



Canterbury District Health Board

**Report For the Year Ended
30 June 2006**

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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 Olive Webb is a clinical psychologist and has more than 30 years experience working in the Chair 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
	<u>294</u>	<u>61</u>

* 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
	<u>23</u>	<u>23</u>

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.

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:	<p>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.</p> <p>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.</p>
(b) to promote the integration of health services, especially primary and secondary health services:	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> ▪ 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. <p>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.</p> <p>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 <i>Finding Better Ways of Working</i>. This framework will address strategic work for each of the four disease priorities</p>

	<p>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.</p>
<p>(c) to promote effective care or support for those in need of personal health services or disability support services:</p>	<p>The CDHB has developed an Older People's Health Strategy entitled <i>Healthy Ageing, Integrated Support</i>. 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:</p> <ul style="list-style-type: none"> ▪ 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.
<p>(d) to promote the inclusion and participation in society and independence of people with disabilities:</p>	<p>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.</p> <p>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.</p> <p>All new CDHB building developments are assessed for meeting the needs of people with disabilities.</p>
<p>(e) to reduce health disparities by improving health outcomes for Māori and other population groups:</p>	<p>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.</p> <ul style="list-style-type: none"> ▪ 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. <p>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.</p>

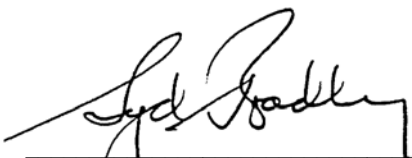
<p>(f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:</p>	<p>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.</p> <p>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).</p>
<p>(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:</p>	<p>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.</p> <p>Under its Core Direction <i>Working Together</i>, the CDHB will focus in 2006/2007 on <i>Sharing Responsibility for Quality Health Outcomes with Our Community</i>. 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.</p>
<p>(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:</p>	<p>The CDHB actively participates in forums such as Healthy Christchurch and information gathered from these forums assists the service planning process.</p> <p>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.</p> <p>The CDHB's <i>Healthy Eating Active Living Plan</i> (HEAL) is in place to promote and support healthy eating and active living within DHB settings. Streams of work include:</p> <ul style="list-style-type: none"> ▪ Working on the recently funded project <i>Community Action To Improve Nutritional Capacity</i>, 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 <i>Canterbury Active Communities Project</i> 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.
<p>(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p>(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:</p>	<p>The CDHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme.</p>

(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.
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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:	<ul style="list-style-type: none"> • 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):	<ul style="list-style-type: none"> • 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

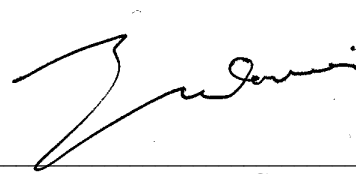
STATEMENT OF RESPONSIBILITY

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	Actual 30/06/06 \$'000	Group Budget 30/06/06 \$'000	Actual 30/06/05 \$'000	Parent Actual 30/06/06 \$'000	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)

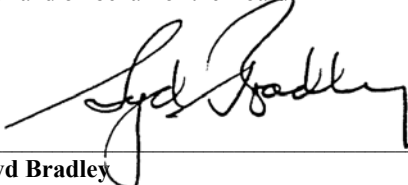
STATEMENT OF MOVEMENTS IN EQUITY FOR THE YEAR ENDED 30 JUNE 2006

	Notes	Actual	Group	Actual	Actual	Actual
		30/06/06 \$'000	Budget 30/06/06 \$'000	30/06/05 \$'000	30/06/06 \$'000	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	Actual as at 30/06/06 \$'000	Group Budget as at 30/06/06 \$'000	Actual as at 30/06/05 \$'000	Parent Actual as at 30/06/06 \$'000	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	Actual as at 30/06/06 \$'000	Group Budget as at 30/06/06 \$'000	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
		<u>1,011,361</u>	<u>988,575</u>	<u>953,677</u>	<u>1,002,559</u>	<u>945,817</u>
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
		<u>963,738</u>	<u>953,496</u>	<u>879,132</u>	<u>956,768</u>	<u>872,622</u>
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	-
		<u>6,881</u>	<u>9,750</u>	<u>70</u>	<u>7,607</u>	<u>70</u>
Cash was applied to:						
Increase in Investments & Restricted Assets		-	-	645	-	489
Purchase of Assets		29,775	44,200	47,076	28,810	45,698
		<u>29,775</u>	<u>44,200</u>	<u>47,721</u>	<u>28,810</u>	<u>46,187</u>
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	-	-	-
		<u>-</u>	<u>3,000</u>	<u>-</u>	<u>-</u>	<u>-</u>
Cash was applied to:						
Loans Repaid		-	-	15,950	-	15,950
Equity repaid to Crown		22,000	-	-	22,000	-
		<u>22,000</u>	<u>-</u>	<u>15,950</u>	<u>22,000</u>	<u>15,950</u>
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		<u>12,838</u>	<u>(2,702)</u>	<u>10,109</u>	<u>12,270</u>	<u>9,682</u>

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
	<u>25,391</u>	<u>16,341</u>	<u>24,898</u>	<u>15,795</u>

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
	<u>7,954</u>	<u>7,465</u>	<u>7,891</u>	<u>7,414</u>
Provision for Obsolescence	(758)	(871)	(758)	(871)
	<u>7,196</u>	<u>6,594</u>	<u>7,133</u>	<u>6,543</u>

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)	-
	<u>126,174</u>	<u>148,174</u>	<u>126,312</u>	<u>148,312</u>
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	<u>(31,435)</u>	<u>(34,591)</u>	<u>(33,170)</u>	<u>(35,734)</u>
Represented by :				
Accumulated Deficit in Parent and Subsidiary	(31,513)	(34,669)	(33,248)	(35,812)
Accumulated Surplus in Associates	78	78	78	78
	<u>(31,435)</u>	<u>(34,591)</u>	<u>(33,170)</u>	<u>(35,734)</u>
REVALUATION RESERVE				
Opening Balance	77,717	77,717	77,717	77,717
Current Year Movement	106,760	-	106,760	-
Closing Balance	<u>184,477</u>	<u>77,717</u>	<u>184,477</u>	<u>77,717</u>
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
	<u>184,477</u>	<u>77,717</u>	<u>184,477</u>	<u>77,717</u>
TRUST RESERVE				
Opening Balance	8,405	7,779	8,308	7,452
Transfers from/(to) Retained Earnings	(295)	626	(315)	856
Closing Balance	<u>8,110</u>	<u>8,405</u>	<u>7,993</u>	<u>8,308</u>

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
	<u>564,428</u>	<u>503,596</u>	<u>558,226</u>	<u>497,644</u>
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
	<u>98,283</u>	<u>121,129</u>	<u>94,862</u>	<u>117,979</u>
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
	<u>466,145</u>	<u>382,467</u>	<u>463,364</u>	<u>379,665</u>
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
	<u>47,372</u>	<u>39,519</u>	<u>46,386</u>	<u>38,570</u>

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
	<u>375</u>	<u>311</u>	<u>1,187</u>	<u>1,829</u>

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	<u>168</u>	<u>168</u>	<u>168</u>	<u>168</u>
Advances	207	143	207	143
	<u>375</u>	<u>311</u>	<u>375</u>	<u>311</u>

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)
	<u>812</u>	<u>1,518</u>

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

	<u>Group</u>		<u>Parent</u>	
	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
	<u>46,608</u>	<u>40,037</u>	<u>45,010</u>	<u>38,583</u>
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	<u>47,623</u>	<u>74,545</u>	<u>45,791</u>	<u>73,195</u>

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	-	-
	<u>13,908</u>	<u>14,682</u>	<u>7,725</u>	<u>8,040</u>
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
	<u>13,908</u>	<u>14,682</u>	<u>7,725</u>	<u>8,040</u>

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:

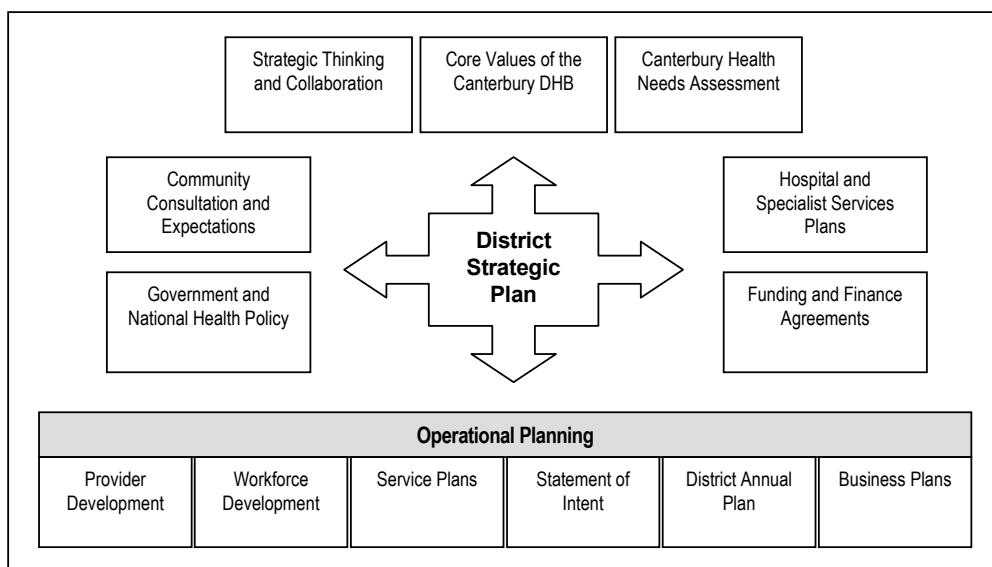
- *A District Strategic Plan* – a long-term strategic document outlining the DHB’s intended direction and vision for the next five to ten years. This document is produced through a public consultation and health needs assessment process and enables the DHB to determine key priorities for focus;
- *A 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.

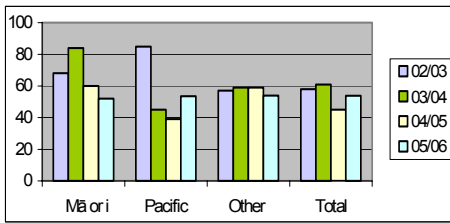
The indicators in the full report reflect the performance measures specified in the Canterbury DHB's 2005/2008 SOI (unless otherwise stated), and reflect the Canterbury DHB's District Strategic Plan priorities. The performance measurements, outlined in the *Statement of Objectives and Service Performance*, 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

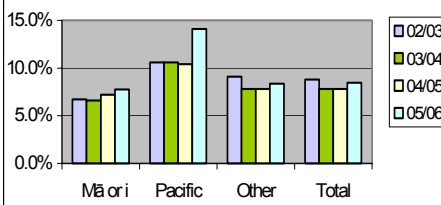
1.1 Child and Youth Health

<p>Objective: <i>Improved health status for Canterbury's Children and Youth.</i></p>	<p>Brief Description: Keeping children and youth healthy gives them a better chance of becoming healthy adults. The Canterbury District Health Board (DHB) completed a Child Health and Disability Action Plan (in June 2004) to address the specific health issues of children in Canterbury. The Action Plan targets ten key priorities: access, information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments.</p> <p>It is important to note that due to the lack of fluoridation of public water supplies oral health outcomes for Canterbury children are getting worse, particularly in low decile areas. The Canterbury DHB agreed a Position Statement on fluoridation in 2003 (available on the DHB website¹) and is actively promoting fluoridation.</p>			
<p>Objective 2005/2006</p>	<p>Performance</p>			
<p>Reduced number of low birth weight babies.</p>	<p>Number of babies born in public hospital with low birth weight (rate per 1000 births).</p> 	<p>Baseline 04/05</p> <p>Māori 60 Pacific 39 Other 59 Total 45</p>	<p>Target 05/06</p> <p>Māori <72 Pacific <44 Other <58 Total <60</p>	<p>Result 05/06</p> <p>Māori 52 Pacific 53 Other 54 Total 54</p>
<p>Minimised impact of hearing loss in children.</p>	<p>Percentage of children passing school entry hearing tests.</p> <p><i>Early detection of hearing problems facilitates early intervention and allows the impact to be minimised.</i></p>	<p>Māori 93% Pacific 90% Other 95% Total 95%</p>	<p>Māori 92% Pacific 88% Other 95% Total 95%</p>	<p>Unavailable</p> <p><i>The National Audiology Centre is currently processing the data but figures were unavailable to the DHB at the time of preparing this report.</i></p>
<p>Improved Child Oral Health.</p>	<p>Average proportion of Missing or Filled teeth of year 8 children.²</p> <p>Percentage of children caries free (no fillings or holes in teeth) at age 5.</p>	<p>Total 1.58</p> <p>Total 51%</p>	<p>Total 1.6</p> <p>Total 52%</p>	<p>Unavailable</p> <p>Unavailable</p> <p><i>Due to a failure in the system collecting the data associated with this measure, performance cannot be reported for 2005/06.</i></p> <p><i>Due to a failure in the system collecting the data associated with this measure, performance cannot be reported for 2005/06.</i></p>
<p>Implement the Meningococcal B (MeNZB) Immunisation Project.</p>	<p>Percentage of children between 6 weeks and 5 years of age who have received their 3rd dose of the MeNZB vaccine.</p>	<p>N/A</p>	<p>Total 90%</p>	<p>Total 77%</p> <p><i>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%.</i></p>
	<p>Percentage of school enrolled children who have received their 3rd dose of MeNZB vaccine.</p>	<p>N/A</p>	<p>Total 90%</p>	<p>Total 86%</p> <p><i>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.</i></p>

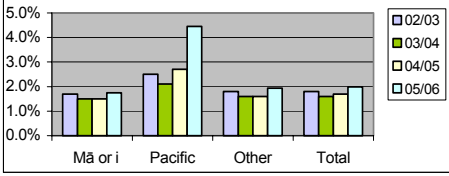
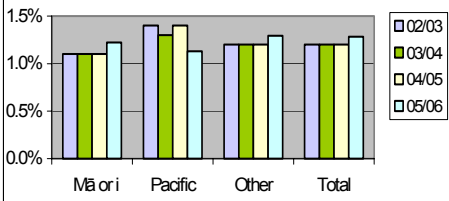
¹ www.cdhb.govt.nz

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

<p>Objective: <i>Reduced barriers to primary health care.</i></p>	<p>Brief Description: 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:</p> <ol style="list-style-type: none"> 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. 																												
<p>Objective 2005/2006</p>	<p>Performance</p>																												
<p>PHO Development – supporting the ongoing development of PHOs within the Canterbury Region.</p>	<p>Services to Improve Access Plans in place in all PHOs.</p> <p><i>These services aim to reduce barriers to first contact services for groups with the highest health needs.</i></p>	<p>Three PHOs had Plans in place³.</p>	<p>All five PHOs have Plans in place.</p>	<p>Three PHOs have Plans. One has a draft currently in consultation with its community and one PHO does not have a Plan.</p>																									
	<p>Health Promotion Plans (HPP) implemented by all PHOs.</p>	<p>N/A</p>	<p>Again three PHOs have Plans in place with the fourth PHO’s Plan under way.</p>																										
	<p>PHO Plans are consistent with CDHB health gain priority plans.</p>	<p>Achieved consistent focus.</p>	<p>PHO Plans support the DHB’s health gain priorities and have been approved by the DHB.</p> <p>▪ <i>Target Achieved.</i></p>																										
<p>Improved retention of Rural GPs through maintaining reasonable on-call rosters.</p>	<p>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).</p>	<p>100%</p>	<p>100%</p>	<p>100%</p> <p>▪ <i>Target Achieved.</i></p>																									
<p>Reduce Ambulatory Sensitive Admissions. <i>Ambulatory sensitive admissions are admissions that are potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care.</i></p>	<p>Reduced standardised discharge rates for ambulatory sensitive admissions 0-4 years of age, as a percentage discharged per population.</p>  <table border="1" data-bbox="440 1451 878 1654"> <caption>Standardised discharge rates for ambulatory sensitive admissions 0-4 years of age, as a percentage discharged per population</caption> <thead> <tr> <th>Group</th> <th>02/03</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>~6.5%</td> <td>~6.5%</td> <td>~7.2%</td> <td>~7.8%</td> </tr> <tr> <td>Pacific</td> <td>~10.4%</td> <td>~10.4%</td> <td>~9.0%</td> <td>~14.1%</td> </tr> <tr> <td>Other</td> <td>~7.8%</td> <td>~7.8%</td> <td>~7.2%</td> <td>~8.3%</td> </tr> <tr> <td>Total</td> <td>~7.8%</td> <td>~7.8%</td> <td>~7.2%</td> <td>~8.4%</td> </tr> </tbody> </table>	Group	02/03	03/04	04/05	05/06	Māori	~6.5%	~6.5%	~7.2%	~7.8%	Pacific	~10.4%	~10.4%	~9.0%	~14.1%	Other	~7.8%	~7.8%	~7.2%	~8.3%	Total	~7.8%	~7.8%	~7.2%	~8.4%	<p>Māori 7.2% Pacific 10.4% Other 7.8% Total 7.8%</p>	<p>Māori 6.5% Pacific 9.0% Other 7.2% Total 7.2%</p>	<p>Māori 7.8% Pacific 14.1% Other 8.3% Total 8.4%</p>
Group	02/03	03/04	04/05	05/06																									
Māori	~6.5%	~6.5%	~7.2%	~7.8%																									
Pacific	~10.4%	~10.4%	~9.0%	~14.1%																									
Other	~7.8%	~7.8%	~7.2%	~8.3%																									
Total	~7.8%	~7.8%	~7.2%	~8.4%																									
		<p><i>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%.</i></p>																											

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

Objective 2005/2006	Performance			
	Measure	Baseline 04/05	Target 05/06	Result 05/06
Reduce Ambulatory Sensitive Admissions. <i>Ambulatory sensitive admissions are admissions that are potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care.</i>	Reduced standardised discharge rates for ambulatory sensitive admissions 5-14 years of age, as a percentage discharged per population. 	Māori 1.5% Pacific 2.7% Other 1.6% Total 1.7%	Māori 1.5% Pacific 2.0% Other 1.6% Total 1.6%	Māori 1.8% Pacific 4.4% Other 1.9% Total 2.0%
	Reduced standardised discharge rates for ambulatory sensitive admissions 15-24 years of age, as a percentage discharged per population. 	Māori 1.1% Pacific 1.4% Other 1.2% Total 1.2%	Māori 1.1% Pacific 1.1% Other 1.1% Total 1.1%	Māori 1.2% Pacific 1.1% Other 1.3% Total 1.3%
<p><i>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.</i></p> <p><i>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%.</i></p>				
<p><i>Note: the 65 to 74 year age group is included in the Older Person's Health section.</i></p>				

1.3 Māori Health

<p>Objective: <i>Whanau Ora Māori families supported to achieve their maximum health and wellbeing.</i></p>	<p>Brief Description: 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), <i>Whakamahere Hauora Māori Ki Waitaha</i>. 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:</p> <ul style="list-style-type: none"> ▪ 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. 			
<p>Objective 2005/2006</p>	<p>Performance</p>			
<p>Monitoring of Māori health outcomes. <i>Current collection of ethnicity data is a significant barrier to achieving this objective. The DHB therefore plans to continue to implement accurate Ethnicity Data Collection⁴.</i></p>	<p>Measure</p>	<p>Baseline 04/05</p>	<p>Target 05/06</p>	<p>Result 05/06</p>
<p>Reduced health inequalities in priority areas – improving Māori service development in priority areas.</p>	<p>Improved ethnicity reporting. The percentage of discharges classified with the following ethnicity groups: Māori, Other and Not stated. <i>Targets are set to reduce the percentage of people classified as 'other' or 'not stated' (NS), and increase those classified as Māori.</i></p> <p>Develop an integrated health outcome and performance monitoring framework aligning the DHB's Māori Health Plan <i>Whakamahere Hauora Māori ki Waitaha</i> with the Ministry of Health (MoH) Māori Health Strategy <i>He Korowai Oranga</i> and the Māori Health Action Plan <i>Whakatataka</i>.</p>	<p>Māori 6.0% Other 5.0% NS 2.7%</p> <p>Draft monitoring performance framework put out for community consultation.⁵</p>	<p>Māori >7.5% Other <2.5% NS <1.0%</p> <p>Completion of monitoring framework.</p>	<p>Māori 6.0% Other 5.5% NS 2.7%</p> <p>A framework has not yet been completed.</p>
<p>Refer to the relevant section of this document. Where data is available Māori specific targets have been provided.</p>	<p>CDHB has made progress in improving performance against targets set for Māori.</p>	<p>See ethnicity breakdowns under relevant Performance Indicators.</p>	<p>Refer to sections: Child 1.1 Diabetes 1.7.</p>	<p>Although the framework has not yet been completed alignment of the DHB and MoH Māori Health Plans has been made with key actions being the building of quality data and the development of a framework for monitoring of Māori health outcomes over 2006/2007. These key actions are embedded in the revised Māori Health Plan which is awaiting Board sign-off.</p>

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

<p>Objective: <i>Improved Health Status for Canterbury Residents who have a serious ongoing mental illness.</i></p>	<p>Brief Description: 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.</p>			
<p>Objective 2005/2006</p>	<p>Performance</p>			
<p>Mental Health Volume Delivery (Hospital and Specialist Services) ensured <i>delivery of contracted Mental Health Volumes.</i></p>	<p>Actual service delivered as a percentage of the value of Hospital and Specialist Services (HSS) Mental Health funding provided⁶.</p>	<p>99% of contracted volumes delivered.</p>	<p>100% delivery of contracted volumes.</p>	<p>99% of contracted volumes were delivered.</p>
<p>Mental Health Service Funding: <i>expenditure is allocated to levels specified by the Mental Health "ring-fence".</i></p>	<p>Total contracted funding (both HSS and Non-Government Organisations) as a percentage of the Mental Health Ring-fence Target.</p>	<p>100% allocation of the ring-fenced funding to providers</p>	<p>100% allocation of funding</p>	<p>100%</p>
<p>Improved access to Mental Health Services: <i>The New Zealand Mental Health Strategy sets targets for access to treatment and support services for people of different age groups with severe mental illness.</i></p>	<p>Percentage of people within each age group accessing mental health treatment and support services.</p> <p><i>These targets are set in line with estimated proportions of people with mental illnesses for each age group and ethnicity. The higher the percentage, the more people accessing services.</i></p> <p><i>The CDHB aims to improve access to services (in line with the demographics and mental health needs of our population) therefore higher percentages are favourable.</i></p>	<p>▪ <i>Target Achieved.</i></p>		
		<p>Total 0-9: 0.24% 10-14: 0.73% 15-19: 1.03% 20-64: 1.03% 65+: 0.19%</p> <p><i>There has been a change in groupings and no broken-down historical data is available.</i></p>	<p>Māori 0-19 0.65% 20-64 1.31% 65+ 0.28%</p> <p>Other 0-19 0.65% 20-64 1.00% 65+ 0.19%</p> <p>Total 0-19 0.65% 20-64 1.10% 65+ 0.19%</p>	<p>Māori 0-19 0.41% 20-64 1.33% 65+ 0.31%</p> <p>Other 0-19 0.64% 20-64 0.98% 65+ 0.17%</p> <p>Total 0-19 0.61% 20-64 1.00% 65+ 0.17%</p>
		<p><i>The targets were generally not achieved across all age groups although there is some positives in two of the age groups for Māori.</i></p> <p><i>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.</i></p>		

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)

<p>Objective: Improved cardiovascular health status –reducing the incidence of CVD and improving the quality of care.</p>	<p>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 <i>Canterbury Heart Health Strategy</i> which has the following priorities:</p> <ul style="list-style-type: none"> ▪ 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. 			
<p>Objective 2005/2006</p>	<p>Performance</p>			
<p>Reducing the Impact of Cardiovascular Disease.</p>	<p>Measure Percentage of people with certainty who waited no more than six months for a coronary artery bypass graft.</p>	<p>Baseline 04/05 52%</p>	<p>Target 05/06 100%</p>	<p>Result 05/06 45%</p>
	<p>Delivery of target levels of Cardiac Surgery for key procedures - Cardiac Valves and Coronary Artery Bypasses Grafts(CABG).⁷</p>	<p>3000cwd (100%)</p>	<p>1500cwd by 31/12/05 3000cwd by 30/06/06</p>	<p>1,424 cwd 2,548 (85%)</p>
	<p><i>Cost Weighted Discharges (cwd) are a relative measure of the cost of different surgeries; ie cataract procedures have lower cwd than hip replacements</i></p>	<p><i>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</i></p>		
	<p>Percentage with certainty who waited for no more than six months for an angioplasty.</p>	<p>97%</p>	<p>100%</p>	<p>100%</p>
<p>Implement the actions of the Heart Health Strategy:</p> <p>Improve heart health information – to improve ability to monitoring change and evaluation programs.</p>	<p>Design and implement a pilot project (in primary care) that would lead to the development of a Heart Health Register for Canterbury.</p> <p><i>The Core Data Set is to be collected by primary and secondary providers.</i></p>	<p>N/A</p>	<p>Core Data Set Pilot under way in at least three general practices in Rangiora.</p>	<p>The pilot was not run in 2005/2006.</p> <p><i>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.</i></p>
<p>Improve the quality of rehabilitation care after acute events.</p>	<p>Trial the New Zealand Heart Manual in primary care in Canterbury – beginning with six general practices.</p> <p>The Heart Manual trial is jointly funded by the Canterbury DHB and the Heart Foundation.</p>	<p>N/A</p>	<p>Heart Manual Trial under way in at least six general practices.</p>	<p>Trial under way with the Heart Foundation running the first training for practices in June 2006.</p>
	<p>▪ <i>Target Achieved.</i></p>			

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.

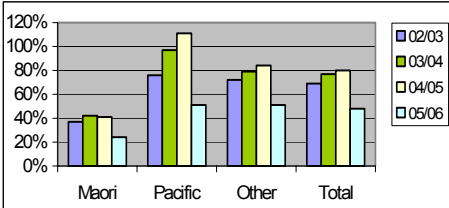
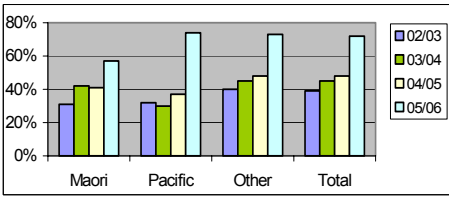
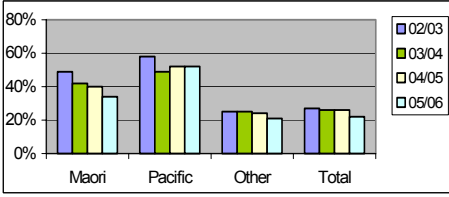
1.6 Disease Prevention and Management – Cancer

<p>Objective:</p> <p><i>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.</i></p>	<p>Brief Description:</p> <p>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.</p> <p>These measures focus on reducing the impact of Cancer rather than prevention. Cancer results for multiple causes, which limits the ability of the DHB to prevent it. However, actions such as making the Canterbury DHB smokefree and the introduction of smokefree legislation will have positive effects.</p>			
<p>Objective 2005/2006</p>	<p>Performance</p>			
<p>Reducing the impact of Cancer.</p>	<p>Measure</p> <p>Improved Access to Radiation Therapy.⁹</p> <p>Delay to radiotherapy is defined as the time between the specialist decision to commence radiotherapy and the start of treatment. Patients who need radiotherapy are categorised into 4 groups:</p> <p>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</p>	<p>Baseline 04/05</p> <p>Group A: 100% on time.</p> <p>Group B: 52% on time 42% wait 4-8wk 3% wait 8-12wk 3% wait 12+wks</p> <p>Group C: 79% on time 15% wait 4-8wk 2% wait 8-12wk 3% wait 12+wks</p>	<p>Target 05/06</p> <p>Group A: 100% on time.</p> <p>Group B: 100% on time.</p> <p>Group C: 95% on time 5% wait 4-8wk</p> <p>0% of patients in Groups A, B, or C wait longer than 8 weeks.</p>	<p>Result 05/06</p> <p>Group A: 100% on time.</p> <p>Group B: 65% on time 30% wait 4-8wk 4% wait 8-12wk 1% wait 12wk+</p> <p>Group C: 78% on time 20% wait 4-8 wk 2% wait 8-12 wk</p> <p>1% of all groups waited longer than 12+wks.</p>
<p><i>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.</i></p>				

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.

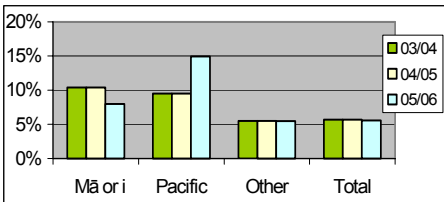
1.7 Disease Prevention and Management – Diabetes

<p>Objective: Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes.</p>	<p>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</p>																												
Objective 2005/2006	Performance																												
<p>Improved Diabetes Detection: Increasing the proportion of people with diabetes who receive annual diabetic reviews and the associated primary care.</p>	<p>Measure Increase Diabetes Annual Checks. Increase the percentage of the expected number of people with diagnosed diabetes who have annual reviews during the year.</p>  <table border="1" data-bbox="440 726 886 932"> <caption>Annual Diabetes Checks Data</caption> <thead> <tr> <th>Group</th> <th>02/03</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>41%</td> <td>41%</td> <td>41%</td> <td>24%</td> </tr> <tr> <td>Pacific</td> <td>111%¹²</td> <td>111%</td> <td>111%</td> <td>51%</td> </tr> <tr> <td>Other</td> <td>84%</td> <td>84%</td> <td>84%</td> <td>51%</td> </tr> <tr> <td>Total</td> <td>80%</td> <td>80%</td> <td>80%</td> <td>48%</td> </tr> </tbody> </table>	Group	02/03	03/04	04/05	05/06	Maori	41%	41%	41%	24%	Pacific	111% ¹²	111%	111%	51%	Other	84%	84%	84%	51%	Total	80%	80%	80%	48%	<p>Baseline 2004 9,793</p>	<p>Target 2005 10,616</p>	<p>Results 2005 6142</p>
Group	02/03	03/04	04/05	05/06																									
Maori	41%	41%	41%	24%																									
Pacific	111% ¹²	111%	111%	51%																									
Other	84%	84%	84%	51%																									
Total	80%	80%	80%	48%																									
<p>Early diagnosis and treatment of eye problems: Increase the proportion of people with diabetes having their eyes regularly screened.</p>	<p>Increase the percentage of people having diabetes reviews who have regular Eye Screens (in the past two years).</p>  <table border="1" data-bbox="440 1129 886 1325"> <caption>Regular Eye Screens Data</caption> <thead> <tr> <th>Group</th> <th>02/03</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>41%</td> <td>45%</td> <td>45%</td> <td>57%</td> </tr> <tr> <td>Pacific</td> <td>37%</td> <td>39%</td> <td>39%</td> <td>74%</td> </tr> <tr> <td>Other</td> <td>48%</td> <td>80%</td> <td>80%</td> <td>73%</td> </tr> <tr> <td>Total</td> <td>48%</td> <td>75%</td> <td>75%</td> <td>72%</td> </tr> </tbody> </table>	Group	02/03	03/04	04/05	05/06	Maori	41%	45%	45%	57%	Pacific	37%	39%	39%	74%	Other	48%	80%	80%	73%	Total	48%	75%	75%	72%	<p>Māori 41% Pacific 37% Other 48% Total 48%</p>	<p>Māori 45% Pacific 39% Other 80% Total 75%</p>	<p>Māori 57% Pacific 74% Other 73% Total 72%</p>
Group	02/03	03/04	04/05	05/06																									
Maori	41%	45%	45%	57%																									
Pacific	37%	39%	39%	74%																									
Other	48%	80%	80%	73%																									
Total	48%	75%	75%	72%																									
<p>Improved Diabetes Management: Reducing the proportion of people with diabetes who have relatively poor control of their diabetes.</p>	<p>Decrease the percentage of people having annual diabetes reviews who have poor diabetes control (HbA1c>8%).</p>  <table border="1" data-bbox="440 1453 886 1648"> <caption>Poor Diabetes Control Data</caption> <thead> <tr> <th>Group</th> <th>02/03</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>40%</td> <td>39%</td> <td>39%</td> <td>34%</td> </tr> <tr> <td>Pacific</td> <td>52%</td> <td>45%</td> <td>45%</td> <td>52%</td> </tr> <tr> <td>Other</td> <td>24%</td> <td>20%</td> <td>20%</td> <td>21%</td> </tr> <tr> <td>Total</td> <td>26%</td> <td>23%</td> <td>23%</td> <td>22%</td> </tr> </tbody> </table>	Group	02/03	03/04	04/05	05/06	Maori	40%	39%	39%	34%	Pacific	52%	45%	45%	52%	Other	24%	20%	20%	21%	Total	26%	23%	23%	22%	<p>Māori 40% Pacific 52% Other 24% Total 26%</p>	<p>Māori 39% Pacific 45% Other 20% Total 23%</p>	<p>Māori 34% Pacific 52% Other 21% Total 22%</p>
Group	02/03	03/04	04/05	05/06																									
Maori	40%	39%	39%	34%																									
Pacific	52%	45%	45%	52%																									
Other	24%	20%	20%	21%																									
Total	26%	23%	23%	22%																									
		<p>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.</p>																											

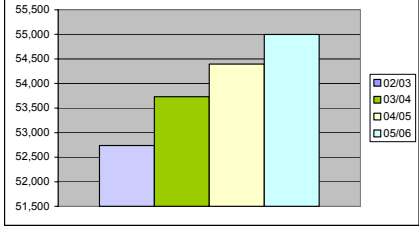
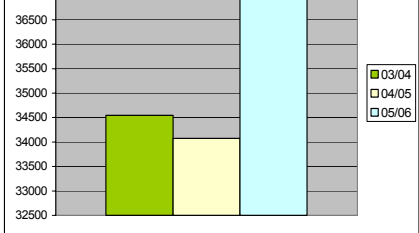
¹¹ The figures presented in this section are subject to confirmation from the Local Diabetes Team (LDT) who collate the data and set targets for Canterbury on an annual basis – these figures are also set by calendar year rather than financial year.

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

<p>Objective: Maintain/improve health and independence outcomes for older Canterbury residents within available resources.</p>	<p>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, <i>Finding Better Ways of Working</i>. As this work progresses the performance measures in this section will be revised.</p>																							
<p>Objective 2005/2006</p>	<p>Performance</p>																							
<p>Reduce Ambulatory Sensitive Admissions – these are admissions that are potentially preventable through appropriate care and support.</p>	<p>Reduced standardised discharge rates for Ambulatory Sensitive Admissions 65 to 75 years of age, as a percentage discharged per population.</p>  <table border="1" data-bbox="440 646 881 846"> <thead> <tr> <th>Measure</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>10.4%</td> <td>9.0%</td> <td>8.0%</td> </tr> <tr> <td>Pacific</td> <td>9.5%</td> <td>9.5%</td> <td>14.9%</td> </tr> <tr> <td>Other</td> <td>5.5%</td> <td>5.5%</td> <td>5.4%</td> </tr> <tr> <td>Total</td> <td>5.7%</td> <td>5.5%</td> <td>5.6%</td> </tr> </tbody> </table>	Measure	03/04	04/05	05/06	Māori	10.4%	9.0%	8.0%	Pacific	9.5%	9.5%	14.9%	Other	5.5%	5.5%	5.4%	Total	5.7%	5.5%	5.6%	<p>Baseline 04/05</p> <p>Māori 10.4% Pacific 9.5% Other 5.5% Total 5.7%</p>	<p>Target 05/06</p> <p>Māori 9.0% Pacific 9.5% Other 5.5% Total 5.5%</p>	<p>Result 05/06</p> <p>Māori 8.0% Pacific 14.9% Other 5.4% Total 5.6%</p>
Measure	03/04	04/05	05/06																					
Māori	10.4%	9.0%	8.0%																					
Pacific	9.5%	9.5%	14.9%																					
Other	5.5%	5.5%	5.4%																					
Total	5.7%	5.5%	5.6%																					
<p>Increase the number of older people receiving education on falls prevention – falls are a major cause of injury and ongoing disability for older people in Canterbury.</p>	<p>Increase the number of people referred to the Stay On Your Feet (SOYF) Home Exercise Program</p> <p><i>(The SOYF Program is a collaborative inter-sectorial initiative launched to raise awareness of the risks and consequences of falls amongst the elderly and how to prevent them.)</i></p>	<p>230 people referred.</p>	<p>250 people referred.</p>	<p>287 referrals.</p>																				
<p>Develop a local DHB Strategy for Older People’s Health.</p>	<p>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.</p>	<p>N/A.</p>	<p>Strategy developed, consistent with National Strategy, and Performance measures in place.</p>	<p>Older People’s Health Services Strategy was approved in February 2006.</p>																				
<p>▪ Target Achieved. <i>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%.</i></p> <p>▪ Target Achieved. <i>Implementation of the Strategy is well under-way with consistent Health Performance Measures currently under development for implementation 2006/2007.</i></p>																								

1.9 Elective Services

<p>Objective: <i>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.</i></p>	<p>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:</p> <ul style="list-style-type: none"> ▪ 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. 			
<p>Objective 2005/2006</p>	<p>Performance</p>			
<p>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.</p>	<p>Percentage of patients who receive their FSA within six months of referral.</p>	<p>94%</p>	<p>100%</p>	<p>94%</p>
	<p>Delivery of a level of publicly funded FSA volumes at the levels specified by contract (outlined in the DHB's District Annual Plan).</p>	<p>54,398 FSA completed (99%)</p>	<p>27,330 by 31/12/05 54,660 by 30/06/06</p>	<p>27,091 54,998</p>
		<p>Areas of longer waits are in orthopaedics, gastroenterology, respiratory and rheumatology. These services have plans in place to clear the backlog.</p> <p>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.</p>		
<p>Improved certainty of treatment: <i>Provide certainty to elective surgical patients as to whether they will/will not receive access to publicly funded inpatient surgery.</i></p>	<p>Percentage of patients provided with certainty of treatment receiving that treatment within six months.</p>	<p>87%</p>	<p>100%</p>	<p>78%</p>
<p>Provide access in a timely manner.</p>	<p>Percentage given certainty - the number of patients given certainty of treatment as a percentage of all patients receiving elective surgery during the period.</p>	<p>65%</p>	<p>90%</p>	<p>33%</p>
<p>Surgical Volume Delivery: <i>Delivery of the level of surgery specified by contract.</i></p>	<p>Case Weighted Discharges (CWD) delivered as specified in the DHB District Annual Plan¹⁵.</p>	<p>34,074 cwd delivered year-end (within 0.8% of target).</p>	<p>17,900cwd by 31/12/05 35,825cwd by 30/06/06</p>	<p>18,857 36,981</p>
		<p>Target Achieved. The Canterbury DHB delivered 1156 cwnds over contract and 2907 additional cwnds than the previous year.</p>		

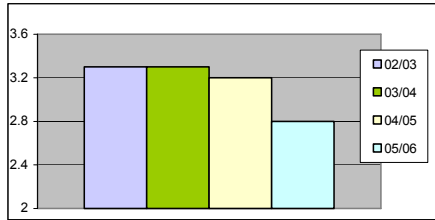
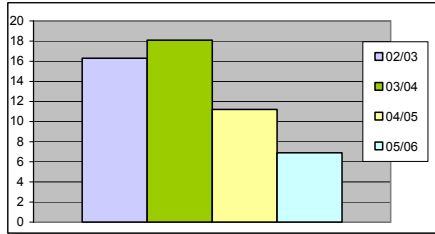
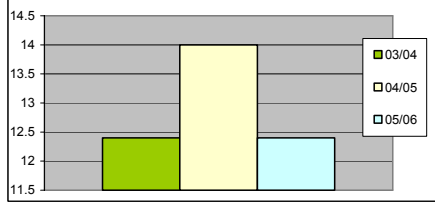
¹³ A FSA is the first appointment a patient has with a specialist following referral.

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.

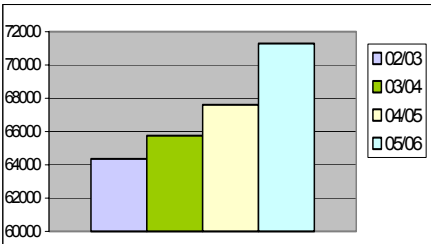
¹⁵ CWD are a relative measure of the cost of different types of surgery- eg cataract procedures have a lower cost weight than hip replacements.

2 PROVIDER HOSPITAL AND SPECIALIST SERVICE MEASURES

2.1 Hospital Safety and Effectiveness

<p>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.</p>	<p>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.</p>			
Objective 2005/2006	Performance			
<p>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.</p>	Measure	Baseline 04/05	Target 05/06	Result 05/06
	<p>Sick Leave Rate (as per Hospital Benchmarking Indicator (HBI)).¹⁶</p> 	<p>3.2% of contracted hours.</p>	<p>3.2% of contracted hours or less.</p>	<p>2.8% of contracted hours.</p>
	<p>▪ Target Achieved.</p>			
	<p>Work Place Injuries per 1,000,000 hours (as per HBI).</p> 	<p>11.2 per million hours.</p>	<p>14 per million hours or less.</p>	<p>6.9 per million hours.</p>
	<p>▪ Target Achieved.</p>			
	<p>Staff Retention and Turnover (as per HBI).</p> 	<p>14.0% turnover.</p>	<p>13% turnover.</p>	<p>12.4% turnover.</p>
	<p>▪ Target Achieved.</p>			
<p>Patient Satisfaction – Percentage of Good and Very Good responses from Satisfaction Surveys.</p>	<p>Inpatient – Overall Satisfaction (HBI).</p>	<p>90%</p>	<p>Greater than 90%.</p>	<p>89%</p>
	<p><i>This target has been only missed by 0.7% and the DHB is pleased with the consistent patient satisfaction results.</i></p>			
	<p>Outpatient – Overall Satisfaction (HBI).</p>	<p>90%</p>	<p>Greater than 90%.</p>	<p>91%</p>
<p>▪ Target Achieved.</p>				

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. <i>Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals.</i>	Maintain accreditation at the following divisions: <ul style="list-style-type: none"> ▪ 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.
Maintain appropriate levels of Clinical Quality within CDHB Hospitals.	Hospital Acquired Bacteraemia Rate. ¹⁷	0.13	0.15 or less	0.16
	<i>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.</i>			
	Patient Falls ¹⁸ (causing moderate or serious injury).	Historical Data not available.	0.10 or less. ¹⁹	0.02
Monitor levels of attendance at Christchurch Hospital's Emergency Department.	IV Medication Error Rate per 1000 inpatient days. ²⁰	1.8	2.5 or more	1.5
	<i>Work continues with initiatives such as the 0800 event reporting that will facilitate an increase in the reporting of these types of incidents.</i>			
Reduce wait times for people attending Christchurch Hospital's ED.	Number of attendances at the Christchurch Hospital Emergency Department (ED).	67,599	No target set, included for information purposes only.	71,279
				
Percentage of people seen in ED within expected wait time by triage level. <i>Triage 1 should be attended to immediately</i> <i>Triage 2 within 10 mins</i> <i>Triage 3 within 30 mins</i>	Triage 1 98%	Triage 1 100%	Triage 1 100%	Triage 1 100%
	Triage 2 50%	Triage 2 80%	Triage 2 45%	Triage 2 45%
		Triage 3 44%	Triage 3 70%	Triage 3 46%
<i>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.</i>				

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

<p>Objective: To provide good governance to ensure that health services meet the needs of Canterbury people while staying within available funding.</p>	<p>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.</p>			
<p>Objective 2005/2006</p>	<p>Performance</p>			
<p>Manage expenditure (including external providers) within available funding.</p>	<p>DHB expenditure on health services is within the funding it receives and that its operating result, after interest, depreciation and capital charge, is breakeven.</p>	<p>Net operating result = \$0.361m consolidated surplus</p>	<p>Breakeven or better.</p>	<p>\$2.861 million consolidated surplus.</p>
<p>District Strategic Plan developed within set time frame.</p>		<p>All milestones and targets met.</p>	<p>First draft 29/07/05 and second draft 03/10/05.</p>	<p>First draft 29/07/05, second draft 19/10/05.</p>
<p>Governance Training <i>Good Governance requires training and support, particularly for members new to governance.</i></p>		<p>N/A</p>	<p>Governance and Treaty training available for all Board members.</p>	<p>Governance Training has been provided.</p>
<p>A training register is established and maintained as required by the New Zealand Public Health and Disability Act 2000.</p>		<p>N/A</p>	<p>Registered established and maintained.</p>	<p>Training Register in place.</p>
<p>Clinical Governance Board</p>		<p>N/A</p>	<p>CDHB model of operation in place.</p>	<p>Board established. A model under development.</p>
		<p>▪ <i>Target Achieved</i> A Clinical Governance Framework is progressing with a number of options currently under consideration.</p>		

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.
	<ul style="list-style-type: none"> ▪ <i>Target Achieved.</i> 			
	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.
	<ul style="list-style-type: none"> ▪ <i>Target Achieved.</i> 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.
	<ul style="list-style-type: none"> ▪ <i>Target Achieved.</i> 			

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 <i>Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998)</i> .
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 subspecialties.
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 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.