

In our opinion the financial statements of the Health Board and group on pages 15 to 54:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - the Health Board and group's financial position as at 30 June 2006;
  - the results of operations and cash flows for the year ended on that date; and
  - the service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 25 September 2006, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements.

We evaluated the overall adequacy of the presentation of information in the financial statements. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2006. They must also fairly reflect the results of operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001, section 43 of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

In addition to the audit, we completed an engagement reviewing the Health Board's draft 2006/07 Statement of Intent. This engagement complied with the independence requirements set by the Auditor-General. Other than the annual audit and this engagement, we have no relationship with or interests in the Health Board or any of its subsidiaries.

Julian Tan
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of Canterbury District Health Board for the year ended 30 June 2006 included on Canterbury District Health Board's web site. The Board is responsible for the maintenance and integrity of the Canterbury District Health Board's web site. We have not been engaged to report on the integrity of the Canterbury District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 25 September 2006 to confirm the information included in the audited financial statements presented on this web site.

Legislation in New Zealand governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

APPENDIX 7

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Canterbury District Health Board

Report For the Year Ended
30 June 2007

Table of Contents

DIRECTORY

Board Members

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

Chief Executive

Gordon Davies (Chief Executive Officer)

Registered Office

2nd Floor, H Block
The Princess Margaret Hospital
Cashmere Road
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Westpac Banking Corporation

MISSION STATEMENT

The Canterbury DHB's mission is to improve, promote and protect the health of the people in the community and foster the well-being and independence of people with disabilities and reduce disparities.

BOARD MEMBERS

Syd Bradley - Chair	Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB. Syd has served on a number of boards since resigning as General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.
Robin Booth	Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
Heather Carter	Heather Carter is devoted to accessible and affordable health care for all New Zealanders. Heather runs LifeMasters, a personal development and workplace counselling consultancy. In addition, Heather serves on the Council of the Christchurch Polytechnic Institute of Technology, and Health Cuts Hurt (a group aimed at improving healthcare for people of Canterbury).
David Morrell	David Morrell was City Missioner in Christchurch from 1982 to 2005 and has had over 30 years involvement with general health and mental health through hospital chaplaincy, primarily at Christchurch Hospital during the 1970s and subsequently at the City Mission. David has had extensive management training, both here and in the United Kingdom. David is also Chair of Brackenridge Estate Limited, a member of Anglican Aged Care Committee and Environment Canterbury, Christchurch Area Committee.
Neville Fagerlund	Neville Fagerlund is a Chartered Accountant in public practice with over 25 years experience. He has provided financial and commercial advice to Pegasus Health Ltd since its inception in 1993 and advises The 24-Hour Surgery Ltd. Neville is a Director of Cambridge Clinic Ltd, a charitable company in the health arena.
Olive Webb – Deputy Chair	Olive Webb is a clinical psychologist and has more than 30 years experience working in the disability sector, particularly with people with intellectual disabilities. Based in Hororata, Olive has a focus on rural health issues and delivery. She provides clinical consultancy to IHC, and also consults in the Mental Health sector. Olive is a director of Institute of Applied Human Services and Access Home Health. She is also a member of the Health Practitioners Disciplinary Tribunal.
Alister James	Alister James is a barrister in private practice and a Board member of the Legal Services Agency. He is also the Honorary British Consul in Christchurch and spent more than 20 years in local Government as a Christchurch City Councillor. Alister is a Trustee on Nga Hau e Wha National Marae and Pegasus Employment and Environmental Trust, and the Chairperson of Home Made Partnership Trust. With a strong involvement in the community and voluntary sector, Alister has a particular interest in community health issues. His involvement in the pilot Youth Drug Court and the Youth Court itself has led to an interest in adolescent and alcohol and drug services.

/ continued /

BOARD MEMBERS - continued

Karen Guilliland	Karen Guilliland is Chief Executive of the New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the PHARMAC Board. She also provides consultancy to Parents Centre NZ.
Jo Kane	Jo Kane is a Waimakariri District Councillor and Deputy Mayor, who believes in the basic right to protect health and well being for all.
Laurence Malcolm	Laurence Malcolm is a medical graduate, Professor Emeritus and former Professor of Community Health at the Wellington School of Medicine. He currently works as a consultant in health services research and development, is a member of the Council and Executive of Age Concern Canterbury, and has been on many national and international boards and committees. He has a special interest in primary health care and the quality of clinical services.
Norman Dewes	Norm Dewes is the Chief Executive of the urban Māori authority based in Canterbury (Te Runanga o Nga Maata Waka). Norm is a member of the New Zealand Advertising Standards Authority, Canterbury Museum Advisory Committee, and Canterbury Community Primary Health Organisation. He is the Chairperson of Te Rito Arahi Māori Alcohol, Drug and Resource Centre, Otautahi Social Services, Māori Legal Services and Capital Planning and Development, and is the Manager of Nga Hau e Wha National Marae. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the year ended 30 June 2007.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based district health board, which provides Health and Disability Support Services, principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB Group recorded a net deficit of $0.848 million against a budgeted net deficit of $2.50 million. (2005/06 result was a net surplus of $2.86 million).

BOARD FEES

Board fees paid, or due payable, to Board and Committee Members for services during the year, were as follows:

	Board Fees Year ended 30/06/07 $'000	Committee Fees Year ended 30/06/07 $'000
Syd Bradley	49	2
Olive Webb	31	5
Robin Booth	24	1
Heather Carter	25	5
Norman Dewes	24	4
Neville Fagerlund	25	3
Karen Guilliland	24	2
Alister James	25	2
Jo Kane	24	4
Laurence Malcolm	25	4
David Morrell	24	5
Peter Ballantyne	-	6
Alison Wilkie	-	2
Richard Buchanan*	-	-
David Kerr	-	2
Winston McKean*	-	2
John Musgrove	-	2
Tuari Potiki	-	1
Trevor Read	-	2
William Tate	-	2
Margaret Schwass*	-	1
	300	**57**

* appointed/resigned during the year

Total fees paid for the year were $357,000 (2005/06 - $355,000). The limit of fees authorised for the year ended 30 June 2007 was $385,000 (2005/06 - $384,000).

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the year were as follows:

	Year Ended 30/06/07 $'000	Year Ended 30/06/06 $'000
David Morrell	10	10
Graham Heenan	13	13
	23	23

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the Interest Register:

CANTERBURY DHB	
Syd Bradley	Christchurch International Airport Co Limited – Chair
	Waipara Hills Wine Estate – Advisor
	McLeans Institute – Board Member (Canterbury DHB representative) - provides residential aged care services under contract with the Canterbury DHB.
Olive Webb	Health Practitioners Disciplinary Tribunal – Member - potentially a member of a tribunal panel when a clinical psychologist is before the panel. The tribunal has procedures for dealing with potential conflicts of interests for tribunal members. Should an issue of conflict arise, this will be disclosed at the time.
	Institute of Applied Human Services Limited (IAHS) – Chairperson - provides individual consultation, service advice and workforce training in the intellectual disability area, on contract to various individuals and providers in Australasia. New Zealand providers of intellectual disability services are usually funded by the Ministry of Health. IAHS has no contracts with Canterbury DHB.
	Special Olympics New Zealand – Trustee - as well as providing sporting events, also provides health screening and assistance.
	Access Home Health Limited – Director - provides home based healthcare and personal support on contract to the Accident Compensation Corporation, Ministry of Health and several DHBs, including Canterbury DHB.
Heather Carter	Christchurch Polytechnic Institute of Technology (CPIT) – Council Member
	Health Cuts Hurt Incorporated (Health Lobby Organisation) - Member
	LifeMasters (Life skills and personal development) – Company Owner and Consultant
	Otautahi Education Development Trust (OEDT) – Trustee - this trust is related to CPIT activities.
Norman Dewes	Te Runanga o Nga Maata Waka – Chief Executive Officer - this Runanga provides a range of advocacy, community and social services. These services include a contract for the Canterbury DHB to deliver mother & pepi services. The Runanga also provides a range of education services which are NZQA registered and accredited under the Education Act. The Runanga is a part of a national body, the National Urban Maori Authority.
	Nga Hau e Wha, National Marae – Manager - there is a proposal that an oral health service clinic be located on part of the land held by the trust.
	Canterbury Community Primary Health Organisation (Access PHO) – Member - one of the PHOs within the Canterbury DHB's area – contracts with the DHB for primary services.
	Te Runanga o Ngati Kahungunu ki Waitaha – Secretary

	Te Rito Arahi Maori Alcohol, Drug and Resource Centre – Chair
	Otautahi Social Services – Chair
	Otautahi Sports Association - Secretary
Karen Guilliland	New Zealand College of Midwives – Chief Executive Officer - the College of Midwives is the professional body for midwives that promotes and sets standards for the profession. The College provides expert advice in relation to midwifery and maternity services to district health boards (including Canterbury DHB) on request. The College nominates representatives to various related bodies such as MERAS (Midwives Union) (who are party to a collective employment agreement with the Canterbury DHB), schools of midwifery, and a number of government advisory committees.
	Midwifery and Maternity Provider Organisation Limited – Director - College of Midwives representative as a director in this midwifery practice management organisation. Its primary function is to process midwifery service claims to the Ministry of Health on behalf of self employed midwifes, obstetricians, some district health boards, and private trusts.
	PHARMAC – Board Member.
Neville Fagerlund	Cambridge Clinic (DSAC) Limited - Director of a company which holds a contract with the Canterbury DHB for the delivery of medical services to victims of sexual abuse.
	Pegasus Health (Charitable) Limited - Financial Advisor to a company which holds a contract with the Canterbury DHB for observation and continuing care nurse co-ordination, and a contract in the co-ordination role of immunisation services. The 24 hour clinic in Bealey Avenue is 100% owned by Pegasus Health (Charitable) Limited, who hold the observation contract.
	A wide range of trusts and private companies as a result of private accountancy practice (where potential conflicts arise these will be disclosed individually)
Alister James	Barrister and Youth Advocate - acting for clients including young persons with mental health, alcohol and drug issues and dealing with Mental Health Services, in particular Youth Specialty Services.
	Home Made Partnership Trust (Christchurch Supergrans) – Chair - sometime recipient of funding grants from Community and Public Health for courses run by the organisation.
	Honorary British Consul - interest relates to support of British visitors who may be hospitalised arising from injury related accidents.
	Legal Services Agency (Crown Entity) - Board Member - Legal Services Agency provides legal services and funding, including granting legal aid for persons who may be involved in any proceedings against the Canterbury DHB, and in respect to mental health reviews.
	Nga Hau E Wha National Marae Charitable Trust - Chair - there is a proposal that an oral health service clinic be located on part of the land held by the trust.
	Spouse is a Canterbury DHB employee.
Jo Kane	Waimakariri District Council - Deputy Mayor - Waimakariri District Council is responsible for the health and wellbeing of their community – health is a high priority in community derived outcomes. Interest may relate to intersectoral collaboration – where potential conflicts arise these will be disclosed at the appropriate time.
	North Canterbury Sport and Recreation Trust – Trustee - provision of a range of physical health initiatives for the community. Could apply for funding from Canterbury DHB (where potential conflicts arise, they will be disclosed at the appropriate time).
	Te Kohaka o Tuhaitara Trust – Chairperson - provides for a range of cultural, historical, recreational and educational opportunities for the community within the

	Coastal Reserve. It is not envisaged any potential conflicts of interest, but will be disclosed at the appropriate time.
Laurence Malcolm	Aotearoa Health Limited – Director and Shareholder - company provides research under contract to a variety of organisations. Currently providing services to Partnership Health PHO in the area of Maori Health planning.
	Age Concern Canterbury, Council and Executive – Member - advocacy and support group for older people.
David Morrell	Brackenridge Estate Limited – Chairman (appointed by Canterbury DHB) - wholly owned subsidiary of the Canterbury DHB - provides intellectual disability services under contracts with the Ministry of Health, Work and Income New Zealand, Accident Compensation Corporation and the Child, Youth and Family Service.
	Social Services Council of the Diocese of Christchurch (Anglican Aged Care) - Committee Member - provides residential aged care services (rest home and hospital) under contracts with the Canterbury DHB.
David Kerr	Centrecare Limited - Chair
	General Medical Practitioner
	Health Education Trust - Trustee
	Medical Protection Society - Advisor
	Pegasus Health - Advisor
	Ryman Healthcare Limited – Chair
John Musgrove	Windsor House Board of Governors - Windsor House has a contract with the Canterbury DHB for provision of hospital and rest-home services for the elderly and has recently been successful in obtaining a contract for 20 beds for dementia patients with the Canterbury DHB.
Trevor Read	Assistance with strengthening IT strategy and systems planning for the South Canterbury District Health Board.
Alison Wilkie	Rural Canterbury Primary Health Organisation – Employee
	Christchurch Primary Health Organisation - Employee
	Family Help Trust – Trustee
	Christchurch Resettlement Services – Board member
Peter Ballantyne	Bishop Julius Hall of Residence - Trust Board Member
	University of Canterbury, Audit and Risk Committee - Member
	Anglican Aged Care - Committee Member
	Deloitte - Consultant
	Spouse is a Canterbury DHB employee
Tuari Potiki	He Oranga Pounamu - Board Member
	Drug and Alcohol Practitioners Association of NZ - Executive Member
	Spouse is a board member of the Rural Canterbury Primary Health Organisation

SUBSIDIARY AND ASSOCIATED COMPANIES

Garth Bateup	Director of subsidiaries Brackenridge Estate Limited and Canterbury Laundry Service Limited. No directors' fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Paul Numan	Director of subsidiary, Brackenridge Estate Limited. No directors' fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB.
Wei Yoon	Director of associate company New Zealand Centre for Reproductive Medicine Limited. No directors' fees or any other benefits were received from the associate company except as an employee of Canterbury DHB. Resigned.
Dr Nigel Millar	Director of associate company New Zealand Centre for Reproductive Medicine Limited. No directors' fees or any other benefits were received from the associate company except as an employee of Canterbury DHB. Appointed.

DIRECTORS' AND BOARD MEMBERS' LOANS

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensure that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

USE OF BOARD OR SUBSIDIARIES' INFORMATION

During the year, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place, eg: amounts for redundancy (based on length of service), and payment in lieu of notice etc.

The total payments made by Canterbury DHB were $32,130 (2005/06 – 4 employees totalling $35,074) comprise negotiated settlements with all of the former employees.

Number of Employees	TOTAL $
1	32,130
1	**32,130**

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands is as follows:

	30/06/07 Including Benefits Number	30/06/06 Including Benefits Number	30/06/06 Excluding Benefits Number
$100,000 - $110,000	98	54	77
$110,001 - $120,000	77	48	55
$120,001 - $130,000	54	49	49
$130,001 - $140,000	42	43	34
$140,001 - $150,000	34	30	26
$150,001 - $160,000	33	19	26
$160,001 - $170,000	22	30	41
$170,001 - $180,000	23	29	25
$180,001 - $190,000	25	27	16
$190,001 - $200,000	16	15	20
$200,001 - $210,000	26	26	24
$210,001 - $220,000	21	15	10
$220,001 - $230,000	11	17	7
$230,001 - $240,000	17	3	6
$240,001 - $250,000	7	10	3
$250,001 - $260,000	8	4	3
$260,001 - $270,000	3	4	2
$270,001 - $280,000[1]	5	2	1
$280,001 - $290,000	2	2	2
$290,001 - $299,000	1	1	1
$300,001 - $310,000	1	2	-
$310,001 - $320,000	2	1	-
$320,001 - $330,000	1	-	-
$330,001 - $340,000	-	-	1
$350,001 - $360,000	-	1	-
$360,001 - $370,000	1	-	-
$460,001 - $470,000[1]	1	-	-
	531	**432**	**429**

Of the 531 positions identified above, 491 (2005/06 - 399 including benefits, 397 excluding benefits) were predominantly clinical and 40 (2005/06 - 33 including benefits, 32 excluding benefits) were management/administrative.

[1] CEO remuneration and other benefits are included in these brackets.

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STATUTORY DISCLOSURE

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000;

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000; and

(c) a report on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2007, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 39.

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	**Extent objectives met**
(a) to improve, promote, and protect the health of people and communities:	The DHB funds and delivers a range of services from health promotion and protection services, primary care to specialist tertiary services to meet the needs of its population. The key areas of focus were Child and Youth Health, Older Persons' Health, Maori Health, Primary Health, Disease Prevention/Management covering, Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease. Further to this the Minister of Health's expectations saw a particular focus on implementation of the national Mental Health Strategy and the Mental Health Blueprint and a focus on information systems and services, workforce development, elective services and service delivery, collaboration, productivity and value for money. The DHB is also aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health and continues to work collaboratively to set goals and objectives for our community's health, to share data and research on health outcomes and to provide a healthy environment for our population. One of the groups the DHB works with, in an effort to build relationships with other organisations and develop a shared approach to the health of our community, is Healthy Christchurch. This involves over 200 organisations who have signed the 'Healthy Christchurch Charter' who aim to forge a common vision for a healthy city, to foster healthy relationships between diverse agencies and sectors, from 'grassroots' groups to government agencies, to enable flexible, collaborative and prompt responses to emergent health issues and to ensure all policy incorporates a health perspective. The initiative recognises that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, transport or any other aspect of city life. Some of the projects to date include: ▪ Healthy Homes - aimed at promoting awareness of environmental issues and their potential financial and health impacts among the Christchurch population with sessions focused on energy, transport, waste, gardening, water and shopping; ▪ Oral Health - proposed to address the adverse oral health impacts of the decision not to fluoridate the Christchurch water supply. One achievement included every Christmas food parcel distributed through the Methodist Mission containing a toothbrush and fluoridated toothpaste for each child – this reached around 800 children across the city; and

	▪ City Harvest - a citywide celebration of growing your own food and eating healthily linked to the central themes of good nutrition, gardening/ harvesting and celebration .
(b) to promote the integration of health services, especially primary and secondary health services:	As part of the Ministry's national Primary Care Strategy, PHOs have been created to help deliver primary care services to communities. Canterbury has five PHOs that encompass the region and the DHB has developed a close working relationship with those PHOs. Together the PHOs and the DHB have achieved a number of successes in implementing the Primary Care Strategy over the past year: ▪ PHO enrolments cover 94% of the Canterbury population; ▪ Several 'Services to Improve Access' programmes implemented including: longer GP consultations, school health clinics, community nursing services; ▪ Collaboration on health promotion programmes including smoking cessation, youth oral health, physical activity and nutrition programmes. Successful implementation of the Meningococcal B vaccination campaign was a significant collaborative effort between the DHB and PHOs along with the development of a nutritional cookbook for older people. Health promotion funding has also enable initiatives such as the funding of a Pacific Worker in Ashburton (by the Rural Community PHO) focused on chronic conditions; ▪ A review of Acute Demand and After Hours Cover in Canterbury in collaboration with PHOs and GPs, resulting in the development of the Canterbury DHB After Hours Discussion Paper; ▪ Additional resources to increase Pacific community nursing services in Canterbury. District Nursing Organisations and PHOs will be able to utilise the expertise of this nursing position to help reduce inequalities faced by Pacific People particularly around chronic conditions management; and ▪ The development of the Canterbury DHB Primary Mental Health Positioning Paper and continued implementation of Mental Health Demonstration Models within primary care. The DHB continues with its Improving the Patient Journey Programme. This is a major DHB initiative to improve the quality and effectiveness of the service we provide to patients. Significant investment has been made on ED flow issues, establishing new acute clinical pathways and understanding acute surgical pathways. The DHB has continued to work on the development of an overarching chronic conditions management framework. This framework has been signed off by the DHB's Board and will begin by addressing continuums of care for Cardiovascular Disease, Diabetes, Respiratory Disease and Depression. This work look at the continuum of care from 'wellness' at one end to 'unwellness' at the other and work to place the patient at the centre of the health continuum. The expected outcomes are early detection and intervention, continuity and coordination of care, improved information exchange and workforce alignment. This work will heavily influence the activity in each of the DHB's four Disease Priority areas in coming years and will involve integration between primary and secondary services to improve the continuum of care for our community.

(c) to promote effective care or support for those in need of personal health services or disability support services:	The DHB has developed an Older People's Health Strategy: *Healthy Ageing, Integrated Support*. The underlying objective is to maintain older people's independence for as long as possible, reduce the period and levels of dependence and at the same time provide effective, integrated services when they are required. Successes over the past year have included: ▪ Further development of home care packages as alternatives to residential care and transitioning of rest home beds to hospital level to meet changes in demand; ▪ A review of community day support options, with increases in capacity for general and dementia stand-alone day activity centres; ▪ A joint initiative with the Nurse Maude Association and Healthcare NZ to improve access to complex wound care for subsidised residents in aged residential care. This two year project is a first in NZ and will also focus on mentoring registered nurses and promoting improved wound management (less pressure ulcers and other complex wounds) and therefore fewer admissions to secondary care; ▪ Completion of the two year trial of the geriatric assessment tool, International Resident Assessment Instrument (InterRAI) (Minimum Data Set Home Care Version) with approval for wider use of the tool within our HSS Older People's Health Service. This tool aims to improve coordinated clinical assessment by avoiding duplication and using one integrated plan for each patient. The information captured will also provide insight into the health needs of our ageing population; ▪ Utilisation of Blueprint funding for re-establishing a Psychiatric Service for the Elderly Memory Assessment Clinic; ▪ Completion of an HSS Community Stroke Service pilot, resulting in improved outcomes for older people and their families; and ▪ Completion of a pilot to explore the needs of older Maori with particular focus on those admitted to inpatient units which contributed to the development of Te Huanui, our Maori Health Plan for Older People and the employment of a dedicated Maori Health Worker.
(d) to promote the inclusion and participation in society and independence of people with disabilities:	The DHB aims to ensure it contributes to a 'non disabling' society through its actions, and the actions of the providers with whom it contracts. As such the DHB has developed a Disability Strategic Action Plan (DSAP) that outlines the steps it is making to implement the NZ Disability Strategy. The DSAP involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring. All new building and facility developments are assessed for meeting the needs of people with disabilities.

(e) to reduce health disparities by improving health outcomes for Māori and other population groups:	The DHB has reviewed its Maori Health Action Plan over the past year. The key objectives include reducing health inequalities and supporting Maori participation in health and Maori health workforce development. Over the past year progress has been made in implementing projects that support the DHB's Maori Health Plan including: ▪ Extension of the Christchurch Hospital Maori Health Team working in key services to achieve better health outcomes for Maori patients, particularly services that require cultural protocols (Paediatrics, Oncology, Sexual Health, the Emergency Department and the Mortuary); ▪ Provision of a cultural programme to Burwood Hospital staff, assisting them to understand how Maori views and values can impact on their clinical practice; ▪ Collaboration with Partnership Health PHO in developing a smoking cessation service targeting Maori women and their families to improve the health of this at risk population; and ▪ Collaboration with local Maori groups to implement a smoke-free marae campaign with several local marae now having designated smoking areas and one becoming smoke-free.
(f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The DHB's local Health Needs Assessment (completed in 2005) has identified groups in the community, which have health inequalities. The DHB's District Strategic Plan identifies a number of Health Gain Priority Areas where the DHB will focus its efforts to reduce these health inequalities. The DHB has identified: Child and Youth Health, Older Persons' Health, Maori Health, Primary Health and Disease Prevention and Management as key areas of focus with Cancer, Cardiovascular, Diabetes and Respiratory Disease as identified disease priorities where change can help to eliminate health inequalities in our community. Work continues with PHOs in Canterbury to reduce barriers to primary care including financial barriers through the reduction of co-payments with reductions being achieved for all 18-25 year olds, 25-44 year olds and 45-64 year olds. The DHB is also working with PHO to implement Services to Improve Access to primary care.
(g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The DHB has established inter-agency relationships with a wide range of government agencies including: the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, of Education and of Social Development, ACC and the Department of Corrections. The DHB works collaboratively with the TLAs and regional council in the Canterbury region along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other Non-Government Organisations (NGOs) in our region. The DHB also actively support a number of collaborative ventures which endeavour to improve the environment and the health of our residents. The DHB actively engages with providers of health services working with them in a cooperative way for the benefit of our population. In important areas of policy development or for significant projects the DHB seeks input from our community and our providers. This may be in the form of providing opportunities for input on early development of papers/ideas or involvement in working parties. The DHB has established, or is involved with, a number of consumer and community reference groups, working parties and advisory groups which provide advice and input on the development of

	strategy, policy and direction for the DHB. The DHB also works closely with Maori and Pacific communities to ensure Maori and Pacific input into the development of strategies, policy and initiatives to improve health care access and delivery. Over the past year the DHB has undertaken considerable consultation on a number of key strategies and plans. It is important that the long-term direction being set through these key strategies is relevant to, and supported by, consumers, service users, our community and our staff and that any change will have a positive impact on the health status of our community.
(h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	The DHB actively participates in forums such as Healthy Christchurch and information gathered from these forums assists the service planning process. The DHB also engages in active consultation through formal processes (such as the consultation process to develop our District Strategic Plan) and sector representation on project steering groups. The DHB has also embarked on the development of a Health Services Plan which will be linked to a workforce strategy and facilities master-plan. If the DHB intends to ensure effective utilisation of resources and delivery of the best possible health outcomes within the funding allocated we need to ensure that health resources are protected, sustainable and supported long-term. The Health Services Planning focus is to progress planning for future health services through the development of health services models, the development of a framework for the management of chronic conditions and the development of integrated service models. These developments will provide a strategic roadmap for changes in future funding models, the development of workforce strategies and the development of a Facilities Master-Plan. This will mean new thinking around the best way to provide care to our population, looking at the best location, the best service and the best provider. However this will enable us to ensure ongoing provision of health and disability services and to provide services which are better integrated and configured, and that operate seamlessly across geographical, professional and service boundaries. The DHB has introduced a 'participatory model' to involve staff, providers, consumers and our community in this Health Services Planning and extensive participatory workshops and 'design teams' are being established to drive the thinking and planning.
(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	The DHB has a Quality and Patient Safety Council and a Clinical Board to provide advice to the CEO on quality and clinical issues. The Quality and Patient Safety Council is a forum for the wider DHB (including community providers) to discuss quality issues. This also facilitates ongoing quality improvement processes. The DHB also has processes in place to maintain and improve quality including Quality Health New Zealand accreditation process for its hospitals and performance targets and measures to maintain appropriate levels of clinical quality. The Clinical Board has a strong focus on clinical governance and has a solution oriented proactive role in the setting of clinical policy and standards and encourages best practice and innovation. The Board supports the organisation's vision and values and will set a leadership role by example.

(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	The DHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme. The DHB is also aware of the interaction of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work collaboratively to set goals and objectives for our community's health and to provide a healthy environment for our population.
(k) To be a good employer	The DHB is committed to the principles of being a good employer and values diversity amongst its staff. It has in place, as appropriate, a number of organisational policies and procedures (to promote a healthy and safe workplace) including the DHB's Equal Opportunities and Harassment Policies. The DHB also provides a safe and health promoting environment through safe handling programmes and membership of the ACC Partnership Programme. The DHB also encourages its workforce to lead by example in terms of healthier lifestyles and practices.

Section 42(3)(i) – Statement of how CDHB has given effect and intends to give effect to its functions specified in section 23 (1) (b)-(e)	
Function:	**What has been done to meet function**
(b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	▪ The CDHB has involved stakeholders in selection of its Health Gain Priority Areas for the District Strategic Plan and actively involves relevant groups and individuals in planning specific service areas including its current Health Services Planning Programme. ▪ The DHB has established joint arrangements with external providers for the provision of some additional surgical services, such as orthopaedic and cardiac surgery. ▪ The DHB participates in a number of regional initiatives with other DHBs such as working with South Island DHBs on the Cancer Control Network and the implementation of national information systems. ▪ The DHB has a Memorandum of Understanding with the West Coast DHB which assists in the development of closer clinical collaboration. ▪ The DHB has established inter-agency relationships with a wide range of government agencies including: the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, of Education and of Social Development, ACC and the Department of Corrections. ▪ The DHB also works with the Ministry of Health in a number of joint/collaborative ways participating in national projects including national benchmarking exercises and national pricing projects.
(c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of	The DHB uses a variety of written media, TV and radio work to outline general issues and priorities and the community and responds directly to media / personal / group enquires. The DHB has developed a website, which includes community based health information and its primary planning documents. The DHB

paragraphs (a) and (b):	also circulates and makes available significant documents and plans for its population in summary and comprehensive form either at libraries, via groups or individually and on it website. The DHB continues to provide health promotion information through its Community Health Information Centre, open to the public five days a week. Supplies of health education resources are held and a number of satellite health information stands have been developed – there are currently 20 of these sites with particular emphasis being placed on Marae, TLA service centres, hospitals, and other appropriate settings for target communities.
(d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:	Relationships with Manawhenua Ki Waitaha, Te Runanga and Nga Maata Waka continue to develop. Māori community hui are held quarterly and regular meetings with Māori providers and other Māori community organisations. The outcomes of these meetings are fed directly into the DHB planning process. The DHB is also committed to the establishment of a Crown Relationship Agreement with local iwi.
(e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:	The DHB has established Te Kahui Taumata, which includes the Kaumatua and Taua, the Executive Director Māori and Pacific Health, and senior Māori staff who provide Māori specific advice to the Chief Executive. The DHB continues to work on capacity and capability issues through Te Herenga Hauora o te Waka a Maui (the South Island Maori Managers Network), where a number of projects have been developed to support Maori service provision in Canterbury. These include: ▪ The development of a Maori Health Workforce Development Plan, *Te Waipounamu*, now in the final stages of consultation; ▪ The development of a South Island regional Maori workforce recruitment project to enhance the Maori health workforce in our region; and ▪ The development of a Maori health training and education opportunities directory, currently being distributed to Maori health providers.

For and on behalf of the Board

Syd Bradley
Chair
26 September 2007

Olive Webb
Board Member
26 September 2007

STATEMENT OF RESPONSIBILITY

Pursuant to Section 155 of the Crown Entities Act 2004, we acknowledge that:

a) The preparation of financial statements and statement of service performance of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2007, are our responsibility.

c) In our opinion, the financial statements and statement of service performance for the year under review fairly reflect the financial position and operations of Canterbury DHB.

Syd Bradley
Chair
26 September 2007

Olive Webb
Board Member
26 September 2007

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2007

	Notes	Group			Parent	
		Actual 30/06/07 $'000	Budget 30/06/07 $'000	Actual 30/06/06 $'000	Actual 30/06/07 $'000	Actual 30/06/06 $'000
OPERATING REVENUE						
Ministry of Health Revenue		1,050,404	994,542	972,575	1,042,064	964,726
Patient Related Revenue		33,458	29,298	31,224	33,876	31,661
Other Revenue		27,463	25,754	19,843	25,277	18,499
TOTAL REVENUE		**1,111,325**	**1,049,594**	**1,023,642**	**1,101,217**	**1,014,886**
OPERATING EXPENSES						
Employee Costs		437,912	417,600	406,846	429,287	399,201
Treatment Related Costs		105,727	101,748	109,289	108,864	112,310
External Service Providers		433,074	411,229	381,660	433,074	381,660
Depreciation	11	47,228	44,272	47,372	46,046	46,386
Interest Expense		5,069	6,696	4,936	5,140	4,957
Other Expenses		60,269	52,477	55,602	57,288	53,047
TOTAL OPERATING EXPENSES		**1,089,279**	**1,034,022**	**1,005,705**	**1,079,699**	**997,561**
OPERATING SURPLUS BEFORE CAPITAL CHARGE		**22,046**	**15,572**	**17,937**	**21,518**	**17,325**
Capital Charge Expense		(22,894)	(18,072)	(15,076)	(22,894)	(15,076)
NET SURPLUS / (DEFICIT) FOR THE YEAR		**(848)**	**(2,500)**	**2,861**	**(1,376)**	**2,249**

STATEMENT OF MOVEMENTS IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2007

		Group			Parent	
	Notes	Actual 30/06/07 $'000	Budget 30/06/07 $'000	Actual 30/06/06 $'000	Actual 30/06/07 $'000	Actual 30/06/06 $'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD:		287,326	243,205	199,705	285,612	198,603
TOTAL RECOGNISED REVENUES AND EXPENSES:						
Net surplus / (deficit) for the period		(848)	(2,500)	2,861	(1,376)	2,249
Revaluation of Property		-	-	106,760	-	106,760
		(848)	(2,500)	109,621	(1,376)	109,009
OTHER MOVEMENTS						
Contribution from/(back to) Crown	5	(1,861)	(14,500)	(22,000)	(1,861)	(22,000)
		(1,861)	(14,500)	(22,000)	(1,861)	(22,000)
TOTAL EQUITY AT END OF THE PERIOD		**284,617**	**226,205**	**287,326**	**282,375**	**285,612**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2007

	Notes	Group Actual 30/06/07 $'000	Group Budget 30/06/07 $'000	Group Actual 30/06/06 $'000	Parent Actual 30/06/07 $'000	Parent Actual 30/06/06 $'000
CROWN EQUITY						
General Funds	5	124,313	126,174	126,174	124,451	126,312
Revaluation Reserve	5	184,477	125,126	184,477	184,477	184,477
Retained Earnings	5	(32,273)	(33,500)	(31,435)	(34,547)	(33,170)
Trust Reserve	5	8,100	8,405	8,110	7,994	7,993
TOTAL EQUITY		**284,617**	**226,205**	**287,326**	**282,375**	**285,612**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and Bank		50,633	3	12,838	49,282	12,270
Receivables and Prepayments	3	24,132	17,122	25,391	23,529	24,898
Stocks	4	8,175	7,000	7,196	8,110	7,133
TOTAL CURRENT ASSETS		**82,940**	**24,125**	**45,425**	**80,921**	**44,301**
CURRENT LIABILITIES						
Creditors and Accruals		79,914	72,909	74,456	80,527	75,433
Owing to the Ministry of Health		13,852	4,500	3,738	13,852	3,738
Staff Entitlements due within 1 year	8	56,475	38,914	48,919	55,509	48,157
Provisions due within 1 year	9	36,092	29,000	29,217	36,048	29,189
TOTAL CURRENT LIABILITIES		**186,333**	**145,323**	**156,330**	**185,936**	**156,517**
NET WORKING CAPITAL		**(103,393)**	**(121,198)**	**(110,905)**	**(105,015)**	**(112,216)**
NON CURRENT ASSETS						
Investments	12	11,689	311	375	14,796	2,592
Fixed Assets	11	456,147	422,087	466,145	452,307	463,364
Surplus Property		8,250	8,250	11,760	8,250	11,760
Restricted Assets	6	8,100	8,405	8,110	7,994	7,993
TOTAL NON CURRENT ASSETS		**484,186**	**439,053**	**486,390**	**483,347**	**485,709**
NON CURRENT LIABILITIES						
Provisions	9	8,526	7,000	9,509	8,307	9,231
Loans repayable after 1 year	10	87,650	84,650	78,650	87,650	78,650
TOTAL NON CURRENT LIABILITIES		**96,176**	**91,650**	**88,159**	**95,957**	**87,881**
NET ASSETS		**284,617**	**226,205**	**287,326**	**282,375**	**285,612**

For and on behalf of the Board

Syd Bradley
Chair
26 September 2007

Olive Webb
Board Member
26 September 2007

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2007

	Notes	Group Actual 30/06/07 $'000	Group Budget 30/06/07 $'000	Group Actual 30/06/06 $'000	Parent Actual 30/06/07 $'000	Parent Actual 30/06/06 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,051,140	994,542	963,919	1,042,109	956,024
Other Receipts		49,893	46,053	44,340	48,773	43,348
Interest Received		5,146	-	3,102	5,278	3,187
		1,106,179	1,040,595	1,011,361	1,096,160	1,002,559
Cash was applied to:						
Payments to Employees		424,411	417,600	392,601	416,000	384,907
Payments to Suppliers		593,859	570,455	549,811	594,297	549,098
Interest Paid		4,883	6,696	4,928	4,953	4,949
Capital Charge		12,780	18,072	19,955	12,780	19,955
GST - net		728	-	(3,557)	751	(3,546)
		1,036,661	1,012,823	963,738	1,028,781	955,363
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	13	**69,518**	**27,772**	**47,623**	**67,379**	**47,196**
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of Assets		11,315	17,000	6,650	11,297	6,650
Decrease in Restricted Assets and Investments		10	-	231	-	-
		11,325	17,000	6,881	11,297	6,650
Cash was applied to:						
Increase in Investments & Restricted Assets		11,314	-	-	12,205	448
Purchase of Assets		38,873	36,000	29,775	36,598	28,810
		50,187	36,000	29,775	48,803	29,258
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		**(38,862)**	**(19,000)**	**(22,894)**	**(37,506)**	**(22,608)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		15,000	6,000	-	15,000	-
		15,000	6,000	-	15,000	-
Cash was applied to:						
Loans Repaid		6,000	-	-	6,000	-
Equity repaid to Crown		1,861	14,500	22,000	1,861	22,000
		7,861	14,500	22,000	7,861	22,000
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		**7,139**	**(8,500)**	**(22,000)**	**7,139**	**(22,000)**
Overall Increase/(Decrease) in Cash Held		37,795	272	2,729	37,012	2,588
Opening Cash Balance		12,838	(269)	10,109	12,270	9,682
CLOSING CASH BALANCE		**50,633**	**3**	**12,838**	**49,282**	**12,270**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2007

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004.

The group currently consists of Canterbury DHB, its subsidiaries Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entities, New Zealand Centre for Reproductive Medicine Ltd (50% owned) and South Island Shared Services Agency Ltd (47% owned).

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and section 154 of the Crown Entities Act 2004, which includes the requirements to comply with generally accepted accounting practice in New Zealand.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain fixed assets.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Funding for health related services received from the Ministry of Health by the Funder arm of Canterbury DHB is recognised as revenue in the financial year. Revenue from other contracts for services where funding is still the responsibility of the Ministry of Health, is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of Canterbury Health Ltd. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of Canterbury DHB

Assets acquired by the DHB since its establishment are recorded at cost except for land, buildings and fitout plant and equipment that are revalued every five years. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of land, buildings and fitout plant and equipment

Land, buildings and fitout plant and equipment are revalued every five years in accordance with FRS3. The value of land, buildings and fitout plant and equipment is determined by an independent registered valuer by reference to the highest and best use of these assets or, if sufficient market based evidence is not available, by reference to their optimised depreciated replacement cost. Additions between revaluations are recorded at cost. The results of revaluing land, buildings and fitout plant and equipment are credited or debited to the assets revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

The latest valuation was performed as at 30 June 2006 by Chris Stanley (Registered Valuer) of TelferYoung (Canterbury) Ltd.

Donated Assets

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

iv) Depreciation

Depreciation is charged on a straight line basis so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	20 - 50
Leasehold Building & Fitout	3 - 20
Fitout Plant and Equipment	5 - 50
Plant and Equipment (incl pool)	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) Goods and Services Tax

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) Stocks

Stocks are valued at the lower of cost and net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

vii) Accounts Receivable

Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

vii) Investments

The investment in the associate companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis.

Other investments are stated at the lower of cost and net realisable value.

Dividend and interest income is accounted for on an accrual basis.

ix) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CW31 of the Income Tax Act 2004.

In prior years, Canterbury DHB subsidiaries were subject to income tax, with the exception of Brackenridge Estate Ltd. From the beginning of 1 July 2004 Canterbury Laundry Service Limited is also exempt from income tax under Section CW31 of the Income Tax Act 2004. Previously, income tax expense was charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. The tax provisions have been reversed following the tax exempt status given to Canterbury Laundry Service Limited.

x) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xi) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as finance leases and the related lease assets are capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected economic lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiii) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xiv) Provision for Staff Entitlements

Provision is made in respect of the DHB's liability for annual leave, long service leave, retirement gratuities, parental leave, conference leave, and sabbatical leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xv) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non current securities and advances (other than securities and advances included within cash) and any other non current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvi) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xvii) Financial Instruments

Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost and market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xviii) Basis of Consolidation

The consolidated financial statements include the parent DHB and its subsidiaries. The subsidiaries are accounted for by adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis which shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

D CHANGE IN ACCOUNTING POLICIES

There have been no changes in accounting policies during the year. All policies have been applied on a basis consistent with the previous period though the presentation of some comparatives have changed in order to be comparable with the current presentation.

Canterbury DHB's adoption of the New Zealand equivalent International Financial Reporting Standards (NZ IFRS) is in line with government entity timeframe, effective 1 July 2007. Therefore the first set of fully compliant financial statements will be prepared as at 30 June 2008. This will require the 2007/08 financial statements to include restated NZ IFRS–compliant comparatives for the year ended 2007 and opening balances as at 1 July 2006. The DHB has been working with representatives of the Ministry of Health and Treasury along with external advisers, to identify and quantify the impacts of NZ IFRS adoption and also to implement processes for capturing all relevant information. This work has identified some areas that will result in changes in presentation and classification, and also may have some impact on the Statement of Financial Performance. These changes include the areas associated with Employee Benefits, Financial Instruments, Revenue Recognition, Leases, Impairment, and Related Parties. The opening balances as at 30 June 2006 have been recalculated to reflect the changes in these areas, however, the full financial effects of NZ IFRS have yet to be determined or calculated for the year ended 30 June 2007.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating surplus/(deficit) is stated:	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
After Charging:				
Remuneration of Auditor:				
- Audit Fees	166	148	137	117
- Other Services	14	3	14	3
Board Members' Fees	300	294	300	294
Directors' Fees	23	23	-	-
Interest Expense	5,070	4,936	5,140	4,957
Bad Debts Written Off	376	408	376	408
Increase/(Decrease) in Bad Debts Provision	985	(680)	985	(680)
Rental and Operating Lease Costs	4,211	3,444	3,773	2,997
After Crediting:				
Interest Income	5,146	3,102	5,278	3,187
Gain (loss) on Disposal of Assets	6,162	3,625	6,178	3,625

3. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Trade Debtors	7,516	7,782	7,323	7,678
Receivable from the Ministry of Health	8,854	8,849	8,480	8,525
Other Debtors	7,104	7,859	7,104	7,825
Prepayments	658	901	622	870
	24,132	**25,391**	**23,529**	**24,898**

4. STOCKS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Pharmaceuticals	2,538	2,468	2,538	2,468
Surgical and Medical Supplies	4,716	3,985	4,716	3,985
Other Supplies	1,532	1,501	1,467	1,438
	8,786	7,954	8,721	7,891
Provision for Obsolescence	(611)	(758)	(611)	(758)
	8,175	**7,196**	**8,110**	**7,133**

Some of the stocks may be subject to restriction of title, ie Romalpa Clauses or securities registered by suppliers under the Personal Property Securities Act. The value of stocks subject to the above cannot be quantified due to the inherent difficulties in identifying stocks that are still subject to the Romalpa Clauses or security registered under the PPSA at year end.

5. EQUITY

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
GENERAL FUNDS				
Opening Balance	126,174	148,174	126,312	148,312
Equity repayment to Crown	(1,861)	(22,000)	(1,861)	(22,000)
	124,313	**126,174**	**124,451**	**126,312**
RETAINED EARNINGS				
Opening Balance	(31,435)	(34,591)	(33,170)	(35,734)
Operating Surplus/(Deficit)	(848)	2,861	(1,376)	2,249
Transfers from/(to) Trust Reserve	10	295	(1)	315
Closing Balance	**(32,273)**	**(31,435)**	**(34,547)**	**(33,170)**
Represented by:				
Accumulated Deficit in Parent and Subsidiary	(32,351)	(31,513)	(34,625)	(33,248)
Accumulated Surplus in Associates	78	78	78	78
	(32,273)	**(31,435)**	**(34,547)**	**(33,170)**
REVALUATION RESERVE				
Opening Balance	184,477	77,717	184,477	77,717
Current Year Movement	-	106,760	-	106,760
Closing Balance	**184,477**	**184,477**	**184,477**	**184,477**
Represented by:				
Revaluation of land	68,603	68,603	68,603	68,603
Revaluation of building including fitout	114,374	114,374	114,374	114,374
Revaluation of reversionary interest in buildings	1,500	1,500	1,500	1,500
	184,477	**184,477**	**184,477**	**184,477**
TRUST RESERVE				
Opening Balance	8,110	8,405	7,993	8,308
Transfers from/(to) Retained Earnings	(10)	(295)	1	(315)
Closing Balance	**8,100**	**8,110**	**7,994**	**7,993**

6. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2007, the amount of funds received where the conditions attached have not been fulfilled is $8,100,000 ($8,110,000 at 30 June 2006).

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
This is represented by:				
Cash at Bank	647	355	647	355
Term Deposits	2,116	836	2,010	719
Local Authorities & Government Stocks	1,030	830	1,030	830
Bonds & Stocks	4,307	6,089	4,307	6,089
Total Restricted Assets	**8,100**	**8,110**	**7,994**	**7,993**

7. RESIDENTS' TRUST ACCOUNT

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Residents' Trust Account Balance	**870**	**806**	**400**	**383**

Residents' Trust Account comprises bank balances representing funds managed on behalf of Residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual residents' balances. Therefore, transactions occurring during the year are not included in the Statement of Financial Performance, Financial Position or Cash Flow of Canterbury DHB.

8. STAFF ENTITLEMENTS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Staff Entitlements consist of:				
Annual Leave Accruals	35,007	31,797	34,466	31,344
Unpaid Days Accruals	12,226	10,004	11,946	9,799
ACC Accruals	4,641	2,959	4,554	2,955
Other	4,601	4,159	4,543	4,059
Staff Entitlement Due Within 1 Year	**56,475**	**48,919**	**55,509**	**48,157**

9. PROVISIONS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Provisions due within 1 year	36,092	29,217	36,048	29,189
Provisions due after 1 year	8,526	9,509	8,307	9,231
Total Provisions	**44,618**	**38,726**	**44,355**	**38,420**
Movement in Provisions				
Opening balance	38,726	29,051	38,420	28,729
Additional provisions made during the year	26,429	19,812	26,409	19,828
Charged against provisions for the year	(20,537)	(10,137)	(20,474)	(10,137)
Closing balance	**44,618**	**38,726**	**44,355**	**38,420**

These provisions primarily relate to staff entitlements, but also include a refurbishment provision for Brackenridge. Staff entitlements include gratuities, long service leave, conference and sabbatical leave expenses, parental leave, and collective employment contracts pending finalisation of pay negotiations.

10. LOANS AND BANK OVERDRAFT

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Loans consist of:				
Crown Financing Agency	87,650	78,650	87,650	78,650
	87,650	**78,650**	**87,650**	**78,650**
Repayable as follows:				
Due Within 1 Year	-	-	-	-
Two - Five Years	72,650	78,650	72,650	78,650
Beyond Five Years	15,000	-	15,000	-
	87,650	**78,650**	**87,650**	**78,650**

The bank overdraft facility available totals $1,000,000 for both the parent and the group.

Security
Canterbury DHB commercial loans and the overdraft facilities are secured by Deed of Negative Pledge which requires the Board to comply with certain covenants such as limitations on borrowings, interest cover and working capital ratio.

Interest Rates
Average interest rates on the group's borrowing for the year are as follows:

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Commercial Loans	-	-	-	-
Crown Financing Agency	6.23%	6.24%	6.23%	6.24%
Bank Overdraft	9.18%	8.80%	9.18%	8.80%

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
At Cost				
Buildings and Fitout Plant	13,095	-	12,810	-
Leasehold Building & Fitout	894	1,281	894	894
Plant and equipment	87,309	74,720	80,759	69,693
Computer equipment and software	43,482	40,578	43,482	40,521
Motor vehicles	5,462	4,988	4,663	4,371
Capital work-in-progress	21,529	15,841	21,483	15,727
At Valuation				
Land	100,083	99,913	100,083	99,913
Buildings and Fitout Plant	300,816	300,816	300,816	300,816
Plant and equipment	24,791	24,791	24,791	24,791
Reversionary interest in buildings	1,500	1,500	1,500	1,500
	598,961	**564,428**	**591,281**	**558,226**
Accumulated Depreciation				
Buildings and Fitout Plant	29,729	-	29,691	-
Leasehold Building & Fitout	894	891	894	808
Plant and equipment	68,365	58,549	64,957	55,557
Computer equipment and software	40,069	35,930	40,069	35,882
Motor vehicles	3,757	2,913	3,363	2,615
	142,814	**98,283**	**138,974**	**94,862**
Net Book Value				
Land	100,083	99,913	100,083	99,913
Buildings and Fitout Plant	284,182	300,816	283,935	300,816
Leasehold Building & Fitout	-	390	-	86
Plant and equipment	43,735	40,962	40,593	38,927
Computer equipment and software	3,413	4,648	3,413	4,639
Motor vehicles	1,705	2,075	1,300	1,756
Capital work-in-progress	21,529	15,841	21,483	15,727
Reversionary interest in buildings	1,500	1,500	1,500	1,500
	456,147	**466,145**	**452,307**	**463,364**
Depreciation charged during the year:				
Buildings and Fitout Plant & leasehold	29,880	27,585	29,851	27,548
Plant and equipment	12,266	10,860	11,250	10,050
Computer equipment and software	4,261	7,920	4,241	7,886
Motor vehicles	821	1,007	704	902
	47,228	**47,372**	**46,046**	**46,386**

Canterbury DHB revalued its land, buildings and fitout plant as at 30 June 2006. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of TelferYoung (Canterbury) Ltd), which is consistent with FRS3 Accounting for Property Plant & Equipment, and resulted in the net increases in the value of land ($41,072,000), buildings and fitout ($65,178,000) and reversionary interest in a car park building ($510,000). This increase had been recognised in the Revaluation Reserve. The total optimised depreciated replacement cost of Canterbury DHB's land and buildings including fitout as at 30 June 2006 was $400,729,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 2019. This interest has not been included in the Statement of Financial Position, other than the total revaluation effect of $1,500,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

12. INVESTMENTS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Investment in Associates	519	375	519	375
Investment in Subsidiaries	-	-	3,107	2,217
Other Investments	11,170	-	11,170	-
	11,689	**375**	**14,796**	**2,592**

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Share of Associates Equity Brought Forward	168	168	168	168
Share of Associates Operating Surplus	-	-	-	-
Share of Associates Equity Carried Forward	168	168	168	168
Advances	351	207	351	207
	519	**375**	**519**	**375**

At 30 June 2007, Associate Companies comprised:

	Percentage Interest	Balance Date
New Zealand Centre for Reproductive Medicine Ltd	50	30 June
South Island Shared Services Agency Ltd	47	30 June

New Zealand Centre for Reproductive Medicine Ltd provides reproductive medicine services to private and publicly funded patients.

South Island Shared Services Agency Ltd provides a range of support services such as contracting, contract monitoring and provider audits on behalf of the South Island DHBs Funding arms.

INVESTMENT IN SUBSIDIARIES

	Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000
Equity - Canterbury Laundry Service Ltd	394	394
Advances - Canterbury Laundry Service Ltd	2,713	1,823
Equity - Brackenridge Estate Ltd	-	-
Advances - Brackenridge Estate Ltd	-	-
	3,107	**2,217**

At 30 June 2007 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Laundry Service Ltd	100%	30 June
Brackenridge Estate Ltd	100%	30 June

Canterbury Laundry Service Ltd provides laundry services. Brackenridge Estate Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

Canterbury DHB appoints all the directors of Canterbury Laundry Service Ltd. The company provides services predominantly to Canterbury DHB, and Canterbury DHB has control over the objectives of the company.

Canterbury DHB appoints three out of five directors of Brackenridge Estate Ltd. Its control over the company is exercised through these directors and the provision of financial support and administrative services by Canterbury DHB.

OTHER INVESTMENTS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Term Deposit	5,000	-	5,000	-
Bonds	6,170	-	6,170	-
	11,170	**-**	**11,170**	**-**

13. RECONCILIATION OF NET SURPLUS/(DEFICIT) AFTER TAXATION WITH NET CASH FLOW FROM OPERATING ACTIVITIES

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Net Operating Deficit before Share of Associate Companies' Surplus	(848)	2,861	(1,376)	2,249
Add Back Non-Cash Items:				
Depreciation	47,228	47,372	46,046	46,386
Add Back Items Classified as Investing Activity:				
(Gain) / loss on Asset Sale	(6,162)	(3,625)	(6,178)	(3,625)
	40,218	46,608	38,492	45,010
Movement in Term Portion Provisions	(983)	2,998	(924)	3,042
Movement in Deferred Tax	-	-	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	1,259	(9,050)	1,369	(9,103)
Decrease/ (Incr.) in Stocks	(979)	(602)	(977)	(590)
Increase/ (Decr.) in Creditors & Other Accruals	5,458	95	5,094	1,218
Increase/ (Decr.) in Capital Charge due to Crown	10,114	(3,633)	10,114	(3,633)
Increase/ (Decr.) in Staff Entitlements	7,556	4,530	7,352	4,603
Increase/ (Decr.) in Provisions	6,875	6,677	6,859	6,649
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	**69,518**	**47,623**	**67,379**	**47,196**

14. COMMITMENTS

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
CAPITAL COMMITMENTS				
Committed at Balance Date	39,200	31,536	39,200	30,762
NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Leases	9,481	13,901	4,996	7,725
Vehicle Leases	-	-	-	-
Other	11	7	-	-
	9,492	**13,908**	**4,996**	**7,725**
For Expenditure Within:				
1 Year	1,634	1,387	1,136	923
2 Years	1,307	1,151	936	687
3 Years and Beyond	6,551	11,370	2,924	6,115
	9,492	**13,908**	**4,996**	**7,725**

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are re-negotiated periodically reflecting the general principle that an on-going business relationship exists with those providers. Examples of these contracts include contracts for primary care, personal health and mental health.

There are also contracts for demand-driven items where the total expenditure is not defined in advance. Examples of this type of expenditure are pharmaceuticals, subsidy payments to rest homes and carer support relief payments.

The value of the Board's commitment relating to these contracts has not been included in the disclosure above.

15. TRANSACTIONS WITH RELATED PARTIES

a) GOVERNMENT FUNDING

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the Canterbury DHB. Canterbury DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

b) INTER-GROUP TRANSACTIONS

During the financial year the group had the following inter-group transactions:

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Revenue				
Interest on advance and director's fees from Canterbury Laundry Service Ltd	-	-	202	138
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	-	13
Services to Canterbury Laundry Service Ltd	-	-	427	478
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	58	53	58	53
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	4,073	3,403
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	25	-
Services from New Zealand Centre for Reproductive Medicine Ltd	1,940	2,015	1,940	2,015
Services from South Island Shared Services Agency Ltd	553	555	553	555

Interest charged on advances Canterbury Laundry Service Ltd, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Ltd are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June 2006 are as follows :

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd (relates to expenses paid on their behalf and recharged)	351	207	351	207
Amount Payable owing to subsidiaries				
Brackenridge Estate Ltd – Advance	-	-	713	1,317
Canterbury Laundry Service Ltd	-	-	346	279
Amount Receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – Debtor	-	-	80	45
Canterbury Laundry Service Ltd – Advance	-	-	2,750	1,823

c) BOARD AND COMMITTEE MEMBERS

During the financial year Canterbury DHB and its subsidiaries have purchased services provided on an arm's length basis by the organisations listed below which fall within the related party definition:

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Pegasus Health	2,716	14,565	2,716	14,565
He Oranga Pounamu Charitable Trust	171	171	171	171
Te Amorangi Richmond Wellness Village	8	151	8	151
Te Rito Arahi Māori Alcohol Drug & Resource Centre	228	308	228	308
Windsor House	1,952	1,778	1,952	1,778
Ryman Healthcare Ltd	6,056	4,985	6,056	4,985
TimeOut Carers	261	213	261	213
Canterbury Community Primary Health Organisation	1,450	796	1,450	796
Rural Canterbury Primary Health Organisation	9,110	6,450	9,110	6,450
Access Home Health	3,139	2,569	3,139	2,569
Deloitte	64	2	64	2
Te Puawaitanga ki Otautahi Trust	531	687	531	687
Te Rununga O Nga Maata Waka	127	-	127	-
McLeans Institute	130	192	130	192
Christchurch Resettlement Services	69	-	69	-
University of Canterbury	422	77	422	77
Christchurch Polytechnic	29	12	29	12
New Zealand College of Midwives	1	1	1	1
Cambridge Clinic (DSAC) Limited	112	110	112	110
Age Concern Canterbury	1	1	1	1
Parents Centre NZ	116	92	116	92
24 Hour Surgery Ltd	102	13	102	13
Social Services Council of the Diocese of Christchurch	4,023	3,641	4,023	3,641

Canterbury DHB and its subsidiaries have provided the following services on an arm's length basis to the organisations listed below which fall within the related party definition:

	Group		Parent	
	As at 30/06/07 $'000	As at 30/06/06 $'000	As at 30/06/07 $'000	As at 30/06/06 $'000
Pegasus Health	130	127	130	127
Christchurch Polytech	332	313	332	313
Pegasus After Hours Ltd	4	6	4	6

16. CAPITAL CHARGE

Canterbury DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2007 was 8% (8% for the year ended 30 June 2006).

17. FINANCIAL INSTRUMENTS

CREDIT RISK

Financial instruments which potentially subject the group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts.

The group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2007, the Ministry of Health owed Canterbury DHB $8.5 million ($8.8 million at 30 June 2006).

CURRENCY RISK

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary.

There were no forward exchange contracts outstanding at 30 June 2007 (30 June 2006 nil).

INTEREST RATE RISK

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities.

There are interest rates swap and options outstanding at 30 June 2007 of $8 million (30 June 2006 $46 million). The valuation of these contracts at 30 June 2007 is an unrecognised loss of $0.163 million (30 June 2006 $0.042 million loss).

FAIR VALUES OF FINANCIAL INSTRUMENTS

Financial instruments recorded in the financial statements have been recorded at their fair values.

18. SEGMENTAL REPORTING

Canterbury DHB operates in the provision of Health and Disability Support Services Industry in the South Island of New Zealand. Therefore, no segmental reporting is required.

19. CONTINGENCIES

Canterbury DHB has the following contingencies at year end:

Collective Employment Agreements negotiations

There are a number of collective employment agreements that expired before 30 June 2007. Negotiations are in progress at a National level and Canterbury DHB has limited influence over such negotiations. While significant industrial action may occur, due to the high degree of uncertainty, the financial impact of such events had not been allowed for in the financial results.

Outstanding Legal Proceedings

The Group has outstanding legal proceedings at year end. The Group disputes these claims and believe that it is unlikely any material financial loss will eventuate

(30 June 2006 – there was one contingency in relation to collective employment agreements negotiations.)

20. BUDGET VARIANCE

Additional personal health funding for PHO, new government health initiatives, funding for impact of property revaluation and funding for settlement of the national Public Service Association (PSA) Multi Employer Collective Agreement (MECA) were devolved during the year and were not reflected in these budgets.

21. SUBSEQUENT EVENTS

There were no events after 30 June 2007 which could have a material impact on the information in Canterbury DHB's financial statements (30 June 2006 – no events).

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2006/2007

All District Health Boards (DHBs) 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 objectives and set priorities;
- *A Statement of Intent (SOI)* - 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 Service Performance determining the performance targets the DHB needs to meet to achieve the long term vision outlined in its District Strategic Plan; and
- *A District Annual Plan (DAP)* - a more detailed document outlining the intended actions and activity the DHB has planned over the coming year to progress the long-term direction and achieve the objectives and performance targets outlined in the other two documents.

In their 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 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 measures included in this section reflect activity in the Strategic Health Gain Priority health areas identified in the Canterbury DHB's long-term District Strategic Plan. This activity requires the Canterbury DHB (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 DHB updates its SOI documents it continues to develop and refine the measures for its *Statement of 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 2006/2007 performance target and the year-end 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. With limited funding and workforce shortage in some specialist areas the scope for service expansion can be limited; therefore performance targets in some areas tend to reflect the objective of maintaining current performance levels.

It is important to note that during 2006/07 the DHB experienced prolonged industrial action particularly around Medical Radiation Technologists (MRTs), Lab Workers (including Blood Services) and Radiation Therapists. This action was ongoing from September 2006 and had significant affect on the DHB's ability to meet performance targets associated with delivery and wait-times. The performance measure regarding the percentage of people waiting for a coronary artery bypass graft, the delivery of Cardiac Surgery for key procedures, and that for improving access to radiation therapy on page 50 and 51 are examples of the indicators directly affected by the prolonged industrial action.

Also of note is the DHB's inclusion of several indicators over which it has limited direct control. The DHB has chosen to include these indicators as important measures of the determinants of health, however it should be recognised that the DHB's ability to influence the behaviour of its community and the provision of services by third parties is limited. By including these measures the DHB is essentially recognising its role in contributing to improving health outcomes while recognising that change cannot be made through its actions alone. The DHB continues to work with other providers, external agencies and organisations to collectively improve the health of its community.

Strategic Priorities and Directions

To achieve its primary objective, to improve the health and wellbeing of people living in Canterbury, the DHB determined to focus on achieving improved outcomes in five Strategic Health Gain Priority areas. These Strategic Priorities were identified through a health needs assessment and consultation process during the development of the DHB's five-year District Strategic Plan in 2006; *A Healthier Canterbury: Directions 2010*. The Strategic Priorities chosen were:

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

In addition, Older Persons' Health, Elective Services, Mental Health, Hospital Efficiency and Effectiveness and Good Governance represented further areas of focus in 2006/2007.

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

- 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 Our Health Care Workforce - to ensure that we have the appropriate workforce to meet the health needs of the people of Canterbury.
- Being a Leader in Health - to ensure the best possible level of care is provided to maximise outcomes for the people of Canterbury.

Overview of Performance

The indicators in this report reflect the performance measures specified in the DHB's 2006/2009 SOI (unless otherwise stated), and reflect the DHB's District Strategic Plan priorities. The performance measurements, outlined in the *Statement of Service Performance*, are loosely grouped under three output classes and these are reflected in this document:

- Funding and Performance;
- Provider-arm Hospital and Specialist Services(HSS); and
- Governance.

It should be noted that the number of Pacific people in the Canterbury region is small (10,476 at the 2006 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.

Where possible the DHB has included national averages for performance measures to give context to the DHB's performance. In some cases, for example, while the DHB may not have achieved the target set in 2006 the DHB may be performing well in terms of the national average and against DHBs in other regions.

1. FUNDING AND PERFORMANCE: Strategic Plan Health Gain Priorities

1.1 Child and Youth Health

Long-term Objective:
Improved health status for Canterbury's Children and Youth.

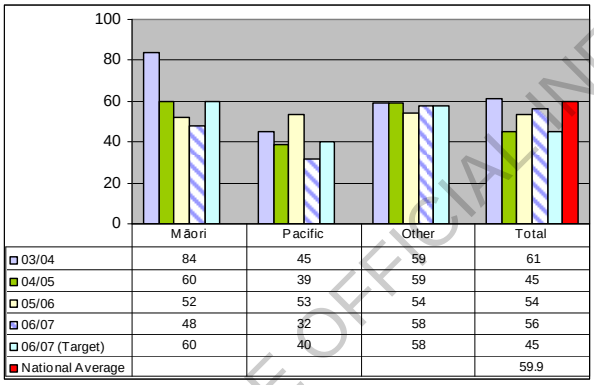
Brief Description:
Keeping children and young people healthy gives them a better chance of becoming healthy adults. The DHB completed a Child Health and Disability Action Plan (in 2004) to address the specific health issues of children in Canterbury. The Action Plan targets ten key priorities: access, information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments.

The DHB also completed a Youth Health Position Paper in April 2007 focusing on providing a safer and more supportive environment for young people, a measurable improvement in young people's mental health and a measurable improvement in their physical health.

Reduce the number of low birth weight babies.

Infants born under 2500gm are more likely to have poor health outcomes and increased disabilities and are more susceptible to serious illness during infancy, early childhood and adulthood.

Measure: Number of babies born in public hospital with low birth weight (rate per 1000 births).



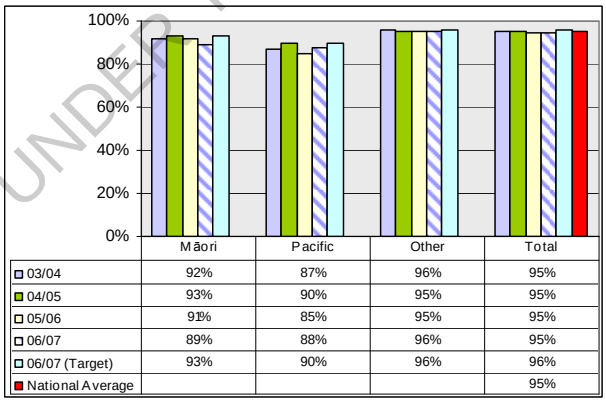
	Base 05/06	Target 06/07	Result 06/07
Maori	52	<60	48
Pacific	53	<40	32
Other	54	<58	58
Total	54	<45	56

While the total target has not been met the DHB is still below the National Average for this indicator and the DHB's ability to directly influence this indicator is limited. It is positive to see the rate of Maori and Pacific babies born with a low birth weight dropping against last year's results and coming in under target.

Facilitate earlier detection of hearing problems in children.

Earlier detection of hearing problems will help facilitate early intervention and help to minimise the impact of hearing loss in children.

Measure: Percentage of children passing school entry hearing screening tests.

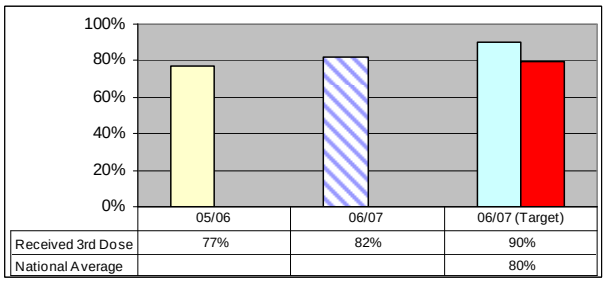


	Base 05/06	Target 06/07	Result 06/07
Maori	91%	93%	89%
Pacific	85%	90%	88%
Other	95%	96%	96%
Total	95%	96%	95%

Implement the Meningococcal B (MeNZB) Immunisation Project.

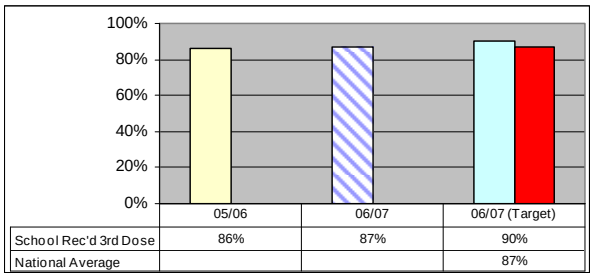
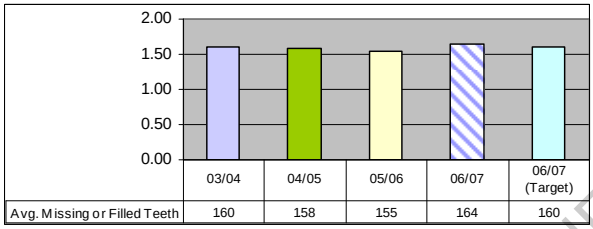
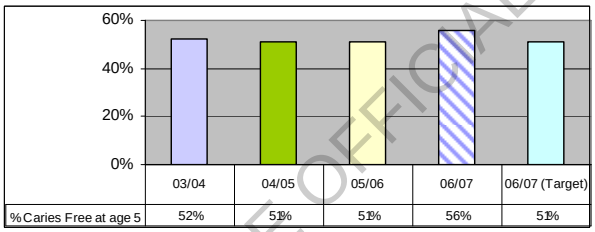
Providing immunisations reduces the impact of vaccine preventable diseases.

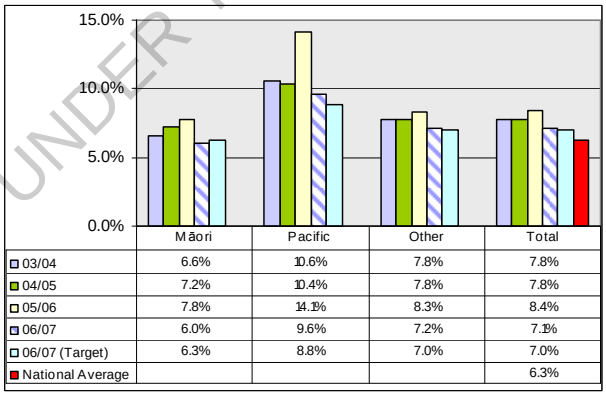
Measure: Percentage of children between 6 weeks and 5 years of age who received their 3rd dose of the MeNZB vaccine.



	Base 05/06	Target 06/07	Result 06/07
Total	77%	90%	82%

In Canterbury 82% of the DHB's under fives received dose three of the MeNZB Immunisation, slightly higher than the National Average for this indicator.

<table>
<tr>
<td></td>
<td>Percentage of school enrolled children who received their 3rd dose of MeNZB vaccine.
 
</td>
<td>
<table>
<tr><th></th><th>Base 05/06</th><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Total</td><td>86%</td><td>90%</td><td>87%</td></tr>
</table>
The DHB's rate for school aged children meets the National Average and performance is improved on the previous year. This work continues to be a successful collaboration between the DHB, General Practice Teams, Public Health Nurses, Immunisation Coordinators, Outreach Providers, Plunket and the many organisations responsible for raising community awareness.
</td>
</tr>
<tr>
<td>Improve Child Oral Health.</td>
<td>Proportion of Missing or Filled (MF) teeth of year 8 children (the mean MF score).[1]
 
</td>
<td>
<table>
<tr><th></th><th>Base 05/06</th><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Total</td><td>1.55</td><td>1.60</td><td>1.64</td></tr>
</table>
The public water supplies in Canterbury are not fluoridated. The oral health of children, particularly in low decile areas, is affected by this lack of fluoridation. While the DHB agreed a Position Statement on Fluoridation in 2003 and is actively promoting fluoridation, the DHB is not able to directly influence change.
</td>
</tr>
<tr>
<td></td>
<td>Percentage of children caries free (no fillings or holes in teeth), at age 5.
 
</td>
<td>
<table>
<tr><td>Total</td><td>51%</td><td>51%</td><td>56%</td></tr>
</table>
This is a positive improvement. Increased oral health promotion for under-5s is prioritised for 2007/08, but it will take 2-4 years for resultant changes to manifest.
</td>
</tr>
<tr>
<td>Reduce Ambulatory Sensitive Admissions.

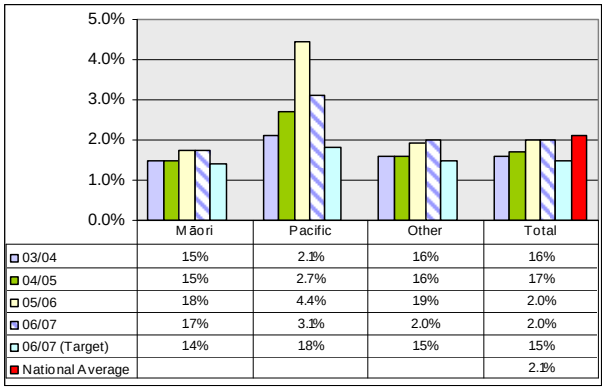
Ambulatory sensitive admissions are admissions that are seen as potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care services.</td>
<td>Ambulatory Sensitive Admissions for those aged 0-4 years (percentage discharged per population).
 
</td>
<td>
<table>
<tr><th></th><th>Base 05/06</th><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Maori</td><td>7.8%</td><td>6.3%</td><td>6.0%</td></tr>
<tr><td>Pacific</td><td>14.1%</td><td>8.8%</td><td>9.6%</td></tr>
<tr><td>Other</td><td>8.3%</td><td>7.0%</td><td>7.2%</td></tr>
<tr><td>Total</td><td>8.4%</td><td>7.0%</td><td>7.1%</td></tr>
</table>
Ambulatory Sensitive Admissions are based on admissions for 37 conditions influenced primarily by services in primary care and population health initiatives. The contributing conditions include: Asthma, Dehydration, Diabetes, Ruptured Appendix, Stroke, Angina, ENT Infections, Gastroenteritis and 'Failure to Thrive'.

While the DHB has not met targets in all population groups under this indicator, and the percentages for those aged 0-4 years still need some work to meet the National Average, it is pleasing to see the rates dropping against the previous year.

Analysis of the DHB's rates is being undertaken, concentrating on the areas where results are above the National Average. Investigation shows child rates appear to be driven (at least in part) by admission practices for short stay patients in the Child Acute Admitting Service, which appear to differ from those used by other DHBs. Further work on this issue is being progressed.
</td>
</tr>
</table>

[1] The Mean MF Score is the total permanent teeth MF due to holes divided by the number of children seen by school dental services in the period.

Ambulatory Sensitive Admissions for those aged 5-14 years (percentage discharged per population).



	Māori	Pacific	Other	Total
03/04	15%	2.1%	16%	16%
04/05	15%	2.7%	16%	17%
05/06	18%	4.4%	19%	2.0%
06/07	17%	3.1%	2.0%	2.0%
06/07 (Target)	14%	18%	15%	15%
National Average				2.1%

	Base 05/06	Target 06/07	Result 06/07
Maori	1.8%	1.4%	1.7%
Pacific	4.4%	1.8%	3.1%
Other	1.9%	1.5%	2.0%
Total	2.0%	1.5%	2.0%

In 2006 the targets set were primarily based on the DHB's performance in previous years rather than the National Average. Since then the Ministry of Health (Ministry) has made it clear that their expectations around Ambulatory Sensitive Admissions are based on national performance and expectations that DHBs will work to improve results if their performance is poor in comparison to other DHBs.

While the DHB has not reached targets for this age group, performance has improved against the previous year and the DHB is performing better than the National Average in terms of 5-14 year-olds.

Analysis of Ambulatory Sensitive Admission rates is being undertaken and this will look at the reasons for admissions and the areas where targeted activity might influence a downturn in the rates across all age groups.

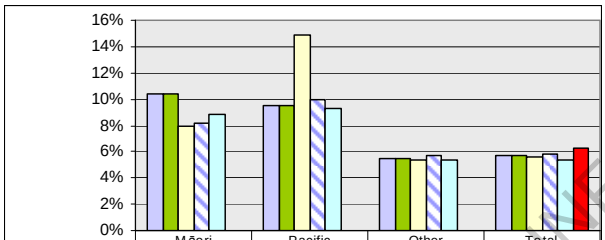
1.2 Older Persons' Health

Long-term Objective:	***Brief Description:***
Maintain/improve health and independence outcomes for older Canterbury residents within available resources.	With the demand implications of an ageing population, Older Persons' Health has been identified as an area of specific focus by the DHB going forward. In 2005/06 the DHB began the implementation of its local Aged Care Strategy; *Healthy Ageing, Integrated Support*. This work contributes to the implementation of the national Health of Older People's Strategy, is aligned with the DHB's Core Direction, Finding Better Ways of Working, and with the development of an integrated continuums of care. The emphasis is on flexible, holistic, quality and needs-based care in the community.

Objective 2006/2007: Reduce Ambulatory Sensitive Admissions.

Ambulatory sensitive admissions are admissions that are seen as potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care services.

Measure: Ambulatory Sensitive Admissions for those aged 65-74 years (percentage discharged per population).



	Māori	Pacific	Other	Total
03/04	10.4%	9.5%	5.5%	5.7%
04/05	10.4%	9.5%	5.5%	5.7%
05/06	8.0%	14.9%	5.4%	5.6%
06/07	8.2%	10.0%	5.7%	5.8%
06/07 (Target)	8.8%	9.3%	5.4%	5.4%
National Average				6.3%

	Base 05/06	Target 06/07	Result 06/07
Maori	8.0%	8.8%	8.2%
Pacific	14.9%	9.3%	10.0%
Other	5.4%	5.4%	5.7%
Total	5.6%	5.4%	5.8%

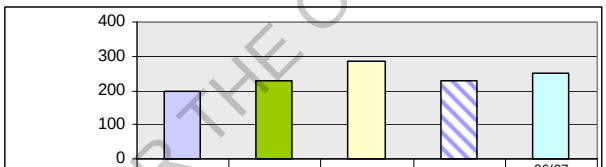
The DHB's admissions for the 65-74 age group are below the National Average which is reassuring, as is the drop in Pacific admissions. However the overall result has increased a little across this age group against the previous year.

It is expected that analysis work around Ambulatory Sensitive Admissions will also assist the DHB to understand and target improvements in the rates for this age group.

Build the focus on Health Promotion Services by increasing the number of older people receiving education on falls prevention through the Stay On Your Feet (SOYF) Home Exercise Programme.

Falls are a major cause of injury and ongoing disability for older people in Canterbury. The DHB and the Christchurch City Council jointly fund the SOYF Programme.

The number of people referred to the SOYF Home Exercise Programme.



	03/04	04/05	05/06	06/07	06/07 (Target)
Number Referred	200	230	287	229	250

	Base 05/06	Target 06/07	Result 06/07
Number Referred	287	250	229

The project has lost two SOYF Coordinators in the past year and the DHB has just recruited to the position with the new Coordinator starting in August 2007. This disruption has impacted on the referrals and the uptake of the programme.

However, ten new volunteers have just completed the volunteer programme and they will be ready to start with the new Coordinator which is a positive step for the 2007/08 year.

Implement the DHB's Health of Older People Strategy including the development of performance and evaluation indicators.

Develop a database to assist with future capacity planning and monitoring of the progress of service and funding shifts within aged care.

Target 06/07	Result 06/07
Database complete	Complete

The DHB has developed a database which identifies entry, exit and length of stay trends in residential care which will assist with future capacity planning.

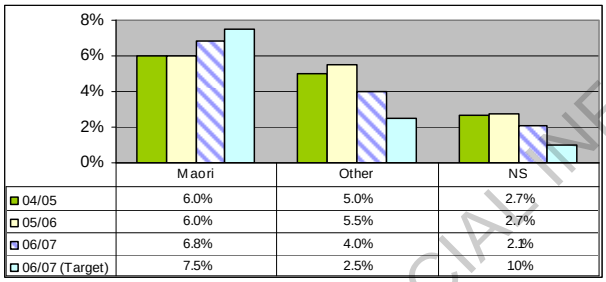
1.3 Maori Health

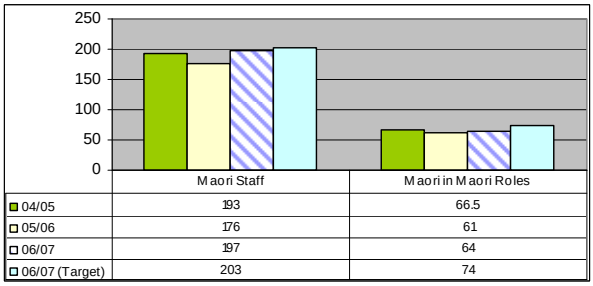
Long-term Objective:
Whanau Ora, Maori families supported to achieve their maximum health and wellbeing.

Brief Description:
Evidence of Maori health disparities is well known and compelling and to address these health disparities, the DHB developed a Maori Health Plan (2002), *Whakamahere Hauora Maori Ki Waitaha*. This Plan was reviewed and updated, after consultation with Canterbury's Maori community, and identifies a number of key areas where the DHB will focus its efforts over the coming years.

These key priorities are: monitoring of Maori health outcomes, Maori participation in health planning, service provision and the workforce, effective, assurance of culturally appropriate and high quality services and working across sectors to ensure a continuum of care. The updated Maori Health Plan was approved by the Board in April 2007.

Objective 2006/2007	***Performance***				
	Measure		**Base 05/06**	**Target 06/07**	**Result 06/07**
Improve the monitoring of Maori health outcomes. *Poor ethnicity data is a significant barrier to achieving this objective. Targets are set to reduce the percentages classified as 'other' or 'not stated' which contributes to under reporting of Maori (measured against Census population) and limits the DHB's ability to monitor health outcomes.*	Percentage of discharges classified by Ethnicity Groups: Maori, Other or Not Stated (NS).	Maori	6.0%	>7.5%	6.8%
		Other	5.5%	<2.5%	4.0%
		Not Stated	2.7%	<1.0%	2.1%
		Specific measures and targets have been placed in the revised Maori Health Plan to ensure improved quality of ethnicity data collection. The targets for this indicator are long-term targets moving the ethnicity identification into alignment with the Census figures for the Canterbury population. The steady progress being made towards the longer-term goal is a positive outcome.			
Increase Maori participation in health planning, in service provision and in the health workforce. *Increasing the participation of Maori is seen as a means of improving the cultural responsiveness of our health services.*	Implement a Memorandum of Understanding (MoU) between Manawhenua ki Waitaha and the DHB's Board to increase Maori participation in developing and identifying strategies to improve Maori health.	**Target 06/07**		**Result 06/07**	
		MoU in place		Not achieved	
		While a MoU was not progressed, formalising the relationship remains a priority. The revised Maori Health Plan requires a formal Crown-Maori Relationship Instrument agreement to be in place by June 2008.			
	Develop an integrated health outcome and performance monitoring framework aligning the DHB's Maori Health Plan *Whakamahere Hauora Maori Ki Waitaha* with the Ministry's Maori Health Strategy *He Korowai Oranga* and Maori Health Action Plan *Whakatataka*.	**Target 06/07**		**Result 06/07**	
		Develop monitoring framework		Framework developed.	
		A framework has been developed in alignment with the DHB's revised Maori Health Plan.			
	Number of DHB (i) staff identifying as Maori and DHB (ii) Maori staff working in Maori roles.		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total FTE	i) 176 (ii) 61	(i) 203 (ii) 74 [2]	(i)197 (ii)64
		The coming year will see additional focus on increasing the percentage of our staff with their ethnicity on record, in 2005/06 approximately 70% of staff had their ethnicity recorded. It is anticipated that a concentrated focus will improve identification significantly and increase our ability to monitor Maori staff numbers.			
Reduced health inequalities.	Provide Maori specific targets for indicators, particularly in areas of key concern for Maori health such as Child and Youth Health and Diabetes.	**Result 06/07**			
		Specific targets provided i.e. 1.1 Child and Youth Health and 1.8 Diabetes Indicators.			





[2] These are long term measures and were set for achievement by 2009/10. The DHB is expecting continual progress to this point.

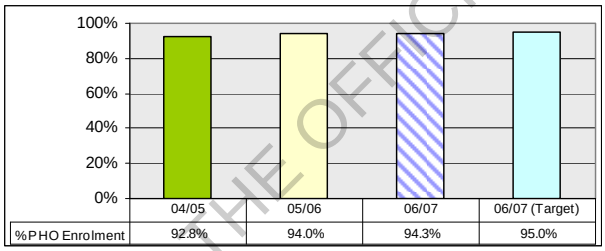
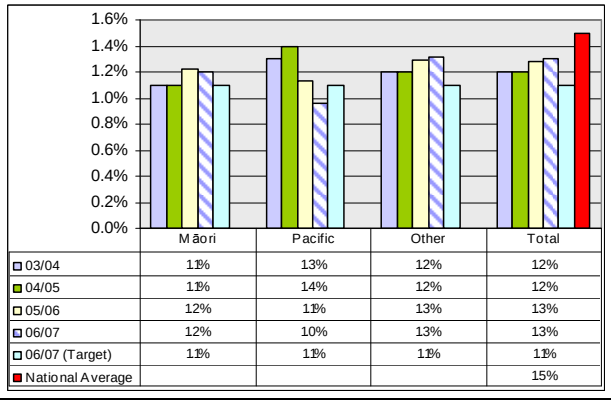
1.4 Primary Health

Long-term Objective:
Reduced barriers to primary health care.

Brief Description:
Reducing the barriers to good primary health care helps people stay well resulting in improved health status. During the 2006/07 year the DHB continued to focus its primary care activities on the implementation of the national Primary Health Care Strategy, via the ongoing development of PHOs within Canterbury.

The DHB also focused on addressing the needs of those populations with the greatest barriers to accessing primary health care through the implementation of Services to Improve Access and Health Promotion Plans and through the implementation of its Rural Health Services Action Plan ensuring equitable access for rural based communities.

Canterbury based PHOs continue to develop and implement new services to improve access and enrolment and work together in partnership. The PHOs have worked with the DHB on the Review of Acute Demand and After Hours Cover in Primary Care and the After Hours Direction Paper. The PHOs have also begun joint planning and service implementation.

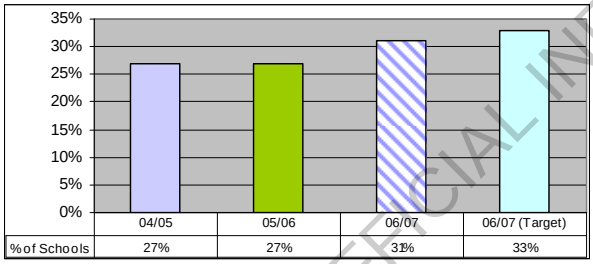
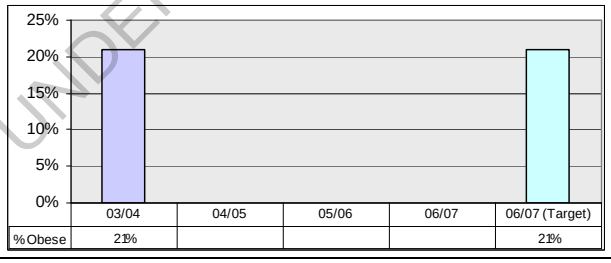
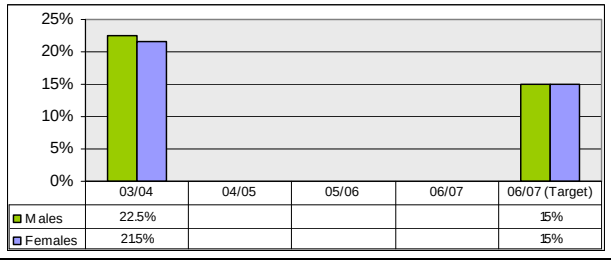
Objective 2006/2007	***Performance***				
	Measure	**Base 05/06**		**Target 06/07**	**Result 06/07**
Continued PHO Development – ensuring improved access to services and continuums of care that are developed in line with DHB priorities and ongoing health needs assessment.	All PHOs have implemented Health Promotion (HP) plans and have Services to Improve Access (SIA) Plans in place. These plans are consistent with, and support, the DHB's Strategic Priorities and are regularly reviewed.	3 out of five HP in place		5 of 5 in place	4 of 5 in place
		3 out of five SIA in place		5 of 5 in place	4 of 5 in place
		The DHB continues to work with the two PHOs yet to implement their plans.			
	Percentage of the population enrolled with PHOs. 	Total	94.0%	>95%	94.3%
Continued retention of Rural GPs - through provision of assistance in maintaining reasonable on-call rosters.	Percentage of GPs with a rural ranking of greater than 35 points, who work no more than a one in four weekend roster (unless by choice).		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total	100%	100%	100%
Reduce Ambulatory Sensitive Admissions. *Ambulatory sensitive admissions are admissions that are seen as potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care services.*	Ambulatory Sensitive Admissions for those aged 15-24 years (percentage discharged per population). 		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Maori	1.2%	1.1%	1.2%
		Pacific	1.1%	1.1%	1.0%
		Other	1.3%	1.1%	1.3%
		Total	1.3%	1.1%	1.3%
		The DHB's admission results for the 15-24 age groups are below the National Average – the performance for Maori and Pacific is also pleasing to see with the total performance remaining constant.			

1.5 Disease Prevention and Management

Long-term Objective:
Reduction in the risks associated with chronic disease.

Brief Description:
Chronic conditions are a major health burden for NZ, both now and into the foreseeable future. The DHB has identified four Disease Priorities (Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease) which it plans to give additional focus to over the next five years. However ongoing risk reduction provides an environment in which communities are supported to eat well, exercise regularly and attain and maintain healthy body weights. Ongoing risk reduction also supports smokefree environments and provides health promotion messages and programmes to encourage healthy living.

Risk reduction and the prevention and management of disease are integrated into a continuum of care whereby the reduction of one risk assists in the reduction of another and the DHB recognises this interplay in its focus on disease prevention. Obesity and smoking cessation, for example, are a crucial component in the prevention of a number of chronic conditions.

Objective 2006/2007	***Performance***			
	Measure		**Base 05/06**	**Target 06/07**	**Result 06/07**
Increase the number of Health Promoting Schools (HPS) – as a means to reducing the incidence of obesity. *The definition of HPS considers HPS as a framework used to address health issues. The approach is based on activities within the school setting that can impact on health: the inclusion of health education in curricula and the creation of a healthy environment. As such, HPS includes schools promoting Fruit in Schools and Active Schools.*	The percentage of schools in the Canterbury region using the HPS Framework, as a percentage of the total number of schools with the DHB's region.  	Total	27%	33%	31%
		81 of the 262 schools (31%) are currently actively following the health promotion in schools model. These include Fruit in Schools, schools working with Community and Public Health's Health Promoting Schools Team and Sport Canterbury's Active Schools Team. Although the DHB has not met the target set in 2006; 72 additional schools are currently moving towards the Health Promoting Schools model.			
Stabilise the proportion of the Canterbury population that are obese. *Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Maori or Pacific.*	The proportion of the Canterbury population who are obese.  		**Base 03/04**	**Target 06/07**	**Result 06/07**
		Total	21%	<21%	n/a
		The DHB's only measurement for this indicator is using statistics from the NZ Health Survey collected nationally by the Ministry. This survey was undertaken in 2004 and will be repeated every three years. The latest results are not yet available as the survey is currently being collected.			
Decrease the smoking rates in Canterbury.	The smoking rate for people over 15 years in Canterbury.  		**Base 03/04**	**Target 06/07**	**Result 06/07**
		Males	22.5%	<15%	n/a
		Females	21.5%	<15%	n/a
		The DHB's only measurement for this indicator is using statistics from the NZ Health Survey collected nationally by the Ministry. This survey was undertaken in 2004 and will be repeated every three years. The latest results are not yet available as the survey is currently being collected.			

1.6 Disease Prevention and Management – Cancer

Long-term Objective:

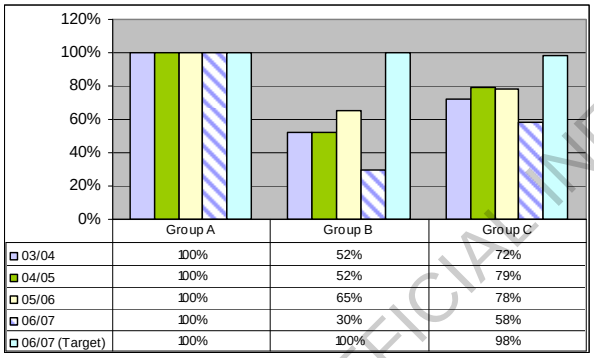
Improved health status for Canterbury's residents who are at risk of developing Cancer and appropriate and timely treatment for those who do.

Brief Description:

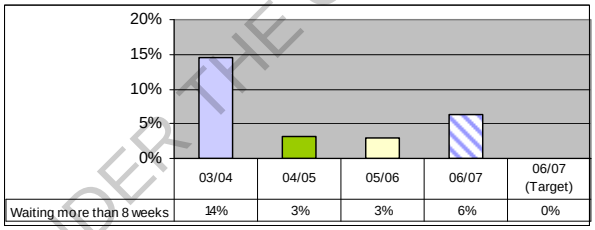
Cancer has been identified by the DHB as a priority area for improving the health status of its population. The DHB is currently in the process of developing a health strategy for the management of Cancer in Canterbury in collaboration with the other South Island DHBs through the South Island Shared Services Agency Limited.

The following indicators focus on reducing the impact of cancer rather than on prevention. However, actions such as making the DHB smokefree and the introduction of smokefree legislation will have positive effects as will a risk reduction focus in disease management and the development of continuums of care for chronic conditions.

Objective 2006/2007	***Performance***			
	Measure		**Base 05/06**	**Target 06/07**	**Result 06/07**
Reduce the impact of Cancer – through the provision of improved access to Cancer treatments (specifically Radiation Therapy). *Delay to radiation therapy is defined as the time between the specialist decision to commence treatment and the start of treatment. Patients are categorised into four groups:* *Group A - Ideally treated within 24 hours* *Group B - Ideally treated within 2 weeks* *Group C - Ideally treated within 4 weeks* *Group D – Patients with planned radiation treatment i.e. those taking part in a trial or having specific treatment protocols. These patients have to wait until a given time to start treatment, which is not usually within 4 weeks and they are therefore not included in the DHB's targets.*	Percentage of patients in categories A, B and C treated on time.	**Group A**			
		On Time	100%	100%	100%
		4-8 wks			
		8-12 Wks			
		12 wks +			
		Group B			
		On Time	65%	100%	30%
		4-8 wks	30%		63%
		8-12 Wks	4%		8%
		12 wks +	1%		
		Group C			
		On Time	78%	98%	58%
		4-8 wks	20%	2%	35%
		8-12 Wks	2%		6%
		12 wks +			1%
		Total	3% waited more than 8 weeks	0% wait longer than 8 weeks	6% waited more than 8 weeks



Percentage of patients in categories A, B or C who waited more than 8 weeks for treatment.



Of those patients in Category B and C who were not seen within eight weeks 28% were due to patient preference.

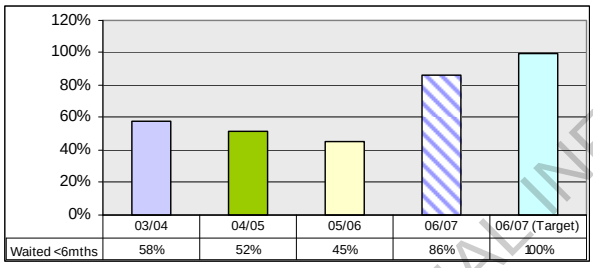
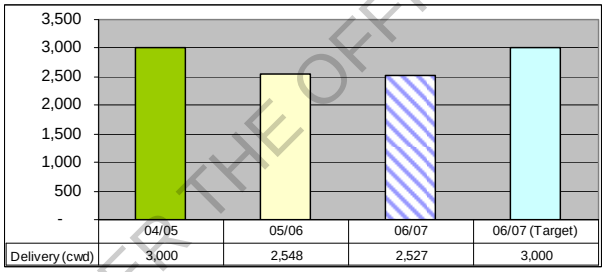
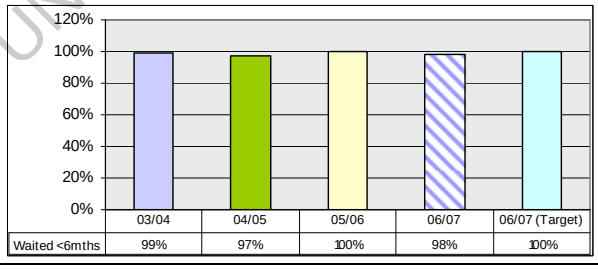
The majority of patients who were not seen 'on time' were affected by industrial action over the past year which resulted in an estimated loss in throughput of 60-80 complete treatment courses – which increased the waiting times.

Although the DHB was able to increase treatment capacity by running an additional shift we are unable to sustain this due to staffing numbers and under resourcing of Radiation Oncologists. The DHB has recruited one Oncologist (beginning August 2007), however two other Oncologists have reduced their working hours. Recruitment efforts continue and the DHB remains fully staffed with Radiation Therapists.

The Ministry's national Cancer Indictor is based on DHBs seeing all category A, B and C patients within 12 weeks. Under this national target the Canterbury DHB has achieved 100% for Groups A and B and 99% for Group C.

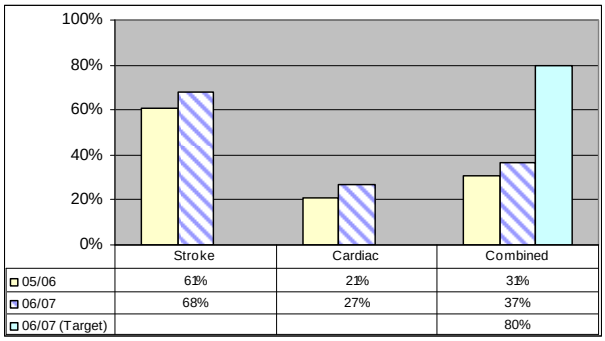
1.7 Cardiovascular Disease (CVD)

Long-term Objective:	***Brief Description:***
Improved Cardiovascular health status for Canterbury residents.	In September 2004, the DHB approved its Canterbury Heart Health Strategy, which outlines key priorities in the effort to reduce the incidence and impact of CVD. These priorities include: improving access to cardiovascular services, improving information with respect to heart health, developing an information strategy and implementing training and research with respect to heart health, improving the quality of care after acute events and devolving supported impact reduction of CVD disease to primary and community care providers. The DHB continues to focus on implementing the recommendations from its Heart Health Strategy.

Objective 2006/2007	***Performance***				
	Measure		**Base 05/06**	**Target 06/07**	**Result 06/07**
Reduce the Impact of CVD – through ensuring provision of improved access for those requiring treatment.	Percentage of people with certainty who waited no more than six months for a coronary artery bypass graft.  	Total	45%	100%	86%
		This is a positive result considering that this is one of the services most affected by the ongoing industrial action the DHB has faced since September 2006. Industrial action has particularly affected these elective surgery levels.			
	Delivery of Cardiac Surgery for key procedures - Cardiac Valves and Coronary Artery Bypasses Grafts.[3]  	Total CWD[4]	2,548	3,000	2,527
		Workflow issues and industrial action experienced over 2006/07 have meant a drop in CWD. A cardiac surgery agreement is currently being established with a private provider to increase delivery.			
	Percentage of people with certainty who waited for no more than six months for an angioplasty.  	Total	100%	100%	98%
		As at 30 June 2007 Cardiology had six patients exceeding their promise date. Two have since been treated, three are booked within the next month and one is not fit enough to undergo the procedure so will therefore be removed from the list.			

[3] Cardiac Valves and Coronary Bypass Grafts are counted using Diagnostic Related Groups; F03Z, F04A, F04B, F05A, F05B, F06A, F06B.

[4] Cost Weighted Discharges (CWD) are a relative measure of the cost of different surgeries.

<table>
<tr>
<td rowspan="3">Reduce the Impact of CVD – through improved quality of care after acute events.</td>
<td>Percentage of patients discharged after suffering an acute event, who attend a cardiac rehabilitation outpatient programme or who were admitted to organised stroke services.
 
</td>
<td>
<table>
<tr><th></th><th>Base 05/06</th><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Cardiac</td><td>21%</td><td>80%</td><td>27% [5]</td></tr>
<tr><td>Stroke</td><td>61%</td><td>80%</td><td>68%</td></tr>
</table>
The target of 80% reflects the DHB's long-run target for rehabilitation attendance as specified in its District Strategic Plan.

The reported performance for 2005/06 and for 2006/07 reflects the development of a baseline for this indicator.

There are a number of smaller cardiac rehabilitation courses running in rural areas and from GP Practices and the DHB is in the process of verifying baseline data from these centres. These numbers will be included in the 2007/08 results.
</td>
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<tr>
<td>Trial the New Zealand Heart Manual in primary care in Canterbury, beginning with six general practices.</td>
<td>
<table>
<tr><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Heart Manual Trial underway.</td><td>Trial Underway</td></tr>
</table>
Referrals are flowing to Maori Disease State Nurses and the six GP Practices in the trial. 17 enrolments have been counted since the programme began in March 2007 to the end of June 2007.
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<tr>
<td>Improve Heart Health information – to improve the DHB's ability to monitor change and evaluation programmes.</td>
<td>Design and implement a pilot project (in primary care) to collect a core database on CVD risk factors which will lead to the development of a Heart Health Register for Canterbury.</td>
<td>
<table>
<tr><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Three general practices implementing the project.</td><td>Pilot Project Complete</td></tr>
</table>
A primary care based CVD risk assessment pilot project was completed in three GP Practices and identified a number of issues around varying levels of computerisation, levels of recording information and the need to standardise methods for recording of some information. Unfortunately research funding was not secured to support the implementation of the full project and the establishment of a Heart Health Register.
</td>
</tr>
</table>

[5] These figures include the Maori Cardiac Outreach Programme run at Rehua Marae, the Christchurch Hospital Cardiac Rehabilitation Programme run primarily in the Canterbury Horticultural Hall and the Heart Guide Aotearoa Programme.

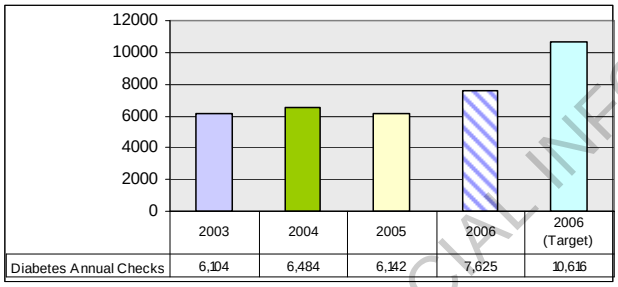
1.8 Disease Prevention and Management – Diabetes

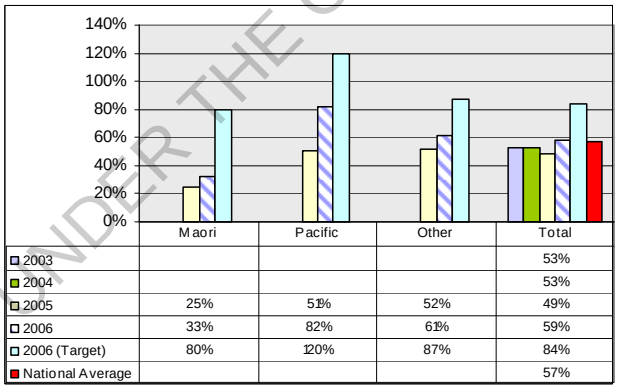
Long-term Objective:
Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes.

Brief Description:
To achieve improved health status with regard to Diabetes a number of accepted areas for action exist, namely: health promotion, early detection, effective treatment and improved patient awareness and information. In Canterbury the greatest benefit is considered to be gained through a range of actions, which include early diagnosis and treatment of eye problems and foot problems and improved access for Maori.

The DHB intends to continue to primarily focus its activities on continuing to encourage early detection and management of diabetes within the community and improving the level of retinal screening. The DHB has also been working collaboratively to improve the collection and verification of data around diabetes screening and will continue to do so in the coming year.

Objective 2006/2007	***Performance***				
	Measure [6]		**Base 05/06**	**Target 06/07**	**Result 06/07**
Reduce the Impact of Diabetes – through improving Diabetes detection by increasing the proportion of people with Diabetes who receive annual Diabetic Checks and the relevant associated primary care. *All Diabetics are entitled to an Annual Diabetes Check. The number of Checks relative to the number of expected Diabetics gives an indication of how well Diabetics are being identified and diagnosed.*	The number of Diabetes Annual Checks undertaken in Canterbury.	Total	6,142	10,616	7,625
		Investigation into data accuracy has demonstrated that the actual activity rates around Diabetes Annual Checks had been much lower than reported in past years and that the targets set were therefore unrealistic. The DHB has worked with the Local Diabetes Team (LDT) to aim for realistic targets based on actual performance and revised targets are recorded in the DHB's SOI 2007/2010. While the DHB has not met the target set, the total number of Annual Checks has increased against the previous year's performance.			
	The percentage of expected diabetics who have Annual Diabetes Checks/Reviews during the year.		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Maori	25%	80%	33%
		Pacific	51%	120%[7]	82%
		Other	52%	87%	61%
		Total	49%	84%	59%
		The DHB will continue to work closely with the LDT to improve and validate the accuracy of the information reported and with PHOs to draw their attention to ongoing concerns regarding data collection. The DHB will also work to gain support from PHOs to release to the DHB more detailed screening data to enable validation.[8]			





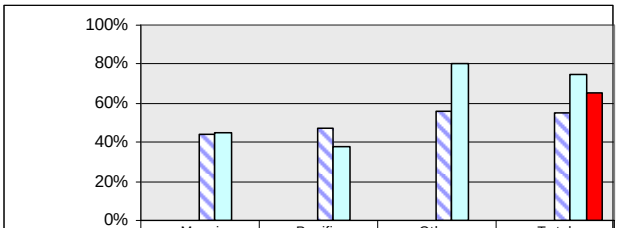
[6] Note these figures are collected by the Local Diabetes Team (LTD) by calendar year not by financial year.

[7] The higher percentage for Pacific is an anomaly caused by the LDT's belief that the estimated number of Pacific People in Canterbury is too low.

[8] The LDT has revised its reported number of Annual Checks for 2005, 2004 and 2003. The DHB has used the figures originally provided from the LDT for 2005 as the difference between these and the revised 2005 figures were not considered materially different and the revised figures did not include ethnicity breakdowns. The DHB has reported the LDT's revised figures for 2004 and 2003 as these figures are more aligned to the invoicing by PHOs for Annual Checks over this period.

Reduce the Impact of Diabetes – through the early diagnosis and treatment of eye problems.

The percentage of people having an Annual Diabetes Check who have also had a Retinal (Eye) Screen in the past two years.



	Maori	Pacific	Other	Total
2003				
2004				
2005				
2006	44%	47%	56%	55%
2006 (Target)	45%	38%	80%	75%
National Average				65%

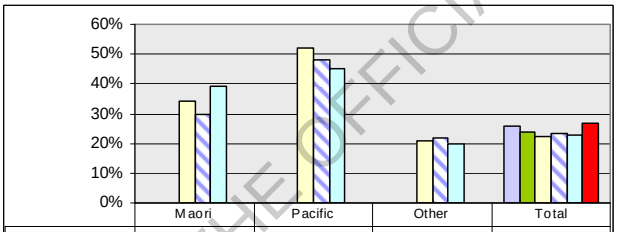
	Base 05/06	Target 06/07	Result 06/07
Maori		45%	44%
Pacific		38%	47%
Other		80%	56%
Total		75%	55%

The DHB continues to be concerned with the reported level of retinal screens. The DHB's provider-arm is delivering 4,500 retinal screens per annum (9000 bi annually), yet the latest LDT Annual Report shows only 55% of the 7,625 people reported as having Annual Diabetes Checks reported having had bi annual retinal screen. This would indicate that the DHB is only delivering about 2,087 screens annually (less than half of the actual volumes of screens completed). [9]

To move forward the DHB will work with the support of PHOs to undertake more detailed analysis to allow the two currently independent datasets to be integrated so that we can understand why the level of retinal screens is different. We will look to establish the actual rate of retinal screens for those patients having Annual Checks and the number of patients outside both datasets so that PHOs can undertake further follow-up.

Reduce the Impact of Diabetes – through improved Diabetes Management.

The percentage of people having an Annual Diabetes Check who have poor diabetes control (HBA1c>8%).



	Maori	Pacific	Other	Total
2003				26%
2004				24%
2005	34%	52%	21%	22%
2006	30%	48%	22%	23%
2006 (Target)	39%	45%	20%	23%
National Average				27%

	Base 05/06	Target 06/07	Result 06/07
Maori	34%	39%	30%
Pacific	52%	45%	48%
Other	21%	20%	22%
Total	22%	23%	23%

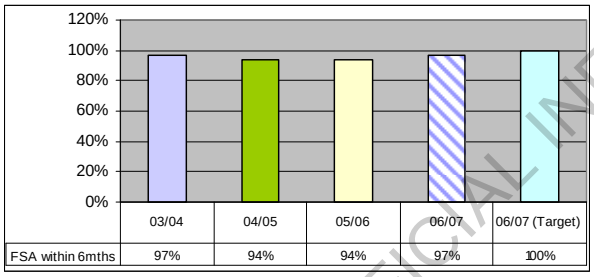
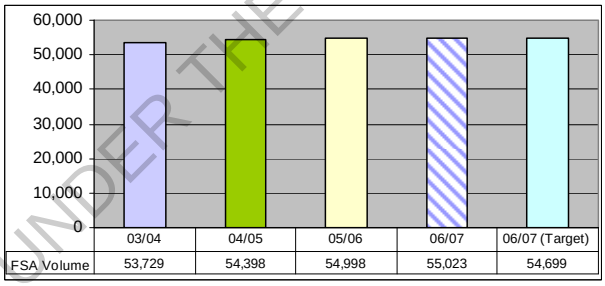
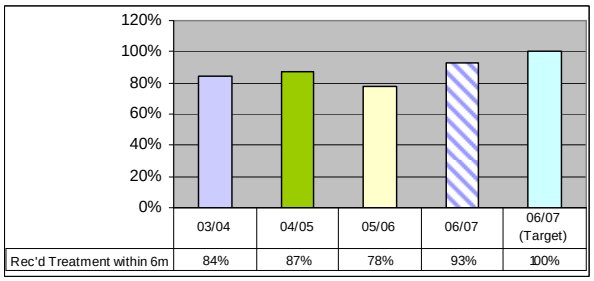
Although the results for the 'other' population grouping is higher than the previous years results, (therefore driving the total result up), the Maori and Pacific results have improved and these are our key risk groups for Diabetes – a positive improvement. [10]

[9] The LDT has revised its reported numbers relating to Diabetes for 2005, 2004 and 2003. The DHB has reported the most recent LDT figures for bi-annual retinal screening. However the DHB is concerned with the differential between the reported number of retinal screens from the LDT and the numbers reported from our provider-arm. The DHB has chosen not to include historical figures which it believes may be inaccurate.

[10] As part of its review the LDT has revised its reported percentages of those having those Annual Checks who had poor diabetes control for 2005, 2004 and 2003. The DHB has used the figures originally provided from the LDT for 2005 as the difference between these and the revised 2005 figures were not considered materially different and the revised figures did not include ethnicity breakdowns. The DHB has reported the LDT's revised figures for 2004 and 2003 as these revised figures are more aligned to the invoicing by PHOs for Annual Checks over this period.

1.9 Other Performance Measures – Service Delivery Targets

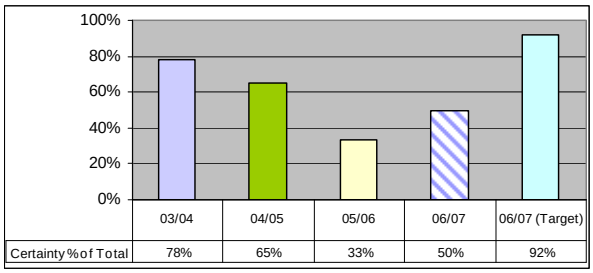
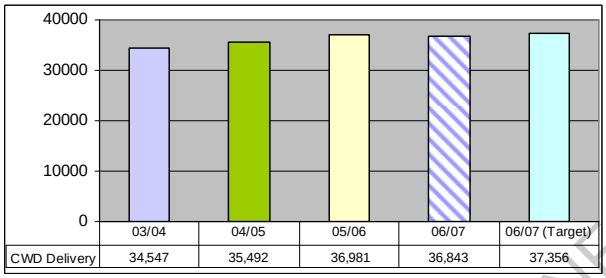
Long-term Objective:	***Brief Description:***
Improved health status for Canterbury's residents via the provision of services in a timely manner, within the available resources, for those with the greatest level of need.	Providing access to outpatient services and elective surgery has been an ongoing issue for the DHB. The funding and human resources available are limited and are not sufficient to meet all of the demand for health services. The DHB must therefore prioritise services and has been focused on the implementation of the Ministry's national Elective Service Policy in relation to elective services. These include; the provision of timely access to specialist assessment and elective surgery and 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. The DHB has also been focused on elective procedures undertaken on a daycase basis, which are associated with reduced risk to the patient and cost less than the same procedures undertaken on an inpatient basis.[11]

Objective 2006/2007	***Performance***			
	Measure		**Base 05/06**	**Target 06/07**	**Result 06/07**
Improve access to treatment – through reducing the waiting lists for First Specialist Assessments (FSA) so that all appropriately referred patients can be assessed within appropriate timeframes. *A FSA is the first appointment a patient has with a specialist following referral.*	Percentage of patients who receive their FSA within six months of referral. [12]  	Total	94%	100%	97%
		The DHB is focused on not making unnecessary FSA appointments for patients who would not actually receive surgery for medical or physical reasons. Initiatives have been introduced to screen patients for FSA such as the Physiotherapist and Nurse-led screening for Hip and Knee Replacements. This has meant that our Hip and Knee Replacement FSAs now have a 90% conversion to surgery rate as opposed to the 56% conversion to surgery rate that was previously held. These initiatives resulted in less FSAs being required to deliver the surgical CWDs.			
	Delivery of a level of publicly funded FSA volumes at the levels specified by contract (outlined in the DHB's DAP).  		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total FSA	54,998	54,699 [13]	55,023
		The Year-End figure shows an additional 324 FSA volumes delivered against contract and a small increase against the previous year's volumes.			
Improve certainty of treatment – through provision of certainty to patients as to whether they will/will not receive access to publicly funded inpatient surgery and where patients are given certainty ensure this is provided in a timely manner.	Percentage of patients provided with certainty of treatment receiving that treatment within six months.  		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total	78%	100%	93%
		Again these indicators have been replaced by the Ministry's national ESPIs. This indicator has been replaced by ESPI 5. Under ESPI 5 the DHB is required to see 95% of patients given a commitment to treat within six months of receiving that commitment. The DHB was compliant for ESPI 5 in June 2007.			

[11] Day Case Procedures are cases where the patient is not admitted to hospital overnight.

[12] This indicator has been replaced by one of the Ministry's national Elective Services Patient-flow Indicators (ESPIs), as part of the Ministry's Elective Services Policy. This older indicator used slightly different parameters and business rules than the ESPI that replaced it - ESPI 2. ESPI 2 requires DHBs to see 98% of patients waiting for FSAs within six months and the Canterbury DHB was compliant under this indicator in June 2007.

[13] The target set in the 2006/07 SOI was not consistent with the volume specified in the 2006/07 DAP. The target has been revised to reflect the DAP target (an increase of 1,395 FSAs).

<table>
<tr>
<td></td>
<td>Percentage of patients given certainty who are treated within the period indicated.
 
</td>
<td>
<table>
<tr><th></th><th>Base 05/06</th><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Total</td><td>33%</td><td>92%</td><td>50%</td></tr>
</table>
The DHB has been focused on matching a commitment to treat (or giving certainty) with its capacity to deliver those promises. There needs to be an understanding that the DHB's capacity fluctuates. Too much emphasis on providing certainty can mean a fluctuation in capacity would see the DHB not meeting its commitment to its patients. This is an ongoing process.
</td>
</tr>
<tr>
<td>Improve the Delivery of Treatment – through maintenance of surgical volume delivery, ensuring that all contracted surgery is delivered.</td>
<td>Case Weighted Discharges Delivered, as specified in the DHB DAP.[14]
 
</td>
<td>
<table>
<tr><th></th><th>Base 05/06</th><th>Target 06/07</th><th>Result 06/07</th></tr>
<tr><td>Total CWD</td><td>36,981</td><td>37,356[15]</td><td>36,843</td></tr>
</table>
36,843 CWD have been delivered, this is 513 under contract and less than the previous year's performance.

However, the DHB has faced ongoing industrial action since September 2006, which has affected elective surgery levels. This is a positive result considering the impact of the industrial action.

In addition to the above volumes an estimated 1,990 CWD of additional surgery (734 cases) were also delivered by a range of other providers under contract to the DHB in the past year which is not reflected in this indicator.
</td>
</tr>
</table>

[14] CWD delivery reflects the surgical (including Dental CWD) CWD delivery by the DHB provider-arm, against the Price Volume Schedule targets contained in the DHB's DAP. The result for 2004/05 is different from that published (34,074) as the previous number did not include Dental CWDs.

[15] The target set in the DHB's 2006/07 SOI was not consistent with the volume specified in the 2006/07 DAP. The target has been revised to reflect the DAP target (an increase of 1418 CWD).

1.10 Mental Health

Long-term Objective:

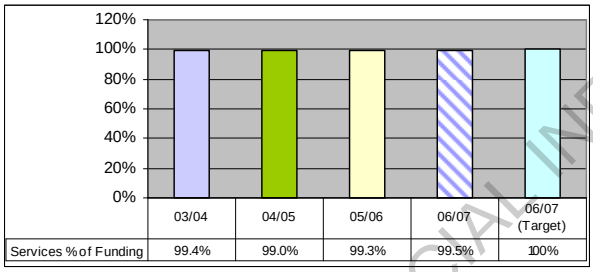
Improved Health Status for Canterbury Residents who have a serious ongoing mental illness.

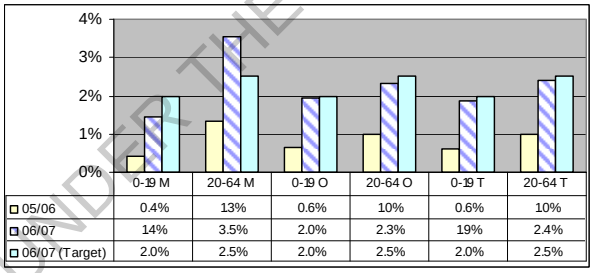
Brief Description:

It is estimated that 3% of New Zealanders will have a serious ongoing mental illness, which requires specialist care and treatment by a range of health and social service providers. The DHB plans to continue implementing the Mental Health Strategy, Blueprint for Mental Health Services, the Youth Suicide Strategy and national guidelines. The DHB has also completed its own Mental Health and Addictions Strategic Plan, which had its first year of implementation in 2005/06 and will continue to implement this Plan.

Over the next few years the DHB will continue to focus on improving access to services (in line with the demographics and mental health needs of the people in our region) and ensuring that the services provided are provided by the right provider, in the right place and at the right time.

Objective 2006/2007	***Performance***				
	Measure		**Base 05/06**	**Target 06/07**	**Result 06/07**
Improve the provision of Mental Health Services – through ensuring the delivery of contracted Mental Health Volumes by Hospital and Specialist Services (HSS) and ensuring services funded meet expenditure targets set by the Ministry.	Actual services delivered by the provider arm as a percentage of the contract with HSS, as outlined in the DHB's DAP.[16]	Total	99%	100%	99.5%
	Total contracted funding (both HSS and external Non-Government Organisations (NGOs)) as a percentage of the mental health target specified by the Ministry's Mental Health 'Ring-fence'.		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total	100%	100%	100%
Improved access to Mental Health Services through achievement of nationally set targets for access to treatment and support services for those with severe mental illness. *These targets are set in line with estimated proportions of people with mental illnesses for each age group and ethnicity in Canterbury. The higher the percentage, the more people accessing services.*			**Base 05/06**	**Target 06/07**	**Result 06/07**
		Maori			
		0-19	0.4%	2.0%	1.4%
		20-64	1.3%	2.5%	3.5%
		Other			
		0-19	0.6%	2.0%	2.0%
		20-64	1.0%	2.5%	2.3%
		Total			
		0-19	0.6%	2.0%	1.9%
		20-64	1.0%	2.5%	2.4%
		Although the access rates have not met target in some of the population groupings there is still a positive increase in access rates against the previous year. There are a number of clients seen by NGO providers in the community that are not linked in with Mental Health HSS and are therefore not reported through to the Mental Health Information National Collection (MHINC) database (where this access information is collected). The activity of many of our NGO community providers, who work with high needs and at risk groups, is not reflected under this measure. If NGO data was reported to MHINC the DHB is confident it would exceed every population target		



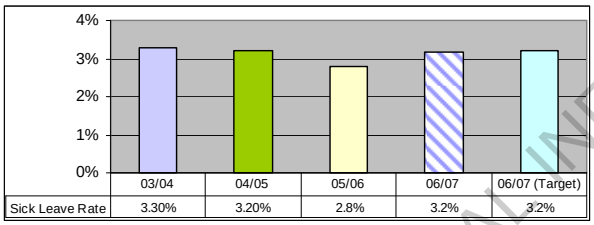
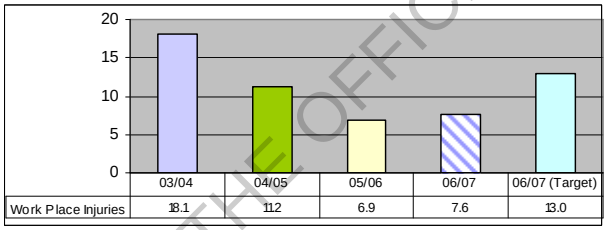
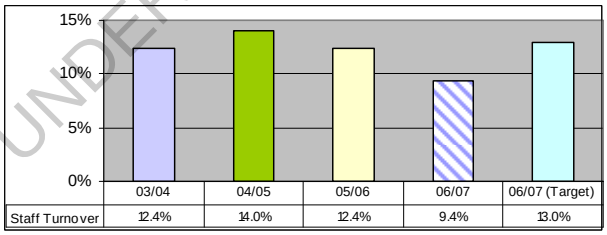
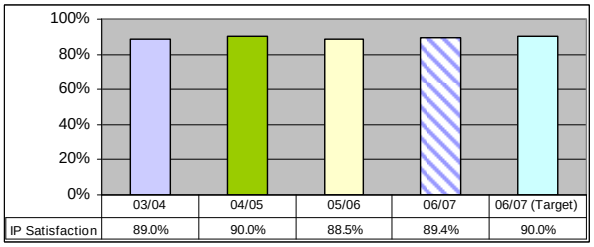


[16] Adjustment is made to vacant Full-time Equivalent (FTE) positions where cover has been provided.

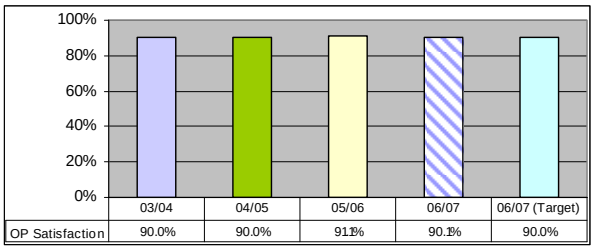
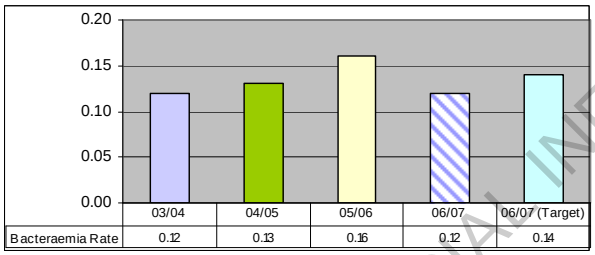
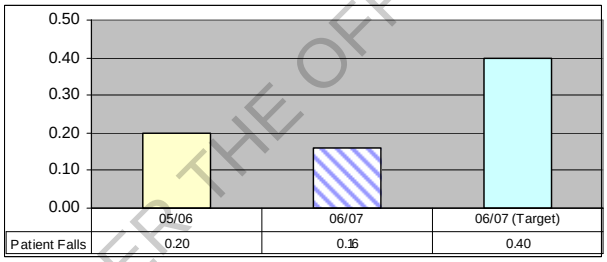
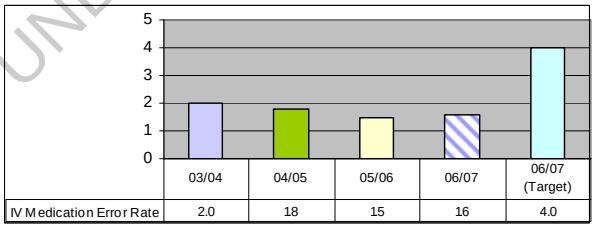
2. PROVIDER HOSPITAL AND SPECIALIST SERVICE MEASURES

2.1 Hospital Efficiency and Effectiveness

Long-term Objective:	***Brief Description:***
Efficient, effective and quality provision of health services to maximise the health status of Canterbury's residents within its available resources.	The DHB is a major provider (as well as the major funder) of health services to Canterbury residents. As a provider of health services the DHB must ensure that it operates in an effective and efficient manner, that the services provided are of a high quality and that patient safety is maximised.

Objective 2006/2007	***Performance***				
	Measure		**Base 05/06**	**Target 06/07**	**Result 06/07**
Improve performance as a good employer – through initiating systems and processes to promote a good working environment and foster partnerships between staff and management.	Sick Leave Rate (as per Hospital Benchmarking Indicator (HBI)).[17] 	Total	2.8%	3.2%	3.2%
	Work Place Injuries per million hours (HBI). 		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total	6.9	13	7.6
		The Workplace Injury Rate provides an indicator of the lost time injury rate over a period. There has been an overall downward trend over the last few years however recent quarters have seen a small increase in the number of lost time injuries. The result still remains well below the target set of 13 per million hours.			
	Staff Retention and Turnover (HBI). 		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total	12.4%	13%	9.4%
Improve Patient Satisfaction – through initiating systems and processes to ensure quality service.	Percentage of Good and Very Good responses from Inpatient Satisfaction Surveys (HBI). 		**Base 05/06**	**Target 06/07**	**Result 06/07**
		Total	88.5%	>90%	89.4%
		There is an insignificant difference between the 2006/07 results and the target.			

[17] Hospital Benchmark Indicators are national Ministry indicators used to measure national performance between DHBs.

	Percentage of Good and Very Good responses from Outpatient Satisfaction Surveys (HBI).  	**Base 05/06** / **Target 06/07** / **Result 06/07** Total: 91.0% / >90% / 90.1% While the 2006/07 results show a reduction against the previous year's result, the result still reaches the target set by the DHB.
Continue to maintain Quality – through Quality Health New Zealand Accreditation.	Maintain accreditation at all major DHB provider-arm (HSS) facilities.	**Target 06/07**: Maintain accreditation status **Result 06/07**: Maintained
Maintain appropriate levels of Clinical Quality within CDHB Hospitals.	Hospital Acquired Bacteraemia Rate, per 100 inpatient days (excluding the Mental Health Division).  	**Base 05/06** / **Target 06/07** / **Result 06/07** Total: 0.16 / 0.14 or less / 0.12
	Patient Falls (causing moderate or serious injury) per 1000 inpatient days. [18]  	**Base 05/06** / **Target 06/07** / **Result 06/07** Total: 0.20 / 0.40 or less / 0.16
	IV Medication Error Rate per 1000 inpatient days.[19]  	**Base 05/06** / **Target 06/07** / **Result 06/07** Total: 1. 3 [20] / 4 or more / 1.6 The DHB has set a high target in response to a commitment to increase reporting of IV and medication errors. There are a number of initiatives in this area including: introduction of the 0800 reporting line, educating staff through orientation and quality training programmes and the introduction of key patient safety policies such as the No-Blame Incident/Accident Policy and Culture of Patient Safety Policy. The aim of these initiatives is to help reinforce the benefit of staff reporting and to pass on important safety messages.

[18] The patient falls indicator is a patient falls rate per 1000 inpatient days. The target set in the 2006/2007 SOI document was incorrectly set at a rate per 100 days the target is reflected here per 1000 inpatient days. 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 total inpatients days plus half the total daypatient attendances.

[19] 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 target is set to increase the rate of reported errors, in line with the DHB policy of emphasising staff responsibility to report error and reflects the Institute of Healthcare Improvement recommendation that increasing reporting levels is an essential step in reducing overall harm.

[20] This figure is different to that reported in the DHB's 2005/06 Annual Report (1.5) due to a data collection error (the reported figure included events not directly related to a medication error and these have been removed).

Improve the continuum of care for patients – through innovation and patient orientated processes reducing unnecessary waits and delays for people attending Christchurch Hospital Emergency Department (ED).

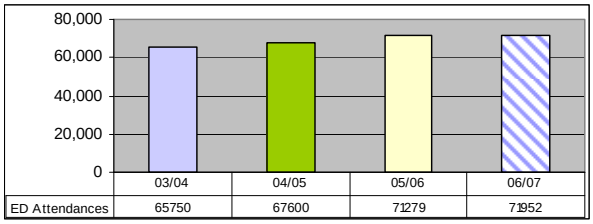
Patients coming into the ED are triaged upon presentation into one of five categories, dependant on need:

Triage 1 should be attended to immediately

Triage 2 within 10 mins

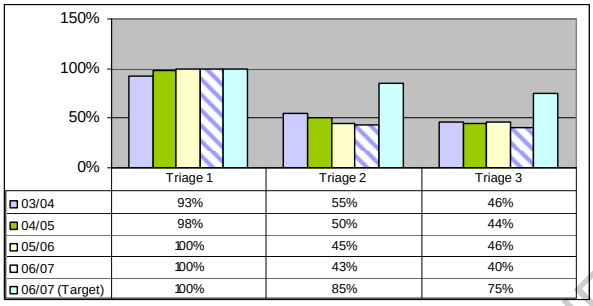
Triage 3 within 30 mins.

Number of attendances at the Christchurch Hospital ED.



	Base 05/06	Target 06/07	Result 06/07
Total	71,279	n/a [21]	71,952

Percentage of patients seen in ED (by a Doctor) within target time (by triage level).



	Base 05/06	Target 06/07	Result 06/07
Triage 1	100%	100%	100%
Triage 2	45%	85%	43%
Triage 3	46%	75%	40%

The waiting times by triage category performance measure shows a poorer performance than last year, and performance is below the targets. These performance measures are influenced by many factors, including the number of people seeking care (and their complexity), the capacity of the department to treat them, and the ability to free up more capacity by moving existing patients onto the next phase of care (a hospital bed in nearly half the cases).

A focus of the Improving the Patient Journey programme has been to improve efficiency of patient flow, so that those who are admitted can access a bed promptly. Consequently we have achieved ED length of stay figures which are better than anywhere in Australasia (length of stay is soon to be a key performance measure for NZ EDs, in addition to waiting time by triage category).

Unfortunately the number and complexity of patients presenting continues to increase and recently hospital 'gridlock' has increased the length of stay in ED for patients waiting for hospital beds. The ED is very small for its work profile, and this contributor has not been able to be addressed to date, however a business case for expanding the working area of the ED is currently being finalised.

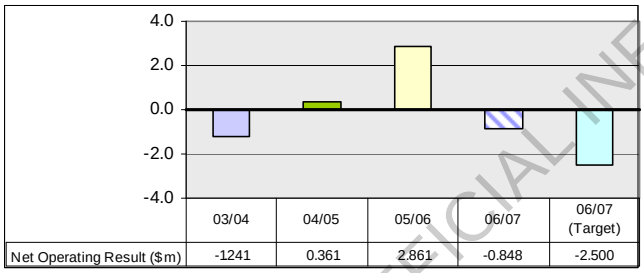
As part of the ED stream of the Improving the Patient Journey Programme, and more recently as part of the new Project RED, there is a concentration on efficiencies to reduce waiting times, especially for Triage 2 patients. It is hoped that this work will improve the ED's performance, in addition to increasing ED staff and space and addressing wider hospital patient flow issues. Due to the multi-factorial and systemic contributors to the ED's poor performance, this work will need to be associated with a continued high level of support from the DHB.

[21] This service is demand driven and as such no target for attendances can be set. This indicator is included for information purposes only.

3. GOVERNANCE

3.1 Good Governance

Long-term Objective: *To provide good governance to ensure that health services meet the needs of Canterbury people while staying within available funding.*	***Brief Description:*** The DHB 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 2006/2007	***Performance***			
	Measure	**Base 05/06**	**Target 06/07**	**Result 06/07**
Break Even – by managing expenditure (including funding to external providers) within available funding.	Net Operating Results. 	$2.861M	$2.5M deficit	$0.848M deficit
Develop District Strategic Plan within set time frame.	Delivery against Strategic Plan monitored.	Regular monitoring of Strategic Plan against targets.		Regular activity reports presented.
Provide Governance Training - good governance requires training and support, particularly for members new to governance.	Board members (new and existing) have received Governance training and Treaty of Waitangi training.	Governance and Treaty training available for all Board members.		Achieved.
		Treaty of Waitangi training provided in March 2007 with seven of eleven members attending.		
	A training register is established and maintained as required by the New Zealand Public Health and Disability Act 2000.	Registered established and maintained.		Register in place.
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.	Maintain provider monitoring processes.		Maintained.
	Regular routine audits are carried out and issues based audits are undertaken where process indicates it is appropriate.	Maintain annual audit plan processes.		Annual audit plan complete.
		There have been no issues based audits this year and 27 routine quality audits have been carried out.		
	The DHB leads a provider quality network which is an information sharing forum on quality related issues.	Continuation of this quality forum.		Quality forum continued.

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
Revenue					
MoH Revenue	1,008,495	3,934	610,930	(572,955)	1,050,404
Patient Related Revenue			33,458		33,458
Other			27,463		27,463
Total Revenue	1,008,495	3,934	671,851	(572,955)	1,111,325
Expenditure					
Personnel		2,633	435,279		437,912
Depreciation		57	47,171		47,228
Interest			5,069		5,069
Capital Charge			22,894		22,894
Other	1,006,029	988	165,008	(572,955)	599,070
Total Expenditure	1,006,029	3,678	675,421	(572,955)	1,112,173
Net Surplus/(Deficit)	**2,466**	**256**	**(3,570)**	**-**	**(848)**

5. Glossary

Ambulatory Sensitive Admissions	Admissions that are seen as potentially preventable by appropriate effective and efficient primary care, preventive or therapeutic programmes.
Angioplasty	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.
Bacteraemia Rate	Hospital Acquired Bacteraemia rate measures the number of hospital acquired blood stream infections as a proportion of the number of inpatients.
Certainty	When a 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).
CABG - Coronary Artery Bypass Graft	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 (nonbeating) heart.
CWD - Case Weighted Discharges	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.
FSA – First Specialist Assessment	(Outpatients only) The FSA is the first time a patient is seen by a doctor for a consultation in a particular speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
FTE - Full Time Equivalent	Full Time Equivalent means an Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
Governance	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
HBI - Hospital Benchmark Indicator	Indicators of national DHB performance established and monitored by the Ministry of Health.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin. The level of HbA1c reflects the average blood glucose level over the past 3 months.
Mental Health Blueprint Funding or Mental Health Ring-fence	Blueprint funding is allocated by the Ministry to ensure the development of mental health services for the 3% of the total NZ population estimated to have 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 NZ: How Things Need to Be (1998).* 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 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.
MeNZB - Meningococcal B	Meningococcal disease is a bacterial infection. It causes severe illnesses including: meningitis (an infection of membranes that cover the brain) and septicaemia (a serious infection in the blood). There are several different strains of bacteria which cause meningococcal disease including A, B and C.
NGO - Non-Government Organisation	NGOs are defined as independent community organisations operating on a not-for-profit basis, which bring a value to society that is distinct from government and market organisations – meaning 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 or community organisation rather than a NGO. However, for the purposes of a definition a "NGO" includes all these types of organisations.
PHO - Primary Health Organisation	A new development in service delivery, PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.

Radiation Therapy	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 sub-specialities.
Triage Levels - Emergency Department (ED)	Patients coming into the ED are triaged upon presentation into one of five categories. 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.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

AUDIT REPORT

TO THE READERS OF CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION FOR THE YEAR ENDED 30 JUNE 2007

The Auditor-General is the auditor of Canterbury District Health Board (the District Health Board) and group. The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand to carry out the audit on his behalf. The audit covers the financial statements and statement of service performance of the District Health Board and group for the year ended 30 June 2007.

Unqualified opinion

In our opinion:

- The financial statements of the District Health Board and group on pages 19 to 38:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the District Health Board and group's financial position as at 30 June 2007; and
    - the results of operations and cash flows for the year ended on that date.
- The statement of service performance of the District Health Board and group on pages 39 to 62:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 26 September 2007, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.
We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and the statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statements and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements or statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing financial statements and a statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the District Health Board and group as at 30 June 2007 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the District Health Board and group's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

Other than the audit, we have no relationship with or interests in the District Health Board or any of its subsidiaries.

Julian Tan
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

Matters relating to the electronic presentation of the audited financial statements and statement of service performance

This audit report relates to the financial statements and the statement of service performance of the Canterbury District Health Board for the year ended 30 June 2007 included on the District Health Board's web-site. The District Health Board's Board is responsible for the maintenance and integrity of the web site. We have not been engaged to report on the integrity of the District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements and the statement of service performance since they were initially presented on the web site.

The audit report refers only to the financial statements and the statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and the statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 26 September 2007 to confirm the information included in the audited financial statements and statement of service performance presented on this web site.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.

APPENDIX 8

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Canterbury District Health Board

Report For the Year Ended
30 June 2008

TABLE OF CONTENTS

DIRECTORY

Board Members
Alister James - Chair
Olive Webb – Deputy Chair
Andrew Dickerson
Anna Crighton
Chris Ryan
David Morrell
Eleanor Carter
Elizabeth Cunningham
Jo Kane
Matea Gillies
Peter Ballantyne
Heather Carter *
Karen Guilliland *
Laurence Malcolm *
Neville Fagerlund *
Norm Dewes *
Robin Booth *
Syd Bradley *
(* Board Member retired in December 2007)

Chief Executive
Gordon Davies (Chief Executive Officer)

Registered Office
2nd Floor, H Block
The Princess Margaret Hospital
Cashmere Road
Christchurch

Auditor
Audit New Zealand on behalf of the Auditor-General

Banker
Westpac Banking Corporation

MISSION STATEMENT

The Canterbury DHB's mission is to improve, promote and protect the health of the people in the community and foster the well-being and independence of people with disabilities and reduce disparities.

BOARD MEMBERS

Alister James - Chair	Alister served 20 years as a Christchurch City Councillor and is a lawyer with a particular interest in adolescent health, mental health, and alcohol and drug treatment services. He is keen to improve DHB and community relations.
Olive Webb - Deputy Chair	Olive is a Clinical Psychologist and independent Health and Disability Consultant with more than 35 years experience. She has served on the Board for seven years and is committed to rural health issues and delivery.
Andrew Dickerson**	Andrew has 20 years experience in the health and disability sector and is Chief Executive of Age Concern Canterbury. He would like to see improved access to elective surgery, better integration between hospital and General Practice services.
Anna Crighton **	Anna intends to use her 15 years as a Christchurch City Councillor and Community Board member, to help improve governance and accountability. She has a record of being effective, vocal, publicly accessible and accountable.
Chris Ryan **	An Ashburton GP for 18 years, Chris has been Chair of the Ashburton District Health Committee, GP representative Rural Canterbury PHO Board, Secretary of the Canterbury Faculty of the Royal NZ College of GPs and a GP education facilitator. Chris believes health professionals should be involved in planning and management at every level.
David Morrell	David has been a member of the District Health Board for six years and has been Christchurch City Missioner. He is committed to more accessible and affordable services for all. David is Chair of the CDHB Hospital Advisory Committee, member of the Finance Audit & Risk Committee and Chair of Brackenridge Estate.
Eleanor Carter **	Eleanor is an advocate for patient needs. Previously a Health Cuts Hurt spokesperson, Eleanor believes that health services should be funded according to community need in a transparent and effective manner.
Elizabeth Cunningham **	Elizabeth Cunningham, who is of Ngāi Tahu and Ngati Mutunga descent, is a research manager (Māori) at the University of Otago, Christchurch School of Medicine She has worked at all levels of the health sector, including as a health professional; a service manager; and as an advisor to Ministers of Health on Māori health issues. She is also a longstanding member of the Māori Women's Welfare League. In her current role with the University of Otago, her role is to manage and develop strategies to ensure university researchers' work responds to the needs and aspirations of Māori.
Jo Kane	In her second term on the Board, Jo is keen to follow through on community focused health initiatives. Jo believes early intervention and healthy lifestyle choices will assist our health system.
Matea Gillies **	Matea has been a GP for 30 years. He is of Ngai Tahu descent and Chairperson of the Ngai Tahu Runanga Health collective - Manawhenua ki Waitaha. He believes primary and secondary health services need to work together more efficiently.
Peter Ballantyne **	Peter is Chair of the CDHB's Finance Audit & Risk Committee and is a retired Chartered Accountant in a consultancy role. He is involved in the aged care sector and has financial accounting and auditing experience.

BOARD MEMBERS – continued

Heather Carter *	Heather Carter is devoted to accessible and affordable health care for all New Zealanders. Heather runs Life Masters, a personal development and workplace counselling consultancy. In addition, Heather serves on the Council of the Christchurch Polytechnic Institute of Technology, and Health Cuts Hurt (a group aimed at improving healthcare for the people of Canterbury).
Karen Guilliland *	Karen Guilliland is Chief Executive of the New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the PHARMAC Board. She also provides consultancy to Parents Centre NZ.
Laurence Malcolm *	Laurence Malcolm is a medical graduate, Professor Emeritus and former Professor of Community Health at the Wellington School of Medicine. He currently works as a consultant in health services research and development, is a member of the Council and Executive of Age Concern Canterbury, and has been on many national and international boards and committees. He has a special interest in primary health care and the quality of clinical services.
Neville Fagerlund *	Neville Fagerlund is a Chartered Accountant in public practice with over 25 years experience. He has provided financial and commercial advice to Pegasus Health Ltd since its inception in 1993 and advises The 24-Hour Surgery Ltd. Neville is a Director of Cambridge Clinic Ltd, a charitable company in the health arena.
Norm Dewes *	Norm Dewes is the Chief Executive of the urban Māori authority based in Canterbury (Te Runanga o Nga Maata Waka). Norm is a member of the New Zealand Advertising Standards Authority, Canterbury Museum Advisory Committee, and Canterbury Community Primary Health Organisation. He is the Chairperson of Te Rito Arahi Māori Alcohol, Drug and Resource Centre, Otautahi Social Services, Māori Legal Services and Capital Planning and Development, and is the Manager of Nga Hau e Wha National Marae. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.
Robin Booth *	Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
Syd Bradley *	Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB. Syd has served on a number of boards since resigning as General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.

* retired during the year
** appointed/elected during the year

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders on the affairs of the Board for the year ended 30 June 2008.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based district health board, which provides Health and Disability Support Services principally to the people of Canterbury, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB Group recorded a net deficit of $16.766 million against a budgeted breakeven position. (2006/07 result was a net deficit of $2.249 million).

BOARD FEES

Board fees paid, or due payable, to Board and Committee Members for services during the year, were as follows:

	Board Fees Year ended 30/06/08 $'000	Committee Fees Year ended 30/06/08 $'000
Alister James	39	2
Olive Webb	32	5
Syd Bradley*	26	1
Jo Kane	26	4
David Morrell	26	5
Robin Booth*	13	1
Heather Carter*	13	3
Norman Dewes*	13	3
Neville Fagerlund*	13	1
Karen Guilliland*	13	1
Laurence Malcolm*	13	3
Anna Crighton	13	1
Andrew Dickerson	13	3
Christopher Ryan	13	2
Eleanor Carter	13	1
Peter Ballantyne	13	5
Matea Gillies	13	3
Elizabeth Cunningham	2	1
Alison Wilkie	-	1
David Kerr	-	3
John Musgrove	-	1
Tuari Potiki	-	1
Trevor Read	-	3
William Tate	-	3
Margaret Schwass	-	2
Wendy Dallas-Katoa	-	1
	307	**60**

*retired during the year

Total fees paid for the year were $367,000 (2006/07 - $357,000). The limit of fees authorised for the year ended 30 June 2008 was $392,875 (2006/07 - $385,000).

DIRECTOR FEES

Director fees paid, or due and payable, to directors of subsidiaries during the year were as follows:

	Year Ended 30/06/08 $'000	Year Ended 30/06/07 $'000
David Morrell	10	10
Graham Heenan	13	13
	23	**23**

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the Interest Register:

CANTERBURY DHB

Alister James

Barrister and Youth Advocate - acting for clients including young persons with mental health, alcohol and drug issues and dealing with Mental Health Services, in particular Youth Specialty Services.

Home Made Partnership Trust (Christchurch Supergrans) – Chair - sometime recipient of funding grants from Community and Public Health for courses run by the organisation.

Legal Services Agency (Crown Entity) - Board Member - Legal Services Agency provides legal services and funding, including granting legal aid for persons who may be involved in any proceedings against the Canterbury DHB, and in respect to mental health reviews.

State Housing Appeal Authority – Deputy Principal Member - This relates to appeals relating to the allocation of State houses and the assessment of income related rentals. Conflicts of interest are not likely.

The McLean Institute – Board of Governors - The Chair of the Canterbury DHB is an ex-officio member of the Board of Governors pursuant to the will of Allan McLean and Act of Parliament. The McLean Institute operates Holly Lea, a rest home and some commercial property which supports its charitable purpose. The Institute provides residential aged care services under contract with the Canterbury DHB.

Spouse, Sue James is an employee with the Community and Public Health Division.

Olive Webb

Health Practitioners Disciplinary Tribunal – Member

Potentially a member of a tribunal panel when a clinical psychologist is before the panel. The tribunal has procedures for dealing with potential conflicts of interests for tribunal members. Should an issue of conflict arise, this will be disclosed at the time.

Institute of Applied Human Services Limited (IAHS) – Chairperson

Provides individual consultation, service advice and workforce training in the intellectual disability area, on contract to various individuals and providers in Australasia. New Zealand providers of intellectual disability services are usually funded by the Ministry of Health. IAHS has no contracts with Canterbury DHB.

Special Olympics New Zealand – Trustee

As well as providing sporting events, also provides health screening and assistance.

Access Home Health Limited – Director

Provides home based healthcare and personal support on contract to the Accident Compensation Corporation, Ministry of Health and several DHBs, including Canterbury DHB.

Alison Wilkie	Rural Canterbury Primary Health Organisation – Employee
	Christchurch Primary Health Organisation - Employee
	Family Help Trust – Trustee
	Christchurch Resettlement Services – Board member
Andrew Dickerson **	Health Care of the Elderly Education Trust – Chair - Promotes and supports teaching and research in the area of care of older people. Recipients of financial assistance for research, education or training could include employees of the Canterbury DHB.
	Age Concern Canterbury Inc. - Chief Executive - Provides social support services and advocacy services to approximately 13,500 older people per annum in the Canterbury area. Does not have any contracts with the Canterbury District Health Board but does have contracts with: ▪ Ministry of Health (through Age Concern New Zealand) for Health Promotion Services ▪ Capital & Coast District Health Board (through Age Concern New Zealand) for Visiting Services ▪ Partnership Health PHO for the Winter Warmth Project ▪ Ministry of Social Development (through Age Concern New Zealand) for Elder Abuse & Neglect Prevention Services.
	Canterbury Medical Research Foundation – Member - Provides financial assistance for medical research and research facilities in Christchurch. Recipients of financial assistance for research, education or training could include employees of the Canterbury DHB.
	Elder Care Canterbury Reference Group – Member - Intersectorial community group that works collaboratively to identify, discuss and make recommendations on issues affecting older person's health services. Funded by the Canterbury District Health Board, on contract to Presbyterian Support Services.
	NZ Historic Places Trust – Member - The Trust promotes the identification, preservation and conservation of the historical & cultural heritage of New Zealand. Canterbury District Health Board owns buildings that may be considered by the Trust to have historical significance.
	No Conflicts of Interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time. ▪ NZ Gerontology Association – Member - Professional association that promotes the interests of older people and an understanding of ageing. ▪ Hope Foundation for Research on Ageing – Member - Promotes research on New Zealand's ageing population and its implications for the future. ▪ Osteoporosis (Canterbury) Inc. – Member - Provides support, information and advice to people with osteoporosis. ▪ Neurological Foundation of New Zealand Inc. – Member - Provides support and information to people with diseases and disorders of the brain and nervous system. ▪ Abbeyfield New Zealand Inc. – Member - Promotes and establishes community housing for lonely and socially isolated older people using the Abbeyfield model. ▪ Mayors Welfare Fund Trust Board – Member - Provides assistance in cases of extreme hardship.
	Ministry of Social Development Home Equity Conversion Reference Group – Member - Provides advice to the Minister for Senior Citizens (through the Office for Senior Citizens) on Home Equity Conversion.

Anna Crighton **	University of Canterbury Council – Council Member - Governance of University. New Zealand Historic Places Trust – Board Member - Governance of New Zealand Heritage. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance. Christchurch Heritage Trust and Director – Director - Governance of Christchurch Heritage. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance. No Conflicts of Interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time. ▪ The Art Registry Co. Limited – Director - Principal Registrar and Director of collections management. ▪ Theatre Royal Charitable Foundation – Director - Governance of theatre operations. ▪ Lottery Canterbury / Kaikoura Community Distribution Committee- Member - Distribution of profits from NZ Lotteries for funding of Community projects.
Bob Lineham	Civic Assurance (Local Government Insurance Corporation Ltd) – Director - This is a specialist Insurance Company servicing Local Government Riskpool – Director - This is a mutual fund covering Liability Insurance for Local Government members Christchurch City Networks Ltd – Director - This involves the installation of Broadband Infrastructure in Christchurch. There is a possibility that it could offer services to the Canterbury DHB in the future. Local Government Finance Corp Ltd – Director - This involves investing and borrowing on behalf of Local authorities (currently in wind down mode). Christchurch City Holdings – Chief Executive - This is an infrastructure Investment Company.
Chris Ryan **	Southlink Health IPA - member - Southlink Health provides managerial support for PHOs, who are contracted to the DHB and intends to advocate on behalf of health practitioners. General Practitioner - Contracted to the Rural Canterbury PHO, with capitation payments and other payments, such as Performance Management Payments coming from the DHB through the PHO. Royal New Zealand College of GPs - Fellow and member of Canterbury Faculty Board - The RNZCGP prepares statements and advocates at times on Workforce, Recruitment and Quality issues.
David Kerr	Centercare Limited – Chair - Centercare purchases supplies for Medical Practitioners. General Medical Practitioner - Doctor providing primary care services. Health Education Trust – Trustee - Health Education Trust develops and provides educational materials and training programmes for those caring for the elderly within the health sector. Medical Protection Society – Advisor - Organisation that advises and provides legal support to doctors. The MPS role is to support the doctor, which can occasionally conflict with the DHB. Should an issue of conflict arise, that will be disclosed at the time. Pegasus Health – Advisor - Provides a management services organisation for primary medical providers and other primary care providers. Ryman Healthcare Limited – Chair - Provides residential aged care services under contracts with the Canterbury DHB. Pharmaceutical Management Agency (Pharmac) – Board Member - Pharmac purchases pharmaceuticals to New Zealand (including on behalf of DHB's) within New Zealand for the New Zealand Pharmaceutical schedule. New Zealand Medical Association - President - The New Zealand Medical

	Association is the largest medical organisation in New Zealand. Members come from all disciplines within the medical profession, and include specialists, general practitioners, doctors-in-training and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values and the health of New Zealanders. The key roles of the NZMA are to provide advocacy on behalf of doctors and their patients; to provide support and services to members and their practices; to publish and maintain the Code of Ethics for the profession; and to publish the New Zealand Medical Journal.
David Morrell	Brackenridge Estate Limited – Chairman (appointed by Canterbury DHB) - wholly owned subsidiary of the Canterbury DHB - provides intellectual disability services under contracts with the Ministry of Health, Work and Income New Zealand, Accident Compensation Corporation and the Child, Youth and Family Service. Honorary British Consul - Interest relates to my supporting British visitors who may be hospitalised arising from injury related accidents Social Services Council of the Diocese of Christchurch (Anglican Aged Care) - Committee Member - provides residential aged care services (rest home and hospital) under contracts with the Canterbury DHB. Historic Places Trust – Subscribing Member - The Trust's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. The Trust identifies records and acts in respect of significant ancestral sites and buildings. The Trust has already been involved with Canterbury DHB buildings.
Eleanor Carter **	Health Cuts Hurts- Member – Patient Lobby Group.
Elizabeth Cunningham**	University of Otago, Christchurch – Research Manager, Māori (0.6FTE) - part of Senior Management Team. The University has various relationships with the Canterbury DHB, including medical training, research, the provision of library services, and leasing of premises. Otautahi Runaka – Member - Includes Māori community groups and representatives of government agencies, including Canterbury DHB staff. Te Runanga o Ngai Tahu (TRONT) – Alternate Member - Governance body for Ngai Tahu Te Runanga o Koukorarata (Port Levy) – Runanga member - A Runanga of Ngai Tahu, and a signatory for the Memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB. Manawhenua ki Waitaha – Member - Representative of Te Runanga o Koukourata. Manawhenua ki Waitaha is a collective of health representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB. Māori Women's Welfare League – Member -The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori. Kawa Whakaruruhau Roopu Bachelor of Nursing/Midwifery Christchurch Polytechnic – Chair - A committee of Christchurch Polytechnic, Department of health services, providing input and oversight in relation to course programmes. Avon Heathcote Estuary Ihutai Trust – Member - The Trust has an interest in improving water quality within the estuary. Special Education Strategy Committee – Member - A committee of the Ministry of Education. Registered Resource Management Act (RMA) Commissioner - From time to time asked to sit on these panels given involvement with the Regional Council and in particular understanding the Māori issues around Section 8 of the RMA Act. If conflicts arise they will be advised. Son, Manaia Cunningham, is a Board member of the Christchurch Primary Health

	Organisation.
Heather Carter *	Christchurch Polytechnic Institute of Technology (CPIT) – Council Member
	Health Cuts Hurt Incorporated (Health Lobby Organisation) - Member
	LifeMasters (Life skills and personal development) – Company Owner and Consultant
	Otautahi Education Development Trust (OEDT) – Trustee - this trust is related to CPIT activities.
Jo Kane	Environment Canterbury – Deputy Chairperson - Environment Canterbury is involved in the promotion of sustainable management of natural and physical resources and ensures safe and efficient movement of people and goods for the benefit of people, communities and future generations. As part of its role Environment Canterbury is responsible for the health and well-being of its community, as part of its key priorities. Intersectorial collaboration is a key focus, where potential conflicts arise these will be disclosed at the time. One area of potential conflict is with issues surrounding the proposed Central Plains Water Scheme.
	Te Kohaka o Tuhaitara Trust – Chairperson - Provides for a range of cultural, historical, recreational and educational opportunities for the community within the Coastal Reserve. It is not envisaged any potential Conflicts of Interest, but will be disclosed at the appropriate time.
	Health North Canterbury – Steering Group Member - Involved in a community trust that is looking at a future use of land at the Rangiora Hospital site, which is likely to involve putting a proposal to the Canterbury DHB for consideration (including potential commercial negotiations).
	Council of Social Services – member (no voting rights) - Intersectorial/Community Group whose predominate role is the health, safety and well being of our community. Provides social support services, advocacy and works collaboratively with multiple agencies including the determinates of health that are faced by the community.
John Musgrove	Windsor House Board of Governors - Windsor House has a contract with the Canterbury DHB for provision of hospital and rest-home services for the elderly and has recently been successful in obtaining a contract for 20 beds for dementia patients with the Canterbury DHB.
Karen Guilliland *	New Zealand College of Midwives – Chief Executive Officer - the College of Midwives is the professional body for midwives that promotes and sets standards for the profession. The College provides expert advice in relation to midwifery and maternity services to district health boards (including Canterbury DHB) on request. The College nominates representatives to various related bodies such as MERAS (Midwives Union) (who are party to a collective employment agreement with the Canterbury DHB), schools of midwifery, and a number of government advisory committees.
	Midwifery and Maternity Provider Organisation Limited – Director - College of Midwives representative as a director in this midwifery practice management organisation. Its primary function is to process midwifery service claims to the Ministry of Health on behalf of self employed midwifes, obstetricians, some district health boards, and private trusts.
	PHARMAC – Board Member.
Laurence Malcolm *	Aotearoa Health Limited – Director and Shareholder - company provides research under contract to a variety of organisations. Currently providing services to Partnership Health PHO in the area of Māori Health planning.
	Age Concern Canterbury, Council and Executive – Member - advocacy and support group for older people.

Matea Gillies **	Partnership Health "Te Kei o te Waka" - Board Member - Partnership Health Canterbury is a Primary Health Organisation (PHO). The PHO has entered into an agreement with the Canterbury DHB under which the PHO agreed to provide a range of health care services and the management tasks associated with the delivery and funding of these services. The PHO has the power to subcontract the delivery of any or all such services and associated management tasks. Pegasus Health (Charitable) Ltd – Member - Pegasus Health is an Independent Practice Association (IPA) that supports General Practitioners delivering care to approximately 290,000 patients. Pegasus Health is part of Partnership Health Canterbury PHO. Much of the organisation's work is funded either from the Ministry of Health and the DHB via Partnership Health. Taupunga Ltd - Director - Taupunga Ltd provides General Medical Services. I am employed by Taupunga Ltd to provide General Practitioner services. Taupunga has a contract with the Pegasus 24 Hrs Clinic and Dr James Shanks. Manawhenua ki Waitaha – Chairperson - Manawhenua ki Waitaha is a collective of health representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB. Te Hapu o Ngati Wheke Inc – Chairperson - Te Hapu o Ngati Wheke Inc is the legal body of Te Hapu o Ngati Wheke , one of the 18 Papatipu Runanga that make up Ngai Tahu. Te Poho o Tamatea - Board Member - Te Poho o Tamatea is a charitable company which is the investment company for Te Hapu o Ngati Wheke, distributing money for primarily education, health, and cultural purposes. MIHI (Māori /Indigenous Health Institute) - Senior Clinical Lecture - University of Otago Christchurch School of Medicine
Neville Fagerlund *	Cambridge Clinic (DSAC) Limited - Director of a company which holds a contract with the Canterbury DHB for the delivery of medical services to victims of sexual abuse. Pegasus Health (Charitable) Limited - Financial Advisor to a company which holds a contract with the Canterbury DHB for observation and continuing care nurse co-ordination, and a contract in the co-ordination role of immunisation services. The 24 hour clinic in Bealey Avenue is 100% owned by Pegasus Health (Charitable) Limited, who hold the observation contract. A wide range of trusts and private companies as a result of private accountancy practice (where potential conflicts arise these will be disclosed individually)
Norm Dewes *	Te Runanga o Nga Maata Waka – Chief Executive Officer - this Runanga provides a range of advocacy, community and social services. These services include a contract for the Canterbury DHB to deliver mother & pepi services. The Runanga also provides a range of education services which are NZQA registered and accredited under the Education Act. The Runanga is a part of a national body, the National Urban Māori Authority. Nga Hau e Wha, National Marae – Manager - there is a proposal that an oral health service clinic be located on part of the land held by the trust. Canterbury Community Primary Health Organisation (Access PHO) – Member - one of the PHOs within the Canterbury DHB's area – contracts with the DHB for primary services. Te Runanga o Ngati Kahungunu ki Waitaha – Secretary Te Rito Arahi Māori Alcohol, Drug and Resource Centre – Chair Otautahi Social Services – Chair Otautahi Sports Association - Secretary

Peter Ballantyne **	Bishop Julius Hall of Residence - Trust Board Member - University of Canterbury Audit and Risk Committee – Member
	Social Service Council of the Diocese of Christchurch – Trust Board Member, Chair Aged Care Division.
	Deloitte – Consultant - Deloitte carries out certain consulting assignments for the Canterbury DHB from time to time.
	Spouse, Claire Ballantyne is a Canterbury DHB employee
Syd Bradley *	Christchurch International Airport Co Limited – Chair
	Waipara Hills Wine Estate – Advisor
	McLeans Institute – Board Member (Canterbury DHB representative) - provides residential aged care services under contract with the Canterbury DHB.
Trevor Read	Francis Group Consultants - Consultant
	South Canterbury District Health Board - Contracted to provide advice and consultancy services. The service can involve facilitation and discussion with Canterbury DHB exploring how Canterbury and South Canterbury DHBs may work together, particularly in the development of shared services in the provision of information services, related clinical and administrative support areas. Also provide assistance with strengthening IT strategy and systems planning.
	Ministry of Health - Undertaking a review on addressing the Disincentive Fund Pilots – the Canterbury District Health Board was one of the pilots
Tuari Potiki	He Oranga Pounamu - Board Member
	Drug and Alcohol Practitioners Association of NZ - Executive Member
	Spouse is a board member of the Rural Canterbury Primary Health Organisation
Wendy Dallas-Katoa	Pegasus Health – Māori Health Advisor
	IPA – Primary Health Care working with General Practice.
	MIHI (Māori/Indigenous Health Institute) - Research Fellow Lecturer - University of Otago – Christchurch School of Medicine
	Research Projects – International Indigenous Resilience health worker – cross study between Canadian Indigenous & Māori. Lecturer undergraduate 4 & 5 yr medical students.
	Ka Wahine Board – Board Member - Women's Whare – newly released women from prison halfway house.
	Partnership Health PHO – Board Member – iwi/manawhenua representative - Partnership Health Canterbury is a Primary Health Organisation (PHO). The PHO has entered into an agreement with the Canterbury DHB under which the PHO agreed to provide a range of health care services and the management tasks associated with the delivery and funding of these services. The PHO has the power to subcontract the delivery of any or all such services and associated management tasks.
William Tate	Global Catering Limited-Director
	Pulp Kitchen- Director
	Pulp Kitchen Catering Limited-Director
	New Zealand Institute of Management Foundation-Trustee
	New Zealand Institute of Management Life Fellows Committee

* retired during the year

** appointed / elected during the year

SUBSIDIARY AND ASSOCIATED COMPANIES

Garth Bateup	Director of subsidiaries Brackenridge Estate Limited and Canterbury Laundry Service Limited. No directors' fees or any other benefits were received from the subsidiary companies except as an employee of Canterbury DHB.
Paul Numan *	Director of subsidiary, Brackenridge Estate Limited. No directors' fees or any other benefits were received from the subsidiary company except as an employee of Canterbury DHB. Resigned.
Dr Nigel Millar	Director of associate company New Zealand Centre for Reproductive Medicine Limited. No directors' fees or any other benefits were received from the associate company except as an employee of Canterbury DHB.

* resigned during the year

DIRECTORS' AND BOARD MEMBERS' LOANS

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

DIRECTORS' AND BOARD MEMBERS' INSURANCE

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensure that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

USE OF BOARD OR SUBSIDIARIES' INFORMATION

During the year, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place, eg: amounts for redundancy (based on length of service), and payment in lieu of notice etc.

The total payments made by Canterbury DHB were $16,915 (2006/07 – 1 employee totalling $32,130) comprising negotiated settlements with all of the former employees.

Number of Employees	TOTAL $
4	16,915
4	**16,915**

REMUNERATION OF EMPLOYEES

The number of employees for the Group whose income was within the specified bands is as follows:

	30/06/08 (including benefits)				30/06/07 (including benefits)			
	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total
100,000-109,000	3	14	59	**76**	4	17	77	**98**
110,000-119,000	2	11	59	**72**	1	3	73	**77**
120,000-129,000		4	54	**58**		3	51	**54**
130,000-139,000	1	4	44	**49**		3	39	**42**
140,000-149,000		3	26	**29**		5	29	**34**
150,000-159,000			30	**30**			33	**33**
160,000-169,000		1	33	**34**		4	18	**22**
170,000-179,000		2	23	**25**			23	**23**
180,000-189,000		2	25	**27**			25	**25**
190,000-199,000			15	**15**			16	**16**
200,000-209,000		1	17	**18**		2	24	**26**
210,000-219,000		1	23	**24**		1	20	**21**
220,000-229,000			25	**25**			11	**11**
230,000-239,000			18	**18**			17	**17**
240,000-249,000			11	**11**			7	**7**
250,000-259,000		1	7	**8**			8	**8**
260,000-269,000			6	**6**			3	**3**
270,000-279,000			2	**2**		1	4	**5**
280,000-289,000			3	**3**			2	**2**
290,000-299,000			2	**2**			1	**1**
300,000-309,000							1	**1**
310,000-319,000			1	**1**			2	**2**
320,000-329,000			2	**2**			1	**1**
330,000-339,000			1	**1**				
350,000-359,000			1	**1**				
360,000-370,000							1	**1**
370,000-379,000			1	**1**				
410,000-419,000			1	**1**				
450,000-459,000		1[1]	1	**2**				
460,000-469,000			1	**1**		1[1*]		**1**
Total	**6**	**45**	**491**	**542**	**5**	**40**	**486**	**531**

Of the 542 (2006/07 531) positions identified above, 497 (2006/07 491) positions were predominantly clinical and 45 (2006/07 40) positions were management/administrative.

OTHER ENTITLEMENTS (employees earning over $100,000)

	Allied Health	Mgmt / Admin	Nursing	RMO	SMO
Annual leave pa	5 wks	4.4 wks	5 wks	6 wks	6 wks
Long Service Leave	1 wk after every 5 yrs	2 wks after 15 yrs	1 wk after every 5 yrs	No	2 wks after 15 yrs
CME** - 10 days pa up to maximum of 30 days accumulated	No	No	No	$3,000	$12,000
Conference leave - maximum pa	No	No	3 days PDRP**	6 wks	30 days
Sabbatical eligibility (not as of right)	No	No	No	No	3 mths every 6 yrs
Gratuity	No	No	No	No	Grandparented
Professional membership	Yes	Not for majority	Yes	Yes	Yes
Overtime and penal rates	Yes	No	Yes	Yes	Yes
Professional protection membership	No	No	No	Yes	Yes

1 CEO remuneration and other benefits are included in these bands
** includes arrears from previous years*
*** CME – Continuing Medical Education; PDRP – Professional Development and Recognition Programme*

STATUTORY DISCLOSURE

Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires DHBs to report:

(a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000;

(b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000; and

(c) on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2008, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 58.

Section 42(3)(b) – Report on the extent CDHB has met the objectives under Section 22	
Objective:	**Extent objectives met**
(a) To improve, promote, and protect the health of people and communities:	The DHB funds and delivers a range of services including health promotion and protection services, primary care, secondary care, specialist and tertiary services to meet the needs of its population. The key areas of focus for the DHB are: Child and Youth Health, Older Persons' Health, Māori Health, Primary Health, Disease Prevention and Management, Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease. The Minister of Health's expectations see an additional focus on implementation of the national Mental Health and Disability Strategies and a focus on information systems and services, workforce development, elective services, service delivery, collaboration, productivity and value for money. The DHB is also aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health and continues to work collaboratively to set goals and objectives for our community's health, to share data and research on health outcomes and to provide a healthy environment for our population. The DHB's local commitment to the national Health Eating Healthy Activity (HEHA) Strategy recognises that all sectors and groups have a role to play in improving community health and wellbeing, whether their specific focus is older person's health, child and youth health, education, recreation, transport or any other aspect of city life. Some of the HEHA initiatives which involve collaboration with community groups and government agencies to improve and promote the health or our population include: ▪ Training for more than 50 practice nurses/community support workers to facilitate Appetite for Life programmes in Canterbury. The Appetite for life course is a 6-week programme focused on helping women overcome barriers to adopting healthy behaviours, and aims to provide them with the skills, knowledge and confidence to make positive sustainable change to food choices and activity levels. ▪ The trial of smokefree children's playgrounds. A child is seven times more likely to take up smoking later in life if they are exposed to parental smoking and smokefree children's playgrounds aim to reduce the number of times children see adults smoking and therefore the chances of them taking it up in later life. The emphasis is on peer pressure and social change rather

	than a ban or a bylaw. It is hoped that the trial will lead to a city-wide policy that promotes smokefree children's playgrounds across Christchurch.
(b) To promote the integration of health services, especially primary and secondary health services:	Together Canterbury's five PHOs and the DHB have achieved a number of successes in implementing the Primary Care Strategy over the past year: ▪ The Review of Acute Demand and After Hours Cover in Primary Care, undertaken in 2006, continues to be implemented. This Review outlined a number of key recommendations and identified ten projects for implementation. These included a primary health care public education and information programme, enhanced telephone advice for the general public, alternative rapid response service or pathways, a variety of community based acute care services and an After Hours Direction Paper. ▪ PHO enrolments cover 95.6% of the Canterbury population; ▪ 84% of two year olds are fully immunised. ▪ Services to Improve Access programmes continue to be implemented including: longer GP consultations, school health clinics and community nursing services; ▪ Collaboration continues around health promotion programmes including smoking cessation, youth oral health promotion, flu vaccinations for over 65s and programmes such as Appetite for Life The DHB has also worked over the past year on the challenge to create shared vision and ownership across Canterbury's health sector in order to create capacity and improve access to electives services. The (Canterbury Community-based) Referrals Project was established to provide a platform for delivering the DHB's electives goals in an objective and collaborative way. It is jointly sponsored by the DHB's Elective Services Steering Group and Canterbury's five PHOs and involves wide representation from primary and secondary care and the community. The aim is to design a consistent electives referral management process and pathway that informs alternative models of care and increases access to services. Unmet need in the community will be more appropriately measured by a specific focus on the gaps as determined by the community and general practice, which in turn will inform funding decisions and application of electives initiative funding allocations. GPs and hospital specialists are providing clinical input and leadership in the design and implementation of the pathways and new models of care with a project methodology of constant communication. The aim is to enable evaluation of new pathways where the need for a referral or hospital visit is avoided by ready access to diagnostics, enabling patients to remain in the care of general practise.
(c) To promote effective care or support for those in need of personal health services or disability support services:	The DHB has developed an Older People's Health Strategy: *Healthy Ageing, Integrated Support*. The underlying objective is to maintain older people's independence for as long as possible, reduce the period and levels of dependence and at the same time provide effective, integrated services when they are required. Successes over the past year include: ▪ Development of a new model of CARE for the delivery of specialist community health services for older people. The CARE model aims to strengthen the primary/secondary interface and ensure older people receive appropriate and effective care in a home-based or community setting. ▪ The InterRAI (International Home-based Assessment Instrument)

	roll-out in the DHB's Hospital and Specialist Service division with the aim of providing consistency in the assessment process and evidence based evaluation. The tool also has potential for improving care planning in residential care settings. ▪ Collaboration with community pharmacies to roll-out the Medicines Use Review Service. This Service targets patients with long term conditions, those on multiple medications and those with multiple prescribers to ensure safe medication use and reduce avoidable hospital admissions. ▪ Supporting Canterbury PHOs to increase the enrolment of patients in CarePlus programmes and work towards a target of 75% of their enrolled populations receiving the flu vaccine in the over 65 age group. Patients over the age of 65 are more at risk of contracting the flu virus and complications from this.
(d) To promote the inclusion and participation in society and independence of people with disabilities:	The DHB aims to ensure it contributes to a 'non-disabling' society through its actions, and the actions of the providers with whom it contracts. As such the DHB has developed an Action Plan for Disability that outlines the steps it is taking to implement the NZ Disability Strategy. The Action Plan involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring. All new building and facility developments are assessed for meeting the needs of people with disabilities.
(e) To reduce health disparities by improving health outcomes for Māori and other population groups:	The DHB has reviewed its Māori Health Action Plan over the past year. The key objectives include reducing health inequalities and supporting Māori participation in health and Māori health workforce development. Over the past year progress has been made in implementing projects that support the DHB's Māori Health Plan including: ▪ Signing of a formal Memorandum of Understanding with Manawhenua Ki Waitaha in March 2008. This agreement aims to establish a clear relationship between the two groups and to improve Māori input into the planning and development of health and disability services in Canterbury. ▪ An Ethnicity Data Collection Project was introduced with the aim of improving the accuracy of ethnicity data collection. The Project focused on updating codes for all patients coded as Not Stated or Other and raising the awareness of the importance of accurate ethnicity code collection. Over 2,000 patients who previously had the codes Not Stated or Other have had their codes updated. ▪ Collaboration around strategies that promote healthy nutrition and increased physical activity for Māori through community-based projects have been a successful focus including: Kaikoura's Positive Vibration (focusing on overweight children) and the Hundie Club (focusing on overweight/obese adults). Training of Māori health workers in breastfeeding and nutrition issues has also been positive in ensuring that front line workers are providing consistent HEHA messages. ▪ Smokefree lifestyles have been promoted to improve Māori health status through Auahi Kore initiatives and the Aukati Kai Paipa programme. The Auahi Kore and Aukati Kai Paipa both use a social marketing emphasis recognising local champions to promote and reinforce smokefree lifestyles. There is also an emphasis on Marae with three Marae in Canterbury now smokefree.

(f) To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The DHB's local Health Needs Assessment (completed in 2005) has identified groups in the community, which have health inequalities. The DHB's District Strategic Plan identifies a number of strategic priority areas where the DHB will focus its efforts to reduce health inequalities: Child and Youth Health, Older Persons' Health, Māori Health, Primary Health, Disease Prevention and Management, Cancer, Cardiovascular, Diabetes and Respiratory Disease. Work continues with PHOs in Canterbury to reduce barriers to primary care including financial barriers through the reduction of co-payments with reductions being achieved for all age groups. Specific work has been undertaken in the past 6 months to increase the number of general practices in Canterbury who have adopted the under 6s subsidies and provide free services for under 6 year olds. At present 50% of all children under the age of 6 have access to free fees. The DHB also continues to work with PHOs to implement Services to Improve Access to primary care.
(g) To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The DHB has established inter-agency relationships with a wide range of government agencies including: the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, Education and Social Development, ACC and the Department of Corrections. The DHB works collaboratively with the TLAs and regional council in the Canterbury region along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other Non-Government Organisations (NGOs) in our region. The DHB also actively supports a number of collaborative ventures which endeavour to improve the environment and the health of our residents. The DHB actively engages with providers of health services working with them in a cooperative way for the benefit of our population. In important areas of policy development or for significant projects the DHB seeks input from community and providers. This may be in the form of providing opportunities for input on early development of papers/ideas or involvement in working parties. The DHB has established, or is involved with, a number of consumer and community reference groups, working parties and advisory groups which provide advice and input on the development of plans and strategies. This includes a number of Māori and Pacific groups to ensure Māori and Pacific input into decision making to improve delivery of health and disability services and to reduce inequalities in health status. In 2007, as part of the DHB's focus on long-term health services planning, the DHB established a Consumer Council to provide input into decision making as part of its Health Services Planning Programme. The Consumer Council consists of representatives nominated by consumers and consumer lobby/advocacy groups and covers nine key areas; family health, older persons' health, disabilities, Māori health, Pacific health, chronic conditions, mental health, rural communities and primary care. The Consumer Council will give focus to a true partnership model that will provide a strong and viable voice for the community and consumers in health service planning and service delivery.
(h) To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	The DHB has embarked on the development of a Health Services Plan which will be linked to a workforce strategy and facilities master-plan. If the DHB intends to ensure effective utilisation of resources and delivery of the best possible health outcomes within the funding allocated we need to ensure that health resources are protected, sustainable and supported long-term. The Health Services Planning

	focus is to progress planning for future health services through the development of health services models, the development of a framework for the management of chronic conditions and the development of integrated service models. These developments will provide a strategic roadmap for changes in future funding models, the development of workforce strategies and the development of a Facilities Master-Plan. This will mean new thinking around the best way to provide care to our population, looking at the best location, the best service and the best provider. However this will enable us to ensure ongoing provision of health and disability services and to provide services which are better integrated and configured, and that operate seamlessly across geographical, professional and service boundaries. The DHB has introduced a 'participatory model' to involve staff, providers, consumers and our community in this Health Services Planning and extensive participatory workshops and 'design teams' are being established to drive the thinking and planning which includes the establishment of the DHB's Consumer Council.
(i) To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	The DHB has a Quality and Patient Safety Council and a Clinical Board to provide advice to the CEO on quality and clinical issues. In 2002 the DHB established its Quality and Patient Safety Council to promote quality improvement within the DHB. The Council provides governance for the organisation with respect to quality and patient safety and provides advice to the Chief Executive. The Quality and Patient Safety Council facilitates continuous improvement and looks to offer support and guidance to positively influence quality care. The Council also identifies key issues for quality improvement and promotes the development of appropriate information systems for monitoring and reporting on quality and supports and promotes training and education programmes. The Council sponsors both the DHB's Quality Strategic Plan and the DHB's Quality and Innovation Awards and has developed key policies, which promote quality and patient safety (the culture of patient safety policy, open disclosure policy and the no blame incident/accident reporting policy). Alongside quality and patient safety, clinical governance places a responsibility on the Chief Executive to have effective mechanisms in place for planning, monitoring and managing the quality of clinical care and for meeting identified targets for quality and budget objectives. The DHB's Clinical Board was established in 2003 to give a focus to clinical leadership and to take a lead in developing clinical governance systems. The Clinical Board is a multi-disciplinary DHB-wide clinical forum consisting of clinical representatives from the primary, secondary and community sectors. The Board provides oversight of the DHB's clinical activity and advice to the Chief Executive and is charged with having a proactive role in setting clinical policy and standards and encouraging best practice and innovation. The Clinical Board also supports the DHB's vision and values and provides a leadership role for the organisation. The DHB also has processes in place to maintain and improve quality including Quality Health New Zealand accreditation process for its hospitals and performance targets and measures to maintain appropriate levels of clinical quality.

(j) To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	The DHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme. The DHB is also aware of the interaction of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work collaboratively to set goals and objectives for our community's health and to provide a healthy environment for our population.
(k) To be a good employer	The DHB is committed to the principles of being a good employer and has in place, as appropriate, a number of organisational policies and procedures (to promote a healthy and safe workplace) including the DHB's Equal Opportunities and Harassment Policy. The DHB also provides a safe and health promoting environment through safe handling programmes and membership of the ACC Partnership Programme. The DHB also encourages its workforce to lead by example in terms of healthier lifestyles and practices.

Section 42(3)(i) – Statement of how the CDHB has given effect and intends to give effect to its functions specified in Section 23 (1) (b)-(e)	
Function:	**What has been done to meet function**
(b) To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	The DHB has involved stakeholders in selection of its strategic priority areas for the District Strategic Plan and actively involves relevant groups and individuals in planning specific service areas including its current Health Services Planning Programme. The DHB has established joint arrangements with external providers for the provision of some additional surgical services, such as orthopaedic and cardiac surgery. The DHB participates in a number of regional initiatives with other DHBs such as working with South Island DHBs on the Cancer Control Network and the implementation of national information systems. The DHB has a Memorandum of Understanding with the West Coast DHB which assists in the development of closer clinical collaboration. The DHB has established inter-agency relationships with a wide range of government agencies including: the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, Education and Social Development, ACC and the Department of Corrections. The DHB also works with the Ministry of Health in a number of joint/collaborative ways participating in national projects including national benchmarking exercises and national pricing projects and on the implementation of a number of national screening programmes such as B4 School Checks.

(c) To issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):	The DHB uses a variety of written media, TV and radio work to outline general issues and priorities and the community and responds directly to media, personal, community and group enquires. The DHB also provides written media to inform the community and other sectors of current activity including Healthfirst (a community newsletter), Healthbeat (a newsletter for DHB staff and community providers) and Health Promoting Schools (a newsletter for Canterbury schools). The DHB has developed a website, which includes community based health information and its primary planning documents. The DHB also circulates and makes available significant documents and plans for its population in summary and comprehensive form either at libraries, via groups or individually and on it website. The DHB continues to provide health promotion information through its Community Health Information Centre, open to the public five days a week. Supplies of health education resources are held and a number of satellite health information stands have been developed - there are currently 20 of these sites with particular emphasis being placed on Marae, TLA service centres, hospitals, and other appropriate settings for target communities.
(d) To establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:	In the past the DHB has had an informal relationship with groups such as Manawhenua Ki Waitaha and Te Rūnanga o Ngā Maata Waka and has engaged at many levels with Māori providers and other Māori community organisations. The outcomes of these meetings are fed directly into the DHB planning process.groups. [2] In March 2008 the DHB signed a Memorandum of Understanding with Manawhenua Ki Waitaha as a first formal step to enabling the participation of Māori in DHB decision making and in the planning and delivery of health and disability services. The Memorandum of Understanding commits the DHB to regular meetings with, and reporting to, Manawhenua Ki Waitaha as a pathway to shared decision making. The DHB's Māori Health Plan, approved in 2007, also commits the DHB to establishing formal relationships with Māori representative groups beyond Manawhenua Ki Waitaha, such as Taura Here community groups.[3] In collaboration with Manawhenua Ki Waitaha the DHB will explore mechanisms to facilitate greater participation of Māori at a governance level. Possibilities for such participation may include a Māori governance/advice board providing advice to the DHB's Board and allowing Māori opportunities to engage with the Board of the DHB. The DHB will continue to consult with Māori communities at appropriate levels of operations and to provide Māori with opportunities to engage and feedback to the DHB.

[2] *Manawhenua ki Waitaha is a representative group which comprises of seven Ngāi Tahu Rūnanga.*

[3] *Taura Here refers to all other collective pan-tribal Māori groups.*

(e) To continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:	The DHB has established Te Kahui Taumata, which includes the Kaumatua and Taua, the Executive Director Māori and Pacific Health, and senior Māori staff who provide Māori specific advice to the Chief Executive. The DHB continues to work on capacity and capability issues through Te Herenga Hauora o te Waka a Maui (the South Island Māori Managers Network), where a number of projects have been developed to support Māori service provision in Canterbury. These include: ▪ The development of a Māori Health Workforce Development Plan, *Te Waipounamu*; ▪ The development of a South Island regional Māori workforce recruitment project to enhance the Māori health workforce in our region; and ▪ The development of a Māori health training and education opportunities directory, currently being distributed to Māori health providers.

For and on behalf of the Board

Alister James
Chair
10 October 2008

Olive Webb
Board Member
10 October 2008

STATEMENT OF RESPONSIBILITY

Pursuant to Section 155 of the Crown Entities Act 2004, we acknowledge that:

a) The preparation of financial statements and statement of service performance of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2008, are our responsibility.

c) In our opinion, the financial statements and statement of service performance for the year under review fairly reflect the financial position and operations of Canterbury DHB.

Alister James
Chair
10 October 2008

Olive Webb
Board Member
10 October 2008

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2008

	Notes	Group			Parent	
		Actual 30/06/2008 $'000	Budget 30/06/2008 $'000	Actual 30/06/2007 $'000	Actual 30/06/2008 $'000	Actual 30/06/2007 $'000
Income						
Ministry of Health revenue		1,116,673	1,096,676	1,050,170	1,107,697	1,042,064
Patient related revenue	2	36,545	33,536	33,458	36,972	33,876
Other operating income	3	19,011	22,513	22,317	16,538	19,999
Interest income		8,819	3,746	5,146	9,040	5,278
Total income		1,181,048	1,156,471	1,111,091	1,170,247	1,101,217
Operating expenses						
Employee benefit costs	4	472,445	444,945	439,146	462,320	430,517
Treatment related costs		105,008	115,187	105,727	108,493	108,864
External service providers		480,389	462,314	433,074	480,389	433,074
Depreciation and amortisation		47,808	50,405	47,228	46,439	46,046
Interest expenses on loans		5,584	5,932	5,069	5,745	5,140
Other Expenses	5	65,963	55,992	60,202	62,743	57,232
Total operating expenses		1,177,197	1,134,775	1,090,446	1,166,129	1,080,873
Operating surplus before capital charge		3,851	21,696	20,645	4,118	20,344
Capital charge expense	6	(20,617)	(21,696)	(22,894)	(20,617)	(22,894)
Net surplus/(deficit)		**(16,766)**	**-**	**(2,249)**	**(16,499)**	**(2,550)**

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2008

	Notes	Group			Parent	
		Actual 30/06/2008 $'000	Budget 30/06/2008 $'000	Actual 30/06/2007 $'000	Actual 30/06/2008 $'000	Actual 30/06/2007 $'000
Total equity at beginning of the period		268,142	269,972	272,252	266,240	270,651
Net surplus/(deficit) for the period		(16,766)	-	(2,249)	(16,499)	(2,550)
Amounts recognised directly in equity						
Revaluation of property, plant and equipment		-	-	-	-	-
Total recognised revenues and expenses		(16,766)	-	(2,249)	(16,499)	(2,550)
Other movements						
Contribution from/(back to) Crown		(1,861)	-	(1,861)	(1,861)	(1,861)
Total equity at end of the period		**249,515**	**269,972**	**268,142**	**247,880**	**266,240**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2008

	Notes	Group Actual as at 30/06/2008 $'000	Group Budget as at 30/06/2008 $'000	Group Actual as at 30/06/2007 $'000	Parent Actual as at 30/06/2008 $'000	Parent Actual as at 30/06/2007 $'000
CROWN EQUITY						
General Funds	7	122,452	124,313	124,313	122,590	124,451
Revaluation Reserve	7	184,477	184,477	184,477	184,477	184,477
Retained earnings/(losses)	7	(57,414)	(38,818)	(40,648)	(59,187)	(42,688)
TOTAL EQUITY		**249,515**	**269,972**	**268,142**	**247,880**	**266,240**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and cash equivalents	8	42,339	14,282	50,633	40,240	49,282
Trade and other receivables	9	36,009	25,800	24,282	35,441	23,913
Inventories	10	8,963	7,000	8,175	8,894	8,110
Investments	11	-	-	5,000	-	5,000
TOTAL CURRENT ASSETS		87,311	47,082	88,090	84,575	86,305
CURRENT LIABILITIES						
Trade and other payables	12	86,411	65,377	80,110	86,160	80,786
Owing to the Ministry of Health		7,229	4,500	13,852	7,229	13,852
Employee benefits due within 1 year	13	109,932	76,744	100,545	108,663	99,535
TOTAL CURRENT LIABILITIES		203,572	146,621	194,507	202,052	194,173
NET WORKING CAPITAL		(116,261)	(99,539)	(106,417)	(117,477)	(107,868)
NON CURRENT ASSETS						
Investments	11	9,170	29,375	6,338	12,378	9,508
Property, plant and equipment	14	430,657	437,295	455,446	427,005	451,606
Intangible assets	15	1,283	-	701	1,283	701
Surplus property		8,250	-	8,250	8,250	8,250
Restricted assets	16	11,522	8,110	10,931	11,402	10,825
TOTAL NON CURRENT ASSETS		460,882	474,780	481,666	460,318	480,890
NON CURRENT LIABILITIES						
Employee benefits	13	8,584	9,509	8,326	8,559	8,307
Provisions	17	-	-	200	-	-
Restricted funds	16	11,522	8,110	10,931	11,402	10,825
Borrowings	18	75,000	87,650	87,650	75,000	87,650
TOTAL NON CURRENT LIABILITIES		95,106	105,269	107,107	94,961	106,782
NET ASSETS		**249,515**	**269,972**	**268,142**	**247,880**	**266,240**

For and on behalf of the Board

Alister James
Chair
10 October 2008

Olive Webb
Deputy Chair
10 October 2008

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2008

	Notes	Group Actual 30/06/2008 $'000	Group Budget 30/06/2008 $'000	Group Actual 30/06/2007 $'000	Parent Actual 30/06/2008 $'000	Parent Actual 30/06/2007 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,105,160	1,096,676	1,051,140	1,096,410	1,042,109
Other Receipts		55,691	48,049	49,715	53,652	48,595
Interest Received		8,819	3,746	5,146	9,040	5,278
		1,169,670	1,148,471	1,106,001	1,159,102	1,095,982
Cash was applied to:						
Payments to Employees		462,833	449,945	424,411	452,940	416,000
Payments to Suppliers		646,530	637,492	593,671	647,565	594,120
Interest Paid		5,602	5,932	4,883	5,772	4,953
Capital Charge		27,240	21,697	12,780	27,240	12,780
GST - net		(320)	-	728	(316)	751
		1,141,885	1,155,066	1,036,473	1,133,201	1,028,604
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	19	27,785	33,405	69,528	25,901	67,378
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant & equipment		67	10,800	11,315	17	11,297
Receipt from sale of investments		2,168	-	-	2,130	-
		2,235	10,800	11,315	2,147	11,297
Cash was applied to:						
Purchase of Investments & Restricted Assets		-	14,500	11,314	-	12,204
Purchase of property, plant & equipment		23,803	30,000	38,873	22,579	36,598
		23,803	44,500	50,187	22,579	48,802
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(21,568)	(33,700)	(38,872)	(20,432)	(37,505)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		-	-	15,000	-	15,000
		-	-	15,000	-	15,000
Cash was applied to:						
Loans Repaid		12,650	-	6,000	12,650	6,000
Equity repaid to Crown		1,861	-	1,861	1,861	1,861
		14,511	-	7,861	(14,511)	7,861
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(14,511)	-	7,139	(14,511)	7,139
Net increase/(decrease) in cash and cash equivalents		(8,294)	(295)	37,795	(9,042)	37,012
Cash and cash equivalents at beginning of year		50,633	14,577	12,838	49,282	12,270
Cash and cash equivalents at end of year	8	**42,339**	**14,282**	**50,633**	**40,240**	**49,282**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2008

1. Statement of accounting policies

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB ("Canterbury DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Canterbury DHB is a Reporting Entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, Public Finance Act 1989, and the Crown Entities Act 2004.

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand International Accounting Standard 1 (NZ IAS 1).

Canterbury DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community.

The consolidated financial statements of Canterbury DHB consists of Canterbury DHB, its subsidiaries, Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entity South Island Shared Service Agency Ltd (47% owned).

The financial statements of CDHB are for the year ended 30 June 2008 and were authorised for issue by the Board on 10 October 2008.

BASIS OF PREPARATION

Statement of compliance

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Section 154 of the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP). In accordance with NZ GAAP, the consolidated financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are Canterbury DHB's first NZ IFRS financial statements. NZ IFRS 1 has been applied, and comparatives for the year ended 30 June 2008 have been restated to NZ IFRS accordingly. An explanation of how the transition to NZ IFRS has affected the reported financial position and financial performance of Canterbury DHB for the year ended 30 June 2007 is provided in note 28.

Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, and land and buildings.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value.

Functional and presentation currency

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand. The functional currency of Canterbury DHB is New Zealand dollars.

Changes in accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZ IFRS statement of financial position at 1 July 2006 for the purposes of the transition to NZ IFRS.

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted and which are relevant to Canterbury DHD include:

- NZ IAS 1 *Presentation of Financial Statements (revised 2007)* relaces NZ IAS 1 *Presentation of Financial Statements (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as "owner". The revised standard gives Canterbury DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). Canterbury DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.
- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. Canterbury DHB intends to adopt this standard for the year ending 30 June 2010 and has not yet determined the potential impact of the new standard.
- NZ specific amendment to NZ IAS 2 *Inventories*. In November 2007 the New Zealand Accounting Standards Review Board approved an amendment to NZ IAS 2 *Inventories*, which requires public benefit entities to measure inventory held for distribution at cost, adjusted when applicable for any loss of service potential. Prior to the amendment, public benefit entities were required to measure inventories held for distribution at the lower of cost and current replacement cost. Application of the amendment is mandatory for reporting periods beginning on or after 1 January 2008. Canterbury DHB will adopt the amended standard for the year ending 30 June 2009 and expects the impact of adopting the new standard to be minimal.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

The purchase method is used to prepare the consolidated financial statements, which involves adding together like items of assets, liabilities, equity, income and expenses on a line-by-line basis. All significant intragroup balances, transactions, income and expenses are eliminated on consolidation.

Canterbury DHB's investments in its subsidiaries are carried at cost in the Canterbury DHB's own "parent entity" financial statements.

Subsidiaries

Subsidiaries are entities controlled by Canterbury DHB. Control exists when Canterbury DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Canterbury DHB measures the cost of a business combination as the aggregate of the fair values, at the date of exchange, of assets given, liabilities incurred or assumed, in exchange for control of subsidiary plus any costs directly attributable to the business combination.

Associates

Associates are those entities in which Canterbury DHB has significant influence, but not control, over the financial and operating policies.

The consolidated financial statements include Canterbury DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When Canterbury DHB's share of losses exceeds its interest in an associate, Canterbury DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Canterbury DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Canterbury DHB's investments in associates are carried at cost in Canterbury DHB's own "parent entity" financial statements.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates are eliminated to the extent of Canterbury DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of financial performance.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

The budget figures are those approved by the Canterbury DHB in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ IFRS, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings and building fitout
- leasehold building
- plant, equipment and vehicles
- work in progress

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance. Additions to land and buildings between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Fixed Assets Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of Canterbury Health Ltd. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Canterbury DHB and the cost of the item can be measured reliably.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Canterbury DHB. All other costs are recognised in the statement of financial performance as an expense is incurred.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Donated Assets

Donated assets are recorded at the best estimate of fair value and recognised as income. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. Land is not depreciated.

The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of Asset	Years	Depreciation Rate
Freehold Buildings & Fitout	10 – 50	2-10%
Leasehold Building	3 – 20	5-33%
Plant, Equipment and Vehicles	3 – 12	8.3-33%

The residual value of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Software development and acquisition

Expenditure on software development activities, whereby the new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the statement of financial performance as an expense as incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Amortisation

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	2 years	50%

Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the statement of financial performance.

Other financial assets held are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the statement of financial performance. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the statement of financial performance.

Financial assets classified as held for trading or available-for-sale are recognised/derecognised on the date the DHB commits to purchase/sell the investments.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified.

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at the lower of cost (calculated using the weighted average cost method) and current replacement cost. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Other inventories are stated at the lower of cost (calculated using the weighted average method) and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

Impairment

The carrying amounts of Canterbury DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset, at which point it is recognised in the statement of financial performance.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on asset's ability to generate net cash inflows and where Canterbury DHB would, if deprived of the asset, replace its reminding future economic benefits or service potential.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the statement of financial performance, a reversal of the impairment loss is also recognised in the statement of financial performance.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of financial performance as incurred.

Defined benefit plans

Canterbury DHB makes contributions to the DBP Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounts, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocations. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave, retirement gratuities and sick leave

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the year end date. Canterbury DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. Sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date; to the extent Canterbury DHB anticipates it will be used by staff to cover those future absences.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

Provisions

A provision is recognised when Canterbury DHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

ACC Partnership Programme

Canterbury DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme the DHB is liable for all its claims costs for a period of two years up to a specified maximum. At the end of the two year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Trade and other payables

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate.

Derivative financial instruments

Canterbury DHB uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational and financing activities. The DHB does not hold these financial instruments for trading purposes and has not adopted hedge accounting.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are remeasured to fair value at each balance date. The gain or loss on remeasured to fair value is recognised immediately in the statement of financial performance.

Income tax

DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Revenue relating to service contracts

Canterbury DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Canterbury DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability

Services rendered

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Canterbury DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Canterbury DHB.

Interest income

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the statement of financial performance.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of disposal group) are not depreciated or amortised while they are classified as held for sale.

Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

Critical judgements in applying CDHB's accounting policies

The preparation of financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. These estimates and assumptions may differ from the actual results. The estimates and underlying assumptions are reviewed on an ongoing basis.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

Property, plant and equipment useful lives and residual value

At each balance date Canterbury DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, and expected disposal proceeds from the future sale of the assets.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. Canterbury DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets;
- Asset replacement programs;
- Review of second hand market prices for similar assets; and
- Analysis of prior asset sales.

Canterbury DHB has not made significant changes to past assumption concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 14.

Retirement and long service leave

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any change in these assumptions will impact on the carrying amount of the liability.

Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Canterbury DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased assets, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Canterbury DHB has exercised its judgement on the appropriate classification of its leases and, has determined all leases arrangements are operating leases.

Non-government grants

Canterbury DHB must exercise judgement when recognising grant income to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

2. Patient related revenue

	Group		Parent	
	30/06/08 $'000	30/06/07 $'000	30/06/08 $'000	30/06/07 $'000
ACC Revenue	21,512	19,565	21,512	19,565
Other patient related revenue	15,033	13,893	15,460	14,311
Total patient related revenue	**36,545**	**33,458**	**36,972**	**33,876**

3. Other operating income

	Group		Parent	
	30/06/08 $'000	30/06/07 $'000	30/06/08 $'000	30/06/07 $'000
Gain/(loss) on sale of property, plant and equipment	(135)	6,162	(142)	6,178
Donations and bequests received	783	649	797	649
Other	18,363	15,506	15,883	13,172
	19,011	**22,317**	**16,538**	**19,999**

4. Employee benefit costs

	Group		Parent	
	30/06/08 $'000	30/06/07 $'000	30/06/08 $'000	30/06/07 $'000
Wages and salaries	455,007	419,016	445,147	410,606
Contributions to defined contribution plans	7,793	5,394	7,793	5,394
Increase/(decrease) in employee benefit provisions	9,645	14,736	9,380	14,517
	472,445	**439,146**	**462,320**	**430,517**

5. Other operating expenses

	Group		Parent	
	30/06/08 $'000	30/06/07 $'000	30/06/08 $'000	30/06/07 $'000
Remuneration of auditor:				
Audit fees for financial statement audit	172	166	148	137
Audit fees for NZ IFRS transition	35	14	18	14
Board members' fees	307	300	307	300
Directors' fees	23	23	-	-
Operating lease costs	4,343	4,211	3,858	3,773
Other	61,083	55,488	58,412	53,008
	65,963	**60,202**	**62,743**	**57,232**

6. Capital charge

CDHB pays capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the year. The capital charge rate for the period ended June 2008 was 8%. (June 2007 8%).

7. Capital and reserves

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
General Funds				
Opening Balance	124,313	126,174	124,451	126,312
Equity repayment to Ministry of Health	(1,861)	(1,861)	(1,861)	(1,861)
	122,452	**124,313**	**122,590**	**124,451**
Retained earnings				
Opening balance	(40,648)	(38,399)	(42,688)	(40,138)
Operating surplus/(deficit)	(16,766)	(2,249)	(16,499)	(2,550)
Transfer from/(to) trust reserve	-	-	-	-
Closing balance	(57,414)	(40,648)	(59,187)	(42,688)
Represented by:				
Accumulated deficit in parent and subsidiary	(57,492)	(40,726)	(59,265)	(42,766)
Accumulated surplus in associates	78	78	78	78
	(57,414)	**(40,648)**	**(59,187)**	**(42,688)**
Revaluation reserve				
Opening balance	184,477	184,477	184,477	184,477
Current year movement	-	-	-	-
Closing balance	184,477	184,477	184,477	184,477
Represented by:				
Revaluation of land	68,603	68,603	68,603	68,603
Revaluation of building including fitout	114,374	114,374	114,374	114,374
Revaluation of reversionary interest in buildings	1,500	1,500	1,500	1,500
	184,477	**184,477**	**184,477**	**184,477**

8. Cash and cash equivalents

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Bank balances and call deposits	29,004	50,633	26,905	49,282
Term deposits less than 3 months	13,335	-	13,335	-
Cash and cash equivalents	42,339	50,633	40,240	49,282
Bank overdrafts	-	-	-	-
Cash and cash equivalents at end of year	**42,339**	**50,633**	**40,240**	**49,282**

The carrying value of short-term deposits with maturity dates of three months or less approximates their fair value.

9. Trade and other receivables

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Trade receivables	9,303	7,516	8,733	7,323
Receivable from the Ministry of Health	15,372	8,620	14,927	8,480
Prepayments	872	658	863	622
Other receivables	10,462	7,488	10,918	7,488
	36,009	**24,282**	**35,441**	**23,913**

The carrying value of receivables approximates their fair value.

Movements in the provision for impairment of receivables are as follows:

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Balance at 1 July	2,549	1,742	2,549	1,742
Additional provisions made during the year	(173)	1,183	(173)	1,183
Receivables written-off during period	(214)	(376)	(214)	(376)
Balance at 30 June	**2,162**	**2,549**	**2,162**	**2,549**

As at 30 June 2008 and 2007, all overdue receivables have been assessed for impairment and appropriate provisions have been applied. The net ageing of trade receivables are:

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Current	6,752	6,029	6,182	5,836
1-30 days	1,538	795	1,538	795
31-60 days	546	175	546	175
> 61 days	467	517	467	517
Balance at 30 June	**9,303**	**7,516**	**8,733**	**7,323**

10. Inventory

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Pharmaceuticals	2,998	2,538	2,998	2,538
Surgical and Medical Supplies	4,944	4,716	4,944	4,716
Other Supplies	1,654	1,532	1,585	1,467
	9,596	8,786	9,527	8,721
Provision for Obsolescence	(633)	(611)	(633)	(611)
	8,963	**8,175**	**8,894**	**8,110**

No inventories are pledged as security for liabilities, however some inventories are subject to retention of title clauses.

11. Investments

Canterbury DHB has the following investments :

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Investment in Associates	-	168	-	168
Investment in Subsidiaries	-	-	3,208	3,170
Other Investments	9,170	11,170	9,170	11,170
	9,170	**11,338**	**12,378**	**14,508**

Investment in Associates

a) General information

Name of entity	Principal activities	Interest held at 30 June 2008	Balance date
South Island Shared Service Agency Limited	Provision of support services relating to contracting to DHBs for their funding arm	47%	30 June

b) Investment in associate entities

	2008 Actual $'000	2007 Actual $'000
Carrying amount at beginning of year	168	168
Investment realised through sale of assets and liabilities of NZCRM	(168)	-
Carrying amount at end of year	**-**	**168**

c) Share of associates' contingent liabilities and commitments

Canterbury DHB is not jointly or severally liable for the liabilities owing at balance date by South Island Shared Service Agency Limited. South Island Shared Service Agency Limited is incorporated in New Zealand.

Investments in subsidiaries

	Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000
Equity - Canterbury Laundry Service Ltd	394	394
Advances - Canterbury Laundry Service Ltd	2,716	2,776
Advances - Brackenridge Estate Ltd	98	-
	3,208	**3,170**

At 30 June 2008 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Laundry Service Ltd	100%	30 June
Brackenridge Estate Ltd	100%	30 June

Both Canterbury Laundry Service Ltd and Brackenridge Estate Ltd are incorporated in New Zealand. Canterbury Laundry Service Ltd provides laundry services. Brackenridge Estate Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

Other investments

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Current investments are represented by:				
Term deposits	-	5,000	-	5,000
Total current portion	-	5,000	-	5,000
Non-current investments are represented by:				
Bonds	9,170	6,170	9,170	6,170
Total non-current portion	9,170	6,170	9,170	6,170
Total other investments	**9,170**	**11,170**	**9,170**	**11,170**

The fair value of equity investments are determined by reference to published price quotations in an active market.

Maturity analysis and effective interest rates of term deposits
The maturity dates and weighted average effective interest rates for term deposits are as follows:

	30/06/08 $'000	30/06/07 $'000
Term deposits with maturities of 6-12 months	-	5,000
Weighted average effective interest rates	-	*8.30%*

The carrying amounts of term deposits with maturities less than 12 months approximate their fair value.

12. Trade and other payables

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Trade payables	10,680	11,268	10,410	11,944
Other payables	75,731	68,842	75,750	68,842
Total trade and other payables	**86,411**	**80,110**	**86,160**	**80,786**

Trade and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of trade and other payables approximates their fair value.

13. Employee benefits

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Non-current liabilities				
Liability for long service leave	3,877	4,172	3,852	4,153
Liability for retirement gratuities	4,707	4,154	4,707	4,154
	8,584	**8,326**	**8,559**	**8,307**
Current liabilities				
Annual leave accruals	38,932	35,007	38,353	34,466
Unpaid days accruals	5,795	12,226	5,733	11,946
ACC accruals	6,431	4,641	6,357	4,554
Conference/Sabbatical leave and expenses	11,839	14,059	11,839	14,059
Sick leave	7,313	7,978	7,192	7,878
Other	39,622	26,634	39,189	26,632
Staff entitlement due within 1 year	**109,932**	**100,545**	**108,663**	**99,535**

The present value of the retirement and long service leave obligation depends on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating the liability include the discount rate and the salary inflation factor. Any changes in these assumptions will impact on the carrying amount of the liability.

14. Property, plant and equipment

Movements for each class of property, plant and equipment for the Group

07/08 Financial year	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Revisionary interest in buildings $'000	Work in progress $'000	Total $'000
Cost or valuation							
Balance at 1 July 2007	100,083	313,912	144,776	894	1,500	21,529	582,694
Additions	-	18,928	15,887	-	-	(13,206)	21,609
Disposals/transfers	-	-	(2,658)	-	-	-	(2,658)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2008	**100,083**	**332,840**	**158,005**	**894**	**1,500**	**8,323**	**601,645**
Depreciation and impairment losses							
Balance at 1 July 2007	-	29,730	96,624	894	-	-	127,248
Depreciation charge for the year	-	29,564	16,632	-	-	-	46,196
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	-	(2,456)	-	-	-	(2,456)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2008	**-**	**59,294**	**110,800**	**894**	**-**	**-**	**170,988**

The disposal of certain properties may be subject to the Ngai Tahu Claims Settlement Act 1995, or the provision of section 40 of the Public Works Act 1981.

06/07 Financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Revisionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation							
Balance at 1 July 2006	99,913	300,816	129,659	1,281	1,500	15,841	549,010
Additions	-	12,803	19,525	27	-	5,688	38,043
Disposals/Transfers	170	293	(4,408)	(414)	-	-	(4,359)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2007	**100,083**	**313,912**	**144,776**	**894**	**1,500**	**21,529**	**582,694**
Depreciation and impairment losses							
Balance at 1 July 2006	-	-	82,847	891	-	-	83,738
Depreciation charge for the year	-	29,794	16,313	85	-	-	46,192
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	(64)	(2,536)	(82)	-	-	(2,682)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2007	**-**	**29,730**	**96,624**	**894**	**-**	**-**	**127,248**
Carrying amounts							
At 1 July 2007	100,083	284,182	48,152	-	1,500	21,529	455,446
At 30 June 2008	100,083	273,546	47,205		1,500	8,323	430,657

Movements for each class of property, plant and equipment for the Parent

07/08 Financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Revisionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation							
Balance at 1 July 2007	100,083	313,625	137,427	894	1,500	21,483	575,012
Additions	-	18,768	14,772	-	-	(13,187)	20,353
Disposals/transfers	-	-	(1,899)	-	-	-	(1,899)
Revaluations	-	-		-	-	-	-
Balance at 30 June 2008	**100,083**	**332,393**	**150,300**	**894**	**1,500**	**8,296**	**593,466**
Depreciation and impairment losses							
Balance at 1 July 2007	-	29,691	92,823	894	-	-	123,408
Depreciation charge for the year	-	29,414	15,409	-	-	-	44,823
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	-	(1,770)	-	-	-	(1,770)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2008	**-**	**59,105**	**106,462**	**894**	**-**	**-**	**166,461**

06/07 Financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Revisionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation							
Balance at 1 July 2006	99,913	300,816	123,957	894	1,500	15,727	542,807
Additions	-	12,803	17,223	-	-	5,756	35,782
Disposals/transfers	170	6	(3,753)	-	-	-	(3,575)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2007	**100,083**	**313,625**	**137,427**	**894**	**1,500**	**21,483**	**575,012**
Depreciation and impairment losses							
Balance at 1 July 2006	-	-	79,509	808	-	-	80,317
Depreciation charge for the year	-	29,764	15,158	86	-	-	45,008
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	(74)	(1,845)	-	-	-	(1,919)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2007	**-**	**29,690**	**92,822**	**894**	**-**	**-**	**123,406**
Carrying amounts							
At 1 July 2007	100,083	283,935	44,605	-	1,500	21,483	451,606
At 30 June 2008	100,083	273,288	43,838	-	1,500	8,296	427,005

Revaluation

Canterbury DHB revalued its land, buildings and fitout plants as at 30 June 2006. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of Telfer Young (Canterbury) Ltd), which is consistent with NZ IAS 16 Property Plant & Equipment, and resulted in the net increases in the value of land ($41,072,000), buildings and fitout ($65,177,000) and reversionary interest in a car park building ($510,000). This increase had been recognised in the Revaluation Reserve. The total optimised depreciated replacement cost of Canterbury DHB's land and buildings including fitout as at 30 June 2006 was $400,729,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 2019. This interest has not been included in the Statement of Financial Position, other than the total revaluation effect of $1,500,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

15. Intangible assets

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Software				
Cost				
Opening balance	16,267	15,418	16,267	15,418
Additions	2,211	849	2,211	849
Disposals	-	-	-	-
Closing balance	18,478	16,267	18,478	16,267
Amortisation and impairment losses				
Opening balance	15,566	14,545	15,566	14,545
Amortisation charge for the year	1,616	1,035	1,616	1,035
Impairment losses	13	(14)	13	(14)
Reversal of impairment losses	-	-	-	-
Disposals	-	-	-	-
Closing balance	17,195	15,566	17,195	15,566
Carrying amounts	**1,283**	**701**	**1,283**	**701**

16. Trust / Special funds

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. An amount equal to the trust fund assets is reflected as a non-current liability.

All trust funds are held in bank accounts that are separate from Canterbury DHB's normal banking facilities.

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Balance at beginning of year	10,931	9,907	10,825	9,818
Interest received	1,121	731	1,099	703
Donations and funds received	683	1,589	683	1,589
Funds spent	(1,213)	(1,296)	(1,205)	(1,285)
Balance at end of year	**11,522**	**10,931**	**11,402**	**10,825**

Residents' trust accounts	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Residents' trust account balance	**846**	**870**	**302**	**400**

Residents' trust account comprises bank balances representing funds managed on behalf of residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual residents' balances. Therefore, transactions occurring during the year are not included in the Statement of Financial Performance, Financial Position or Cash Flow of Canterbury DHB.

17. Provisions

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Provisions due within 1 year	-	-	-	-
Provisions due after 1 year	-	200	-	-
Total provisions	**-**	**200**	**-**	**-**
Movements in provisions				
Opening balance	200	254	-	-
Additional provisions made during the year	-	-	-	-
Now included in other payables	(200)	-	-	-
Charged against provisions for the year	-	(54)	-	-
Closing balance	**-**	**200**	**-**	**-**

Brackenridge has a refurbishment provision in regard to its legal obligation to the Housing Corporation to keep the premises at 150 Madisons Road in the same condition that they were in at the start of their lease in December 1999. The lease will finish in 2019.

18. Borrowings

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Non-current				
Crown Health Financing Agency loans	75,000	87,650	75,000	87,650
Total non-current borrowings	75,000	87,650	75,000	87,650
Total borrowings	**75,000**	**87,650**	**75,000**	**87,650**

The Crown Health Financing Agency loans are issued at fixed rates of interest. The carrying amounts of borrowings approximate their fair values. The details of terms and conditions are as follows:

Interest rates
Average interest rates on the groups' borrowing for the year are as follows:

	Group		Parent	
	30/06/08	30/06/07	30/06/08	30/06/07
Crown Health Financing Agency loans				
Later than one year but not more than five years	60,000	72,650	60,000	72,650
Weighted average effective interest rate	*6.39%*	*6.34%*	*6.39%*	*6.34%*
Later than five years	15,000	15,000	15,000	15,000
Weighted average effective interest rate	*6.13%*	*6.13%*	*6.13%*	*6.13%*

Security
The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent Canterbury DHB cannot perform the following actions:

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any of its assets except disposals at full value in the ordinary course of business

19. Reconciliation of Net Surplus/(Deficit) for the period with net cash flows from operating activities

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Net surplus/deficit	(16,766)	(2,249)	(16,499)	(2,550)
Add back non-cash items:				
Depreciation and amortisation	47,808	47,228	46,439	46,046
Add back items classified as investing activity:				
(Gain) / loss on asset sale	135	(6,162)	142	(6,178)
	31,177	38,817	30,082	37,318
Movement in term portion provisions/staff entitlements	258	(929)	252	(924)
Movements in working capital:				
Decrease/(increase) in receivables & prepayments	(11,727)	1,315	(11,528)	1,191
Decrease/(increase) in stocks	(788)	(979)	(784)	(977)
Increase/(decrease) in creditors & other accruals	6,301	5,579	5,374	5,215
Increase/(decrease) in capital charge due to crown	(6,623)	10,114	(6,623)	10,114
Increase/(decrease) in staff entitlements	9,387	15,665	9,128	15,441
Increase/(decrease) in provisions	(200)	(54)	-	-
Net cash inflow/(outflow) from operating activities	**27,785**	**69,528**	**25,901**	**67,378**

20. Commitments

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Capital Commitments				
Property, plant and equipment	11,201	16,996	11,201	16,996
Intangible assets	4,174	22,204	4,174	22,204
Other capital commitments	11,198	-	11,198	-
Total capital commitments at Balance Date	**26,573**	**39,200**	**26,573**	**39,200**
Non Cancellable Operating Lease Commitments				
Accommodation leases	8,939	9,481	4,754	4,996
Vehicle leases	-	-	-	-
Other	11	11	-	-
	8,950	**9,492**	**4,754**	**4,996**
For Expenditure Within:				
Not later than one year	1,879	1,634	1,352	1,136
Later than one year and not later than five years	3,181	3,554	1,763	2,140
Later than five years	3,890	4,304	1,639	1,720
	8,950	**9,492**	**4,754**	**4,996**

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are re-negotiated periodically reflecting the general principle that an on-going business relationship exists with those providers. Examples of these contracts include contracts for primary care, personal health and mental health.

There are also contracts for demand-driven items where the total expenditure is not defined in advance. Examples of this type of expenditure are pharmaceuticals, subsidy payments to rest homes and carer support relief payments.

The value of the Board's commitment relating to these contracts has not been included in the disclosure above.

Operating leases as lessee
Canterbury DHB leases a number of properties in the normal course of its business. The majority of these leases contain normal clauses in relation to regular rent reviews at current market rates.

21. Contingent liabilities

Canterbury DHB has the following contingencies at year end:

a. Collective Employment Agreements negotiations
There are a number of collective employment agreements that expired before 30 June 2008. Negotiations are in progress at a National level and Canterbury has limited influence over such negotiations. While significant industrial action may occur, due the high degree of uncertainty, the financial impact of such events had not been allowed for in the financial results.

b. Outstanding Legal Proceedings
The Group has outstanding legal proceedings at year end. The Group disputes these claims and believe that it is unlikely any material financial loss will eventuate. Not all information disclosed as this may prejudice the legal position of the DHB.

c. Defined Benefit Contribution Schemes
Canterbury DHB is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, the DHB could be responsible for an increased share of the deficit.

22. Categories of financial assets and liabilities

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Investments in subsidiaries and associates	-	168	3,208	3,338
Loans and receivables				
Cash and cash equivalents	42,339	50,633	40,240	49,282
Debtors and other receivables	36,009	24,282	35,441	23,913
Bonds	9,170	6,170	9,170	6,170
Term deposits (term>3 months)	-	5,000	-	5,000
Total loans and receivables	**87,518**	**86,085**	**84,851**	**84,365**
Fair value through profit and loss				
Restricted assets	11,522	10,931	11,402	10,825
Restricted liabilities	11,522	10,931	11,402	10,825
Other financial liabilities				
Creditors and other payables	93,640	93,962	93,389	94,638
Borrowings- CFA loans	75,000	87,650	75,000	87,650
Total other financial liabilities	**168,640**	**181,612**	**168,389**	**182,288**

23. Financial Instrument Risks

Credit risk

Credit risk is the risk that a third party will default on its obligation to the Group, causing the Group to incur a loss.

Financial instruments which potentially subject the Group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts. The Group only invest funds with those entities which have a specified Standard and Poor's credit rating.

The Group places its funds and enters into foreign currency forward contracts with high quality financial institutions and limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2008, the Ministry of Health owed Canterbury DHB $14.9 million ($8.5 million at 30 June 2007).

At the balance sheet date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. Canterbury DHB is exposed to equity securities price risk on its investments. This price risk arises due to market movements in listed companies. The price risk is managed by diversification of Canterbury DHB's investment portfolio in accordance with the limits set out in Canterbury DHB's investment policy.

Interest rate risk

The interest rates on the Group's investments are disclosed in note 11 and on the Group borrowings in note 18.

Fair value interest rate risk
Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. Borrowing issued at fixed rate and term deposits held at fixed rates expose the Group to fair value interest rate risk.

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities. Canterbury DHB uses interest rate swaps and options in order to manage interest rate risk. The notional principal or contract amount of interest rate swaps and options outstanding at 30 June 2008 was nil (2007: $8 million).

Cash flow interest rate risk
Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The Group currently has no variable interest rate investments or borrowings.

Currency risk
Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2008 (30 June 2007 nil)

Liquidity risk

Liquidity risk is the risk that the Group will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions.

The table below analyses trade and other payables into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date, based on undiscounted cash flows:

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Less than 6 months	86,411	80,110	86,160	80,786
Total	**86,411**	**80,110**	**86,160**	**80,786**

24. Capital management

Canterbury DHB's capital is its equity, which comprises accumulated funds and other reserves. Equity is represented by net assets.

Canterbury DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

Canterbury DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure Canterbury DHB effectively achieves its objectives and purpose, whist remaining a going concern.

25. Related parties

Government funding

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of the Canterbury DHB. Canterbury DHB enters into numerous transactions with government departments and other Crown agencies on an arm's length basis. These transactions are not considered to be related party transactions.

Inter-group transactions

During the financial year the group had the following inter-group transactions:

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Revenue				
Interest on advance and director's fees from/to Canterbury Laundry Service Ltd	-	-	235	202
Service fees to Brackenridge Estate Ltd	-	-	48	45
Services to Canterbury Laundry Service Ltd	-	-	427	427
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	27	58	27	58
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	3,927	4,073
Interest on advance from Brackenridge Estate Ltd	-	-	18	70
Services from New Zealand Centre for Reproductive Medicine Ltd	1,224	1,940	1,224	1,940
Services from South Island Shared Service Agency Ltd	994	553	994	553

Interest charged on advances to / from Canterbury Laundry Service Ltd, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Ltd are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June 2008 are as follows:

	Group		Parent	
	As at 30/06/08 $'000	As at 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Amount receivable owing by associates				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	103	351	103	384
Amount payable owing to associates				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	-	-	-	33
Amount payable owing to subsidiaries				
Brackenridge Estate Ltd – advance	-	-	-	713
Canterbury Laundry Service Ltd	-	-	372	346
Amount receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – debtor	-	-	87	80
Canterbury Laundry Service Ltd – advance	-	-	2,750	2,750
Brackenridge Estate Ltd – advance	-	-	98	-

Board and Committee members

Below are the aggregate value of purchase transactions and outstanding balances which Canterbury DHB and its subsidiaries have made during the financial year on an arm's length basis with the organisations which fall within the related party definition. Balances outstanding are per the Accounts Payable Ledger, and exclude any provisions made.

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/08 $'000	Year ended 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Pegasus Health	2,063	2,716	-	-
He Oranga Pounamu Charitable Trust	191	171	-	-
Te Amorangi Richmond Wellness Village	-	8	-	-
Te Rito Arahi Māori Alcohol Drug & Resource Centre	(57)	228	-	-
Windsor House	2,198	1,952	-	-
Ryman Healthcare Ltd	6,845	6,056	-	-
TimeOut Carers	24	261	-	-
Canterbury Community Primary Health Organisation	4,698	1,450	-	-
Rural Canterbury Primary Health Organisation	12,165	9,110	-	-
Access Home Health	3,946	3,139	-	-
Deloitte	98	64	-	-
Te Puawaitanga ki Otautahi Trust	784	531	-	-
Te Rununga O Nga Maata Waka	166	127	-	-
McLeans Institute	133	130	-	-
Christchurch Resettlement Services	75	69	-	-
University of Canterbury	112	422	4	313
Christchurch Polytechnic Institute of Technology (CPIT)	23	29	-	-
New Zealand College of Midwives	-	1	-	-
Cambridge Clinic (DSAC) Ltd	236	112	-	-
Age Concern Canterbury	1	1	-	-
Parents Centre NZ	121	116	-	-
24 Hour Surgery Ltd	8	102	-	-
Social Services Council of the Diocese of Christchurch	4,262	4,023	-	-
Christchurch Primary Health Organisation	4,181	2,634	-	-
The Nurse Maude Association	22,247	21,162	-	-
Medical Protection Society	102	206	1	-
Partnership Health Primary Health Organisation	63,362	50,268	-	-
Hurunui-Kaikoura Primary Health Organisation	3,429	2,530	-	-
Amuri Health Centre Ltd	3	-	-	-
City Care Limited	27	5	-	1
Orion New Zealand Limited	-	173	-	-
Red Bus Limited	8	6	-	1
Christchurch International Airport Limited	1	2	-	-

Below are the aggregate value of revenue transactions and outstanding balances which Canterbury DHB and its subsidiaries have made during the financial year on an arm's length basis with the organisations which fall within the related party definition. Balances outstanding are per the Accounts Receivable ledger, and exclude any provisions made. A provision for impairment of receivables from related parties of $22,482 has been made (2007 $71,261).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/08 $'000	Year ended 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Pegasus Health	138	130	15	28
He Oranga Pounamu Charitable Trust	38	29	4	4
Rural Canterbury Primary Health Organisation	71	-	-	-
University of Canterbury	55	25	3	(2)
Christchurch Polytechnic Institute of Technology (CPIT)	340	332	20	21
Christchurch Primary Health Organisation	38	-	-	-
The Nurse Maude Association	56	93	19	72
Canterbury Medical Research Foundation	111	98	21	19
Partnership Health Primary Health Organisation	128	289	-	16
Hurunui-Kaikoura Primary Health Organisation	2	3	1	-
24 Hour Surgery Ltd	31	4	-	3
City Care Limited	1	-	-	-
Lyttelton Port Company Limited	3	3	-	-
Orion New Zealand Limited	-	4	-	-

Key Management Personnel

Below are the aggregate value of transactions and outstanding balances relating to key management personnel and entities over which they have control or significant influence. Balances outstanding are per the Accounts Payable and the Accounts Receivable ledgers, and exclude any provisions made. No provision has been required, nor any expense recognised, for impairment of receivables from related parties (2007 $nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/08 $'000	Year ended 30/06/07 $'000	As at 30/06/08 $'000	As at 30/06/07 $'000
Services purchased by Canterbury DHB:				
Heart Centre at St George's	728	554	-	-
Christchurch Polytechnic Institute of Technology	23	29	-	-
Services purchased from Canterbury DHB:				
Heart Centre at St George's	45	29	4	1
Christchurch Polytechnic Institute of Technology	340	332	20	21

Heart Centre at St George's is an unincorporated joint venture between St George's Hospital and Heart Centre (2003) Ltd. When clinical demand requires, "excess" cardiac surgery services are outsourced to this joint venture. These services are provided at St George's Hospital. Graham (Jock) Muir is both a director and shareholder of Heart Centre (2003) Ltd.

Hector Matthews is the Chair of the Christchurch Polytechnic Institute of Technology Council.

Compensation of key management personnel:

	Group		Parent	
	Year ended 30/06/08 $'000	Year ended 30/06/07 $'000	Year ended 30/06/08 $'000	Year ended 30/06/07 $'000
Salaries & other short term employee benefits	1,609	1,777	1,609	1,777
Post-employment benefits	245	183	245	183
Total key management personnel compensation	**1,854**	**1,960**	**1,854**	**1,960**

26. Subsequent events

There were no events after 30 June 2008 which could have a material impact on the information in Canterbury DHB's financial statements (30 June 2007 – no events).

27. Budget variance

Additional personal health funding for aged related care and home based support, and additional funding for settlements of Multi Employer Collective Agreement (MECA), were devolved during the year and were not reflected in these budgets.

28. Explanation of transition to NZ IFRS

These are Canterbury DHB's first consolidated financial statements prepared in accordance with NZ IFRS.

The accounting policies set out in note 1 to the financial statements have been applied in preparing financial statements for the year ended 30 June 2007, and in the preparation of an opening NZ IFRS Balance Sheet at 1 July 2006 (Canterbury DHB's date of transition).

Canterbury DHB's transition date is 1 July 2006 and the opening NZ IFRS balance sheet has been prepared as at that date. Canterbury DHB's NZ IFRS adoption date is 1 July 2007.

In preparing these financial statements in accordance with NZ IFRS 1, Canterbury DHB has not applied any optional and mandatory exemptions to full retrospective application of NZ IFRS.

In preparing its opening NZ IFRS Balance Sheet, Canterbury DHB has adjusted amounts reported previously in financial statements prepared in accordance with its old basis of accounting (previous GAAP). An explanation of how the transition from previous GAAP to NZ IFRS has affected Canterbury DHB's financial position, financial performance and cash flows is set out in the following tables and the notes that accompany the tables.

The following tables show the changes in equity, resulting from the transition from previous NZ GAAP to NZ IFRS as at 1 July 2006 and 30 June 2007 for the group and parent.

Reconciliation of equity – Group

	Note	Transition Balance Sheet 1 July 2006			Comparative Balance Sheet 30 June 2007		
		Previous GAAP	Effect of transition to NZIFRS	NZ IFRS	Previous GAAP	Effect of transition to NZIFRS	NZ IFRS
		$'000	$'000	$'000	$'000	$'000	$'000
Investment	a	375	(207)	168	6,689	(351)	6,338
Property, plant and equipment	b	466,145	(873)	465,272	456,147	(701)	455,446
Intangible assets	b	-	873	873	0	701	701
Surplus property		11,760	-	11,760	8,250	-	8,250
Restricted assets	c	8,110	2,199	10,309	8,100	2,831	10,931
Total non-current assets		486,390	1,992	488,382	479,186	2,480	481,666
Cash and cash equivalents		12,838	-	12,838	50,633	-	50,633
Trade and other receivables	a&d	25,391	29	25,420	24,132	150	24,282
Inventories		7,196	-	7,196	8,175	-	8,175
Investment		-	-	0	5,000	-	5,000
Total current assets		45,425	29	45,454	87,940	150	88,090
Total assets		**531,815**	**2,021**	**533,836**	**567,126**	**2,630**	**569,756**
Equity							
Crown equity		126,174	-	126,174	124,313	-	124,313
Other reserves		184,477	-	184,477	184,477	-	184,477
Retained earning/(losses)	c,d,g,h&i	(31,435)	(6,964)	(38,399)	(32,273)	(8,375)	(40,648)
Trust/Special funds	e	8,110	(8,110)	-	8,100	(8,100)	-
Total equity		287,326	(15,074)	272,252	284,617	(16,475)	268,142
Liabilities							
Employee benefits	f,g&h	-	9,255	9,255	-	8,326	8,326
Patient and restricted funds	c&e	-	10,309	10,309	-	10,931	10,931
Provisions	f	9,509	(9,255)	254	8,526	(8,326)	200
Borrowings		78,650	-	78,650	87,650	-	87,650
Total non-current liabilities		88,159	10,309	98,468	96,176	10,931	107,107
Trade and other payables	a&i	74,456	42	74,498	79,914	196	80,110
Owing to the Ministry of Health		3,738	-	3,738	13,852	-	13,852
Employee benefits		48,919	35,961	84,880	56,475	44,070	100,545
Provisions		29,217	(29,217)	-	36,092	(36,092)	-
Total current liabilities		156,330	6,786	163,116	186,333	8,174	194,507
Total liabilities		244,489	17,095	261,584	282,509	19,105	301,614
Total equity and liabilities		**531,815**	**2,021**	**533,836**	**567,126**	**2,630**	**569,756**

Reconciliation of equity – Parent

	Note	Transition Balance Sheet 1 July 2006 Previous GAAP $'000	Effect of transition to NZIFRS $'000	NZIFRS $'000	Comparative Balance Sheet 30 June 2007 Previous GAAP $'000	Effect of transition to NZIFRS $'000	NZIFRS $'000
Investment	a	2,592	(2,030)	562	9,796	(288)	9,508
Property, plant and equipment	b	463,364	(873)	462,491	452,307	(701)	451,606
Intangible assets	b	-	873	873	-	701	701
Surplus property		11,760	-	11,760	8,250	-	8,250
Restricted assets	c	7,993	2,199	10,192	7,994	2,831	10,825
Total non-current assets		485,709	169	485,878	478,347	(2,543)	480,890
Cash and cash equivalents		12,270	-	12,270	49,282	-	49,282
Trade and other receivables	a&d	24,898	2,207	27,105	23,529	384	23,913
Inventories		7,133	-	7,133	8,110	-	8,110
Investment		-	-	-	5,000	-	5,000
Total current assets		44,301	2,207	46,508	85,921	384	86,305
Total assets		**530,010**	**2,376**	**532,386**	**564,268**	**2,927**	**567,195**
Equity							
Crown equity		126,312	-	126,312	124,451	-	124,451
Other reserves		184,477	-	184,477	184,477	-	184,477
Retained earning/(losses)	c,d,g,h&i	(33,170)	(6,968)	(40,138)	(34,547)	(8,141)	(42,688)
Trust/Special funds	e	7,993	(7,993)	-	7,994	(7,994)	-
Total equity		285,612	(14,961)	270,651	282,375	(16,135)	266,240
Liabilities							
Employee benefits	f,g&h	-	9,231	9,231	-	8,307	8,307
Patient and restricted funds	c&e	-	10,192	10,192	-	10,825	10,825
Provisions	f	9,231	(9,231)	-	8,307	(8,307)	-
Borrowings		78,650	-	78,650	87,650	-	87,650
Total non-current liabilities		87,881	10,192	98,073	95,957	10,825	106,782
Trade and other payables	a&i	75,433	397	75,830	80,527	259	80,786
Owing to the Ministry of Health		3,738	-	3,738	13,852	-	13,852
Employee benefits		48,157	35,937	84,094	55,509	44,026	99,535
Provisions		29,189	(29,189)	-	36,048	(36,048)	-
Total current liabilities		156,517	7,145	163,662	185,936	8,237	194,173
Total liabilities		244,398	17,337	261,735	281,893	19,062	300,955
Total equity and liabilities		**530,010**	**2,376**	**532,386**	**564,268**	**2,927**	**567,195**

Explanatory notes – reconciliation of equity

a. Reclassification of advances to/from associates

Advances to/from associates were classified as part of investment under previous NZ GAAP. Advances to associates are reclassified as part of trade and other receivables and advances from associates are included in trade and other payables under NZ IFRS.

b. Intangible assets

Computer software was classified as part of property, plant and equipment under previous NZ GAAP. The net book value of computer software reclassified as an intangible asset on transition to NZ IFRS is $873,000 and at 30 June 2007 is $701,000.

c. Restricted assets and liabilities
Trust asset/ liabilities have been designated as fair value through P&L under NZ IAS 39. They were recorded at cost under previous NZ GAAP and the increase in carrying value as a result of adopting fair value.

d. Impairment of trade receivables
NZ IAS 39 requires impairment of receivables to be based upon a review of individual debtors, not a general provision as was applied under previous NZ GAAP. The impact of the change has resulted in an increase in the provision for doubtful debts on the date of transition, but there is no impact on the provision as at 30 June 2007.

e. Trust / special funds
Trust/ special funds were classified as part of equity under previous NZ GAAP. In accordance with NZ IAS 37, Appendix E, trust funds are accessed as non-discretionary grants. Therefore trust / special funds were reclassified as patients / restricted funds under liability section.

f. Employee benefits
Employee related benefits were provided by general provision under previous NZ GAAP. NZ IAS 1 recommends employee related benefits to be split out from the provision line and to be reclassified as employee benefits.

g. Sick leave
Sick leave was not recognised as a liability under previous NZ GAAP. NZ IAS 19 requires Canterbury DHB to recognise employees unused sick leave entitlement that can be carried forward at balance date, to the extent that Canterbury DHB anticipates it will be used by staff to cover future absences.

h. ACC partnership programme
The ACC Partnership Programme is accounted for under NZ IFRS 4. An actuarial valuation is used to determine the liability for the present value of future costs to be incurred by Canterbury DHB relating to accidents that have happened. The impact of the change has resulted in an increase in ACC accrual on the date of transition, but there is no impact on the provision as at 30 June 2007.

i. Loss on interest rate swaps
Loss on interest rate swaps was only disclosed in the notes to the financial statements under previous NZ GAAP. NZ IAS 39 requires interest rate swaps to be recognised in the statement of position at their fair value.

Reconciliation of surplus for the year ended 30 June 2007

	Note	Group 30 June 2007 Previous NZ GAAP $'000	Effect of transition to NZ IFRS $'000	NZIFRS $'000	Parent 30 June 2007 Previous NZ GAAP $'000	Effect of transition to NZ IFRS $'000	NZIFRS $'000
Ministry of Health revenue	a	1,050,404	(234)	1,050,170	1,042,064	-	1,042,064
Patient related revenue		33,458	-	33,458	33,876	-	33,876
Other operating income		22,317	-	22,317	19,999	-	19,999
Interest income		5,146	-	5,146	5,278	-	5,278
Total income		1,111,325	(234)	1,111,091	1,101,217	-	1,101,217
Employee benefit costs	b&c	437,912	1,234	439,146	429,287	1,230	430,517
Treatment related costs		105,727	-	105,727	108,864	-	108,864
Depreciation and amortisation expenses		47,228	-	47,228	46,046	-	46,046
External service providers		433,074	-	433,074	433,074	-	433,074
Other operating expenses	d&e	60,269	(67)	60,202	57,288	(56)	57,232
Interest expenses		5,069	-	5,069	5,140	-	5,140
Capital charge		22,894	-	22,894	22,894	-	22,894
Total expenses		1,112,173	1,167	1,113,340	1,102,593	1,174	1,103,767
Surplus before and after tax		**(848)**	**(1,401)**	**(2,249)**	**(1,376)**	**(1,174)**	**(2,550)**

Explanatory notes – reconciliation of surplus

a. Ministry of Health revenue provision
$234,000 represents an adjustment within one of the Subsidiaries made in the IFRS accounts, but not recognised in the GAAP accounts.

b. Employee benefits costs – sick leave
$1,687,000 represents the increase in the sick leave provision for the group ($1,683,000 for the parent), which were not recognised under previous NZ GAAP.

c. ACC partnership programme
NZ IFRS 4 requires the liability for the ACC partnership programme is calculated using actuarial techniques. This represents the additional provision ($453,000) for ACC partnership programme liability on transition to NZ IFRS (1 July 2006).

d. Loss on interest rate swaps
$121,000 represents the net movement in fair value of interest rate swaps, which were not recognised under previous NZ GAAP.

e. Impairment of trade receivables
NZ IAS 39 requires impairment of receivables to be based upon a review of individual debtors, not a general provision as was applied under previous NZ GAAP. This represents change in the measurement basis of the provision for doubtful debts on transition to NZ IFRS, which has impacted on the movement in the provision for doubtful debts recognised in the statement of financial performance by $178,000.

Statement of cash flows

There have been no material adjustments to the statement of cash flows for the year ended 30 June 2007, on transition to NZ IFRS.

STATEMENT OF SERVICE PERFORMANCE

DHB Priorities and Accountability

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

- *A District Strategic Plan* - This is 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 objectives and set its long-term strategic priorities;
- *A Statement of Intent* - This is a three-year document requiring DHBs to demonstrate at a high-level how its activities will contribute to achieving the long-term vision outlined in its District Strategic Plan. Included is a 'Forecast of Service Performance' which presents a set of performance measures against which the DHB will evaluate its performance, with targets set for each performance measure.
- *A District Annual Plan* - This is a more detailed document outlining the intended actions and activity the DHB has planned over the coming year to progress the long-term direction and achieve the objectives and performance targets outlined in the other two documents.

The Canterbury DHB's business covers the funding and provision of population health intervention, primary and secondary services, community care and specialist and secondary services – across all population groups. However, the strategic priorities identified by the DHB in 2004, while developing its District Strategic Plan A Healthier Canterbury Directions 2010, are a mix of population, service and disease based approaches. These represent areas where the Canterbury DHB believes there is potential to make improvements in the health status of its population and in the delivery or effectiveness of the services provided.

Five Health Gain Priorities and four Disease Priorities were selected:

- Child and Youth Health;
- Older Person's Health
- Primary Health;
- Māori Health;
- Disease Prevention and Management;
- Cancer;
- Cardiovascular Disease;
- Diabetes; and
- Respiratory Disease.

The DHB updates its Statement of Intent annually and continues to develop and refine the measures for its Forecast Statement of Service Performance to ensure they appropriately reflect the activity and direction of the DHB and meet the needs of its stakeholders, both in government and in the community.

The performance measures included by the DHB in its Forecast of Service Performance reflect activity in the long-term strategic priority areas identified in its District Strategic Plan. As a major provider of health and disability services and the largest employer in the South Island the DHB also includes additional performance measure around areas of performance focus of interest to its stakeholders. These include; improved service delivery around elective and mental health services, hospital efficiency and effectiveness, clinical quality, patient satisfaction and being a good employer.

Also of note is the inclusion in the DHB's mix of performance measure of several measures over which it has does not have direct control. The DHB chooses to include these indicators as an important measure of the determinants of health however its ability to influence the behaviour of its community and the provision of services by third parties is limited. By including these performance measures the DHB is essentially acknowledging that change cannot be made through its actions alone. The DHB continues to work with other providers, external agencies and organisations to collectively improve the health of its community and these performance measures provide an indication of the success of that collective approach.

Sponsors are identified against each of the performance measurements, identifying one of the three output classes (or roles) of the DHB: Governance; Funder; or Provider. It is the outputs where the DHB is the Provider of the service where it has the most control. Where the DHB is the Funder (and therefore contracts with external providers to deliver

the service) control is limited to influencing change through contracting, support and encouragement, partnership or leadership. Those outputs where the DHB is Funder present more of a risk for the DHB in terms of reliance on a third party to deliver the outputs needed to achieve the desired outcomes or objective.

The performance targets set against each measure 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. With limited funding and workforce shortage in some specialist areas the scope for service expansion can often be limited; performance targets in some areas tend to reflect the objective of maintaining current performance levels.

Where possible past performance and national averages are included against each performance measure, to give the performance target context and to better enable evaluation of DHB performance.

At the end of the year the DHB produces the *Statement of Service Performance*, reporting against all of the performance measures and targets set out in its Forecast of Service Performance at the beginning of the year. This Statement of Service Performance provides an indication of how well the DHB's activity over the past year contributed to improving the health and well-being of the Canterbury population and to progressing the DHB's vision, direction and strategic priorities.

Overview of Performance for 2007/08

The indicators that follow are from the DHB's 2007/2010 Statement of Intent with the targets being those set for the 2007/08 year.

In considering the performance results, it should be noted that the number of Pacific people in the Canterbury region is small (10,476 Pacific at the 2006 Census) so the percentages shown under ethnicity breakdowns should be interpreted with caution. For some performance measures the results involve very low numbers which may result in variability of reported results.

Over the past year the DHB's approach to making progress in all areas has been consistent:

- Promote messages related to improved lifestyle choices, physical activity and nutrition and the reduction of risk behaviours, obesity and smoking cessation to promote and improve the health status of the community;
- Work collaboratively with primary and community sectors, the community and external organisations to find better ways of working through an integrated and patient centred approach to care and the development of robust long-term disease continuums;
- Work together with providers and community agencies to reduce inequalities in health status through increased equity of access and improved uptake of services across population groups, particularly those more at risk and with the highest need;
- Develop Canterbury's health care workforce to ensure the capacity and capability to meet the changing needs of the population and growing demand for health and disability services; and
- Be a leader in health, working to ensure the best possible level of quality care is provided to maximise outcomes for the population.

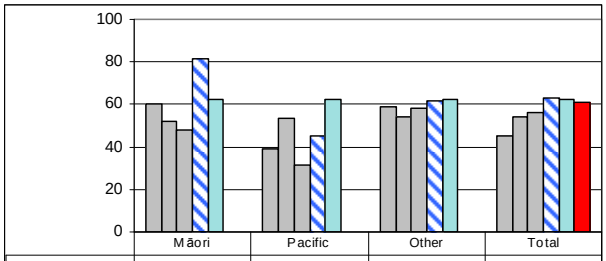
The DHB notes that the following set of performance measures does not include measures around Respiratory Disease, one of the DHB's identified Disease Priorities. The DHB is currently scoping the developing of key indicators for this priority area for use in future Statements of Intent.

Child and Youth Health

Long-Term Objective: Improve the health status of Canterbury's child and youth populations. By keeping young people healthy we give them a better chance of becoming healthy adults.

Maintain the number of babies born with a low birth weight, at below the national average – as a mean of reducing a major cause and association of infant mortality.[4]

The rate of babies born (in public hospitals) with low birth weight - rate per 1000 births.



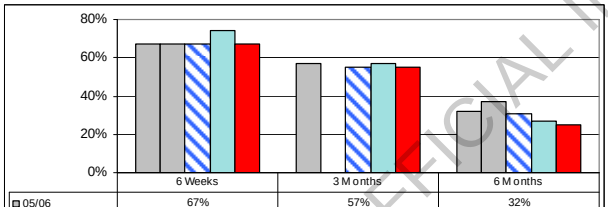
	Māori	Pacific	Other	Total
04/05	60	39	59	45
05/06	52	53	54	54
06/07	48	32	58	56
07/08	82	45	62	63
07/08 (Target)	62	62	62	62
National Average				61

	Base 06/07	Target 07/08	Result 07/08
Māori	48	<62	82
Pacific	32	<62	45
Other	58	<62	62
Total	56	<62	63

The results for low-birth weight babies are influenced by a complex mix of social, environmental and behaviour factors, out the direct control of the DHB. Smoking rates, ethnicity mix and maternal age all influence outcomes. Contributors to the increased rate include an increase in premature rates and admissions of 32-35 week babies and multiple pregnancies with an increase in twin rates. This result is not surprising and is reflected in international as well as national trends.

Improve Breastfeeding Rates – as a means of maximising children's health and providing a positive start to life.

Percentage of children exclusively/fully breastfed at 6 weeks, 3 months and 6 months.[5]

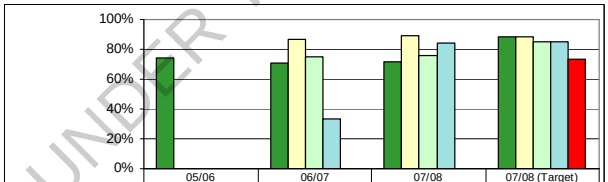


	6 Weeks	3 Months	6 Months
05/06	67%	57%	32%
06/07	67%	55%	37%
07/08	67%	55%	31%
07/08 (Target)	74%	57%	27%
National Average	67%	55%	25%

	Base 06/07	Target 07/08	Result 07/08
6 weeks	67%	>74%	67%
3 months	-	>57%	55%
6 months	37%	>27%	31%

Improve Vaccination Rates – as a means of reducing the impact of vaccine preventable disease.

The percentage of children fully immunised on day they turned 6 months, 12 months, 18 months and 2 years.



	05/06	06/07	07/08	07/08 (Target)
6mths	74%	71%	71%	88%
12mths		87%	89%	88%
18mths		75%	75%	85%
24mths		33%	84%	85%
2 Yr National Average				73%

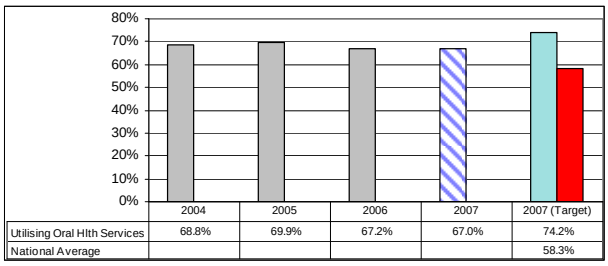
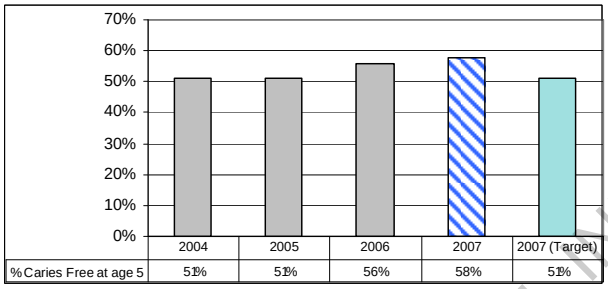
	Base 06/07	Target 07/08	Result 07/08
6 months	71%	88-92%	71%
12 mths	87%	88-92%	89%
18 mths	75%	85-88%	75%
2 years	33%	85-88%	84%

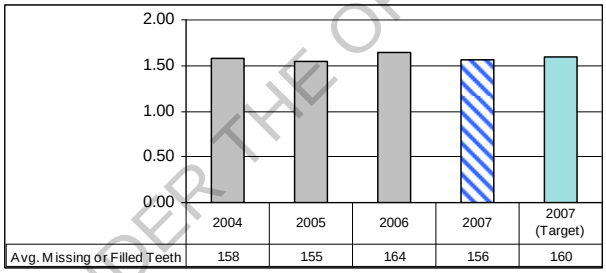
The DHB has maintained or improved immunisation performance across all age groups in the past year.

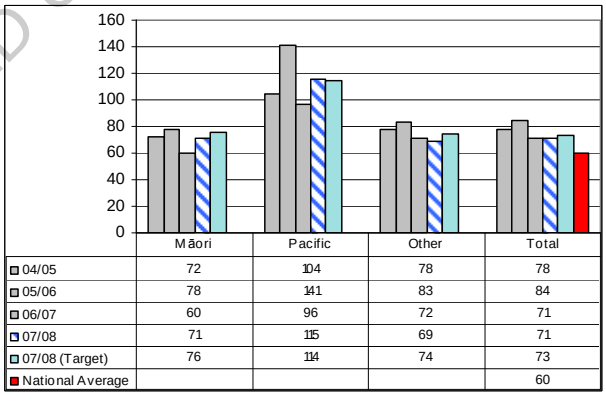
A collaborative immunisation direction has been developed to improving timeliness of vaccinations over the coming year which is expected to improve the 6 and 18 month results.

[4] *Infants born with a low birth weight (under 2500gm) are more likely to have poor health outcomes and increased disabilities and are more susceptible to serious illness during infancy, early childhood and adulthood. This information comes from the Ministry of Health (Ministry) from their National Minimum Data Set (NMDS) and are the most recent results available covering the yearly average to December 2007.*

[5] *These targets reflect our commitment to nationally accepted rates for breastfeeding, in line with Ministry expectations. Although some are already above national expectations, the aim is to reflect the intention to focus on the age groups where performance can be improved. This information is provided by Plunket.*

<table>
<tr><th>Objective 2007/2008</th><th>Performance Measure</th><th></th><th>Base 2006</th><th>Target 2007</th><th>Result 2007</th></tr>
<tr><td rowspan="2">Improve Oral Health Rates – as a means of maximising on-going health.</td><td>The percentage of adolescents utilising oral health services. [6]
 
</td><td>Total</td><td>67.2%</td><td>74.2%</td><td>67%</td></tr>
<tr><td colspan="4">The DHB has not met the target for this indicator but performance continues to be above the national average.</td></tr>
<tr><td rowspan="5"></td><td rowspan="2">The percentage of children caries free, (i.e. no holes or fillings) at age five.
 
</td><td></td><td>Base 2006</td><td>Target 2007</td><td>Result 2007</td></tr>
<tr><td>Māori
Pacific
Other
Total

Results have continued to improve and Māori and Pacific results are within confidence level.
The complex mix of environmental, biological and behavioural factors effecting dental carries mean that reasons for change can be difficult to influence and identify. However, dental enrolment levels for preschool children have been steadily improving and results may demonstrate benefits from the early intervention.</td><td>29%
26%
61%
56%</td><td>19-39%
16-36%
60%
51%</td><td>35%
20%
62%
58%</td></tr>
<tr><td>The average proportion of Decayed, Missing or Filled (DMF) teeth of Year-8 children.
 
</td><td></td><td>Base 2006</td><td>Target 2007</td><td>Result 2007</td></tr>
<tr><td>Māori
Pacific
Other
Total

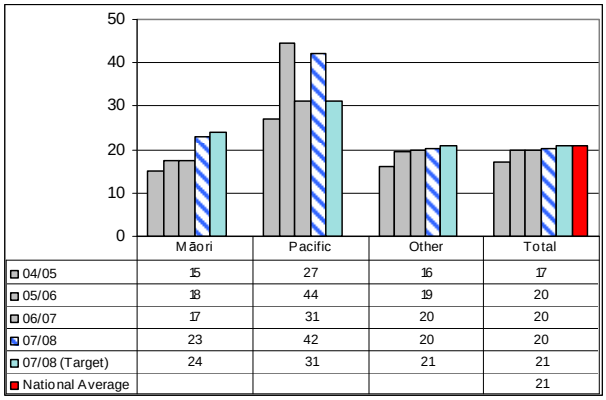
The rate of DMF teeth of Year-8 children has improved, dropping across all population groups over the past year.</td><td>2.59
2.63
1.51
1.64</td><td>2.30-2.82
2.30-2.82
1.46
1.60</td><td>2.41
2.38
1.46
1.56</td></tr>
<tr><td>Reduce Ambulatory Sensitive Admission Rates - as an indication of improved access to, and effectiveness of, primary care services. [7]</td><td>Ambulatory Sensitive Admissions for those aged 0-4 years (rate per 1000 population).
 
</td><td></td><td>Base 06/07</td><td>Target 07/08</td><td>Result 07/08</td></tr>
<tr><td>Māori
Pacific
Other
Total

The DHB has met its targets in all population groups except Pacific, where very small population numbers (128 Pacific children were admitted in 2007/08) make a disproportionate difference in results.
Work is still needed across all population groups to achieve rates closer to the national average. The DHB is working on 'Improving the Child Journey' within its services and anticipates this will improve results in the coming year.</td><td>60
96
72
71</td><td><76
<114
<74
<73</td><td>71
115
69
71</td></tr>
</table>

[6] *Oral health results are provided by calendar year, from the Ministry. The 2006 result differs from that in the 2006/07 Annual Report, reflecting updated information provided by the Ministry after the report was printed.*

[7] *Ambulatory Sensitive Admissions are based on admissions for 37 combined conditions including: Asthma, Dehydration, Diabetes, Ruptured Appendix, Stroke, Angina, Gastroenteritis and 'Failure to Thrive'. The information comes from the Ministry's NMDS and covers the year to December 2007 – which are the latest results available.*

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
	Ambulatory Sensitive Admissions for those aged 5-14 years (rate per 1000 population).	Māori	17	<24	23
		Pacific	31	<31	42
		Other	20	<21	20
		Total	20	<21	20



	Māori	Pacific	Other	Total
04/05	15	27	16	17
05/06	18	44	19	20
06/07	17	31	20	20
07/08	23	42	20	20
07/08 (Target)	24	31	21	21
National Average				21

Again the DHB has met its targets in all population groups except Pacific (there was a total of 78 Pacific children admitted in 2007/08 out of a total of 1,030). The overall results match the national average for this indicator.

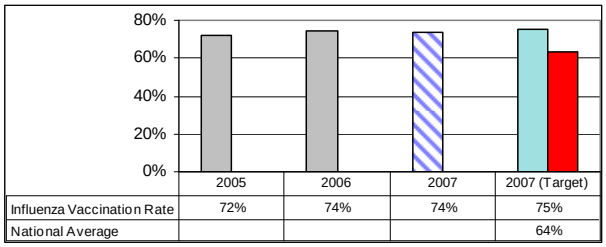
The DHB's 'Improving the Child Journey' work should also see some further improvement within this age grouping in the coming year.

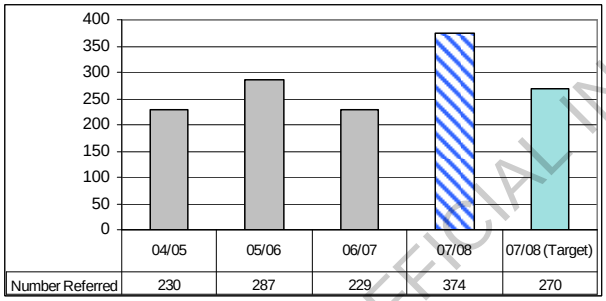
Older Person's Health

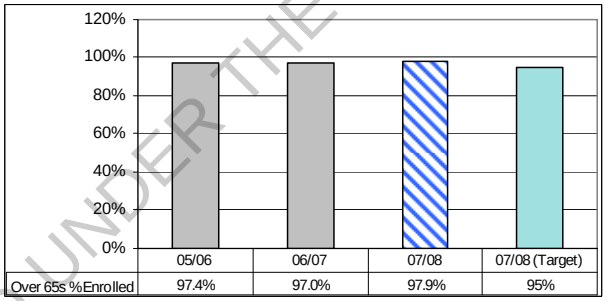
Long-Term Objective: Maintain/improve the health and independence of our older population, within available resources.

In defining Older People the DHB refers to 65+ for European and Other and to 50+ for Māori and Pacific Populations.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Build the Focus on Health Promotion – as a means of maximising the health of older people and helping them to staying healthy in their own homes.	The percentage of the enrolled PHO population over 65 receiving the influenza vaccination.[8]	Total	74%	> 75%	74%
		While the DHB has missed this target, the result reflects an overall increase in the actual number of vaccinations delivered, as the enrolled over 65 population increased between 2006 and 2007.			
	The numbers referred to the Stay On Your Feet (SOYF) Home Exercise Programme. [9]		**Base 06/07**	**Target 07/08**	**Result 07/08**
		Total	229	>270	374
		Referrals to the Stay on Your Feet home exercise programme steadily increased over the past year and the DHB has achieved and exceeded its target.			
Maintain Access to Primary Care Services as a means of maximising ongoing health and well-being.[10]	The percentage of the Canterbury population over 65, enrolled with PHOs.		**Base 06/07**	**Target 07/08**	**Result 07/08**
		Total	97%	> 95%	97.9%
		Enrolments have remained steady over the past several years, and the DHB has achieved its target for this indicator.			





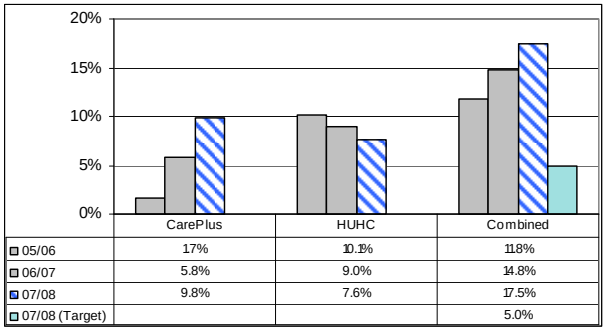


[8] *These results are provided through the PHO Performance Management Programme (PMP) and they relate to the calendar year January – December 2007.*

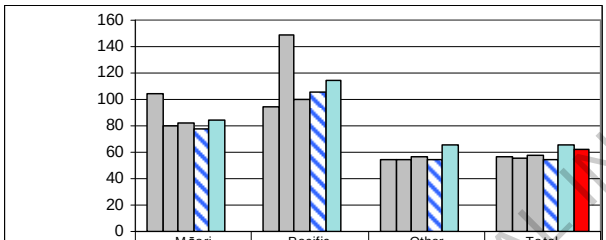
[9] *Falls are a major cause of injury and ongoing disability for older people in Canterbury.*

[10] *Older People face particular barriers to accessing primary care services. They are more likely to lack transport and to have difficulty meeting user part charges, reducing barriers to access is expected to result in improved health outcomes.*

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
	The percentage of the PHO enrolled population over 65, accessing High User or CarePlus services. [11]	High User	9.0%	-	7.6%
		Care+	5.8%	-	9.8%
		Total	14.8%	>5%	17.5%
		The DHB has achieved and exceeded the target set. The move from older High User card services to new CarePlus services is a positive result, with coverage maintained.			
Reduce Ambulatory Sensitive Admission Rates – as an indication of improved access to, and effectiveness of primary care services.	Ambulatory Sensitive Admissions for those aged 65-74 years (rate per 1000 population).	Māori	82	<84	78
		Pacific	100	<114	106
		Other	57	<66	54
		Total	58	<66	55
		Admissions for the 65-74 age group are better than the national average and the DHB has achieved its targets across all population groups. Low Pacific numbers again cause the appearance of disproportionate performance results. While the rate moved from 74 to 106 there were actually 20 Pacific people admitted in 2006/07 and 22 in 207/08, an increase of only two admissions.			



	CarePlus	HUHC	Combined
05/06	17%	10.1%	11.8%
06/07	5.8%	9.0%	14.8%
07/08	9.8%	7.6%	17.5%
07/08 (Target)			5.0%



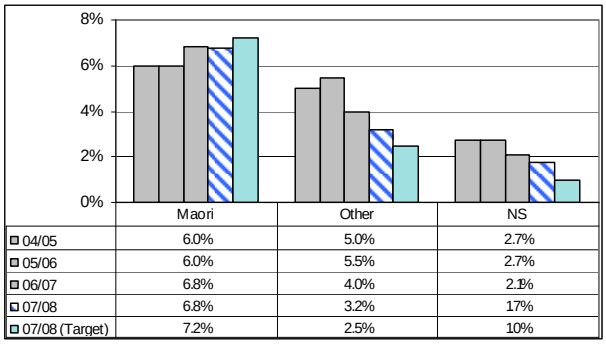
	Māori	Pacific	Other	Total
04/05	104	95	55	57
05/06	80	149	54	56
06/07	82	100	57	58
07/08	78	106	54	55
07/08 (Target)	84	114	66	66
National Average				62

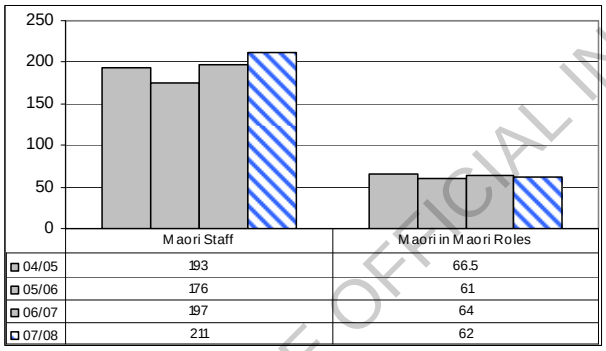
[11] *The goal of Careplus is to develop individualised programmes for those people with two or more chronic conditions, specific goals are then set for each person and monitored on a quarterly basis – older people tend to have more complicated conditions.*

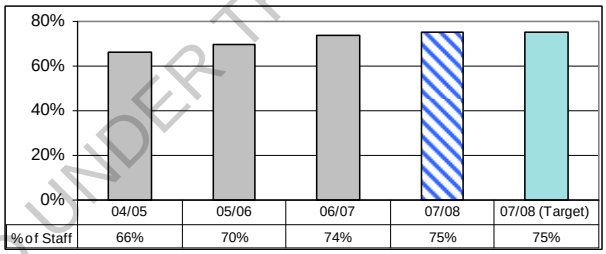
Māori Health

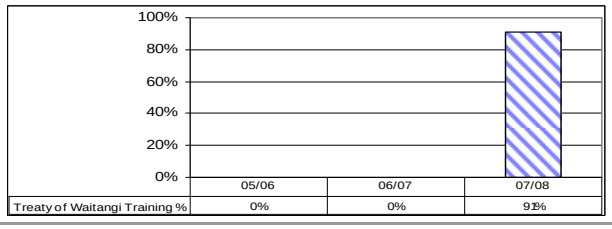
Long-Term Objective: Whanau Ora, Māori are supported to achieve their maximum health and wellbeing.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Improve Ethnicity Data Collection – as a means of reducing barriers to identifying inequalities in health status and monitoring Māori health outcomes.	The percentage of Inpatients with ethnicity recorded.[12]	Māori	6.8%	>7.2%	6.8%
		Other	4.0%	<2.5%	3.2%
		Not Stated	2.1%	<1.0%	1.7%
		While the DHB has not met the targets for this indicator, however these have been set as long-term goals to move ethnicity identification into alignment with Census figures for the Canterbury population. Steady progress is being made, a positive outcome.			
Increase Māori participation in service provision and the health workforce – as a means of improving the cultural responsive of health services.	The number of DHB (i) staff identifying as Māori (ii) Māori staff working in Māori roles.		Base 06/07	Target 07/08	Result 07/08
		(i)	197	-	211
		(ii)	64	-	62
		The DHBs focus is on monitoring staffing levels and on increasing the number of staff with disclosed ethnicity to improve the robustness of this data over time – hence no targets have been set for increasing staffing levels as this is for information only. The DHB is undertaking a number of Roadshows and offering scholarships in 2008/09 to promote health as a career to Māori students.			
	The percentage of DHB staff with ethnicity disclosed.		Base 06/07	Target 07/08	Result 07/08
		Total	74%	>75%	75%
		The DHB has met its target for this indicator.			
Increase Māori engagement and participation in health planning and decision making – as a means of improving the cultural responsive of health services.	Implement a Memorandum of Understanding (MOU or formal relationship agreement) with Manawhenua ki Waitaha.		Target 07/08	Result 07/08	
			Complete	Achieved	
		The DHB has agreed and signed an MOU with Manawhenua, a key Māori Health Plan goal.			
	The percentage of Board members receiving Treaty of Waitangi training.		Base 06/07	Target 07/08	Result 07/08
		Total	0%	100%	91%
		One person missed the Treaty Training; further updates are planned for the coming year.			

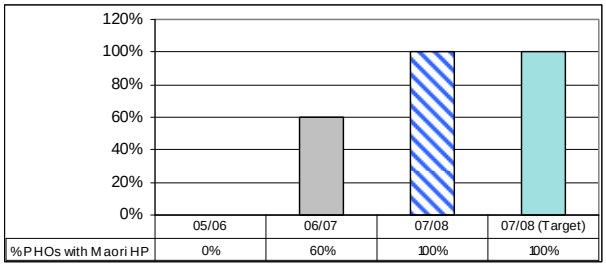








[12] *Targets are set to reduce the percentages classified as 'other' or 'not stated' which contributes to under reporting of Māori (measured against Census population) and limits the DHB's ability to monitor health outcomes.*

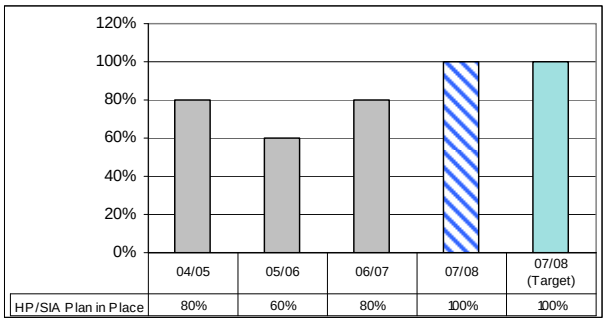
Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
	The percentage of PHOs with Māori Health Plans. 	Total	60%	100%	100%
		The DHB has met its target with all PHOs having Māori Health Plans approved and now beginning implementation of those plans, in consultation with the DHB.			

Primary Health

Long-Term Objective: Reduce barriers to primary health care services and improve the utilisation of services.

Continue PHO Development – as a means of ensuring continuums of care are developed in line with DHB priorities and ongoing health needs assessment.

The percentage of PHOs with Health Promotion and Services to Improve Access.

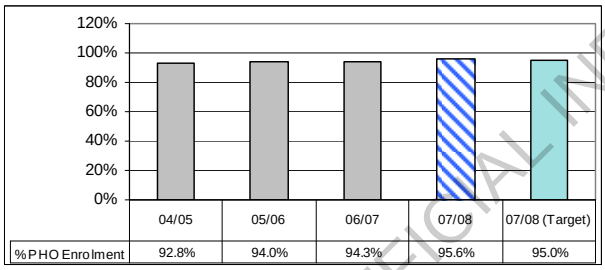


	Base 06/07	Target 07/08	Result 07/08
Total	80%	100%	100%

The DHB has met its target for this indicator with all PHOs having Health Promotion Plans and Services to Improve Access Plan in place.

Reduce Barriers to Primary Care – as a means of maximising ongoing health and wellbeing.

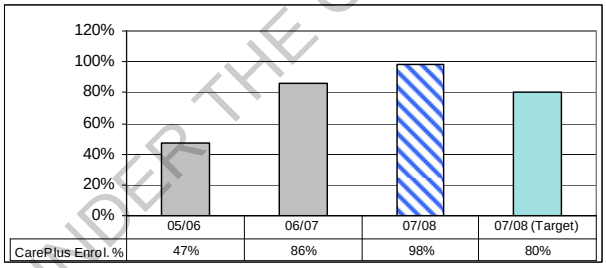
The percentage of the population enrolled in PHOs.



	Base 06/07	Target 07/08	Result 07/08
Māori	75.7%	-	75.1%
Pacific	99.0%	-	91.2%
Other	95.6%	-	97.5%
Total	94.3%	>95%	95.6%

The DHB has achieved its target for PHO enrolment.

The percentage of the eligible enrolled PHO population, enrolled in Careplus services.

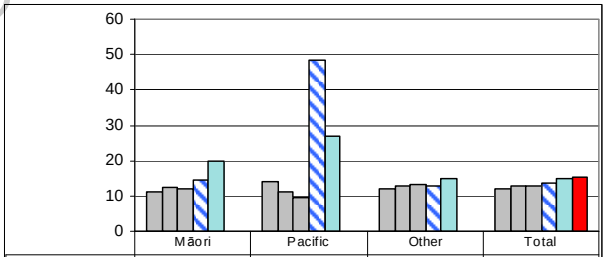


	Base 06/07	Target 07/08	Result 07/08
Total	86%	>80%	98%

The DHB has achieved and exceeded the target set for this indicator.

Reduce Ambulatory Sensitive Admission Rates - as an indication of improved access to, and effectiveness of, primary care services.

Ambulatory Sensitive Admissions for those aged 15-24 years (rate per 1000 population).

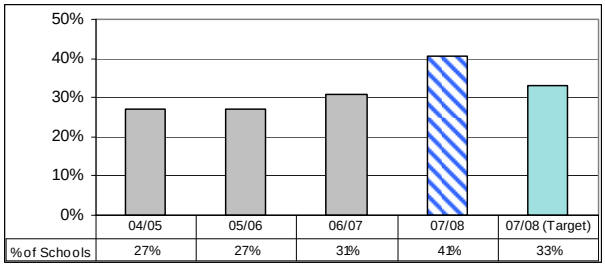
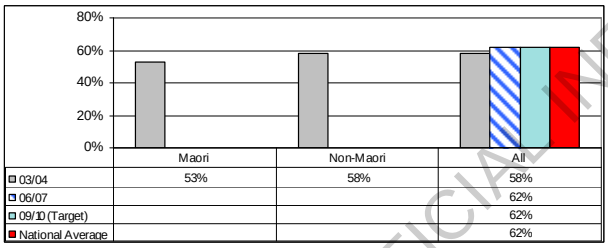
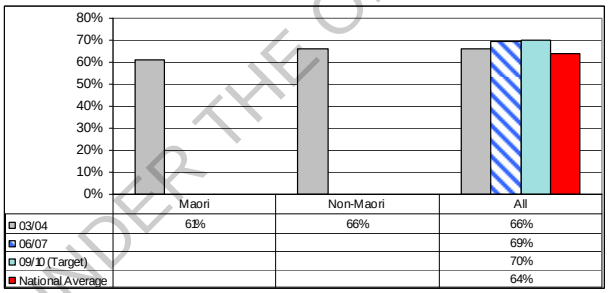


	Base 06/07	Target 07/08	Result 07/08
Māori	12	<20	14
Pacific	10	<27	48
Other	13	<15	13
Total	13	<15	14

The DHB's admission results for the 15-24 age groups are better than the national average and the DHB has met the set targets for all population groups, except for Pacific.

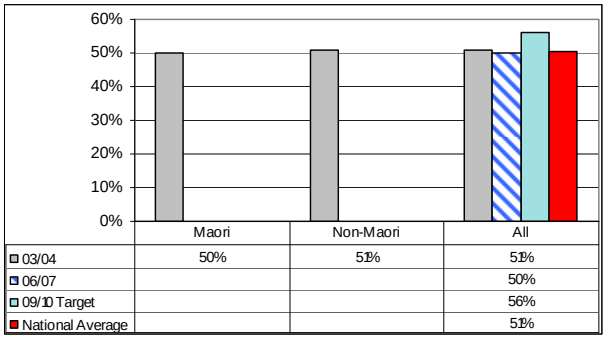
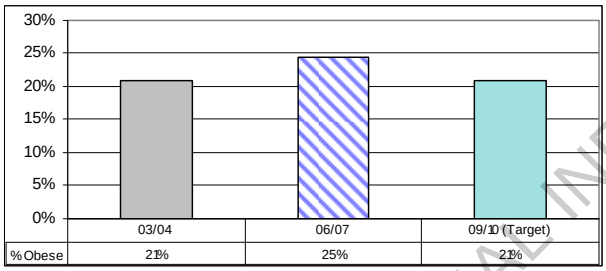
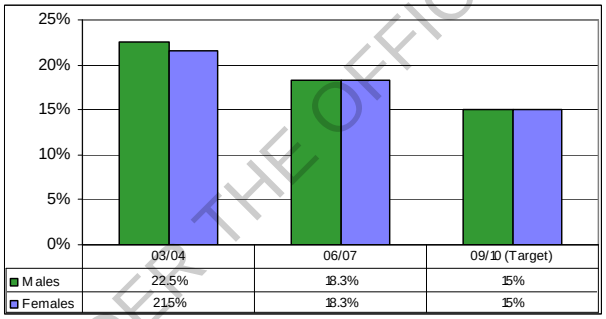
Disease Prevention and Management

Long-Term Objective: Reduce the risks associated with chronic conditions, improve the management of long-term illness and promote well-being.[13]

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Increase the number of Canterbury schools working within the Health Promotion in Schools Framework – as a means to reducing the incidence of obesity, lowering smoking rates and improving overall health and well-being.	The percentage of Canterbury schools, working within the Health Promoting Schools framework. [14] 	Total	31%	>33%	41%
		The DHB has achieved and exceeded the target set for this indicator. A positive momentum is being demonstrated in the uptake of the framework by Canterbury schools.			
Increase the proportion of fruit and vegetables consumed per day by adults (15 years+) in the Canterbury region – as a means to reducing the incidence of obesity and improving overall health and well-being.	The percentage of the population having two or more servings of fruit per day. 		Base 03/04	Target 09/10	Result 06/07
		Māori	53%		
		Non-Māori	58%		
		All	58%	>62%	62%
		The latest results from the 2006/07 NZ Health Survey released in 2007, demonstrate a positive increase in fruit consumption in Canterbury – already meeting the DHB's long-term target.			
	The percentage of the population having three or more servings of vegetables a day. 		Base 03/04	Target 09/10	Result 06/07
		Māori	61%		
		Non-Māori	66%		
		All	66%	>70%	69%
		The latest results from the 2006/07 NZ Health Survey released in 2008, demonstrate a positive increase in vegetable consumption in Canterbury.			

[13] *The DHB sees the indicators listed below as important measures to monitor the health and wellbeing of its population. However (with the exception of the Health Promoting Schools Indicator) the DHB's only means of measuring progress is the national NZ Health Survey collected by the Ministry of Health every three years. The DHB has therefore set long-term targets against these indicators with the aim to move towards these goals over the next three to five years. The Surveys were undertaken in 2003/04 and 2006/07.*

[14] *The DHBs Health Promoting Schools approach is based on activities within the school setting that can impact on health: the provision of health services, the inclusion of health education in curricula, and the creation of a healthy environment. As such, the definition includes schools promoting Fruit in Schools and Active Schools.*

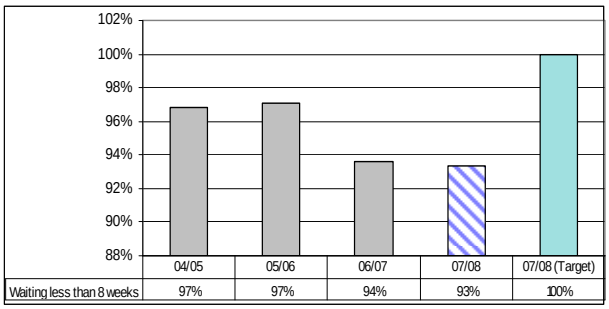
Objective 2007/2008	Performance Measure		Base 03/04	Target 09/10	Result 06/07
Increase the proportion of the Canterbury population undertaking regular physical activity – as a means to reducing the trend in obesity rates and improving health and well-being.	The percentage of the population who are regularly active.[15] 	Māori	50%		
		Non-Māori	51%		
		All	51%	>56%	50%
		The latest results indicate that more work is needed to meet the DHB's long-term target.			
Reduce the trend in obesity rates – as a means of reducing a key risk factor for chronic conditions.	The proportion of the population who are obese.[16] 		Base 03/04	Target 09/10	Result 06/07
		Total	21%	<21%	25%
		The latest results indicate that more work is needed to meet the DHB's long-term target.			
Decrease the smoking rates for people 15 years and above - as a means of reducing a key risk factor for chronic conditions.	The smoking rates in Canterbury. 		Base 03/04	Target 09/10	Result 07/08
		Males	22.5	<15%	18.3%
		Females	21.5	<15%	18.3%
		The latest results indicate positive momentum towards the DHB's long-term targets.			

[15] *Regular Activity is defined as at least 30 minutes of moderate physical activity on five or more days of the week.*

[16] *Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Māori or Pacific.*

Cancer

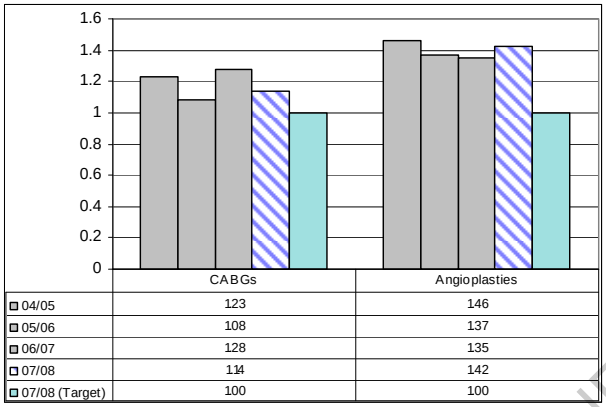
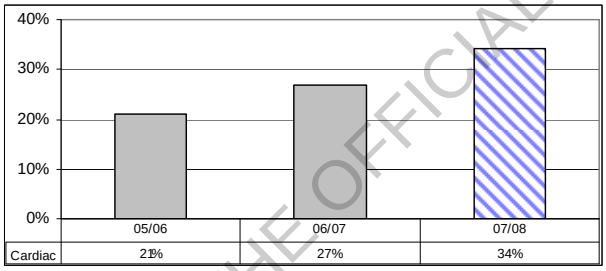
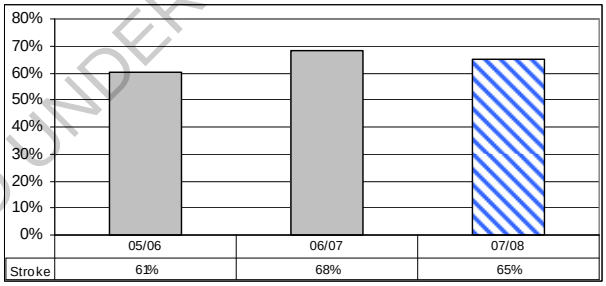
Long-Term Objective: Improved health status for those at risk of developing cancer and appropriate and timely treatment for those that do develop cancer.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Improve access to Radiation Therapy treatment – as a means of reducing the impact of Cancer.[17]	Patients waiting no more than eight weeks for Radiation Therapy treatment (excluding category D). 	Total	94%	100%	93%
		The DHB has not met the target set for radiation therapy treatment waiting-times. Plans are in place to address issues of capacity which will help the DHB to meet its targets in the coming year, including increased shifts to address wait-lists and submission of a business case to replace the DHB's aged Linear Accelerator and seeking to add an additional fourth Linear Accelerator.			

[17] *The delay to radiotherapy is defined as the time between the specialist decision to commence radiotherapy and the start of treatment. The measure reflects categories A, B and C - category D patients have planned treatment (either as part of a trial or because of given protocols) and therefore may have to wait to start treatment these patients are not included in targets.*

Cardiovascular Disease (CVD)

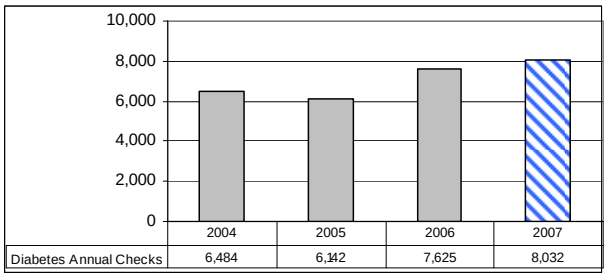
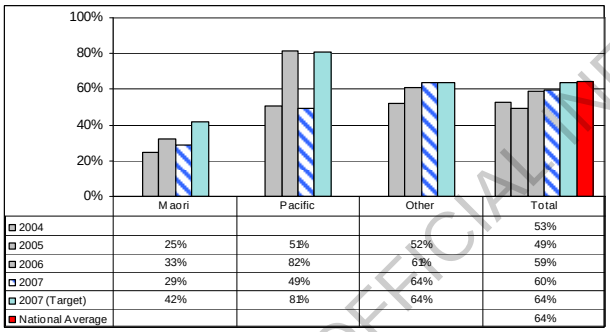
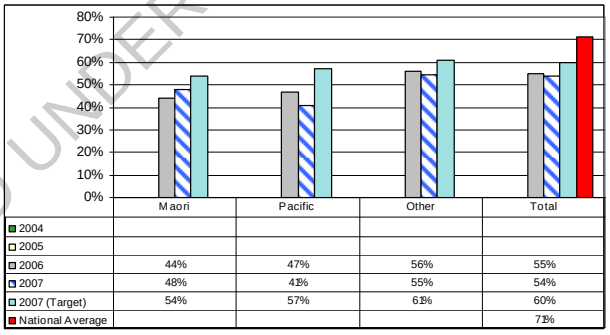
Long-Term Objective: Improved health status for those at risk of developing CVD and appropriate and timely treatment for those that do develop CVD.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Maintain access for those requiring treatment - as a means of reducing the impact of CVD.	The Standardised Discharge Rates for Coronary Artery Bypass Grafts (CABGs) and for Angioplasties (APs).	CABGs	1.28	>1	1.14
		APs	1.35	>1	1.42
		If all DHBs were providing services at the same level, the standardised discharge rate would all be at 1. A rate higher than 1 indicates that the DHB is providing more than the average NZ rate and a rate lower than 1 indicates that the DHB is providing less than the average rate. Intervention analysis does not necessarily indicate what the right rate might be, but compares individual DHBs with the national mean, taking DHB population demographics into account.			
Improve the quality of care after acute events – as a means of reducing the impact of CVD. *These indicators are seen as good measures for this priority area, the aim for 2007/08 was to establish clear definitions and baselines for these indicators and to set targets for achievement in the 2008/09 SOI.*	The percentage of patients who suffered an acute event and attended outpatient cardiac rehabilitation.		Base 06/07	Target 07/08	Result 07/08
		Total	27%	-	34%
		While no target was set for this indicator, results demonstrate a steady increase in the percentage of people attending cardiac rehabilitation programmes.			
	The percentage of patient who suffered an event and where admitted to an organised stroke service.[18]		Base 06/07	Target 07/08	Result 07/08
		Total	68%	-	65%
					

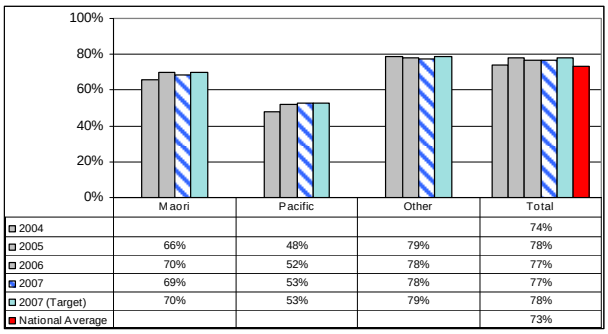
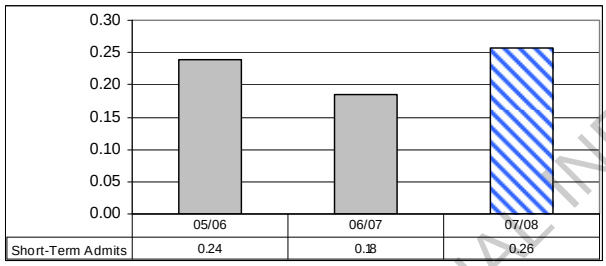
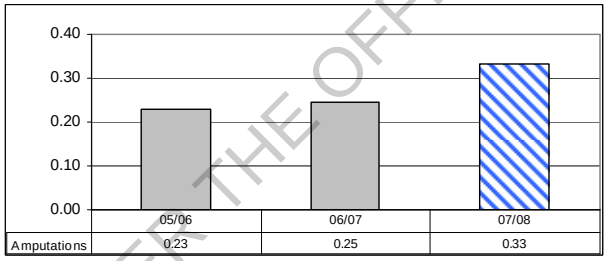
[18] *Note that although the DHB is working on combining data from all its sites, at this time the Stroke Service results do not include Princess Margaret Hospital data.*

Diabetes

Long-Term Objective: Improved health status for those at risk of developing diabetes and appropriate and timely treatment for those that do develop diabetes.[19]

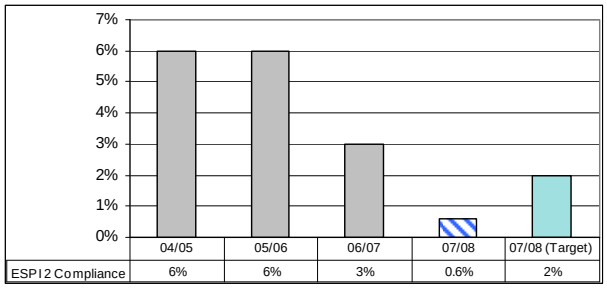
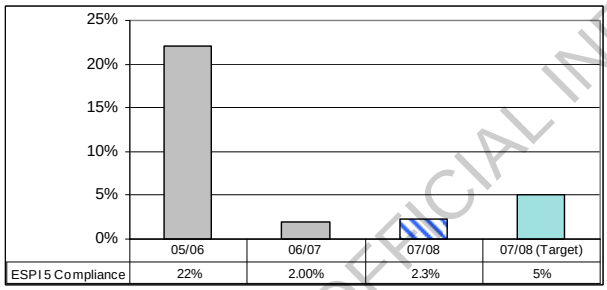
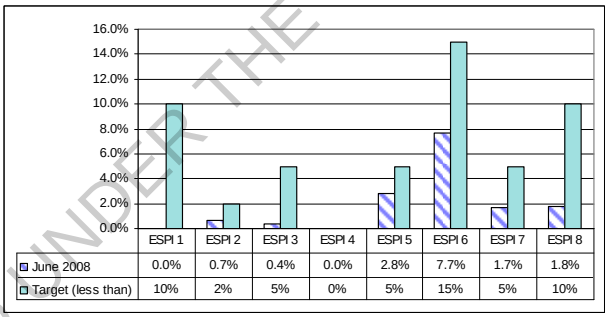
Objective 2007/2008	Performance Measure		Base 2006	Target 2007	Result 2007
Improve the detection and review of those at risk of Diabetes - as a means of reducing the impact of Diabetes. *All those people with diabetes are entitled to a free Annual Diabetes Review or Annual Check. The number of reviews relative to the number of expected diabetics gives an indication of how well diabetes is being identified and diagnosed.*	The number of Annual Reviews (for information only).	Total	7,625	-	8,032
		The total number of annual diabetes checks provided in Canterbury has increased by an additional 407 checks, against the previous year.			
	The percentage of expected diabetics who received their Annual Review.		Base 2006	Target 2007	Result 2007
		Māori	33%	≥42%	29%
		Pacific	82%	≥81%	49%
		Other	61%	≥64%	64%
		Total	59%	≥64%	60%
		The DHB has not met the targets for this indicator and the DHB's performance currently sits below the national average. The DHB has outlined several key areas of collaborative focus around diabetes in 2008/09, working with PHOs, hospital and specialist services and the Local Diabetes Team, to improve pathways and raise diabetes awareness in order to improve outcomes in the coming year.			
	The percentage of those having Annual Reviews who have also had a Retinal Screen (eye check) in the past two years.		Base 2006	Target 2007	Result 2007
		Māori	44%	54%	48%
		Pacific	47%	57%	41%
		Other	56%	61%	55%
		Total	55%	60%	54%
		The DHB has not met the targets for this indicator and the DHB's performance sits below the national average. The DHB continues to be concerned with the reported level of retinal screens. The DHB's provider-arm delivered 5,156 screens in 2007/08 (10,107 biannually), yet the latest results shows only half of those people having Annual Reviews also had a bi annual retinal screen. This would indicate delivery of around 2,000 screens annually (less than a half of the actual volumes of screens completed). To move forward the DHB has been working with PHOs to identify the patients outside the two independent datasets, enabling PHOs to undertake further follow-up.			

[19] *Diabetes Results are provided by individual PHOs to the Local Diabetes Team who then produce an Annual Report and provide aggregated results to the DHB – the results are provided by calendar year and relate to January – December 2007.*

<table>
<tr><th>Objective 2007/2008</th><th>Performance Measure</th><th></th><th>Base 2006</th><th>Target 2007</th><th>Result 2007</th></tr>
<tr><td rowspan="5">Improve the management of Diabetes - as a means of reducing the impact and complications of Diabetes.</td><td rowspan="5">The percentage of people having Annual Reviews who have good diabetes control (HBA1c<=%).
 
</td><td>Māori</td><td>70%</td><td>70%</td><td>69%</td></tr>
<tr><td>Pacific</td><td>52%</td><td>53%</td><td>53%</td></tr>
<tr><td>Other</td><td>78%</td><td>79%</td><td>78%</td></tr>
<tr><td>Total</td><td>77%</td><td>78%</td><td>77%</td></tr>
<tr><td colspan="4">The DHB’s results for this indicator are much closer to target and are above the national average. However these results must be considered next to the lower numbers of expected diabetics receiving Annual Checks.
It is positive to see that the results are holding relatively static across all population groups.</td></tr>
<tr><td rowspan="3">Reduce the complications of Diabetes – as a means of maximising health and wellbeing.</td><td>Rate of admissions due to short-term diabetes complications (per 1000 population, aged 19+).
 
</td><td></td><td>Base 06/07</td><td>Target 07/08</td><td>Result 07/08</td></tr>
<tr><td>Total</td><td>0.18</td><td>-</td><td>0.26</td></tr>
<tr><td colspan="4">These are new indicators developed through the DHB’s Quality and Patient Safety Council. While a positive addition to the set of measures for this priority area, no targets have been set as baseline data is still being confirmed.</td></tr>
<tr><td>Rate of lower extremity amputations due to diabetes complications (per 1000 population, aged 19+).
 
</td><td></td><td>Base 06/07</td><td>Target 07/08</td><td>Result 07/08</td></tr>
<tr><td>Total</td><td>0.25</td><td>-</td><td>0.33</td></tr>
<tr><td colspan="4">As above.</td></tr>
</table>

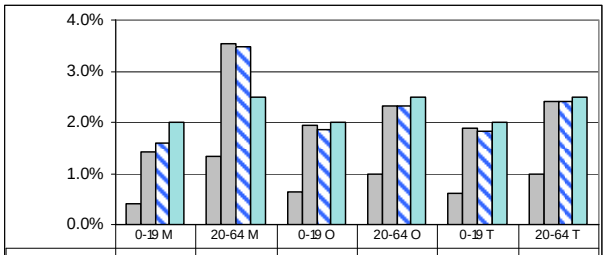
Other Priority Areas - Improved Service Delivery

Long-Term Objective: Improved health status for Canterbury residents through the provision of services in a timely manner, within available resources, and for those with the greatest level of need.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Improve delivery of Elective Services through continued compliance with the Ministry's eight ESPIs - as a means of improving expectation, clarity and access issues around treatment and services.	Compliance with ESPI 2 – The percentage of patients waiting longer than six months for their FSA.[20] 	Total	3%	<2%	0.6%
		The DHB has achieved the target set for this indicator and has significantly exceeded the performance of previous years.			
	Compliance with ESPI 5 – The percentage of patients given a commitment but not treated within six months. 		Base 06/07	Target 07/08	Result 07/08
		Total	2%	<5%	2.3%
		The DHB has achieved the target set for this indictor and continues to meet its commitment to patients.			
	Monthly compliance with all eight of the Ministry's ESPIs. 		Base 06/07	Target 07/08	Result 07/08
		Total	100%	100%	100%
		The DHB continues to maintain compliance with the Ministry's ESPIs.			

[20] *FSA is the first appointment a patient has with a specialist following referral.*

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Improve the delivery of Mental Health Services – as a means of improving access to treatment and support services for those with severe mental illness.	The percentage within each age group, accessing mental health treatment and support services.[21]	**Māori**			
		0-19	1.4%	2%	1.6%
		20-64	3.5%	2.5%	3.5%
		Other			
		0-19	2.0%	2%	1.9%
		20-64	2.3%	2.5%	2.3%
		Total			
		0-19	1.9%	2%	1.8%
		20-64	2.4%	2.5%	2.4%



	0-19 M	20-64 M	0-19 O	20-64 O	0-19 T	20-64 T
05/06	0.4%	13%	0.6%	10%	0.6%	10%
06/07	14%	3.5%	2.0%	2.3%	19%	2.4%
07/08	16%	3.5%	19%	2.3%	18%	2.4%
07/08 (Target)	2.0%	2.5%	2.0%	2.5%	2.0%	2.5%

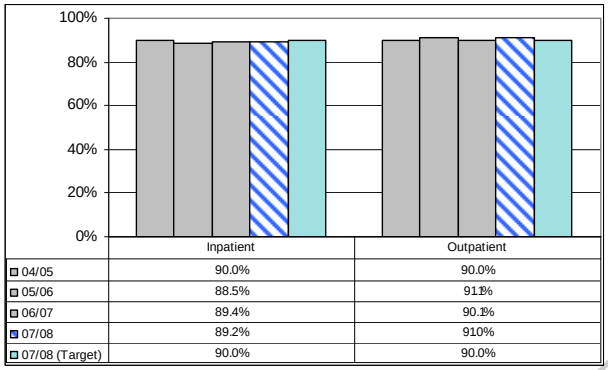
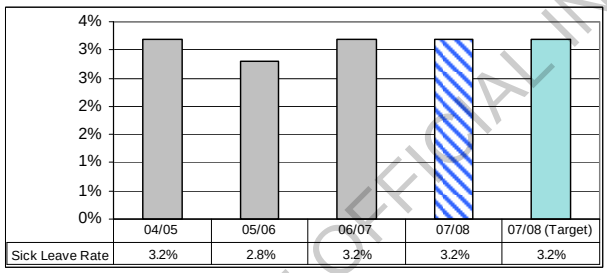
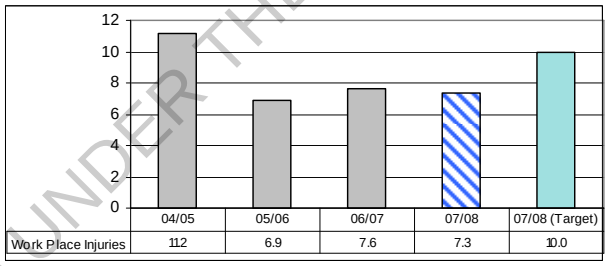
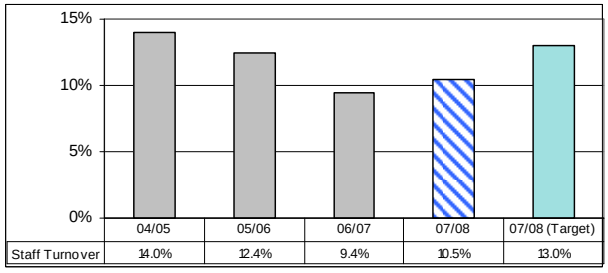
The data for this indicator is collected through the Mental Health Information National Collection (MHINC) database that covers DHB's hospital and specialist services and a limited number of community providers. The activity of many other community providers, who work with high needs and at risk groups, is not fed into this database and therefore not reflected under this measure. While the DHB has set targets to increase access levels, the current focus is on flexible service delivery and increased access to community based services - outside those covered by this indicator.

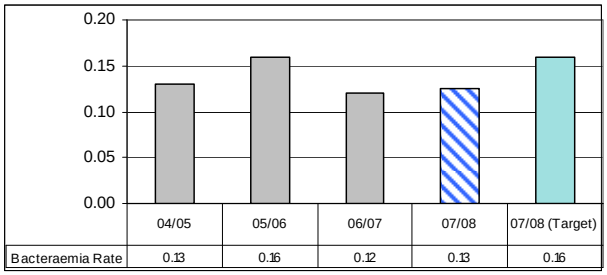
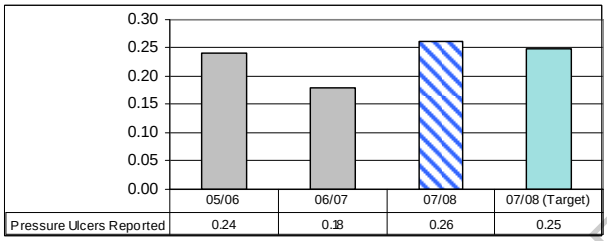
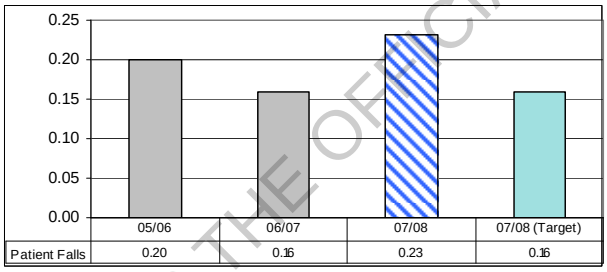
Although not all access rate targets have been met, the rates are positive considering the focus on services outside those covered by the indicator.

[21] *The data for this indicator is collected through the MHINC database and results lag by three months, the results are the latest available and are for the year up to March 2008.*

Improved Efficiency, Effectiveness and Quality

Long-Term Objective: Provision of efficient, effective and quality health services and optimal use of available resources to maximise the health status of Canterbury residents.

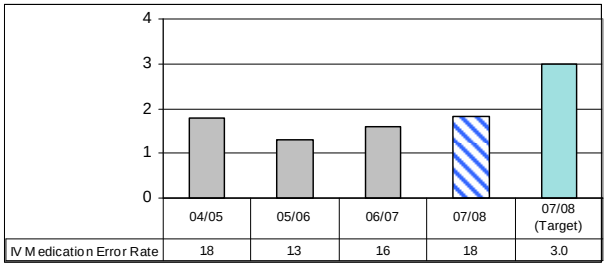
<table>
<tr><th>Objective 2007/2008</th><th>Performance Measure</th><th></th><th>Base 06/07</th><th>Target 07/08</th><th>Result 07/08</th></tr>
<tr><td rowspan="4">Initiating Systems and Processes to Ensure Quality Service Provision – as a means of maintaining patient satisfaction with services.</td><td rowspan="4">The percentage of Overall Inpatient Satisfaction.
The percentage of Overall Outpatient Satisfaction.
 
</td><td>Total</td><td>89.4%</td><td>>90%</td><td>89.2%</td></tr>
<tr><td>Total</td><td>90.1%</td><td>>90%</td><td>91.0%</td></tr>
<tr><td colspan="3">The DHB has achieved the target set for outpatient satisfaction, and has delivered only 0.8% below target for inpatient satisfaction.
Performance with respect to overall patient satisfaction at a national level has remained high and the most recent national data ranks the Canterbury DHB 6th out of all DHBs for overall patient satisfaction, a positive result.</td></tr>
<tr><td></td></tr>
<tr><td rowspan="8">Maintain Performance as a Good Employer – as a means of establishing a healthy working environment and fostering positive partnerships between staff and management.</td><td rowspan="2">The DHB's Sick Leave Rate.
 
</td><td></td><td>Base 06/07</td><td>Target 07/08</td><td>Result 07/08</td></tr>
<tr><td>Total</td><td>3.2%</td><td><3.2%</td><td>3.2%</td></tr>
<tr><td colspan="4">The DHB has maintained its sick leave rate.</td></tr>
<tr><td rowspan="2">Workplace Injuries (per million hours).
 
</td><td></td><td>Base 06/07</td><td>Target 07/08</td><td>Result 07/08</td></tr>
<tr><td>Total</td><td>7.6</td><td><10</td><td>7.3</td></tr>
<tr><td colspan="4">The DHB has achieved the target set and improved performance against the previous year.</td></tr>
<tr><td rowspan="2">The percentage of Staff Turnover.
 
</td><td></td><td>Base 06/07</td><td>Target 07/08</td><td>Result 07/08</td></tr>
<tr><td>Total</td><td>9.4%</td><td><13%</td><td>10.5%</td></tr>
<tr><td colspan="4">The DHB has achieved the target set.</td></tr>
</table>

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Maintain Appropriate Levels of Clinical Quality – as a means to maintain patient safety and quality within our Hospital and Specialist Services.	Hospital Acquired Bacteraemia rate per 100 inpatients.[22] 	Total	0.12	=<0.16	0.13
		The DHB has achieved the target for this indicator.			
	Pressure Ulcers rate per 1000 inpatient days. 		Base 06/07	Target 07/08	Result 07/08
		Total	0.18	<0.25	0.26
		The DHB has missed this target only by 0.01. Given the education programmes occurring around pressure ulcers and skin integrity, the increase in the rate is not surprising. An ongoing increase in the number of pressure ulcers is expected as the education programmes continue, reflecting improved reporting and providing a more accurate picture of pressure ulcer occurrence. Both are seen as positive quality outcomes by the DHB.			
	Patient Fall rate (falls causing moderate or serious injury) per 1000 inpatient day equivalents.[23] [24] 		Base 06/07	Target 07/08	Result 07/08
		Total	0.16	=<0.16	0.23
		The DHB has missed this target and overall there has been an unexpected increase in the serious and moderate falls rate. A multidisciplinary falls prevention review was undertaken and initiatives implemented include; modification of the falls risk assessment tool, introduction of an environmental audit tool, development of education pamphlets and a falls prevention self directed leaning package for staff, development of information leaflets for patients, and sourcing of non-slip footwear. There has been a decrease in the patient falls rate in the later part of the year, which may be a direct result of the work being undertaken.			

[22] *Excludes DHB's Mental Health Division.*

[23] *Past analysis of total falls has included many minor events that cause little or no harm; the CDHB includes only those falls associated with moderate or serious injury to provide a direct measure of injury caused.*

[24] *Inpatient Day Equivalents reflect the total inpatient days plus half the total day patient attendances.*

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
	IV Medication Error rate per 1000 inpatient day equivalents.[25] 	Total	1.6	>3	1.8
		The DHB has set a high target in response to its commitment to increase reporting of IV and medication errors and this target has not been met, it is positive to see an increase in the reporting rate against the previous year. Ongoing initiatives include: introduction of an 0800 reporting line, educating staff through orientation and quality training programmes and the introduction of key patient safety policies such as the No-Blame Incident/Accident Policy and Culture of Patient Safety Policy. The aim of these initiatives is to help reinforce the benefit of staff reporting and to pass on important safety messages.			

[25] *The targets are set to increase the rate of reported errors, in line with DHB policy of emphasising the responsibility of staff to report error - previously set at 6 or more the target has been adjusted to reflect a more achievable increase in reporting levels*

Summary of Revenues and Expenses by Output Class

	Funding $'000	Governance & Funding Admin $'000	Provider $'000	In House Elimination $'000	Total DHB $'000
ACTUAL 07/08					
Revenue					
MoH revenue	1,071,753	3,596	633,653	(592,329)	1,116,673
Patient Related Revenue			36,545		36,545
Other			27,830		27,830
Total Revenue	**1,071,753**	**3,596**	**698,028**	**(592,329)**	**1,181,048**
Expenditure					
Personnel		2,860	469,585		472,445
Depreciation		15	47,793		47,808
Interest			5,584		5,584
Capital Charge			20,617		20,617
Other	1,072,718	616	170,355	(592,329)	651,360
Total Expenditure	**1,072,718**	**3,491**	**713,934**	**(592,329)**	**1,197,814**
Net Surplus/(Deficit)	**(965)**	**105**	**(15,906)**	**-**	**(16,766)**
BUDGET 07/08					
Revenue					
MoH revenue	1,056,985	3,751	630,611	(594,671)	1,096,676
Patient Related Revenue			33,536		33,536
Other			26,259		26,259
Total Revenue	**1,056,985**	**3,751**	**690,406**	**(594,671)**	**1,156,471**
Expenditure					
Personnel		2,507	442,438		444,945
Depreciation		50	50,355		50,405
Interest			5,932		5,932
Capital Charge			21,697		21,697
Other	1,056,985	1,194	169,984	(594,671)	633,492
Total Expenditure	**1,056,985**	**3,751**	**690,406**	**(594,671)**	**1,156,471**
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**
VARIANCE TO 07/08 BUDGET					
Revenue					
MoH revenue	14,768	(155)	3,042	2,342	19,997
Patient Related Revenue	-	-	3,009	-	3,009
Other	-	-	1,571	-	1,571
Total Revenue	**14,768**	**(155)**	**7,622**	**2,342**	**24,577**
Expenditure					
Personnel	-	353	27,147	-	27,500
Depreciation	-	(35)	(2,562)	-	(2,597)
Interest	-	-	(348)	-	(348)
Capital Charge	-	-	(1,080)	-	(1,080)
Other	15,733	(578)	371	2,342	17,868
Total Expenditure	**15,733**	**(260)**	**23,528**	**2,342**	**41,343**
Net Surplus/(Deficit)	**(965)**	**105**	**(15,906)**	**-**	**(16,766)**

Glossary

	Access	Ability of people to reach or use health care services. Barriers to access can be: (1) a persons locality, income or knowledge of services available; or (2) the acceptability or availability of existing services
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
	Ambulatory Sensitive Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
	Blueprint Funding	Blueprint funding is allocated by Government to work to ensure the development of mental health services for the 3% of the total NZ population with moderate to severe mental illness. Service development is based on the service levels set out in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).
CCC	Christchurch City Council	Local Council in the Christchurch region.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
ESPIs	Elective Services Patient flow Indicators	The ESPIs have been developed by the Ministry to assess whether or not DHBs are on the right track with the Government policies on elective services.
FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
FTE	Full Time Equivalent	Means an Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin.	The level of HbA1c reflects the average blood glucose level over the past 3 months.
HEAL	Healthy Eating Active Living 'Action Plan'	This Plan provides us with the platform to implement the national HEHA Strategy at a local level.
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other or others with respects to an issue over which the organisations have concurrent jurisdiction.
MHINC	Mental Health Information National Collection	The national database of mental health information held by the NZ Health Information Service (NZHIS) to support policy formation, monitoring and research.
	Morbidity	Illness, sickness.
	Mortality	Death.
NIR	National Immunisation Register	The NIR is a computerised information system that has been developed to hold immunisation details of NZ children and assist to improve immunisation rates.
PHO	Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Risk Factor	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.
	Treaty of Waitangi	NZ's founding document. It establishes the relationship between the Crown and Māori as tangata whenua and requires both the Crown and Māori to act reasonably toward each other and with utmost good faith
YTD	Year to Date	The 12 month period immediately prior to the date given.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

TO THE READERS OF

CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2008

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, A P Burns, using the staff and resources of Audit New Zealand, to carry out the audit on his behalf. The audit covers the financial statements and statement of service performance of the Health Board and group for the year ended 30 June 2008.

Unqualified Opinion

In our opinion:

- The financial statements of the Health Board and group on pages 24 to 57:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health Board and group's financial position as at 30 June 2008; and
    - the results of operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board and group on pages 58 to 79:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 10 October 2008, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and the Auditor, and explain our independence.

Basis of Opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements and statement of service performance did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements and statement of service performance. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance.

We evaluated the overall adequacy of the presentation of information in the financial statements and statement of service performance. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2008 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board and group's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

In addition to the audit we have carried out one assignment during the reporting period in the area of an independent review of aspects of the Health Board's supply chain enhancement initiative. This assignment is compatible with those independence requirements. Other than the audit and this assignment, we have no relationship with or interests in the Health Board or any of its subsidiaries.

A P Burns
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

Matters Relating to the Electronic Presentation of the Audited Financial Statements and Statement of Service Performance

This audit report relates to the financial statements and statement of service performance of Canterbury District Health Board (the Health Board) for the year ended 30 June 2008 included on the Health Board's website. The Canterbury District Health Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 10 October 2008 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.