



Canterbury District Health Board

**Report For the Year Ended
30 June 2005**

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DIRECTORY

Board Members

Syd Bradley – Chair
Robin Booth
Heather Carter (appointed 6 December 2004)
Norman Dewes
Neville Fagerlund (appointed 6 December 2004)
Karen Guilliland
Randall Allardyce (until 5 December 2004)
Alister James (appointed 6 December 2004)
Jo Kane (appointed 6 December 2004)
Laurence Malcolm (appointed 6 December 2004)
Philip Bagshaw (until 5 December 2004)
Graham Heenan (until 5 December 2004)
David Morrell
Olive Webb
Alison Wilkie (until 5 December 2004)

Chief Executive

Karleen Edwards (Interim Chief Executive Officer)

Registered Office

Charles Luney House
250 Oxford Terrace
PO Box 1600
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Westpac

MISSION STATEMENT

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

BOARD MEMBERS

- Syd Bradley - Chair Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB and DHBNZ. Syd has served on a number of boards since resigning as General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.
- Robin Booth Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
- Heather Carter Heather Carter is devoted to accessible and affordable health care for all New Zealanders. Heather runs LifeMasters, a personal development and workplace counselling consultancy. In addition, Heather serves on the Council of CPIT, the Federation of Graduate Women and Health Cuts Hurt (a group aimed at improving healthcare for people of Canterbury).
- David Morrell David Morrell was City Missioner in Christchurch from 1982 to 2005 and has had over 30 years involvement with general health and mental health through hospital chaplaincy, primarily at Christchurch Hospital during the 1970s and subsequently at the City Mission. David has had extensive management training, both here and in the United Kingdom. David is also Chair of Brackenridge Estate Limited.
- Neville Fagerlund Neville Fagerlund is a Chartered Accountant in Public Practice with over 25 years experience. He has provided financial and commercial advice to Pegasus Health Ltd since its inception in 1993 and advises The 24-Hour Surgery Ltd. Neville is a Director of Cambridge Clinic Ltd, a charitable company in the health arena.
- Olive Webb – Deputy Chair Olive Webb is a clinical psychologist and has more than 30 years experience working in the disability sector, particularly with people with intellectual disabilities. Based in Hororata, Olive has a focus on rural health issues and delivery. She provides clinical consultancy to IHC, is an adviser to Richmond Fellowship, and also consults in the Mental Health sector.
- Alister James Alister James is a barrister in private practice and a Board member of the Legal Services Agency. He is also the Honorary British Consul in Christchurch and spent more than 20 years in local Government as a Christchurch City Councillor.
With a strong involvement in the community and voluntary sector, Alister has a particular interest in community health issues. His involvement in the pilot Youth Drug Court and the Youth Court itself has led to an interest in adolescent and alcohol and drug services.

/ continued /

BOARD MEMBERS - continued

- Karen Guilliland Karen Guilliland is Chief Executive of the New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the PHARMAC Board and Deputy Chairperson of the Health Workforce Advisory Committee.
- Jo Kane Jo Kane is a Waimakariri District Councillor and Deputy Mayor, who believes in the basic right to protect health and well being for all.
- Laurence Malcolm Laurence Malcolm is a medical graduate, Professor Emeritus and former Professor of Community Health at the Wellington School of Medicine. He currently works as a consultant in health services research and development, is a member of the Council and Executive of Age Concern Canterbury, and has been on many national and international boards and committees. He has a special interest in primary health care and the quality of clinical services.
- Norman Dewes Norm Dewes is the Chief Executive of the urban Maori authority based in Canterbury. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the year ended 30 June 2005.

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, Canterbury DHB Group recorded a net surplus of \$0.361 million against a budgeted breakeven position. (2003/04 actual deficit was \$1.241 million).

BOARD FEES

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

	Board Fees Year ended 30/06/05 \$'000	Committee Fees Year ended 30/06/05 \$'000
Syd Bradley	48	3
Randall Allardyce*	10	1
Philip Bagshaw*	10	1
Robin Booth	24	1
Heather Carter*	14	2
Norman Dewes	24	2
Neville Fagerlund*	14	3
Karen Guilliland	24	3
Graham Heenan*	10	2
Alister James*	14	2
Jo Kane*	14	2
Laurence Malcolm*	14	2
David Morrell	24	5
Olive Webb	30	2
Alison Wilkie*	10	3
Julie Barlass*	-	1
Richard Buchanan*	-	-
Ruth Jones	-	1
David Kerr	-	2
Raymond Kirk*	-	1
Winston McKean*	-	1
Sandra McLean*	-	1
Christopher Mene*	-	1
John Musgrove*	-	1
Pauline O'Connor*	-	1
Fiona Pimm*	-	1
Suzanne Pitama*	-	1
Trevor Read*	-	1
Rodney Routledge*	-	1
Jeanette Tarbotton*	-	1
William Tate*	-	1
Susanne Trim*	-	1
Stephanie Waterfield*	-	-
Gloria Weeks*	-	1
	<hr/> 284	<hr/> 52

* resigned or appointed during the year

Total fees paid for the year were \$336,000 (2003/04 - \$305,000). The limit of fees authorised for the year ended 30 June 2005 was \$384,000 (2003/04 - \$384,000).

DIRECTOR FEES

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

	Year Ended 30/06/05 \$'000
Graham Heenan	13
David Morrell	10
	—
	23
	==

BOARD AND COMMITTEE MEMBERS' INTEREST

The Board and Committee Members have declared their interest in the Interest Register:

CANTERBURY DHB

Syd Bradley	Chair - DHBNZ Observer - PHARMAC Board Chair - Christchurch International Airport Co Limited Director - Lincoln Holding Company Ltd Director - McLean Institute Chair - Waipara Hill Wine Estate
Randall Allardyce	Adjunct academic appointee – University of Canterbury Employee providing services to Canterbury DHB – University of Otago Founder, Director and Trustee - Academy of Endosurgery, Christchurch Founder and Member of Planning and Advisory Committee - Christchurch Clinical Skills Educational Facility Member - New Zealand Liver Transplant Advisory Group to Ministry of Health Member of Advisory Board - Mobile Medical Technology (NZ) Surgical Services Limited Chief Co-ordinator, Medical Projects - Syft Technologies Limited Director - Tryst Consulting Limited Wife, Joan Allardyce, General Practitioner - Director of Student Health at the University of Canterbury
Philip Bagshaw	Chair – Council of Medical Colleges Elected Member – New Zealand National Board, Royal Australasian College of Surgeons Employee providing services to Canterbury DHB – University of Otago Founder, Director and Trustee - Academy of Endosurgery, Christchurch Member - Canterbury Medical Library Collection Review Committee Chair - Council of Medical Colleges Advisory Board Member - Mobile Surgical Services Limited Elected member - New Zealand National Board, Royal Australasian College of Surgeons Chair - New Zealand Liver Transplant Advisory Group to Ministry of Health Other various academic, clinical practice, and patient support groups and committees Red Star Films and Digital Video Productions Ltd - Shareholder Wife, Sue Bagshaw, is a medical practitioner active in areas of youth and adolescent health, sexual health and health education
Julie Barlass	Member - Ashburton District Health Committee

Robin Booth	Member - Shirley Papanui Community Board (until October 2004)
Richard Buchanan	Employee - CCS Canterbury West Coast Board Member - TimeOut Carers
Heather Carter	Council Member - Christchurch Polytechnic Institute of Technology Company Owner and Consultant - LifeMasters President - National Council of Women, Canterbury Branch
Norman Dewes	CEO – Te Runanga O Nga Maata Waka Chairman - Te Rito Arahi Maori Alcohol, Drug and Resource Centre Board Member/Vice Chair - Canterbury Community Primary Health Organisation Director - Te Amorangi Richmond Wellness Village Board Member - New Zealand Advertising Standards Authority Advisory Committee Member (Maori) - Canterbury Museum Board Member/Vice Chair - Canterbury Community Primary Health Organisation Chair - Otautahi Social Services Chair - Maori Legal Services Secretary - Te Runanga O Ngati Kahungunu ki Waitaha Council Member - Christchurch Polytechnic Institute of Technology Chair - Capital Planning and Development Committee Member - Polytechnic Midwifery Member - Canterbury Communications Trust (Broadcasting)
Neville Fagerlund	Director - Cambridge Clinic (DSAC) Limited Advisor - Pegasus After Hours Limited Advisor - Pegasus Health (Charitable) Advisor - Pegasus Health Membership Limited (and associate companies) Advisor - 24-Hour Surgery Limited
Karen Guilliland	CEO – New Zealand College of Midwives Director – Midwifery and Maternity Provider Organisation Limited Board Member - PHARMAC Member - Advisory Group to Minister of Health Member - Maternal and Newborn Information Systems Advisory Group Deputy Chair - Health Workforce Advisory Committee Consultant - Parents Centre NZ
Graham Heenan	Chair - Canterbury Laundry Service Ltd Chair - South Island Shared Services Agency Ltd Deputy Chair - Hanmer Springs Thermal Reserve
Alister James	Barrister and Youth Advocate (approved pursuant to Section 323 of the Children, Young Persons and Their Families Act 1989) Chair - Home Made Partnership Trust (Christchurch Supergrans) Honorary British Consul Member - Legal Services Agency Board (Crown Entity) Trustee - Nga Hau e Wha National Marae Trustee - Pegasus Employment and Environmental Trust (PEEPS Trust) Spouse is an employee with Community and Public Health, Canterbury District Health Board
Ruth Jones	Regional Services Co-ordinator - New Zealand CCS
David Kerr	Advisor - Pegasus Health Chairman - Ryman Healthcare Ltd Chair - Centrecare Limited General Medical Practitioner Trustee - Health Education Trust Advisor - Medical Protection Society
Ray Kirk	Director - New Zealand Health Technology Assessment Unit (NZHTA) Co-director - New Zealand Centre for Evidence-Based Research into Complementary and Alternative Medicine (ENZCAM), Department of Health

	and General Practice, Christchurch School of Medicine and Health Sciences, University of Otago
Laurence Malcolm	Consultant - Aotearoa Health Limited Member - Age Concern Canterbury, Council and Executive
Sandy McLean	Employee – Waka Tapu
Winston McKean	Panel Member - Human Rights Review Tribunal Chair - National Taskforce on Primary Health Care and PHO Development Chair - Rural Canterbury Primary Health Organisation
Chris Mene	Elected Member - Heathcote-Spreydon Community Board
David Morrell	Chair – Brackenridge Estate Limited Committee Member- Anglican Aged Care Member - Environment Canterbury, Christchurch Area Committee
John Musgrove	Board of Governors - Windsor House
Fiona Pimm	Board Member - South Canterbury DHB CEO - He Oranga Pounamu Charitable Trust Nga Hau E Wha Marae Director – Public Trust
Trevor Read	Manager, Patient Safety - ACC Establishment Programme
Rodney Routledge	Team Leader – Anglican Care
Jeanette Tarbotton	Member of Advisory Board - National Centre for Rural Health
Susanne Trim	Professional Nursing Advisor - New Zealand Nurses' Organisation Casual Employee - Nurse Maude Association
Stephanie Waterfield	Director - Smith City Group of Companies Health Consultancy
Olive Webb	Clinical Consultant – Richmond Fellowship Member - Health Practitioners Disciplinary Tribunal Health Consultant - IHC New Zealand Director - Institute of Applied Human Services Director - Access Home Health
Gloria Weeks	Secretary and Treasurer - Association of Blind Citizens, Canterbury Branch President - Disabled Person's Assembly, Christchurch Districts Member - Human Rights Commission Network Speaking Group
Alison Wilkie	Trustee - Family Help Trust Member - Pharmaceutical Society of New Zealand Inc, National Executive Board Member - Pharmaceutical Society of New Zealand Limited Trustee - Riccarton Bush Trust - Shareholder interest - Calan Healthcare

SUBSIDIARY AND ASSOCIATED COMPANIES

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

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD OR SUBSIDIARIES' INFORMATION

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

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

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

The total payments listed of \$211,900 comprise negotiated settlements with all of the former employees.

Number of Employees	TOTAL \$
1	22,013
1	22,449
1	39,438
1	128,000
4	211,900

REMUNERATION OF EMPLOYEES

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

	30/06/05 Number	30/06/04 Number
\$100,000 - \$110,000	51	51
\$110,001 - \$120,000	40	41
\$120,001 - \$130,000	28	32
\$130,001 - \$140,000	30	23
\$140,001 - \$150,000	28	27
\$150,001 - \$160,000	20	29
\$160,001 - \$170,000	24	20
\$170,001 - \$180,000	16	23
\$180,001 - \$190,000	21	17
\$190,001 - \$200,000	24	14
\$200,001 - \$210,000	20	11
\$210,001 - \$220,000	11	7
\$220,001 - \$230,000	6	3
\$230,001 - \$240,000	5	2
\$240,001 - \$250,000	2	2
\$250,001 - \$260,000	3	-
\$260,001 - \$270,000	1	-
\$280,001 - \$290,000	2	-
\$300,001 - \$310,000	1	-
\$390,001 - \$400,000 ¹	-	1
\$400,011 - \$410,000 ¹	1	-
	334	303

Of the 334 positions identified above, 304 (2003/04 - 274) were predominantly clinical and 30 (2003/04 - 29) positions were management/administrative.

¹ CEO remuneration and other benefits are included in these brackets.

STATUTORY DISCLOSURE

Legislative Responsibilities

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

- (a) the extent to which the DHB has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000;
- (b) how the DHB has given effect and intends to give effect to functions specified in Section 23 (1) (b) to (e) of the New Zealand Public Health and Disability Act 2000; and
- (c) a report on the performance of the hospital and related services it owns.

The following information reports Canterbury DHB's performance for the year ended 30 June 2005, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 37.

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	Extent objectives met
(a) to improve, promote, and protect the health of people and communities:	<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 seven key areas of focus were He Korowai Oranga, NZ disability strategy, elective services and radiotherapy waiting times, diabetes, inequalities, primary care and the Mental Health Blueprint.</p>
(b) to promote the integration of health services, especially primary and secondary health services:	<p>The CDHB is continuing to develop a Community and Primary Health Care Plan to improve population health and improve access to primary care. The four Primary Health Organisations (PHOs) established by the CDHB together with public health programmes designed to meet local needs will assist in achieving this plan.</p> <p>The CDHB has established an integrated service planning framework, incorporating disease prevention and management and working with the public health and primary care sectors. This will help to address issues such as chronic diseases - respiratory and cardiac illnesses, and diabetes.</p> <p>The CDHB has developed a full health needs assessment policy on ethnicity data collection and improving communication between primary and secondary health sectors.</p> <p>The CDHB is currently embarking on a project called Improving the Patient Journey. This is a major CDHB initiative to improve the quality and effectiveness of the service we provide to patients.</p>

(c) to promote effective care or support for those in need of personal health services or disability support services:	The CDHB is developing an Older People's Health Strategy entitled "Healthy Ageing, Integrated Support". The strategy has arisen from the CDHB's need to plan how it will fund and deliver quality services to older people within Population Based Funding and implement the Ministry of Health's Health of Older People's Strategy by 2010. The underlying objective is to maintain older people's independence for as long as possible, reduce the period and level of dependence and at the same time provide effective, integrated services when they are required.
(d) to promote the inclusion and participation in society and independence of people with disabilities:	The CDHB aims to ensure it contributes to a 'non disabling' society through its actions, and the actions of the providers with whom it contracts. The CDHB has developed a Disability Strategic Action Plan (DSAP) that outlines the steps it is making to implement the NZ Disability Strategy. The DSAP involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring. All new building developments are assessed for meeting the needs of people with disabilities.
(e) to reduce health disparities by improving health outcomes for Maori and other population groups:	The CDHB has produced and implemented its Maori Health Action Plan. The key focus of this is He Korowai Oranga and key objectives include improving ethnicity data collection, reducing health inequalities and supporting Maori health workforce development. The CDHB is continuing with the development of the Pacific People's Health Action Plan which focuses on supporting Pacific People as healthworkers, involving Pacific People in health service development and actively collecting ethnicity data.
(f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The CDHB Health Needs Assessment has identified groups in the community, which have health inequalities. Strategic Plan health gain priority areas (eg, Child and Youth, Maori) have been identified as part of this process.
(g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The CDHB continues to enhance relationships with the community, health providers and social agencies such as Age Concern, Child Youth and Family, Kai Tahu and the Christchurch City Council. The CDHB is also working with Territorial Local Authorities to plan for health and social services as outlined in the Local Government Act 2002.
(h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	The CDHB actively participates in forums such as Healthy Christchurch, Elder Care Canterbury, Maori Hui, DHBNZ and Diabetes. Information gathered from these forums assists the service planning process. The CDHB has engaged in an active consultation through formal processes (eg for the strategic plan) and sector representation on project steering groups.

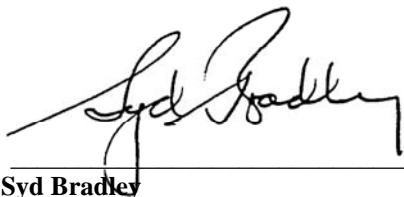
(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	<p>The CDHB has established a Quality and Patient Safety Council and a Clinical Board to provide advice to the CEO on quality and clinical issues.</p> <p>The Quality and Patient 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>
(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	<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	<p>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.</p> <p>In 2005 the CDHB was chosen as a finalist in the Canterbury Champion Awards (for enterprise and excellence) in the medium to large enterprise category. This category recognises the smartest provider of professional service, infrastructure or utilities.</p>

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 delivery of Core Directions and health gain priority areas for the CDHB Strategic Plan. • The CDHB actively involves relevant groups and individuals in planning specific service areas. • The CDHB has established joint arrangements with external providers for some provision of orthopaedic and cardiac surgery services. • The CDHB works with the Ministry of Health in a number of joint/collaborative ways such as Public (Population) Health shared decision making; and the allocation of the Maori and Pacific Health development fund. • The CDHB continues to implement the District Strategic Plan and to develop the Strategic Plan for the next five years.

<p>(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):</p>	<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 enquiries. • The CDHB circulates / makes available significant documents / plans for population in summary and comprehensive form either at libraries, via groups or individually. • The CDHB involves sector representatives in steering groups leading the planning for health services. • The CDHB has developed a website, which includes community based health information. • The CDHB continues to provide health promotion services funded by the Ministry of Health.
<p>(d) to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:</p>	<p>Relationships with Manawhenua Ki Waitaha, Te Runanga and Nga Maata Waka continue to develop. Maori community hui are held quarterly and regular meetings with Maori providers and other Maori community organisations. The outcomes of these meetings are fed directly into the CDHB planning process.</p>
<p>(e) to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori:</p>	<p>The CDHB has established Te Kahui Taumata, which includes the Kaumatua and Taua, the Executive Director Maori and Pacific Health, and senior Maori staff who provide Maori specific advice to the Chief Executive.</p>

For and on behalf of the Board



Syd Bradley
Chair

26 September 2005



Olive Webb
Deputy Chair
26 September 2005

STATEMENT OF RESPONSIBILITY

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

- a) The preparation of financial statements of Canterbury DHB and the judgements used therein, are our responsibility.
- b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2005, are our responsibility.
- c) In our opinion, the financial statements for the year under review fairly reflect the financial position and operations of Canterbury DHB.



Syd Bradley
Chair
26 September 2005



Karleen Edwards
Interim Chief Executive Officer
26 September 2005

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Group			Parent	
		Actual 30/06/05 \$'000	Budget 30/06/05 \$'000	Actual 30/06/04 \$'000	Actual 30/06/05 \$'000	Actual 30/06/04 \$'000
OPERATING REVENUE						
Ministry of Health Revenue		900,187	856,333	811,362	893,545	805,320
Patient Related Revenue		27,851	24,074	24,462	27,795	23,862
Other Revenue		14,550	13,255	13,657	13,268	12,841
TOTAL REVENUE	21	942,588	893,662	849,481	934,608	842,023
OPERATING EXPENSES						
Employee Costs		369,683	353,661	346,910	362,441	340,029
Treatment Related Costs		98,947	90,436	90,207	102,148	93,248
External Service Providers		353,053	335,898	299,921	353,053	299,921
Depreciation	11	39,519	34,419	32,652	38,570	31,663
Interest Expense		4,183	5,236	4,035	4,183	3,987
Other Expenses		55,062	50,612	53,689	52,489	51,436
TOTAL OPERATING EXPENSES	21	920,447	870,262	827,414	912,884	820,284
OPERATING SURPLUS BEFORE CAPITAL CHARGE						
		22,141	23,400	22,067	21,724	21,739
Capital Charge Expense		(21,862)	(23,400)	(23,306)	(21,862)	(23,306)
SURPLUS/(DEFICIT) BEFORE TAXATION						
	2	279	-	(1,239)	(138)	(1,567)
Tax Benefit / (Expense)	3	82	-	(2)	-	-
NET SURPLUS / (DEFICIT) FOR THE YEAR		361	-	(1,241)	(138)	(1,567)

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

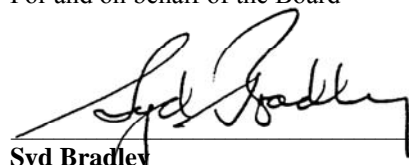
Notes	Group			Parent	
	Actual 30/06/05 \$'000	Budget 30/06/05 \$'000	Actual 30/06/04 \$'000	Actual 30/06/05 \$'000	Actual 30/06/04 \$'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD:	199,344	210,085	211,585	198,741	211,308
TOTAL RECOGNISED REVENUES AND EXPENSES:					
Net surplus / (deficit) for the period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

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2005

	Notes	Group			Parent	
		Actual as at 30/06/05 \$'000	Budget as at 30/06/05 \$'000	Actual as at 30/06/04 \$'000	Actual as at 30/06/05 \$'000	Actual as at 30/06/04 \$'000
CROWN EQUITY						
General Funds	5	148,174	159,174	148,174	148,312	148,312
Revaluation Reserve	5	77,717	77,717	77,717	77,717	77,717
Retained Earnings	5	(34,591)	(34,200)	(34,326)	(35,734)	(34,740)
Trust Reserve	5	8,405	7,394	7,779	8,308	7,452
TOTAL EQUITY		199,705	210,085	199,344	198,603	198,741
REPRESENTED BY:						
CURRENT ASSETS						
Cash and Bank	9	10,109	154	-	9,682	-
Receivables and Prepayments	4	16,341	20,488	27,476	15,795	27,074
Stocks	6	6,594	7,000	6,806	6,543	6,751
TOTAL CURRENT ASSETS		33,044	27,642	34,282	32,020	33,825
CURRENT LIABILITIES						
Bank Overdraft	9	-	-	835	-	1,446
Creditors and Accruals		74,361	69,709	68,281	74,215	68,080
Owing to the Ministry of Health		7,371	5,700	5,810	7,371	5,810
Staff Entitlements due within 1 year	7	44,389	28,500	38,035	43,554	37,404
Provisions due within 1 year	12	22,540	14,000	14,722	22,540	14,623
Loans due within 1 year	9	-	-	42,600	-	42,600
TOTAL CURRENT LIABILITIES		148,661	117,909	170,283	147,680	169,963
NET WORKING CAPITAL		(115,617)	(90,267)	(136,001)	(115,660)	(136,138)
NON CURRENT ASSETS						
Investments	10	311	378	292	1,829	2,196
Fixed Assets	11	382,467	394,051	375,137	379,665	372,758
Surplus Property		9,300	2,800	9,300	9,300	9,300
Restricted Assets	8	8,405	7,394	7,779	8,308	7,452
TOTAL NON CURRENT ASSETS		400,483	404,623	392,508	399,102	391,706
NON CURRENT LIABILITIES						
Provisions	12	6,511	4,271	5,113	6,189	4,827
Deferred Tax	3	-	-	50	-	-
Loans repayable after 1 year	9	78,650	100,000	52,000	78,650	52,000
TOTAL NON CURRENT LIABILITIES		85,161	104,271	57,163	84,839	56,827
NET ASSETS		199,705	210,085	199,344	198,603	198,741

For and on behalf of the Board



Syd Bradley
Chair

26 September 2005



Olive Webb
Deputy Chair

26 September 2005

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 30 JUNE 2005

Notes	Group			Parent	
	Actual 30/06/05 \$'000	Budget 30/06/05 \$'000	Actual 30/06/04 \$'000	Actual 30/06/05 \$'000	Actual 30/06/04 \$'000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash was provided from:					
Receipts from Ministry of Health	905,739	856,333	845,726	898,843	838,385
Other Receipts	46,670	35,079	32,062	45,590	30,608
Interest Received	1,268	279	595	1,384	682
	<u>953,677</u>	<u>891,691</u>	<u>878,383</u>	<u>945,817</u>	<u>869,675</u>
Cash was applied to:					
Payments to Employees	354,144	353,161	335,069	347,012	328,338
Payments to Suppliers	498,730	477,446	450,281	499,337	451,126
Interest Paid	4,023	5,415	4,345	4,023	4,297
Taxes Paid	-	-	3	-	-
Capital Charge	20,301	23,400	21,166	20,301	21,166
GST - net	1,934	-	(1,959)	1,949	(1,917)
	<u>879,132</u>	<u>859,422</u>	<u>808,905</u>	<u>872,622</u>	<u>803,010</u>
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	13	74,545	32,269	69,478	73,195
CASH FLOWS FROM INVESTING ACTIVITIES					
Cash was provided from:					
Sale of Assets	70	9,000	2,132	70	2,132
Decrease in Investments	-	-	-	-	1,214
	<u>70</u>	<u>9,000</u>	<u>2,132</u>	<u>70</u>	<u>3,346</u>
Cash was applied to:					
Increase in Investments & Restricted Assets	645	-	299	489	-
Purchase of Assets	47,076	61,000	52,071	45,698	51,040
	<u>47,721</u>	<u>61,000</u>	<u>52,370</u>	<u>46,187</u>	<u>51,040</u>
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	(47,651)	(52,000)	(50,238)	(46,117)	(47,694)
CASH FLOWS FROM FINANCING ACTIVITIES					
Cash was provided from:					
Loans Raised	-	20,000	52,000	-	52,000
	<u>-</u>	<u>20,000</u>	<u>52,000</u>	<u>-</u>	<u>52,000</u>
Cash was applied to:					
Loans Repaid	15,950	-	56,780	15,950	56,780
Equity repaid to Crown	-	-	11,000	-	11,000
	<u>15,950</u>	<u>-</u>	<u>67,780</u>	<u>15,950</u>	<u>67,780</u>
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES	(15,950)	20,000	(15,780)	(15,950)	(15,780)
Overall Increase/(Decrease) in Cash Held	10,944	269	3,460	11,128	3,191
Opening Cash Balance	(835)	(115)	(4,295)	(1,446)	(4,637)
CLOSING CASH BALANCE	10,109	154	(835)	9,682	(1,446)

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2005

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

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

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

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

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

B. MEASUREMENT BASE

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

C. ACCOUNTING POLICIES

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

i) **Revenue from Contracts for Services**

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

ii) **Specific Purpose Grants and Specific Service Sales**

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

iii) **Fixed Assets**

Fixed Assets Vested from the Hospital and Health Service

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

Fixed Assets acquired since the establishment of Canterbury DHB

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

Revaluation of land, buildings and fitout plant and equipment

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

Donated Assets

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

iv) Depreciation

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

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

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

v) Goods and Services Tax

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

vi) Stocks

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

vii) Accounts Receivable

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

vii) Investments

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

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

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

ix) Taxation

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

In prior years, Canterbury DHB subsidiaries were subject to income tax, with the exception of Brackenridge Estate Ltd. From the beginning of this financial year Canterbury Laundry Service Limited is also exempt from income tax under Section CB3 of the Income Tax Act 1994. Previously, income tax expense was charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. The tax provisions have been reversed following the tax exempt status given to Canterbury Laundry Service Limited.

x) Research and Development

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

xi) Foreign Currencies

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

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

xii) Leased Assets

Leases under which the DHB assumes substantially all the risks and rewards incidental to ownership are classified as finance leases and the related lease assets are capitalised.

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

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

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

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

xiii) Finance Costs

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

xiv) Provision for Staff Entitlements

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

xv) Statement of Cash Flows

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

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

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

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

xvi) Donations and Bequests

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

xvii) Financial Instruments

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

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

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

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

xviii) Basis of Consolidation

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

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

All significant inter-company transactions are eliminated on consolidation.

D CHANGE IN ACCOUNTING POLICIES

There have been no changes in accounting policies during the year. All policies have been applied on a basis consistent with the previous period.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating deficit is stated:

	Group		Parent	
	30/06/05 \$'000	30/06/04 \$'000	30/06/05 \$'000	30/06/04 \$'000
After Charging:				
Remuneration of Auditor:				
- Audit Fees	148	140	127	120
- Other Services	-	-	-	-
Board Members' Fees	284	252	284	252
Directors' Fees	23	19	-	-
Interest Expense	4,183	4,035	4,183	3,987
Bad Debts Written Off	589	518	589	518
Increase/(Decrease) in Bad Debts Provision	(649)	626	(649)	616
Rental and Operating Lease Costs	3,438	3,751	2,991	3,263
After Crediting:				
Interest Income	1,406	595	1,384	682
Gain (loss) on Disposal of Assets	(157)	1,029	(151)	1,029

3. TAXATION

The DHB and its subsidiaries are exempt from income tax. Tax provisions made by subsidiaries in previous years are no longer applicable and were reversed in the 2004/05 financial year.

	Group	
	30/06/05 \$'000	30/06/04 \$'000
Net Operating Surplus/(Deficit) before Taxation	361	(1,239)
Prima facie taxation @ 33%	-	(409)
Plus/(Less) tax effect of:		
Permanent Differences	-	411
Timing Differences not recognised	-	-
Reversal of tax in previous year	(82)	-
Tax Expense / (Benefit)	(82)	2
Comprising:		
Current Tax	(32)	30
Deferred Tax	(50)	(28)
	(82)	2
Deferred Tax Liability		
Opening Balance	50	78
Current Year Movement	(50)	(28)
Closing Balance	-	50

4. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Trade Debtors	6,644	10,315	6,540	10,224
Receivable from the Ministry of Health	8,880	14,074	8,522	13,820
Other Debtors	310	2,534	264	2,491
Prepayments	507	553	469	539
	<u>16,341</u>	<u>27,476</u>	<u>15,795</u>	<u>27,074</u>

5. EQUITY

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
GENERAL FUNDS				
Opening Balance	148,174	159,174	148,312	159,312
Equity contribution from Crown/(Repayment)	-	(11,000)	-	(11,000)
	<u>148,174</u>	<u>148,174</u>	<u>148,312</u>	<u>148,312</u>
RETAINED EARNINGS				
Opening Balance	(34,326)	(32,700)	(34,740)	(32,800)
Operating Surplus/(Deficit)	361	(1,241)	(138)	(1,567)
Transfers from/(to) Trust Reserve	(626)	(385)	(856)	(373)
Closing Balance	<u>(34,591)</u>	<u>(34,326)</u>	<u>(35,734)</u>	<u>(34,740)</u>
Represented by :				
Accumulated Deficit in Parent and Subsidiary	(34,669)	(34,404)	(35,812)	(34,818)
Accumulated Surplus in Associates	78	78	78	78
	<u>(34,591)</u>	<u>(34,326)</u>	<u>(35,734)</u>	<u>(34,740)</u>
REVALUATION RESERVE				
Opening Balance	77,717	77,717	77,717	77,717
Current Year Movement	-	-	-	-
Closing Balance	<u>77,717</u>	<u>77,717</u>	<u>77,717</u>	<u>77,717</u>

Represented by:

Revaluation of land	27,531	27,531	27,531	27,531
Revaluation of freehold buildings	656	656	656	656
Revaluation of fitout plant and equipment	48,540	48,540	48,540	48,540
Revaluation of reversionary interest in	990	990	990	990
	<u>77,717</u>	<u>77,717</u>	<u>77,717</u>	<u>77,717</u>

TRUST RESERVE

Opening Balance	7,779	7,394	7,452	7,079
Transfers from/(to) Retained Earnings	626	385	856	373
Closing Balance	<u>8,405</u>	<u>7,779</u>	<u>8,308</u>	<u>7,452</u>

6. STOCKS

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Pharmaceuticals	2,366	2,226	2,366	2,226
Surgical and Medical Supplies	3,399	3,605	3,399	3,605
Other Supplies	1,700	1,689	1,649	1,634
	<u>7,465</u>	<u>7,520</u>	<u>7,414</u>	<u>7,465</u>
Provision for Obsolescence	(871)	(714)	(871)	(714)
	<u>6,594</u>	<u>6,806</u>	<u>6,543</u>	<u>6,751</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.

7. STAFF ENTITLEMENTS

Staff Entitlements consist of:

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Annual Leave Accruals	27,450	24,319	26,995	23,944
Unpaid Days Accruals	8,833	6,683	8,649	6,518
ACC Accruals	2,546	2,250	2,488	2,210
Other	5,560	4,783	5,422	4,732
Staff Entitlement Due Within 1 Year	<u>44,389</u>	<u>38,035</u>	<u>43,554</u>	<u>37,404</u>

8. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2005, the amount of funds received where the conditions attached have not been fulfilled is \$8,405,000 (\$7,779,000 at 30 June 2004).

This is represented by:

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Cash at Bank	484	416	387	416
Term Deposits	3,291	2,983	3,291	2,656
Local Authorities & Government Stocks	870	840	870	840
Quoted Shares	-	-	-	-
Bonds & Stocks	3,760	3,540	3,760	3,540
Total Restricted Assets	8,405	7,779	8,308	7,452

9. LOANS AND BANK OVERDRAFT

Loans consist of:

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Commercial Loans	-	42,600	-	42,600
Crown Financing Agency	78,650	52,000	78,650	52,000
	78,650	94,600	78,650	94,600
Repayable as follows:				
Due Within 1 Year	-	42,600	-	42,600
Two - Five Years	78,650	52,000	78,650	52,000
	78,650	94,600	78,650	94,600

The bank overdraft facility available totals \$1,000,000 for both the parent and the group.

Security

Canterbury DHB commercial loans and the overdraft facilities are secured by Deed of Negative Pledge which requires the Board to comply with certain covenants such as limitations on borrowings, interest cover and working capital ratio.

Interest Rates

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

	Group		Parent	
	30/06/05	30/06/04	30/06/05	30/06/04
Commercial Loans	6.57%	5.86%	6.57%	5.86%
Crown Financing Agency	5.87%	6.29%	5.87%	6.29%
Bank Overdraft	8.45%	7.30%	8.45%	7.30%

10. INVESTMENTS

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Investment in Associates	311	292	311	292
Investment in Subsidiaries	-	-	1,518	1,904
	<u>311</u>	<u>292</u>	<u>1,829</u>	<u>2,196</u>

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Share of Associates Equity Brought Forward	168	168	168	168
Share of Associates Operating Surplus	-	-	-	-
	<u>168</u>	<u>168</u>	<u>168</u>	<u>168</u>
Share of Associates Equity Carried Forward	168	168	168	168
Advances	143	124	143	124
	<u>311</u>	<u>292</u>	<u>311</u>	<u>292</u>

At 30 June 2005, Associate Companies comprised:

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

New Zealand Centre for Reproductive Medicine Ltd provides reproductive medicine services to private and publicly funded patients.

South Island Shared Services Agency Ltd provides support services for contracting, contract monitoring and provider audits to DHBs for their Funding arm.

INVESTMENT IN SUBSIDIARIES

	Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Equity - Canterbury Laundry Service Ltd	393	393
Advances - Canterbury Laundry Service Ltd	1,677	1,787
Equity - Brackenridge Estate Ltd	(315)	(315)
Advances - Brackenridge Estate Ltd	(237)	39
	<u>1,518</u>	<u>1,904</u>

At 30 June 2005 subsidiary companies comprise:

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

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

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

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

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
At Cost				
Freehold land	-	-	-	-
Buildings - freehold	29,003	3,171	29,003	3,171
Leasehold Building & Fitout	3,042	3,042	3,042	3,042
Fitout plant and equipment	29,499	1,292	29,499	1,292
Plant and equipment	87,465	51,479	82,155	46,515
Computer equipment and software	36,564	32,837	36,517	32,837
Motor vehicles	4,890	4,075	4,295	3,590
Capital work-in-progress	5,842	60,205	5,842	60,205
At Valuation				
Freehold land	64,301	64,301	64,301	64,301
Buildings - freehold	85,920	85,920	85,920	85,920
Fitout plant & equipment	131,289	131,289	131,289	131,289
Plant and equipment	24,791	24,791	24,791	24,791
Reversionary interest in buildings	990	990	990	990
	<u>503,596</u>	<u>463,392</u>	<u>497,644</u>	<u>457,943</u>
Accumulated Depreciation				
Buildings - freehold	8,071	3,819	8,071	3,819
Leasehold Building & Fitout	339	329	339	329
Fitout plant and equipment	33,370	16,588	33,370	16,588
Plant and equipment	49,290	39,924	46,379	36,987
Computer equipment and software	28,010	26,149	27,996	26,148
Motor vehicles	2,049	1,446	1,824	1,314
	<u>121,129</u>	<u>88,255</u>	<u>117,979</u>	<u>85,185</u>

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Net Book Value				
Freehold land	64,301	64,301	64,301	64,301
Buildings - freehold	106,852	85,272	106,852	85,272
Leasehold Building & Fitout	2,703	2,713	2,703	2,713
Fitout plant and equipment	127,418	115,993	127,418	115,993
Plant and equipment	62,966	36,346	60,567	34,319
Computer equipment and software	8,554	6,688	8,521	6,689
Motor vehicles	2,841	2,629	2,471	2,276
Capital work-in-progress	5,842	60,205	5,842	60,205
Reversionary interest in buildings	990	990	990	990
	<u>382,467</u>	<u>375,137</u>	<u>379,665</u>	<u>372,758</u>
Depreciation charged during the year:				
Buildings freehold & leasehold	4,262	3,851	4,262	3,851
Fitout plant and equipment	16,785	16,589	16,785	16,589
Plant and equipment	10,898	8,642	10,045	7,653
Computer equipment and software	6,928	3,209	6,853	3,209
Motor vehicles	646	361	625	361
	<u>39,519</u>	<u>32,652</u>	<u>38,570</u>	<u>31,663</u>

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

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 2019. This interest has not been included in the Statement of Financial Position, other than the June 2003 revaluation effect of \$990,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

12. PROVISIONS

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Provisions due within 1 year	22,540	14,722	22,540	14,623
Provisions due after 1 year	6,511	5,113	6,189	4,827
Total Provisions	29,051	19,835	28,729	19,450
Movement in Provisions				
Opening balance	19,835	13,139	19,450	12,837
Additional provisions made during the year	13,064	12,245	13,101	11,805
Release of surplus provisions during the year	-	(43)	-	-
Charged against provisions for the year	(3,848)	(5,506)	(3,822)	(5,192)
Closing balance	29,051	19,835	28,729	19,450

These provisions primarily relate to staff entitlements, but also includes a refurbishment provision for Brackenridge. Staff entitlements include gratuities, long service leave, conference and sabbatical leave expenses, parental leave, and collective employment contracts pending finalisation of pay negotiations.

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

	Group		Parent	
	30/06/05 \$'000	30/06/04 \$'000	30/06/05 \$'000	30/06/04 \$'000
Net Operating Surplus before Share of Associate Co's Surplus	361	(1,241)	(138)	(1,567)
Add Back Non-Cash Items:				
Depreciation	39,519	32,652	38,570	31,663
Maintenance provision	-	42	-	-
Add Back Items Classified as Investing Activity:				
(Gain) / loss on Asset Sale	157	(1,029)	151	(1,029)
	40,037	30,424	38,583	29,067
Movement in Term Portion Provisions	1,398	622	1,362	556
Movement in Deferred Tax	(50)	(28)	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	11,135	29,673	11,279	28,428
Decrease/ (Incr.) in Stocks	212	114	208	110
Increase/ (Decr.) in Creditors & Other Accruals	6,080	(4,728)	6,135	(4,769)
Increase/ (Decr.) in Capital Charge due to Crown	1,561	2,140	1,561	2,140
Increase/ (Decr.) in Staff Entitlements	6,354	5,187	6,150	5,076
Increase/ (Decr.) in Provisions	7,818	6,074	7,917	6,057
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	74,545	69,478	73,195	66,665

14. COMMITMENTS

	<u>Group</u>		<u>Parent</u>	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
CAPITAL COMMITMENTS				
Committed at Balance Date	32,041	53,719	32,041	53,719
NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Lease	14,646	15,977	8,009	8,736
Vehicle Leases	31	82	31	77
Other	5	5	-	-
	<u>14,682</u>	<u>16,064</u>	<u>8,040</u>	<u>8,813</u>
For Expenditure Within:				
1 Year	1,633	1,695	1,169	1,217
2 Years	1,282	1,308	820	837
3 Years and Beyond	11,767	13,061	6,051	6,759
	<u>14,682</u>	<u>16,064</u>	<u>8,040</u>	<u>8,813</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	
	30/06/05 \$'000	30/06/04 \$'000	30/06/05 \$'000	30/06/04 \$'000
Revenue				
Interest on advance and director's fees from Canterbury Laundry Service Ltd	-	-	124	110
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	40	89
Services to Canterbury Laundry Service Ltd	-	-	427	603
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	57	57	57	57
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	3,349	3,425
Services from New Zealand Centre for Reproductive Medicine Ltd	1,675	1,181	1,675	1,181
Services from South Island Shared Services Agency Ltd	608	502	608	502

Interest charged on advances Canterbury Laundry Service Ltd, New Zealand Centre for Reproductive Medicine Ltd and Brackenridge Estate Ltd are at normal borrowing rates. Other balances are at normal trading terms.

The amounts outstanding for all related party transactions as at 30 June 2005 are as follows :

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd	143	223	143	223
Amount Payable owing to subsidiaries				
Brackenridge Estate Ltd – Advance	-	-	238	-
Canterbury Laundry Service Ltd	-	-	334	364
Amount Receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – Debtor	-	-	9	140
Canterbury Laundry Service Ltd – Advance	-	-	1,700	1,787
Brackenridge Estate Ltd – Advance	-	-	-	39

c) BOARD AND COMMITTEE MEMBERS

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

	Group		Parent	
	30/06/05 \$'000	30/06/04 \$'000	30/06/05 \$'000	30/06/04 \$'000
DHBNZ	332	332	332	332
Pegasus Health	19,350	72,350	19,350	72,350
The Christchurch City Mission	491	448	491	448
Breath Testing Services	-	19	-	19
He Oranga Pounamu Charitable Trust	588	1,555	588	1,555
Te Amorangi Richmond Wellness Village	303	308	303	308
Te Rito Arahi Maori Alcohol Drug & Resource Centre	330	319	330	319
Windsor House	1,298	956	1,298	956
Ryman Healthcare Ltd	3,572	2,568	3,572	2,568
TimeOut Carers	47	-	47	-
Cambridge Clinic (DSAC) Ltd	116	-	116	-
Canterbury Community Primary Health Organisation	723	-	723	-
Rural Canterbury Primary Health Organisation	6,631	-	6,631	-
South Canterbury DHB	1,244	144	1,244	144
Access Home Health	2,765	-	2,765	-
Otautahi Women's Welfare League	210	-	210	-
Smiths City Group	13	12	13	12

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

	Group		Parent	
	30/06/05 \$'000	30/06/04 \$'000	30/06/05 \$'000	30/06/04 \$'000
DHBNZ	56	26	56	26
South Canterbury DHB	10,420	2,620	10,420	2,620

16. CAPITAL CHARGE

Canterbury DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2005 was 11% (11% for the year ended 30 June 2004).

17. FINANCIAL INSTRUMENTS

CREDIT RISK

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

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

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2005, the Ministry of Health owed Canterbury DHB \$8.9 million (\$14.1 million at 30 June 2004).

CURRENCY RISK

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

Forward exchange contracts amounting to US\$100,000 and A\$250,000 were outstanding at 30 June 2005 (30 June 2004 US\$2,000,000 and A\$350,000). The valuation of these contracts at 30 June 2005 is an unrecognised loss of \$1,664.

INTEREST RATE RISK

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

There are interest rates swap options outstanding at 30 June 2005 of \$45 million (30 June 2004 \$37 million). The valuation of these contracts at 30 June 2005 is an unrecognised benefit of \$0.3 million.

FAIR VALUES OF FINANCIAL INSTRUMENTS

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

18. SEGMENTAL REPORTING

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

19. CONTINGENCIES

Canterbury DHB has the following contingencies at year end:

Claim for a breach of patent rights

A third party has indicated that Canterbury DHB has breached their patent rights. This allegation is being contested and the outcome is uncertain.

20. RESIDENTS' TRUST ACCOUNT

	Group		Parent	
	As at 30/06/05 \$'000	As at 30/06/04 \$'000	As at 30/06/05 \$'000	As at 30/06/04 \$'000
Residents' Trust Account Balance	753	682	385	364

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

21. BUDGET VARIANCE

Additional DSS contracts were devolved during the year and are not reflected in these budgets. Additionally, the budget included some national / regional contract expenditure which has subsequently been transferred back to other DHBs.

22. SUBSEQUENT EVENTS

There were no events after 30 June 2005 which could have a material impact on the information in Canterbury DHB's financial statements.

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2004/05

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

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

1. Strategic Priorities and Directions

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

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

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

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

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

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

NOTE: *In order to provide an overview of progress, where available, 2003/04 performance results have been included in parentheses and italics to the right of current results.*

For some measures the results involve low numbers which result in unreliable percentage rates. Where this is the case 95% confidence intervals have been included alongside the percentage rates to provide a more accurate picture. Please see the glossary for an explanation of confidence intervals.

A Week in the Life of the Canterbury DHB

48,000 people visit their GP;
\$1,960,000 worth of prescription items are dispensed;
\$541,000 worth of laboratory tests are completed;
1,560 people are discharged from hospital, of which 1,260 were admitted acutely;
190 people access mental health services;
875 women have a cervical smear;
680 people have a free influenza vaccination;
200 people have a free diabetes check;
1,640 people have their first attendance at Outpatients;
4800 people have a follow up Outpatients attendance;
250 children have a dental check;
1,500 people attend the Emergency Department;
710 people are admitted to hospital from the Emergency Department;
280 people have elective surgery;
76 cases of infectious diseases are notified;
15 people are discharged from hospital with asthma as the principal diagnosis;
100 babies are born; and
20 people die in hospital.

1.1. Overview of Performance

The following table provides an overview of the Canterbury DHB’s performance for the 2004/05 year. Where there is more than one performance measure for an objective, or where results are broken down by ethnicity, a tick in the box indicates a good overall result for the associated objective. For a complete breakdown of these indicators please see the full report that follows.

The indicators in the full report reflect the performance measures specified in the 2004/07 Statement of Intent (unless otherwise stated), which reflect the Canterbury DHB’s Strategic Plan priorities. It should be noted that the number of Pacific people in the Canterbury region is small (7254 at the 2001 Census) so the percentages shown should be interpreted with caution.

Priority Area	Objective	Performance Measure	Achieved or Met Target?	Improved/maintained 2003/04 performance?
Child Health	Reduce the Number of Low Birth Weight Babies [†]	Percentage of babies born in hospital with low birth weight	✓	✓
	Reduce Child Hearing Loss	Percentage of children passing school entry hearing tests	✓	✓
	Improve Child Oral Health	Mean MF score at Year 8 (Form 2) Percentage of children caries free at age 5	✓ N	✓ N
Primary Health	Support the Development of Four PHOs in Canterbury	Ethnicity data being collected by PHOs Services to Improve Access in place in all PHOs Percentage of CDHB population enrolled with PHOs PHO plans support CDHB health gain priority areas	✓ N N ✓	
	Improve Rural GP Retention	Percentage of GPs with a rural ranking of greater than 35 points who work no more than a 1 in 4 weekend roster	✓	✓
	Reduce Ambulatory Sensitive Admissions [†]	Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age	N ✓ N	✓ N ✓
Maori Health	Improve Monitoring of Maori Health	Improved ethnicity reporting: the percentage of discharges classified as Maori, Other or not stated Development of monitoring framework	N ✓	✓
	Reduce Health Inequalities	See relevant performance indicators including those in sections 2.1.1, 2.1.2, 2.1.5, and 2.1.7		
Mental Health	100% Delivery of Contracted Volumes by the Provider-arm	100% delivery of contracted volumes	N	✓
	Mental Health Expenditure to be 100% of Target	100% allocation of funding	✓	✓
	Improved Access to Services	Percentage of people within each age group accessing mental health treatment and support services	Data unavailable	Data unavailable

[†] For a complete breakdown of these indicators by ethnicity please see the full report that follows

Priority Area	Objective	Performance Measure	Achieved or Met Target?	Improved/maintained 2003/04 performance?
Cardiovascular Disease	Reduce the Impact of Cardiovascular Disease	Percentage of people with certainty who waited no more than 6 months for coronary artery bypass	N ✓	N
		Delivery of target levels of cardiac surgery	N	N
		Percentage of people with certainty who waited no more than 6 months for an angioplasty		
Cancer	Reduce the Impact of Cancer	Improved access to radiotherapy	N	✓
Diabetes	Earlier Diagnosis and Treatment of Eye Problems [♦]	Percentage of people having annual reviews who have had their eyes screened in the last two years	N	✓
	Improved Diabetes Monitoring [♦]	Percentage of the expected number of people with diabetes who have been diagnosed with diabetes and had an annual review during the year	N	✓
	Improved Diabetes Management [♦]	Percentage of people having annual reviews who had poor diabetes control	✓	✓
Elective Services	Improved Access to First Specialist Assessments (FSA)	Percentage of patients who receive their FSA within six months of referral Delivery of a level of publicly funded FSA volumes at the levels specified in the DAP	N N	N ✓
	Improved Certainty of Treatment	Percentage of patients with certainty who received treatment within six months Percentage of treated patients who had been given certainty	N N	✓ N
	100% Delivery of Contracted Surgical Volumes	Case weighted discharges delivered as specified in the District Annual Plan	N	N
Hospital Safety and Effectiveness	Improved Performance as a Good Employer	Sick leave rate	✓	✓
		Workplace injuries	✓	✓
		Staff turnover	N	N
	Patient Satisfaction	Inpatient- overall satisfaction	N	✓
		Outpatient- overall satisfaction	N	✓
Improved Quality	Achieve and maintain accreditation status	✓	✓	
Maintain Appropriate Levels of Clinical Quality Within CDHB Hospitals	Hospital acquired bacteraemia rate per 100 inpatient days IV medication error rate per 1000 inpatient days Patient falls per 100 inpatient days		✓	N
			✓	✓
			N	N
Monitor levels of attendance at Christchurch Hospital's Emergency Department		Number of attendances at Christchurch Hospital's Emergency Department	67,599	65,750

[♦] For a complete breakdown of these indicators by ethnicity please see the full report that follows

Priority Area	Objective	Performance Measure	Achieved or Met Target?	Improved/maintained 2003/04 performance?
	Reduce wait times for people attending Christchurch Hospital's Emergency Department	Percentage of people seen within expected wait time by triage level Level 1 Level 2 Level 3	N N N	<input checked="" type="checkbox"/> N N
Good Governance	Break even. Manage expenditure (including funding to external providers) within available funding.	DHB expenditure on health services is within the funding it receives and that its operating result, after interest, depreciation and capital charge, is breakeven	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

2. Service Objectives and Measures

2.1. Funding and Performance: Strategic Plan Health Priorities

2.1.1 Child and Youth Health

<p>Objective: Improved health status for Canterbury's children and youth. (Long term)</p>	<p>Brief Description: Keeping children and youth healthy gives them a better chance of becoming healthy adults. The Canterbury DHB (CDHB) has developed a Child Health and Disability Action Plan to address the health issues of the children of Canterbury. The targets for 2004/05 given here come from the District Annual Plan (note: the immunisation indicator from previous years has not been included due to data quality issues).</p>
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Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05	(95% Confidence intervals for discharge rates)	2003/04
Reduced number of low birth weight babies	Percentage of babies born in public hospital with low birth weight.	<ul style="list-style-type: none"> • Māori < 7.0% • Pacific < 4.7% • Total < 6.0% 	<ul style="list-style-type: none"> • Māori 6.0% • Pacific 3.9% • Total 4.5%¹ 	(3.5---10.1) (1.2---10.5) (3.9---5.3)	(8.4%) (4.5%) (6.1%)
Minimised impact on hearing loss in children	Percentage of children passing school entry hearing tests.	<ul style="list-style-type: none"> • Māori 90.0% • Pacific 86.0% • Total 94.0% 	<ul style="list-style-type: none"> • Māori 93.2% • Pacific 89.7% • Total ² 95.2% 		(91.6%) (86.8%) (95.3%)
Improved child oral health	Average proportion of Missing or Filled teeth of Form 2 (year 8) children (Total permanent teeth missing or filled due to caries (holes) divided by the number of children seen by the school dental service in the period).	<ul style="list-style-type: none"> • Total 1.6 	<ul style="list-style-type: none"> • 1.58 	There were 8,374 permanent teeth filled for 5,296 young people giving a mean MF score of 1.58. ³ It is preferable that there are fewer permanent teeth filled or missing due to holes (caries), hence for this indicator, lower is better. The CDHB achieved its target for this indicator.	(1.6)

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

² Data is from the National Audiology Centre

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

<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i> <i>(95% Confidence intervals for discharge rates)</i> <i>2003/04</i>
	Percentage of children caries free (no fillings or holes in teeth) at age 5.	<ul style="list-style-type: none"> • Total 52% 	<ul style="list-style-type: none"> • 51% (52%) <p>There were 2,418 children at their first publicly funded dental service after their 5th and before their 6th birthday with primary dentition free of caries, with no fillings and with no teeth missing due to caries, out of a total of 4,724 children at their first publicly funded dental service after their 5th and before their 6th birthday. Thus the percentage of children caries free at age 5 is 51%⁴, which was marginally short of the target.</p> <p>A major factor impacting on the CDHB’s performance on this measure is the low proportion of Canterbury’s population receiving optimally fluoridated water supplies. The CDHB agreed a ‘position statement’ on fluoridation in 2003 and this is available on its website www.cdhb.govt.nz.</p>

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

2.1.2 Primary Health

<p>Objective: Reduced barriers to primary health care. (Long term)</p>	<p>Brief Description: Reducing the barriers to good primary health care helps people stay well resulting in improved health status. During the 2004/05 year the Canterbury DHB focused its primary care activities on the following:</p> <ul style="list-style-type: none"> • Implementation of the Government’s primary health care strategy via the development of Primary Health Organisations (PHO) within Canterbury for those populations with the greatest barriers to primary health care. • Implementation of Canterbury DHB’s rural health action plan of May 2002.
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<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i>	<i>(95% Confidence intervals for discharge rates)</i>	<i>2003/04</i>
<p><i>PHO Development</i> Support the development of 4 PHOs within the Canterbury Region (two representing rural communities, one representing lower socio-economic groups in urban Christchurch and one other urban PHO).</p>	<p>Ethnicity data being collected by PHOs.</p>	<p>100% of PHO practices collecting ethnicity data by 1 April 2005</p>	<ul style="list-style-type: none"> • 100% <p>Target Achieved</p>		
	<p>Services to improve access in place in all PHOs.</p>	<p>All PHOs have implemented Services to Improve Access plans by 1 January 2005</p>	<p>All PHOs have Services to Improve Access with the exception of Hurunui Kaikoura PHO, which serves 3% of the CDHB’s population.</p> <p><i>Note: Services to Improve Access reduce barriers to first contact services for groups with the highest health needs.</i></p>		
	<p>Percentage of CDHB population enrolled with PHOs.</p>	<p>95% of CDHB’s census population is enrolled with PHOs by 1 July 2005</p>	<p>As at 1 July 2005 there were 431,878 people enrolled with a PHO. The 2005 population projection from Statistics NZ for 2005 is 459,670. Based on this 94% of CDHB’s population was enrolled with a PHO as at 1 July 2005.</p> <p>On the basis that population projections contain a certain amount of error, it is considered that this result is equal to target.</p>		
	<p>PHO plans support CDHB health gain priority areas.</p>	<p>PHO Health Promotion and Services to Improve Access plans are consistent with CDHB health gain priority plans</p>	<p>Target achieved. PHO Health Promotion Plans and Services focus on nutrition, physical activity, and smoking cessation. These are consistent with CDHB’s health gain priority areas – Child and Youth, Maori, Primary Health, Mental Health, and Disease Management (Diabetes, CVD, Cancer).</p>		
<p><i>Improved retention of Rural GPs:</i> Maintain reasonable on-call rosters for rural GPs. Every GP with a rural ranking of 35 points or more to work no more than 1 in 4 weekends.</p>	<p>Percentage of GPs with a rural ranking of greater than 35 point, who work no more than a 1 in 4 weekend roster (unless by choice).</p>	<ul style="list-style-type: none"> • 100% 	<ul style="list-style-type: none"> • 100% <p>Target Achieved</p>		<p>(100%)</p>

<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i> <i>(95% Confidence intervals for discharge rates)</i> <i>2003/04</i>
<p><i>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.</p> <p><i>(Ambulatory means hospital outpatient or GP care)</i></p>	<p>Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age.</p>	<ul style="list-style-type: none"> • Māori 6.7% • Pacific 6.7% • Total 6.7% 	<ul style="list-style-type: none"> • Māori 7.2% (6.2---8.3) (6.6%) • Pacific 10.4% (8.0---13.4) (10.6%) • Total 7.8%⁵ (7.4---8.2) (7.8%) <p>The 95% confidence interval for Maori covers the range from 6.2 to 8.3, which includes the target. In addition, the rate for Pacific people involves relatively low numbers and, as can be seen from the confidence interval, the true rate may be as low as 8.0.</p> <p>Actions to improve performance on this indicator are embodied within the CDHB's Child Health Action Plan, Maori Health Plan, and Pacific Health Action Plan. The Child Health Action Plan lists the following 10 key child health priorities; Access to Services, Child Health Information, Hearing, Immunisation, Injury Prevention, Mental Health, Nutrition and Physical Activity, Oral Health, Parenting, and Smokefree Environments.</p> <p>Some specific initiatives resulting from these plans that will potentially impact on performance against this indicator are:</p> <ul style="list-style-type: none"> • Pacific Immunisation Outreach Service (targets 0-5 years) • Mother and Papi services (targets 0-2 years) • Development of a Pacific Peoples immunisation database is underway • Continued operation of a Pacific Health Clinic • Well Child/ Tamariki Ora services.

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

<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i> <i>(95% Confidence intervals for discharge rates)</i> <i>2003/04</i>
	Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age.	<ul style="list-style-type: none"> • Māori 1.7% • Pacific 1.7% • Total 1.7% 	<ul style="list-style-type: none"> • Māori 1.5% (1.2---1.9) (1.5%) • Pacific 2.7% (1.9---3.9) (2.1%) • Total 1.7%⁶ (1.7---1.8) (1.6%) <p>The rate for Maori is better than the target and the rate for ‘total’ is equal to target indicating a good result for this measure. The rate for Pacific people, while higher than the target, relates to only 29 admits. The confidence interval for this group is also very wide.</p> <p>Actions to improve performance on this indicator are embodied within the CDHB’s Child Health Action Plan and Pacific Health Action Plan. The Child Health Action Plan lists the following 10 key child health priorities; Access to Services, Child Health Information, Hearing, Immunisation, Injury Prevention, Mental Health, Nutrition and Physical Activity, Oral Health, Parenting, and Smokefree Environments</p> <p>Some specific initiatives resulting from these plans that will potentially impact on performance against this indicator are:</p> <ul style="list-style-type: none"> • Pacific Immunisation Outreach Service (targets 0-5 years) • Mother and Pepi services (targets 0-2 years) • Development of a Pacific Peoples immunisation database is underway • Continued operation of a Pacific Health Clinic • Well Child/ Tamariki Ora services.
	Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age.	<ul style="list-style-type: none"> • Māori 1.1% • Pacific 1.1% • Total 1.1% 	<ul style="list-style-type: none"> • Māori 1.1% (0.8---1.5) (1.1%) • Pacific 1.4% (0.8---2.4) (1.3%) • Total 1.2%⁷ (1.1---1.3) (1.2%) <p>The rate for Maori is equal to the target, while the rate for ‘total’ is slightly above the target. The Pacific peoples rate is higher than the target, however this the rate relates to only 24 admissions and the confidence interval for this value includes the target, as do the confidence intervals for the rates of the other three groups.</p>

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

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

2.1.3 Māori Health

<p>Objective: <i>Whanau Ora</i> Māori families supported to achieve their maximum health and wellbeing. (Long Term)</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>. This 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, • Working across sectors. <p>During the 2004/05 year the Canterbury DHB has continued to focus its efforts on the above as well as improved data quality to support future developments, and reducing health disparities for Māori.</p>
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<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i>
<p><i>Monitoring of Māori health outcomes.</i> Current collection of ethnicity data is a significant barrier to achieving this objective. The DHB therefore plans to continue to implement accurate Ethnicity Data Collection throughout CDHB.</p>	<p>Improved ethnicity reporting. The percentage of discharges classified with the following ethnicity groups:</p> <ul style="list-style-type: none"> • Maori • Other • Not stated <p>Improved ethnicity reporting will result in fewer people classified as ‘other’ or ‘not stated’. Classification of people under these categories contributes to under reporting of groups such as Maori (measured against census population) and limits CDHB’s ability to monitor health outcomes accurately.</p>	<p>Ethnicity reporting targets</p> <ul style="list-style-type: none"> • Maori 7.5% • Other less than 2.5% • Not stated less than 1.0% 	<p>Percentage of discharges from CDHB hospitals with the following ethnicity reported</p> <ul style="list-style-type: none"> • Maori 6.0% • Other 5.0% • Not stated 2.7% <p>2004/05 targets had been set aiming to reduce the percentage of people classified as ‘other’ or ‘not stated’, and increase the percentage classified as Maori.</p> <p>Actions to improve this result include an Ethnicity Data Implementation Plan and recent completion of the appointment of Ethnicity Data Team Leaders for each Hospital and Specialist Services division. The aim over 2005/06 is to establish Ethnicity Data Teams and to action the Implementation Plan throughout the CDHB.</p>
<p><i>Monitoring of Māori health outcomes. Continued ...</i></p>	<p>During 2004/05 CDHB intended to develop an integrated health outcome and performance monitoring framework aligning its Māori Health Plan “<i>Whakamahere Hauora Māori Ki Waitaha</i>” with the MoH Māori Health Strategy “<i>He Korowai Oranga</i>” and the Māori Health Action Plan “<i>Whakatataka</i>”. Continuing work that started in 2003/04.</p>	<ul style="list-style-type: none"> • Completion of monitoring framework by June 2005 	<p>A proposed monitoring performance framework was completed in May 2005 as a result of a review of CDHB Strategic Māori Health plan – <i>Whakamahere Hauora Māori ki Waitaha</i>. The proposed framework was taken out for consultation with the Māori community to see if it provided a clear picture of what has occurred for Māori health since 2002. Discussion occurred and support given from the community on the proviso that CDHB look to capture more disease specific information in the future.</p>

<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i>
			<p>The performance monitoring framework uses a scorecard that summarises CDHB’s five Māori health directions and the number of short, medium and long term projects identified to progress Māori health over the next 5 years. The scorecard grades the level of progress on each project (ie: development, ongoing and completed). At this stage 42 of the 59 key projects within our current plan are under way with a remaining 17 to work on.</p>
<p><i>Reduced health inequalities:</i> Māori Service Development in priority areas eg. Diabetes, Cancers, Cardiovascular disease, Child Health etc</p>	<p>Refer to the relevant section of this document. Where data is available Māori specific targets have been provided.</p>	<p>See relevant Performance Indicators</p>	<p>CDHB has made progress in improving performance against targets set for Maori for the following indicators;</p> <ul style="list-style-type: none"> • Diabetes management (section 2.1.7) • Low birth weight babies (section 2.1.1) <p>Performance for other diabetes and child health indicators needs further improvement. Child health will be addressed through the implementation of CDHB’s Child Health Action Plan. The CDHB is working with PHOs, the Diabetes Centre, Community & Public Health and the Local Diabetes Team to improve knowledge and awareness of good self-management of diabetes.</p>

2.1.4 Mental Health

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

2.1.5 Disease Prevention and Management – Cardiovascular (Heart) Disease

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

2.1.6 Disease Prevention and Management - Cancer

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

2.1.7 Disease Prevention and Management - Diabetes

<p>Objective: Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes. (Long Term)</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:</p> <ul style="list-style-type: none"> • Health promotion, • Early detection, • Effective treatment, • Patient knowledge/information. <p>In Canterbury the greatest benefit is considered to be gained through a range of actions, which include early diagnosis and treatment of eye problems, foot problems and improved access for Māori (refer Local Diabetes Team (LDT) Annual Report 2003 for a full list of priorities). During the 2004/05 year, the Canterbury DHB primarily focused its activities on improving performance in the level of retinal screening while continuing to encourage the detection and management of Diabetes within the community. The Canterbury DHB has concerns about the data presented below and is of the opinion that these figures understate the numbers of people having annual diabetes reviews who had their eyes screened in the last two years.</p>
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<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i>	<i>2003/04</i>
<i>Improved Diabetes Detection:</i> Increasing the proportion of people with diabetes who receive annual checks and the associated primary care.	The percentage of the expected number of people with diagnosed diabetes who had an annual review during the year (expected numbers of people with diabetes: Māori: 1,192 Total: 12,142). Number of diabetes annual checks	Percentage receiving annual reviews during the 2004 year <ul style="list-style-type: none"> • Māori 80% • Total 81% Number of annual checks during 2004 <ul style="list-style-type: none"> • Total 9,827 	<ul style="list-style-type: none"> • Māori 41% • Total 80% <p>The CDHB was very close to the target for Total but has yet to meet its target for Maori. Work continued with Maori to improve the case detection rate through providing extra hours for a Maori health nurse at the Diabetes Centre and targeted screening programmes and education provided through Community and Public Health.</p> <ul style="list-style-type: none"> • 9750 Actual checks delivered	(42%) (77%) (8727)
<i>Early diagnosis and treatment of eye problems:</i> Increase the proportion of people with diabetes who have had their eyes screened in the last two years.	The percentage of people having annual diabetes reviews who have had their eyes screened in the last two years.	<ul style="list-style-type: none"> • Māori 45% • Total 65% 	<ul style="list-style-type: none"> • 41% • 48% <p>The rate for other ethnicities has improved from 2003. Work continues with the Eye Department and other groups, including community optometrists, to provide an eye screening service that is patient centred, convenient and based in the community. This forms part of the review of the Ophthalmology Department currently underway.</p> <p>The CDHB is working with the LDT to address and improve the data collection and measurement process. Approximately 4500 retinal screens are provided by the CDHB each year. Over the two year period for this indicator this is approximately 9000 screens which should provide at least 88% coverage of people with diabetes in Canterbury.</p>	(42%) (45%)

<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i> <i>2003/04</i>
<p><i>Improved Diabetes Management:</i> Reducing the proportion of people with diabetes who have relatively poor control of their diabetes.</p>	<p>The percentage of people having annual diabetes reviews who had poor diabetes control (HBA1c>8%).</p>	<ul style="list-style-type: none"> • Māori 40% • Total 23% 	<ul style="list-style-type: none"> • Māori 40% (42%) • Total 24% (26%) <p>The CDHB met the target for Maori and came very close to meeting the target for other ethnicities. Work continues with PHOs, the Diabetes Centre, Community and Public Health and the LDT to improve knowledge and awareness of good self-management of diabetes.</p>

2.1.8 Elective Services

<p>Objective: Improved health status for Canterbury's residents via the provision of services in a timely manner within the available resources for those with the greatest level of need. (Medium Term)</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 Canterbury DHB intends to continue the implementation of the Governments 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. • 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.
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Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05	2003/04
<p><i>Improved access to first specialist assessment:</i> Reduced waiting lists for first specialist assessments so that all appropriately referred patients can be assessed within appropriate timeframes.</p>	<p>Percentage of patients who receive their First Specialist Assessment (FSA) within six months of referral. <i>Note: a FSA is the first appointment a patient has with a specialist following referral.</i></p>	<ul style="list-style-type: none"> • 100% of patients who have an FSA in 2004/05 have it within six months of referral 	<ul style="list-style-type: none"> • 94% Of the new patients seen during the year, 94.2% waited less than 6 months, leaving 5.8% who waited longer than 6 months. This is slightly higher than the previous year. The CDHB will continue to seek to achieve the target level of performance. <p>At the end of the year there were 1,676 people whom we had not seen who had waited longer than 6 months. This reflects approximately two weeks work at current activity levels.</p>	<p>(97%)</p>
	<p>Delivery of a level of publicly funded FSA volumes at the levels specified in the CDHB DAP.</p>	<ul style="list-style-type: none"> • 27,550 FSA completed by 31 December 2004 • 55,100 FSA completed in total by 30 June 2005 	<ul style="list-style-type: none"> • 54,398 (99%) <p>Although the DAP target was not reached the volume of FSAs delivered in 2004/05 was very close to the target and, when compared with 2003/04, delivery has increased by 669 FSAs or 1.2%.</p>	<p>(53,729)</p>
<p><i>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. Provide access in a timely manner.</p>	<p>Percentage of patients provided with certainty of treatment receiving treatment within 6 months.</p>	<ul style="list-style-type: none"> • 100% 	<p>87%</p>	<p>(84%)</p>

<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i> <i>2003/04</i>
	Percentage given certainty. <i>(The number of treated patients with certainty as a percentage of all patients receiving elective surgery during the period)</i>	<ul style="list-style-type: none"> • 90% 	65% <i>(78%)</i>
<i>Surgical Volume Delivery:</i> Delivery of the level of surgery specified in the CDHB DAP.	Case weighted discharges delivered as specified in the CDHB DAP. <i>(Case weighted discharges (cwd) are a relative measure of the cost of different types of surgery- eg cataract procedures have a lower cost weight than hip replacements)</i>	<ul style="list-style-type: none"> • 17,100cwd delivered by 31 December 2004 • 34,359cwd by 30 June 2005 * <p>*The original target in the 2004/07 SOI did not include Dental (240 cwd)</p>	<ul style="list-style-type: none"> • 34,074 cwd delivered year-end <i>(34,547)</i> Delivery was very close to the target (0.8%). In addition to the volumes delivered by the provider-arm Hospital and Specialist Services, CDHB also has contracts with private providers. These include Canterbury Orthopaedic Services (1465cwd delivered in 2004/05) and St George’s Hospital (215cwd of cardiac surgery). The contract with Canterbury Orthopaedic Services has made an important contribution to CDHB’s performance on the Orthopaedic Initiative to increase the number of hip and knee replacements. This contract was increased to cover shortfall in provider-arm delivery.

2.2. PROVIDER HOSPITAL AND SPECIALIST SERVICE MEASURES

2.2.1 Hospital Safety and Effectiveness

<p>Objective: As a leader in hospital and health care services the Canterbury DHB aims to be an efficient and effective provider and maximise the health status of Canterbury's residents within the available resources.</p>	<p>Brief Description: The Canterbury DHB is a major provider of Health Services (as well as the funder of the majority of hospital and community Personal and Family Health Services and Mental Health services) to Canterbury residents. As a provider of health services the Canterbury DHB must ensure that it operates in an effective and efficient manner.</p>
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<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i>	<i>2003/04</i>
<i>Improved performance as a Good employer. Initiate systems and processes to promote a good working environment that encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management.</i>	Sick Leave Rate (as per balanced scorecard)	<ul style="list-style-type: none"> 3.2% of contracted hours 	<ul style="list-style-type: none"> 3.2 Target achieved	(3.3%)
	Work Place Injuries per 1,000,000 hours (as per balanced scorecard)	<ul style="list-style-type: none"> 17 per 1 million hours 	<ul style="list-style-type: none"> 11.2 Target achieved	(18.1)
	Staff Retention and Turnover (as per balanced scorecard)	<ul style="list-style-type: none"> Less than 10% turnover 	<ul style="list-style-type: none"> 14.0% Target not achieved.	(12.4%)
<i>Patient Satisfaction.</i>	Inpatient – Overall Satisfaction (<i>as per balanced scorecard</i>)	<ul style="list-style-type: none"> Greater than 95% 	<ul style="list-style-type: none"> 90% The CDHB has slightly improved its levels of satisfaction from last year and produced a high level of patient satisfaction at 90%.	(89%)
	Outpatient – Overall Satisfaction. (<i>as per balanced scorecard</i>)	<ul style="list-style-type: none"> Greater than 95% 	<ul style="list-style-type: none"> 90% The CDHB continues to maintain a high level of patient satisfaction at 90%.	(90%)

<i>Objective 2004/05</i>	<i>Performance Measure</i>	<i>Performance Targets</i>	<i>Results 2004/05</i> <i>2003/04</i>
<p><i>Improved Quality.</i> Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals. (Long term)*</p>	<p>Maintain accreditation at Ashburton, Akaroa, Ellesmere, Waikari, Darfield, Burwood and Christchurch Women’s Hospitals.</p> <p>Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services.</p>	<p>100% of facilities maintain current accreditation status</p> <p>Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services</p>	<p>The CDHB has achieved this target. The accreditation status of these facilities is as follows:</p> <ul style="list-style-type: none"> • <i>Rural Health Services (Ashburton & Community Health Services)</i> Ashburton Health Services: Accreditation awarded 28th May 2002. This is their fourth 3-year accreditation having been accredited since 1993. Community Hospitals (Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari): Accreditation awarded 13th February 2004. This is the second accreditation for Akaroa, Darfield, Ellesmere and Waikari and the first for Kaikoura and Oxford. Rural Health Services are certified from March 2004 until March 2007 (3 years). • <i>Burwood Hospital</i> Burwood’s second 3-year accreditation was awarded May 2004. Certified for 1 year from September 2004 until September 2005. • <i>Christchurch Hospital & Corporate Services</i> Christchurch Hospital (including Corporate Services) was surveyed by Quality Health NZ for their first accreditation survey and certification audit in June 2004. Accreditation was awarded in February 2005. Certified for 2 years from September 2004 until September 2006. Technical Services, Medical Physics and Bio-engineering were successful in re-certification against the AS/NZ Standard ISO9001: 2000. • <i>Mental Health Services (MHS) & The Princess Margaret Hospital (TPMH)</i> Accreditation awarded November 2004. The PMH Certified from September 2004 until September 2007 (3 years), MHS Certified from September 2004 until September 2006 (2 years). • <i>Women’s Health Division (WHD)</i> Quality Health NZ confirmed the continued Accreditation status for Women’s Health Division facilities and services. This is the second 3-year accreditation successfully completed by WHD. Certified from November 2003 until November 2005 (2 years). • <i>Laboratory and Support Services</i> Canterbury Laboratories has been accredited with IANZ (ISO: 15189) since 1994.
<p>Maintain appropriate levels of Clinical Quality within CDHB Hospitals.</p>	<p>Hospital Acquired Bacteraemia Rate per 100 inpatient days.</p>	<p>Hospital Acquired Bacteraemia Rate per 100 inpatient days</p> <ul style="list-style-type: none"> • Less than 0.2 	<ul style="list-style-type: none"> • 0.13 Target achieved <p><i>Note: performance now reflects measurement of all CDHB hospitals except Mental Health division</i></p> <p style="text-align: right;">(0.12)</p>

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

2.3. GOVERNANCE

2.3.1 Good Governance

<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 2004/05</p>	<p>Performance Measure</p>	<p>Performance Targets</p>	<p>Results 2004/05 2003/04</p>
<p>Break even. Manage expenditure (including funding to external providers) within available funding.</p>	<p>CDHB expenditure on health services is within the funding it receives and that its operating result, after interest, depreciation and capital charge, for 2004-05, is breakeven.</p>	<p>Net operating result = Breakeven or better</p>	<p>\$0.3M ((\$1.2m)) Target met. The CDHB achieved a slight surplus of \$0.3M for 2004/05</p>

3. Summary of Revenues and Expenses by Output Class

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

4. Glossary of Terms

Accreditation	Achievement against a national system of standards.
Angioplasty	An angioplasty is a noninvasive procedure where a balloon-tipped catheter is inflated inside a diseased blood vessel. As the balloon is inflated, the vessel opens further allowing for improved flow of blood.
Ambulatory Sensitive Admissions	Admissions that are potentially preventable by appropriate primary care.
Audit	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation.
Bacteraemia	Hospital acquired bacteraemia rate measures the number of hospital acquired blood stream infections as a proportion of the number of inpatients.
Cardiac	Relating to the heart
Certainty	When the DHB gives a patient a commitment to treat within six months, this patient has certainty. This commitment can be given either through a certainty letter (promise of surgery date within six months) or being direct booked for treatment (given date for surgery directly).
Confidence Interval	The range within which we can be confident that the true value lies. A 95% confidence interval means that the probability that the interval contains the true value is 95%. The width of the confidence interval gives an indication of the variability within the sampling distribution. A narrow confidence interval indicates smaller variability, while a wide interval indicates large variability. The amount of variability, and hence the width of the interval, is greatly affected by the size of the group being sampled. This is particularly relevant when interpreting statistics for measures that are broken down by ethnicity.
CWD - Cost Weighted Discharges	This is a relative measure of the cost of different types of surgery. For example cataract surgery has a lower cost weight than hip replacement surgery.
FTE	Full time equivalent
Inequality (health)	Difference in health relative to the local community or wider society to which an individual, family or group belongs.
PHO – Primary Health Organisation	Primary Health Organisations are made up of General Practitioners, nurses, and other primary health providers, and are responsible for achieving improved health outcomes for their enrolled populations.
Triage levels (emergency department)	<p>Patients in the emergency department are triaged upon presentation into one of five categories on the Australasian Triage Scale according to the triageur's response to the question: "This patient should wait for medical care no longer than ... minutes". Patients requiring immediate treatment are triaged as level 1, those needing treatment within 10 minutes are level 2, within 30 minutes are level 3, within 60 minutes are level 4, and within 120 minutes are level 5.</p> <p>The triage of patients continues within the Emergency Department, following initial assessment and treatment. Patients may be re-triaged to a different category as the assessment and treatment process develops and particularly in response to significant changes in physiological status. Staff and other resources should be deployed so that treatment acuity thresholds are achieved progressively from Triage Code 1 through to 5.</p>



AUDIT REPORT

TO THE READERS OF CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2005

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health Board and group, on his behalf, for the year ended 30 June 2005.

Unqualified opinion

In our opinion the financial statements of the Health Board and group on pages 16 to 37 and 39 to 60:

- ▲ comply with generally accepted accounting practice in New Zealand; and
- ▲ fairly reflect:
 - the Health Board and group's financial position as at 30 June 2005;
 - the results of operations and cash flows for the year ended on that date; and
 - the service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 26 September 2005, and is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and the Auditor, and explain our independence.

Basis of opinion

We carried out the audit in accordance with the Auditor-General's Auditing Standards, which incorporate the New Zealand Auditing Standards.

We planned and performed the audit to obtain all the information and explanations we considered necessary in order to obtain reasonable assurance that the financial statements did not have material misstatements, whether caused by fraud or error.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

The audit involved performing procedures to test the information presented in the financial statements. We assessed the results of those procedures in forming our opinion.

Audit procedures generally include:

- ▲ determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- ▲ verifying samples of transactions and account balances;
- ▲ performing analyses to identify anomalies in the reported data;
- ▲ reviewing significant estimates and judgements made by the Board;
- ▲ confirming year-end balances;
- ▲ determining whether accounting policies are appropriate and consistently applied; and
- ▲ determining whether all financial statement disclosures are adequate.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements.

We evaluated the overall adequacy of the presentation of information in the financial statements. We obtained all the information and explanations we required to support our opinion above.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2005. They must also fairly reflect the results of operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001, section 43 of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Independence

When carrying out the audit we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the Institute of Chartered Accountants of New Zealand.

Other than the audit, we have no relationship with or interests in the Health Board or any of its subsidiaries.



Julian Tan
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand



Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of the Canterbury District Health Board for the year ended 30 June 2005 included on the Canterbury District Health Board's web site. The Canterbury District Health Board's governing body is responsible for the maintenance and integrity of the Canterbury District Health Board's web site. We have not been engaged to report on the integrity of the Canterbury District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information that may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 26 September 2005 to confirm the information included in the audited financial statements presented on this web site.

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

