



Canterbury District Health Board

**Report For the Year Ended
30 June 2007**

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DIRECTORY

Board Members

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

Chief Executive

Gordon Davies (Chief Executive Officer)

Registered Office

2nd Floor, H Block
The Princess Margaret Hospital
Cashmere Road
Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Westpac Banking Corporation

MISSION STATEMENT

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

BOARD MEMBERS

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

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BOARD MEMBERS - continued

- Karen Guilliland Karen Guilliland is Chief Executive of the New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the PHARMAC Board. She also provides consultancy to Parents Centre NZ.
- Jo Kane Jo Kane is a Waimakariri District Councillor and Deputy Mayor, who believes in the basic right to protect health and well being for all.
- Laurence Malcolm Laurence Malcolm is a medical graduate, Professor Emeritus and former Professor of Community Health at the Wellington School of Medicine. He currently works as a consultant in health services research and development, is a member of the Council and Executive of Age Concern Canterbury, and has been on many national and international boards and committees. He has a special interest in primary health care and the quality of clinical services.
- Norman Dewes Norm Dewes is the Chief Executive of the urban Māori authority based in Canterbury (Te Runanga o Nga Maata Waka). Norm is a member of the New Zealand Advertising Standards Authority, Canterbury Museum Advisory Committee, and Canterbury Community Primary Health Organisation. He is the Chairperson of Te Rito Arahi Māori Alcohol, Drug and Resource Centre, Otautahi Social Services, Māori Legal Services and Capital Planning and Development, and is the Manager of Nga Hau e Wha National Marae. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.

BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders, on the affairs of the Board for the year ended 30 June 2007.

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, Canterbury DHB Group recorded a net deficit of \$0.848 million against a budgeted net deficit of \$2.50 million. (2005/06 result was a net surplus of \$2.86 million).

BOARD FEES

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

	Board Fees Year ended 30/06/07 \$'000	Committee Fees Year ended 30/06/07 \$'000
Syd Bradley	49	2
Olive Webb	31	5
Robin Booth	24	1
Heather Carter	25	5
Norman Dewes	24	4
Neville Fagerlund	25	3
Karen Guilliland	24	2
Alister James	25	2
Jo Kane	24	4
Laurence Malcolm	25	4
David Morrell	24	5
Peter Ballantyne	-	6
Alison Wilkie	-	2
Richard Buchanan*	-	-
David Kerr	-	2
Winston McKean*	-	2
John Musgrove	-	2
Tuari Potiki	-	1
Trevor Read	-	2
William Tate	-	2
Margaret Schwass*	-	1
	<u>300</u>	<u>57</u>

* appointed/resigned during the year

Total fees paid for the year were \$357,000 (2005/06 - \$355,000). The limit of fees authorised for the year ended 30 June 2007 was \$385,000 (2005/06 - \$384,000).

DIRECTOR FEES

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

	Year Ended 30/06/07 \$'000	Year Ended 30/06/06 \$'000
David Morrell	10	10
Graham Heenan	13	13
	<u>23</u>	<u>23</u>

BOARD AND COMMITTEE MEMBERS' INTEREST

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

CANTERBURY DHB

Syd Bradley

Christchurch International Airport Co Limited – Chair

Waipara Hills Wine Estate – Advisor

McLeans Institute – Board Member (Canterbury DHB representative) - provides residential aged care services under contract with the Canterbury DHB.

Olive Webb

Health Practitioners Disciplinary Tribunal – Member - potentially a member of a tribunal panel when a clinical psychologist is before the panel. The tribunal has procedures for dealing with potential conflicts of interests for tribunal members. Should an issue of conflict arise, this will be disclosed at the time.

Institute of Applied Human Services Limited (IAHS) – Chairperson - provides individual consultation, service advice and workforce training in the intellectual disability area, on contract to various individuals and providers in Australasia. New Zealand providers of intellectual disability services are usually funded by the Ministry of Health. IAHS has no contracts with Canterbury DHB.

Special Olympics New Zealand – Trustee - as well as providing sporting events, also provides health screening and assistance.

Access Home Health Limited – Director - provides home based healthcare and personal support on contract to the Accident Compensation Corporation, Ministry of Health and several DHBs, including Canterbury DHB.

Heather Carter

Christchurch Polytechnic Institute of Technology (CPIT) – Council Member

Health Cuts Hurt Incorporated (Health Lobby Organisation) - Member

LifeMasters (Life skills and personal development) – Company Owner and Consultant

Otautahi Education Development Trust (OEDT) – Trustee - this trust is related to CPIT activities.

Norman Dewes

Te Runanga o Nga Maata Waka – Chief Executive Officer - this Runanga provides a range of advocacy, community and social services. These services include a contract for the Canterbury DHB to deliver mother & pepi services. The Runanga also provides a range of education services which are NZQA registered and accredited under the Education Act. The Runanga is a part of a national body, the National Urban Maori Authority.

Nga Hau e Wha, National Marae – Manager - there is a proposal that an oral health service clinic be located on part of the land held by the trust.

Canterbury Community Primary Health Organisation (Access PHO) – Member - one of the PHOs within the Canterbury DHB's area – contracts with the DHB for primary services.

Te Runanga o Ngati Kahungunu ki Waitaha – Secretary

	Te Rito Arahi Maori Alcohol, Drug and Resource Centre – Chair
	Otautahi Social Services – Chair
	Otautahi Sports Association - Secretary
Karen Guilliland	<p>New Zealand College of Midwives – Chief Executive Officer - the College of Midwives is the professional body for midwives that promotes and sets standards for the profession. The College provides expert advice in relation to midwifery and maternity services to district health boards (including Canterbury DHB) on request. The College nominates representatives to various related bodies such as MERAS (Midwives Union) (who are party to a collective employment agreement with the Canterbury DHB), schools of midwifery, and a number of government advisory committees.</p> <p>Midwifery and Maternity Provider Organisation Limited – Director - College of Midwives representative as a director in this midwifery practice management organisation. Its primary function is to process midwifery service claims to the Ministry of Health on behalf of self employed midwives, obstetricians, some district health boards, and private trusts.</p> <p>PHARMAC – Board Member.</p>
Neville Fagerlund	<p>Cambridge Clinic (DSAC) Limited - Director of a company which holds a contract with the Canterbury DHB for the delivery of medical services to victims of sexual abuse.</p> <p>Pegasus Health (Charitable) Limited - Financial Advisor to a company which holds a contract with the Canterbury DHB for observation and continuing care nurse co-ordination, and a contract in the co-ordination role of immunisation services. The 24 hour clinic in Bealey Avenue is 100% owned by Pegasus Health (Charitable) Limited, who hold the observation contract.</p> <p>A wide range of trusts and private companies as a result of private accountancy practice (where potential conflicts arise these will be disclosed individually)</p>
Alister James	<p>Barrister and Youth Advocate - acting for clients including young persons with mental health, alcohol and drug issues and dealing with Mental Health Services, in particular Youth Specialty Services.</p> <p>Home Made Partnership Trust (Christchurch Supergrans) – Chair - sometime recipient of funding grants from Community and Public Health for courses run by the organisation.</p> <p>Honorary British Consul - interest relates to support of British visitors who may be hospitalised arising from injury related accidents.</p> <p>Legal Services Agency (Crown Entity) - Board Member - Legal Services Agency provides legal services and funding, including granting legal aid for persons who may be involved in any proceedings against the Canterbury DHB, and in respect to mental health reviews.</p> <p>Nga Hau E Wha National Marae Charitable Trust - Chair - there is a proposal that an oral health service clinic be located on part of the land held by the trust.</p> <p>Spouse is a Canterbury DHB employee.</p>
Jo Kane	<p>Waimakariri District Council - Deputy Mayor - Waimakariri District Council is responsible for the health and wellbeing of their community – health is a high priority in community derived outcomes. Interest may relate to intersectoral collaboration – where potential conflicts arise these will be disclosed at the appropriate time.</p> <p>North Canterbury Sport and Recreation Trust – Trustee - provision of a range of physical health initiatives for the community. Could apply for funding from Canterbury DHB (where potential conflicts arise, they will be disclosed at the appropriate time).</p> <p>Te Kohaka o Tuhaitara Trust – Chairperson - provides for a range of cultural, historical, recreational and educational opportunities for the community within the</p>

	Coastal Reserve. It is not envisaged any potential conflicts of interest, but will be disclosed at the appropriate time.
Laurence Malcolm	<p>Aotearoa Health Limited – Director and Shareholder - company provides research under contract to a variety of organisations. Currently providing services to Partnership Health PHO in the area of Maori Health planning.</p> <p>Age Concern Canterbury, Council and Executive – Member - advocacy and support group for older people.</p>
David Morrell	<p>Brackenridge Estate Limited – Chairman (appointed by Canterbury DHB) - wholly owned subsidiary of the Canterbury DHB - provides intellectual disability services under contracts with the Ministry of Health, Work and Income New Zealand, Accident Compensation Corporation and the Child, Youth and Family Service.</p> <p>Social Services Council of the Diocese of Christchurch (Anglican Aged Care) - Committee Member - provides residential aged care services (rest home and hospital) under contracts with the Canterbury DHB.</p>
David Kerr	<p>Centrecare Limited - Chair</p> <p>General Medical Practitioner</p> <p>Health Education Trust - Trustee</p> <p>Medical Protection Society - Advisor</p> <p>Pegasus Health - Advisor</p> <p>Ryman Healthcare Limited – Chair</p>
John Musgrove	Windsor House Board of Governors - Windsor House has a contract with the Canterbury DHB for provision of hospital and rest-home services for the elderly and has recently been successful in obtaining a contract for 20 beds for dementia patients with the Canterbury DHB.
Trevor Read	Assistance with strengthening IT strategy and systems planning for the South Canterbury District Health Board.
Alison Wilkie	<p>Rural Canterbury Primary Health Organisation – Employee</p> <p>Christchurch Primary Health Organisation - Employee</p> <p>Family Help Trust – Trustee</p> <p>Christchurch Resettlement Services – Board member</p>
Peter Ballantyne	<p>Bishop Julius Hall of Residence - Trust Board Member</p> <p>University of Canterbury, Audit and Risk Committee - Member</p> <p>Anglican Aged Care - Committee Member</p> <p>Deloitte - Consultant</p> <p>Spouse is a Canterbury DHB employee</p>
Tuari Potiki	<p>He Oranga Pounamu - Board Member</p> <p>Drug and Alcohol Practitioners Association of NZ - Executive Member</p> <p>Spouse is a board member of the Rural Canterbury Primary Health Organisation</p>

SUBSIDIARY AND ASSOCIATED COMPANIES

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

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD OR SUBSIDIARIES' INFORMATION

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

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

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

The total payments made by Canterbury DHB were \$32,130 (2005/06 – 4 employees totalling \$35,074) comprise negotiated settlements with all of the former employees.

Number of Employees	TOTAL \$
1	32,130
1	32,130

REMUNERATION OF EMPLOYEES

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

	30/06/07 Including Benefits Number	30/06/06 Including Benefits Number	30/06/06 Excluding Benefits Number
\$100,000 - \$110,000	98	54	77
\$110,001 - \$120,000	77	48	55
\$120,001 - \$130,000	54	49	49
\$130,001 - \$140,000	42	43	34
\$140,001 - \$150,000	34	30	26
\$150,001 - \$160,000	33	19	26
\$160,001 - \$170,000	22	30	41
\$170,001 - \$180,000	23	29	25
\$180,001 - \$190,000	25	27	16
\$190,001 - \$200,000	16	15	20
\$200,001 - \$210,000	26	26	24
\$210,001 - \$220,000	21	15	10
\$220,001 - \$230,000	11	17	7
\$230,001 - \$240,000	17	3	6
\$240,001 - \$250,000	7	10	3
\$250,001 - \$260,000	8	4	3
\$260,001 - \$270,000	3	4	2
\$270,001 - \$280,000 ¹	5	2	1
\$280,001 - \$290,000	2	2	2
\$290,001 - \$299,000	1	1	1
\$300,001 - \$310,000	1	2	-
\$310,001 - \$320,000	2	1	-
\$320,001 - \$330,000	1	-	-
\$330,001 - \$340,000	-	-	1
\$350,001 - \$360,000	-	1	-
\$360,001 - \$370,000	1	-	-
\$460,001 - \$470,000 ¹	1	-	-
	<u>531</u>	<u>432</u>	<u>429</u>

Of the 531 positions identified above, 491 (2005/06 - 399 including benefits, 397 excluding benefits) were predominantly clinical and 40 (2005/06 - 33 including benefits, 32 excluding benefits) were management/administrative.

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

STATUTORY DISCLOSURE

Legislative Responsibilities

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

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

The following information reports Canterbury DHB's performance for the year ended 30 June 2007, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 39.

Section 42(3)(b) – Report on extent CDHB has met the objectives under section 22	
Objective:	Extent objectives met
(a) to improve, promote, and protect the health of people and communities:	<p>The DHB funds and delivers a range of services from health promotion and protection services, primary care to specialist tertiary services to meet the needs of its population. The key areas of focus were Child and Youth Health, Older Persons' Health, Maori Health, Primary Health, Disease Prevention/Management covering, Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease. Further to this the Minister of Health's expectations saw a particular focus on implementation of the national Mental Health Strategy and the Mental Health Blueprint and a focus on information systems and services, workforce development, elective services and service delivery, collaboration, productivity and value for money.</p> <p>The DHB is also aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health and continues to work collaboratively to set goals and objectives for our community's health, to share data and research on health outcomes and to provide a healthy environment for our population.</p> <p>One of the groups the DHB works with, in an effort to build relationships with other organisations and develop a shared approach to the health of our community, is Healthy Christchurch. This involves over 200 organisations who have signed the 'Healthy Christchurch Charter' who aim to forge a common vision for a healthy city, to foster healthy relationships between diverse agencies and sectors, from 'grassroots' groups to government agencies, to enable flexible, collaborative and prompt responses to emergent health issues and to ensure all policy incorporates a health perspective.</p> <p>The initiative recognises that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, transport or any other aspect of city life. Some of the projects to date include:</p> <ul style="list-style-type: none"> ▪ Healthy Homes - aimed at promoting awareness of environmental issues and their potential financial and health impacts among the Christchurch population with sessions focused on energy, transport, waste, gardening, water and shopping; ▪ Oral Health - proposed to address the adverse oral health impacts of the decision not to fluoridate the Christchurch water supply. One achievement included every Christmas food parcel distributed through the Methodist Mission containing a toothbrush and fluoridated toothpaste for each child – this reached around 800 children across the city; and

	<ul style="list-style-type: none"> ▪ City Harvest - a citywide celebration of growing your own food and eating healthily linked to the central themes of good nutrition, gardening/ harvesting and celebration
<p>(b) to promote the integration of health services, especially primary and secondary health services:</p>	<p>As part of the Ministry's national Primary Care Strategy, PHOs have been created to help deliver primary care services to communities. Canterbury has five PHOs that encompass the region and the DHB has developed a close working relationship with those PHOs. Together the PHOs and the DHB have achieved a number of successes in implementing the Primary Care Strategy over the past year:</p> <ul style="list-style-type: none"> ▪ PHO enrolments cover 94% of the Canterbury population; ▪ Several 'Services to Improve Access' programmes implemented including: longer GP consultations, school health clinics, community nursing services; ▪ Collaboration on health promotion programmes including smoking cessation, youth oral health, physical activity and nutrition programmes. Successful implementation of the Meningococcal B vaccination campaign was a significant collaborative effort between the DHB and PHOs along with the development of a nutritional cookbook for older people. Health promotion funding has also enable initiatives such as the funding of a Pacific Worker in Ashburton (by the Rural Community PHO) focused on chronic conditions; ▪ A review of Acute Demand and After Hours Cover in Canterbury in collaboration with PHOs and GPs, resulting in the development of the Canterbury DHB After Hours Discussion Paper; ▪ Additional resources to increase Pacific community nursing services in Canterbury. District Nursing Organisations and PHOs will be able to utilise the expertise of this nursing position to help reduce inequalities faced by Pacific People particularly around chronic conditions management; and ▪ The development of the Canterbury DHB Primary Mental Health Positioning Paper and continued implementation of Mental Health Demonstration Models within primary care. <p>The DHB continues with its Improving the Patient Journey Programme. This is a major DHB initiative to improve the quality and effectiveness of the service we provide to patients. Significant investment has been made on ED flow issues, establishing new acute clinical pathways and understanding acute surgical pathways.</p> <p>The DHB has continued to work on the development of an overarching chronic conditions management framework. This framework has been signed off by the DHB's Board and will begin by addressing continuums of care for Cardiovascular Disease, Diabetes, Respiratory Disease and Depression. This work look at the continuum of care from 'wellness' at one end to 'unwellness' at the other and work to place the patient at the centre of the health continuum. The expected outcomes are early detection and intervention, continuity and coordination of care, improved information exchange and workforce alignment. This work will heavily influence the activity in each of the DHB's four Disease Priority areas in coming years and will involve integration between primary and secondary services to improve the continuum of care for our community.</p>

<p>(c) to promote effective care or support for those in need of personal health services or disability support services:</p>	<p>The DHB has developed an Older People’s Health Strategy: <i>Healthy Ageing, Integrated Support</i>. The underlying objective is to maintain older people’s independence for as long as possible, reduce the period and levels of dependence and at the same time provide effective, integrated services when they are required.</p> <p>Successes over the past year have included:</p> <ul style="list-style-type: none"> ▪ Further development of home care packages as alternatives to residential care and transitioning of rest home beds to hospital level to meet changes in demand; ▪ A review of community day support options, with increases in capacity for general and dementia stand-alone day activity centres; ▪ A joint initiative with the Nurse Maude Association and Healthcare NZ to improve access to complex wound care for subsidised residents in aged residential care. This two year project is a first in NZ and will also focus on mentoring registered nurses and promoting improved wound management (less pressure ulcers and other complex wounds) and therefore fewer admissions to secondary care; ▪ Completion of the two year trial of the geriatric assessment tool, International Resident Assessment Instrument (InterRAI) (Minimum Data Set Home Care Version) with approval for wider use of the tool within our HSS Older People’s Health Service. This tool aims to improve coordinated clinical assessment by avoiding duplication and using one integrated plan for each patient. The information captured will also provide insight into the health needs of our ageing population; ▪ Utilisation of Blueprint funding for re-establishing a Psychiatric Service for the Elderly Memory Assessment Clinic; ▪ Completion of an HSS Community Stroke Service pilot, resulting in improved outcomes for older people and their families; and ▪ Completion of a pilot to explore the needs of older Maori with particular focus on those admitted to inpatient units which contributed to the development of Te Huanui, our Maori Health Plan for Older People and the employment of a dedicated Maori Health Worker.
<p>(d) to promote the inclusion and participation in society and independence of people with disabilities:</p>	<p>The DHB aims to ensure it contributes to a ‘non disabling’ society through its actions, and the actions of the providers with whom it contracts. As such the DHB has developed a Disability Strategic Action Plan (DSAP) that outlines the steps it is making to implement the NZ Disability Strategy. The DSAP involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring.</p> <p>All new building and facility developments are assessed for meeting the needs of people with disabilities.</p>

<p>(e) to reduce health disparities by improving health outcomes for Māori and other population groups:</p>	<p>The DHB has reviewed its Maori Health Action Plan over the past year. The key objectives include reducing health inequalities and supporting Maori participation in health and Maori health workforce development. Over the past year progress has been made in implementing projects that support the DHB's Maori Health Plan including:</p> <ul style="list-style-type: none"> ▪ Extension of the Christchurch Hospital Maori Health Team working in key services to achieve better health outcomes for Maori patients, particularly services that require cultural protocols (Paediatrics, Oncology, Sexual Health, the Emergency Department and the Mortuary); ▪ Provision of a cultural programme to Burwood Hospital staff, assisting them to understand how Maori views and values can impact on their clinical practice; ▪ Collaboration with Partnership Health PHO in developing a smoking cessation service targeting Maori women and their families to improve the health of this at risk population; and ▪ Collaboration with local Maori groups to implement a smoke-free marae campaign with several local marae now having designated smoking areas and one becoming smoke-free.
<p>(f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:</p>	<p>The DHB's local Health Needs Assessment (completed in 2005) has identified groups in the community, which have health inequalities. The DHB's District Strategic Plan identifies a number of Health Gain Priority Areas where the DHB will focus its efforts to reduce these health inequalities. The DHB has identified: Child and Youth Health, Older Persons' Health, Maori Health, Primary Health and Disease Prevention and Management as key areas of focus with Cancer, Cardiovascular, Diabetes and Respiratory Disease as identified disease priorities where change can help to eliminate health inequalities in our community.</p> <p>Work continues with PHOs in Canterbury to reduce barriers to primary care including financial barriers through the reduction of co-payments with reductions being achieved for all 18-25 year olds, 25-44 year olds and 45-64 year olds. The DHB is also working with PHO to implement Services to Improve Access to primary care.</p>
<p>(g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:</p>	<p>The DHB has established inter-agency relationships with a wide range of government agencies including: the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, of Education and of Social Development, ACC and the Department of Corrections. The DHB works collaboratively with the TLAs and regional council in the Canterbury region along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other Non-Government Organisations (NGOs) in our region. The DHB also actively support a number of collaborative ventures which endeavour to improve the environment and the health of our residents.</p> <p>The DHB actively engages with providers of health services working with them in a cooperative way for the benefit of our population. In important areas of policy development or for significant projects the DHB seeks input from our community and our providers. This may be in the form of providing opportunities for input on early development of papers/ideas or involvement in working parties.</p> <p>The DHB has established, or is involved with, a number of consumer and community reference groups, working parties and advisory groups which provide advice and input on the development of</p>

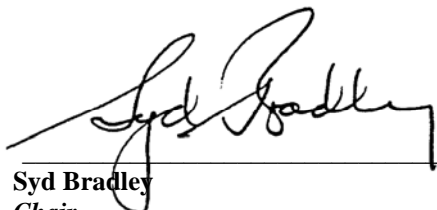
	<p>strategy, policy and direction for the DHB. The DHB also works closely with Maori and Pacific communities to ensure Maori and Pacific input into the development of strategies, policy and initiatives to improve health care access and delivery.</p> <p>Over the past year the DHB has undertaken considerable consultation on a number of key strategies and plans. It is important that the long-term direction being set through these key strategies is relevant to, and supported by, consumers, service users, our community and our staff and that any change will have a positive impact on the health status of our community.</p>
<p>(h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:</p>	<p>The DHB actively participates in forums such as Healthy Christchurch and information gathered from these forums assists the service planning process.</p> <p>The DHB also engages in active consultation through formal processes (such as the consultation process to develop our District Strategic Plan) and sector representation on project steering groups.</p> <p>The DHB has also embarked on the development of a Health Services Plan which will be linked to a workforce strategy and facilities master-plan. If the DHB intends to ensure effective utilisation of resources and delivery of the best possible health outcomes within the funding allocated we need to ensure that health resources are protected, sustainable and supported long-term. The Health Services Planning focus is to progress planning for future health services through the development of health services models, the development of a framework for the management of chronic conditions and the development of integrated service models.</p> <p>These developments will provide a strategic roadmap for changes in future funding models, the development of workforce strategies and the development of a Facilities Master-Plan. This will mean new thinking around the best way to provide care to our population, looking at the best location, the best service and the best provider. However this will enable us to ensure ongoing provision of health and disability services and to provide services which are better integrated and configured, and that operate seamlessly across geographical, professional and service boundaries.</p> <p>The DHB has introduced a 'participatory model' to involve staff, providers, consumers and our community in this Health Services Planning and extensive participatory workshops and 'design teams' are being established to drive the thinking and planning.</p>
<p>(i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:</p>	<p>The DHB has a Quality and Patient Safety Council and a Clinical Board to provide advice to the CEO on quality and clinical issues. The Quality and Patient Safety Council is a forum for the wider DHB (including community providers) to discuss quality issues. This also facilitates ongoing quality improvement processes.</p> <p>The DHB also has processes in place to maintain and improve quality including Quality Health New Zealand accreditation process for its hospitals and performance targets and measures to maintain appropriate levels of clinical quality.</p> <p>The Clinical Board has a strong focus on clinical governance and has a solution oriented proactive role in the setting of clinical policy and standards and encourages best practice and innovation. The Board supports the organisation's vision and values and will set a leadership role by example.</p>


<p>(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:</p>	<p>The DHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme.</p> <p>The DHB is also aware of the interaction of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work collaboratively to set goals and objectives for our community's health and to provide a healthy environment for our population.</p>
<p>(k) To be a good employer</p>	<p>The DHB is committed to the principles of being a good employer and values diversity amongst its staff. It has in place, as appropriate, a number of organisational policies and procedures (to promote a healthy and safe workplace) including the DHB's Equal Opportunities and Harassment Policies.</p> <p>The DHB also provides a safe and health promoting environment through safe handling programmes and membership of the ACC Partnership Programme. The DHB also encourages its workforce to lead by example in terms of healthier lifestyles and practices.</p>

Section 42(3)(i) – Statement of how CDHB has given effect and intends to give effect to its functions specified in section 23 (1) (b)-(e)	
Function:	What has been done to meet function
<p>(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:</p>	<ul style="list-style-type: none"> ▪ The CDHB has involved stakeholders in selection of its Health Gain Priority Areas for the District Strategic Plan and actively involves relevant groups and individuals in planning specific service areas including its current Health Services Planning Programme. ▪ The DHB has established joint arrangements with external providers for the provision of some additional surgical services, such as orthopaedic and cardiac surgery. ▪ The DHB participates in a number of regional initiatives with other DHBs such as working with South Island DHBs on the Cancer Control Network and the implementation of national information systems. ▪ The DHB has a Memorandum of Understanding with the West Coast DHB which assists in the development of closer clinical collaboration. ▪ The DHB has established inter-agency relationships with a wide range of government agencies including: the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, of Education and of Social Development, ACC and the Department of Corrections. ▪ The DHB also works with the Ministry of Health in a number of joint/collaborative ways participating in national projects including national benchmarking exercises and national pricing projects.
<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</p>	<p>The DHB uses a variety of written media, TV and radio work to outline general issues and priorities and the community and responds directly to media / personal / group enquires.</p> <p>The DHB has developed a website, which includes community based health information and its primary planning documents. The DHB</p>

<p>paragraphs (a) and (b):</p>	<p>also circulates and makes available significant documents and plans for its population in summary and comprehensive form either at libraries, via groups or individually and on its website.</p> <p>The DHB continues to provide health promotion information through its Community Health Information Centre, open to the public five days a week. Supplies of health education resources are held and a number of satellite health information stands have been developed – there are currently 20 of these sites with particular emphasis being placed on Marae, TLA service centres, hospitals, and other appropriate settings for target communities.</p>
<p>(d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:</p>	<p>Relationships with Manawhenua Ki Waitaha, Te Runanga and Nga Maata Waka continue to develop. Māori community hui are held quarterly and regular meetings with Māori providers and other Māori community organisations. The outcomes of these meetings are fed directly into the DHB planning process.</p> <p>The DHB is also committed to the establishment of a Crown Relationship Agreement with local iwi.</p>
<p>(e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:</p>	<p>The DHB has established Te Kahui Taumata, which includes the Kaumatua and Taua, the Executive Director Māori and Pacific Health, and senior Māori staff who provide Māori specific advice to the Chief Executive.</p> <p>The DHB continues to work on capacity and capability issues through Te Herenga Hauora o te Waka a Maui (the South Island Maori Managers Network), where a number of projects have been developed to support Maori service provision in Canterbury. These include:</p> <ul style="list-style-type: none"> ▪ The development of a Maori Health Workforce Development Plan, <i>Te Waipounamu</i>, now in the final stages of consultation; ▪ The development of a South Island regional Maori workforce recruitment project to enhance the Maori health workforce in our region; and ▪ The development of a Maori health training and education opportunities directory, currently being distributed to Maori health providers.

For and on behalf of the Board


 Syd Bradley
 Chair
 26 September 2007

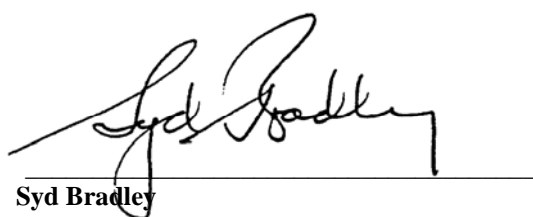

 Olive Webb
 Board Member
 26 September 2007

Lian Tan

STATEMENT OF RESPONSIBILITY

Pursuant to Section 155 of the Crown Entities Act 2004, we acknowledge that:

- a) The preparation of financial statements and statement of service performance of Canterbury DHB and the judgements used therein, are our responsibility.
- b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2007, are our responsibility.
- c) In our opinion, the financial statements and statement of service performance for the year under review fairly reflect the financial position and operations of Canterbury DHB.



Syd Bradley
Chair

26 September 2007



Olive Webb
Board Member

26 September 2007

Lian Tan

STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2007

	Notes	Group		Parent		
		Actual 30/06/07 \$'000	Budget 30/06/07 \$'000	Actual 30/06/06 \$'000	Actual 30/06/07 \$'000	Actual 30/06/06 \$'000
OPERATING REVENUE						
Ministry of Health Revenue		1,050,404	994,542	972,575	1,042,064	964,726
Patient Related Revenue		33,458	29,298	31,224	33,876	31,661
Other Revenue		27,463	25,754	19,843	25,277	18,499
TOTAL REVENUE		1,111,325	1,049,594	1,023,642	1,101,217	1,014,886
OPERATING EXPENSES						
Employee Costs		437,912	417,600	406,846	429,287	399,201
Treatment Related Costs		105,727	101,748	109,289	108,864	112,310
External Service Providers		433,074	411,229	381,660	433,074	381,660
Depreciation	11	47,228	44,272	47,372	46,046	46,386
Interest Expense		5,069	6,696	4,936	5,140	4,957
Other Expenses		60,269	52,477	55,602	57,288	53,047
TOTAL OPERATING EXPENSES		1,089,279	1,034,022	1,005,705	1,079,699	997,561
OPERATING SURPLUS BEFORE CAPITAL CHARGE		22,046	15,572	17,937	21,518	17,325
Capital Charge Expense		(22,894)	(18,072)	(15,076)	(22,894)	(15,076)
NET SURPLUS / (DEFICIT) FOR THE YEAR		(848)	(2,500)	2,861	(1,376)	2,249

STATEMENT OF MOVEMENTS IN EQUITY FOR THE YEAR ENDED 30 JUNE 2007

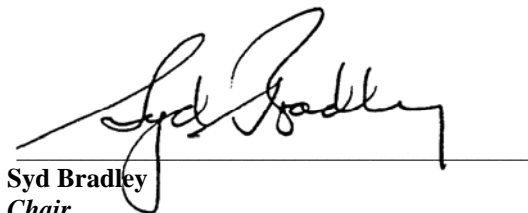
	Notes	Group		Parent		
		Actual 30/06/07 \$'000	Budget 30/06/07 \$'000	Actual 30/06/06 \$'000	Actual 30/06/07 \$'000	Actual 30/06/06 \$'000
TOTAL EQUITY						
AT BEGINNING OF THE PERIOD:		287,326	243,205	199,705	285,612	198,603
TOTAL RECOGNISED REVENUES AND EXPENSES:						
Net surplus / (deficit) for the period		(848)	(2,500)	2,861	(1,376)	2,249
Revaluation of Property		-	-	106,760	-	106,760
		<u>(848)</u>	<u>(2,500)</u>	<u>109,621</u>	<u>(1,376)</u>	<u>109,009</u>
OTHER MOVEMENTS						
Contribution from/(back to) Crown	5	(1,861)	(14,500)	(22,000)	(1,861)	(22,000)
		<u>(1,861)</u>	<u>(14,500)</u>	<u>(22,000)</u>	<u>(1,861)</u>	<u>(22,000)</u>
TOTAL EQUITY AT END OF THE PERIOD		<u>284,617</u>	<u>226,205</u>	<u>287,326</u>	<u>282,375</u>	<u>285,612</u>

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2007

		Group			Parent	
	Notes	Actual 30/06/07 \$'000	Budget 30/06/07 \$'000	Actual 30/06/06 \$'000	Actual 30/06/07 \$'000	Actual 30/06/06 \$'000
CROWN EQUITY						
General Funds	5	124,313	126,174	126,174	124,451	126,312
Revaluation Reserve	5	184,477	125,126	184,477	184,477	184,477
Retained Earnings	5	(32,273)	(33,500)	(31,435)	(34,547)	(33,170)
Trust Reserve	5	8,100	8,405	8,110	7,994	7,993
TOTAL EQUITY		284,617	226,205	287,326	282,375	285,612
REPRESENTED BY:						
CURRENT ASSETS						
Cash and Bank		50,633	3	12,838	49,282	12,270
Receivables and Prepayments	3	24,132	17,122	25,391	23,529	24,898
Stocks	4	8,175	7,000	7,196	8,110	7,133
TOTAL CURRENT ASSETS		82,940	24,125	45,425	80,921	44,301
CURRENT LIABILITIES						
Creditors and Accruals		79,914	72,909	74,456	80,527	75,433
Owing to the Ministry of Health		13,852	4,500	3,738	13,852	3,738
Staff Entitlements due within 1 year	8	56,475	38,914	48,919	55,509	48,157
Provisions due within 1 year	9	36,092	29,000	29,217	36,048	29,189
TOTAL CURRENT LIABILITIES		186,333	145,323	156,330	185,936	156,517
NET WORKING CAPITAL		(103,393)	(121,198)	(110,905)	(105,015)	(112,216)
NON CURRENT ASSETS						
Investments	12	11,689	311	375	14,796	2,592
Fixed Assets	11	456,147	422,087	466,145	452,307	463,364
Surplus Property		8,250	8,250	11,760	8,250	11,760
Restricted Assets	6	8,100	8,405	8,110	7,994	7,993
TOTAL NON CURRENT ASSETS		484,186	439,053	486,390	483,347	485,709
NON CURRENT LIABILITIES						
Provisions	9	8,526	7,000	9,509	8,307	9,231
Loans repayable after 1 year	10	87,650	84,650	78,650	87,650	78,650
TOTAL NON CURRENT LIABILITIES		96,176	91,650	88,159	95,957	87,881
NET ASSETS		284,617	226,205	287,326	282,375	285,612

For and on behalf of the Board



Syd Bradley
Chair

26 September 2007



Olive Webb
Board Member

26 September 2007

Lian Tan

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2007

		Group		Parent		
	Notes	Actual 30/06/07 \$'000	Budget 30/06/07 \$'000	Actual 30/06/06 \$'000	Actual 30/06/07 \$'000	Actual 30/06/06 \$'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,051,140	994,542	963,919	1,042,109	956,024
Other Receipts		49,893	46,053	44,340	48,773	43,348
Interest Received		5,146	-	3,102	5,278	3,187
		<u>1,106,179</u>	<u>1,040,595</u>	<u>1,011,361</u>	<u>1,096,160</u>	<u>1,002,559</u>
Cash was applied to:						
Payments to Employees		424,411	417,600	392,601	416,000	384,907
Payments to Suppliers		593,859	570,455	549,811	594,297	549,098
Interest Paid		4,883	6,696	4,928	4,953	4,949
Capital Charge		12,780	18,072	19,955	12,780	19,955
GST - net		728	-	(3,557)	751	(3,546)
		<u>1,036,661</u>	<u>1,012,823</u>	<u>963,738</u>	<u>1,028,781</u>	<u>955,363</u>
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	13	69,518	27,772	47,623	67,379	47,196
CASH FLOWS FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of Assets		11,315	17,000	6,650	11,297	6,650
Decrease in Restricted Assets and Investments		10	-	231	-	-
		<u>11,325</u>	<u>17,000</u>	<u>6,881</u>	<u>11,297</u>	<u>6,650</u>
Cash was applied to:						
Increase in Investments & Restricted Assets		11,314	-	-	12,205	448
Purchase of Assets		38,873	36,000	29,775	36,598	28,810
		<u>50,187</u>	<u>36,000</u>	<u>29,775</u>	<u>48,803</u>	<u>29,258</u>
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(38,862)	(19,000)	(22,894)	(37,506)	(22,608)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		15,000	6,000	-	15,000	-
		<u>15,000</u>	<u>6,000</u>	<u>-</u>	<u>15,000</u>	<u>-</u>
Cash was applied to:						
Loans Repaid		6,000	-	-	6,000	-
Equity repaid to Crown		1,861	14,500	22,000	1,861	22,000
		<u>7,861</u>	<u>14,500</u>	<u>22,000</u>	<u>7,861</u>	<u>22,000</u>
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		7,139	(8,500)	(22,000)	7,139	(22,000)
Overall Increase/(Decrease) in Cash Held		37,795	272	2,729	37,012	2,588
Opening Cash Balance		12,838	(269)	10,109	12,270	9,682
CLOSING CASH BALANCE		50,633	3	12,838	49,282	12,270

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2007

1. STATEMENT OF ACCOUNTING POLICIES

A. REPORTING ENTITY

Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004.

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

The financial statements of Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and section 154 of the Crown Entities Act 2004, which includes the requirements to comply with generally accepted accounting practice in New Zealand.

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

B. MEASUREMENT BASE

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

C. ACCOUNTING POLICIES

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

i) **Revenue from Contracts for Services**

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

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

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

iii) **Fixed Assets**

Fixed Assets Vested from the Hospital and Health Service

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

Fixed Assets acquired since the establishment of Canterbury DHB

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

Revaluation of land, buildings and fitout plant and equipment

Land, buildings and fitout plant and equipment are revalued every five years in accordance with FRS3. The value of land, buildings and fitout plant and equipment is determined by an independent registered valuer by reference to the highest and best use of these assets or, if sufficient market based evidence is not available, by reference to their optimised depreciated replacement cost. Additions between revaluations are recorded at cost. The results of revaluing land, buildings and fitout plant and equipment are credited or debited to the assets revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

The latest valuation was performed as at 30 June 2006 by Chris Stanley (Registered Valuer) of TelferYoung (Canterbury) Ltd.

Donated Assets

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

iv) Depreciation

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

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

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

v) Goods and Services Tax

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

vi) Stocks

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

vii) Accounts Receivable

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

vii) Investments

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

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

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

ix) Taxation

Canterbury DHB is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under Section CW31 of the Income Tax Act 2004.

In prior years, Canterbury DHB subsidiaries were subject to income tax, with the exception of Brackenridge Estate Ltd. From the beginning of 1 July 2004 Canterbury Laundry Service Limited is also exempt from income tax under Section CW31 of the Income Tax Act 2004. Previously, income tax expense was charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. The tax provisions have been reversed following the tax exempt status given to Canterbury Laundry Service Limited.

x) Research and Development

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

xi) Foreign Currencies

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

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

xii) Leased Assets

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

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

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

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

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

xiii) Finance Costs

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

xiv) Provision for Staff Entitlements

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

xv) Statement of Cash Flows

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

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

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

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

xvi) Donations and Bequests

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

xvii) Financial Instruments

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

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

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

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

xviii) Basis of Consolidation

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

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

All significant inter-company transactions are eliminated on consolidation.

D CHANGE IN ACCOUNTING POLICIES

There have been no changes in accounting policies during the year. All policies have been applied on a basis consistent with the previous period though the presentation of some comparatives have changed in order to be comparable with the current presentation.

Canterbury DHB's adoption of the New Zealand equivalent International Financial Reporting Standards (NZ IFRS) is in line with government entity timeframe, effective 1 July 2007. Therefore the first set of fully compliant financial statements will be prepared as at 30 June 2008. This will require the 2007/08 financial statements to include restated NZ IFRS-compliant comparatives for the year ended 2007 and opening balances as at 1 July 2006. The DHB has been working with representatives of the Ministry of Health and Treasury along with external advisers, to identify and quantify the impacts of NZ IFRS adoption and also to implement processes for capturing all relevant information. This work has identified some areas that will result in changes in presentation and classification, and also may have some impact on the Statement of Financial Performance. These changes include the areas associated with Employee Benefits, Financial Instruments, Revenue Recognition, Leases, Impairment, and Related Parties. The opening balances as at 30 June 2006 have been recalculated to reflect the changes in these areas, however, the full financial effects of NZ IFRS have yet to be determined or calculated for the year ended 30 June 2007.

2. NET OPERATING SURPLUS/(DEFICIT)

The net operating surplus/(deficit) is stated:	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
After Charging:				
Remuneration of Auditor:				
- Audit Fees	166	148	137	117
- Other Services	14	3	14	3
Board Members' Fees	300	294	300	294
Directors' Fees	23	23	-	-
Interest Expense	5,070	4,936	5,140	4,957
Bad Debts Written Off	376	408	376	408
Increase/(Decrease) in Bad Debts Provision	985	(680)	985	(680)
Rental and Operating Lease Costs	4,211	3,444	3,773	2,997
After Crediting:				
Interest Income	5,146	3,102	5,278	3,187
Gain (loss) on Disposal of Assets	6,162	3,625	6,178	3,625

3. RECEIVABLES AND PREPAYMENTS

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Trade Debtors	7,516	7,782	7,323	7,678
Receivable from the Ministry of Health	8,854	8,849	8,480	8,525
Other Debtors	7,104	7,859	7,104	7,825
Prepayments	658	901	622	870
	24,132	25,391	23,529	24,898

4. STOCKS

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Pharmaceuticals	2,538	2,468	2,538	2,468
Surgical and Medical Supplies	4,716	3,985	4,716	3,985
Other Supplies	1,532	1,501	1,467	1,438
	8,786	7,954	8,721	7,891
Provision for Obsolescence	(611)	(758)	(611)	(758)
	8,175	7,196	8,110	7,133

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

5. EQUITY

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
GENERAL FUNDS				
Opening Balance	126,174	148,174	126,312	148,312
Equity repayment to Crown	(1,861)	(22,000)	(1,861)	(22,000)
	124,313	126,174	124,451	126,312
RETAINED EARNINGS				
Opening Balance	(31,435)	(34,591)	(33,170)	(35,734)
Operating Surplus/(Deficit)	(848)	2,861	(1,376)	2,249
Transfers from/(to) Trust Reserve	10	295	(1)	315
Closing Balance	(32,273)	(31,435)	(34,547)	(33,170)
Represented by:				
Accumulated Deficit in Parent and Subsidiary	(32,351)	(31,513)	(34,625)	(33,248)
Accumulated Surplus in Associates	78	78	78	78
	(32,273)	(31,435)	(34,547)	(33,170)
REVALUATION RESERVE				
Opening Balance	184,477	77,717	184,477	77,717
Current Year Movement	-	106,760	-	106,760
Closing Balance	184,477	184,477	184,477	184,477
Represented by:				
Revaluation of land	68,603	68,603	68,603	68,603
Revaluation of building including fitout	114,374	114,374	114,374	114,374
Revaluation of reversionary interest in buildings	1,500	1,500	1,500	1,500
	184,477	184,477	184,477	184,477
TRUST RESERVE				
Opening Balance	8,110	8,405	7,993	8,308
Transfers from/(to) Retained Earnings	(10)	(295)	1	(315)
Closing Balance	8,100	8,110	7,994	7,993

6. RESTRICTED ASSETS

Restricted assets are funds donated and bequeathed for specific purposes. At 30 June 2007, the amount of funds received where the conditions attached have not been fulfilled is \$8,100,000 (\$8,110,000 at 30 June 2006).

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
This is represented by:				
Cash at Bank	647	355	647	355
Term Deposits	2,116	836	2,010	719
Local Authorities & Government Stocks	1,030	830	1,030	830
Bonds & Stocks	4,307	6,089	4,307	6,089
Total Restricted Assets	8,100	8,110	7,994	7,993

7. RESIDENTS' TRUST ACCOUNT

	Group		Parent	
	As at	As at	As at	As at
	30/06/07	30/06/06	30/06/07	30/06/06
	\$'000	\$'000	\$'000	\$'000
Residents' Trust Account Balance	870	806	400	383

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

8. STAFF ENTITLEMENTS

	Group		Parent	
	As at	As at	As at	As at
	30/06/07	30/06/06	30/06/07	30/06/06
	\$'000	\$'000	\$'000	\$'000
Staff Entitlements consist of:				
Annual Leave Accruals	35,007	31,797	34,466	31,344
Unpaid Days Accruals	12,226	10,004	11,946	9,799
ACC Accruals	4,641	2,959	4,554	2,955
Other	4,601	4,159	4,543	4,059
Staff Entitlement Due Within 1 Year	56,475	48,919	55,509	48,157

9. PROVISIONS

	Group		Parent	
	As at	As at	As at	As at
	30/06/07	30/06/06	30/06/07	30/06/06
	\$'000	\$'000	\$'000	\$'000
Provisions due within 1 year	36,092	29,217	36,048	29,189
Provisions due after 1 year	8,526	9,509	8,307	9,231
Total Provisions	44,618	38,726	44,355	38,420
Movement in Provisions				
Opening balance	38,726	29,051	38,420	28,729
Additional provisions made during the year	26,429	19,812	26,409	19,828
Charged against provisions for the year	(20,537)	(10,137)	(20,474)	(10,137)
Closing balance	44,618	38,726	44,355	38,420

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

10. LOANS AND BANK OVERDRAFT

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Loans consist of:				
Crown Financing Agency	87,650	78,650	87,650	78,650
	87,650	78,650	87,650	78,650
Repayable as follows:				
Due Within 1 Year	-	-	-	-
Two - Five Years	72,650	78,650	72,650	78,650
Beyond Five Years	15,000	-	15,000	-
	87,650	78,650	87,650	78,650

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

Security

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

Interest Rates

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

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Commercial Loans	-	-	-	-
Crown Financing Agency	6.23%	6.24%	6.23%	6.24%
Bank Overdraft	9.18%	8.80%	9.18%	8.80%

11. FIXED ASSETS

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
At Cost				
Buildings and Fitout Plant	13,095	-	12,810	-
Leasehold Building & Fitout	894	1,281	894	894
Plant and equipment	87,309	74,720	80,759	69,693
Computer equipment and software	43,482	40,578	43,482	40,521
Motor vehicles	5,462	4,988	4,663	4,371
Capital work-in-progress	21,529	15,841	21,483	15,727
At Valuation				
Land	100,083	99,913	100,083	99,913
Buildings and Fitout Plant	300,816	300,816	300,816	300,816
Plant and equipment	24,791	24,791	24,791	24,791
Reversionary interest in buildings	1,500	1,500	1,500	1,500
	598,961	564,428	591,281	558,226
Accumulated Depreciation				
Buildings and Fitout Plant	29,729	-	29,691	-
Leasehold Building & Fitout	894	891	894	808
Plant and equipment	68,365	58,549	64,957	55,557
Computer equipment and software	40,069	35,930	40,069	35,882
Motor vehicles	3,757	2,913	3,363	2,615
	142,814	98,283	138,974	94,862
Net Book Value				
Land	100,083	99,913	100,083	99,913
Buildings and Fitout Plant	284,182	300,816	283,935	300,816
Leasehold Building & Fitout	-	390	-	86
Plant and equipment	43,735	40,962	40,593	38,927
Computer equipment and software	3,413	4,648	3,413	4,639
Motor vehicles	1,705	2,075	1,300	1,756
Capital work-in-progress	21,529	15,841	21,483	15,727
Reversionary interest in buildings	1,500	1,500	1,500	1,500
	456,147	466,145	452,307	463,364
Depreciation charged during the year:				
Buildings and Fitout Plant & leasehold	29,880	27,585	29,851	27,548
Plant and equipment	12,266	10,860	11,250	10,050
Computer equipment and software	4,261	7,920	4,241	7,886
Motor vehicles	821	1,007	704	902
	47,228	47,372	46,046	46,386

Canterbury DHB revalued its land, buildings and fitout plant as at 30 June 2006. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of TelferYoung (Canterbury) Ltd), which is consistent with FRS3 Accounting for Property Plant & Equipment, and resulted in the net increases in the value of land (\$41,072,000), buildings and fitout (\$65,178,000) and reversionary interest in a car park building (\$510,000). This increase had been recognised in the Revaluation Reserve. The total optimised depreciated replacement cost of Canterbury DHB's land and buildings including fitout as at 30 June 2006 was \$400,729,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 2019. This interest has not been included in the Statement of Financial Position, other than the total revaluation effect of \$1,500,000 included in the Revaluation Reserve and Fixed Assets as reversionary interest.

12. INVESTMENTS

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Investment in Associates	519	375	519	375
Investment in Subsidiaries	-	-	3,107	2,217
Other Investments	11,170	-	11,170	-
	11,689	375	14,796	2,592

INVESTMENT IN ASSOCIATES

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Share of Associates Equity Brought Forward	168	168	168	168
Share of Associates Operating Surplus	-	-	-	-
Share of Associates Equity Carried Forward	168	168	168	168
Advances	351	207	351	207
	519	375	519	375

At 30 June 2007, Associate Companies comprised:

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

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

South Island Shared Services Agency Ltd provides a range of support services such as contracting, contract monitoring and provider audits on behalf of the South Island DHBs Funding arms.

INVESTMENT IN SUBSIDIARIES

	Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Equity - Canterbury Laundry Service Ltd	394	394
Advances - Canterbury Laundry Service Ltd	2,713	1,823
Equity - Brackenridge Estate Ltd	-	-
Advances - Brackenridge Estate Ltd	-	-
	3,107	2,217

At 30 June 2007 subsidiary companies comprise:

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

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

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

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

OTHER INVESTMENTS

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Term Deposit	5,000	-	5,000	-
Bonds	6,170	-	6,170	-
	11,170	-	11,170	-

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

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Net Operating Deficit before Share of Associate Companies' Surplus	(848)	2,861	(1,376)	2,249
Add Back Non-Cash Items:				
Depreciation	47,228	47,372	46,046	46,386
Add Back Items Classified as Investing Activity:				
(Gain) / loss on Asset Sale	(6,162)	(3,625)	(6,178)	(3,625)
	40,218	46,608	38,492	45,010
Movement in Term Portion Provisions	(983)	2,998	(924)	3,042
Movement in Deferred Tax	-	-	-	-
Movements in Working Capital:				
Decrease/ (Incr.) in Receivables & Prepayments	1,259	(9,050)	1,369	(9,103)
Decrease/ (Incr.) in Stocks	(979)	(602)	(977)	(590)
Increase/ (Decr.) in Creditors & Other Accruals	5,458	95	5,094	1,218
Increase/ (Decr.) in Capital Charge due to Crown	10,114	(3,633)	10,114	(3,633)
Increase/ (Decr.) in Staff Entitlements	7,556	4,530	7,352	4,603
Increase/ (Decr.) in Provisions	6,875	6,677	6,859	6,649
NET CASH IN/(OUT)FLOW FROM OPERATING ACTIVITIES	69,518	47,623	67,379	47,196

14. COMMITMENTS

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
CAPITAL COMMITMENTS				
Committed at Balance Date	39,200	31,536	39,200	30,762
NON CANCELLABLE OPERATING LEASE COMMITMENTS				
Accommodation Leases	9,481	13,901	4,996	7,725
Vehicle Leases	-	-	-	-
Other	11	7	-	-
	9,492	13,908	4,996	7,725
For Expenditure Within:				
1 Year	1,634	1,387	1,136	923
2 Years	1,307	1,151	936	687
3 Years and Beyond	6,551	11,370	2,924	6,115
	9,492	13,908	4,996	7,725

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

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

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

15. TRANSACTIONS WITH RELATED PARTIES

a) GOVERNMENT FUNDING

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

b) INTER-GROUP TRANSACTIONS

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

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Revenue				
Interest on advance and director's fees from Canterbury Laundry Service Ltd	-	-	202	138
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	-	13
Services to Canterbury Laundry Service Ltd	-	-	427	478
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	58	53	58	53
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	4,073	3,403
Interest on advance and service fees from Brackenridge Estate Ltd	-	-	25	-
Services from New Zealand Centre for Reproductive Medicine Ltd	1,940	2,015	1,940	2,015
Services from South Island Shared Services Agency Ltd	553	555	553	555

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

The amounts outstanding for all related party transactions as at 30 June 2006 are as follows :

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Amount Receivable owing by associates				
South Island Shared Services Agency Ltd (relates to expenses paid on their behalf and recharged)	351	207	351	207
Amount Payable owing to subsidiaries				
Brackenridge Estate Ltd – Advance	-	-	713	1,317
Canterbury Laundry Service Ltd	-	-	346	279
Amount Receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – Debtor	-	-	80	45
Canterbury Laundry Service Ltd – Advance	-	-	2,750	1,823

c) BOARD AND COMMITTEE MEMBERS

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

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Pegasus Health	2,716	14,565	2,716	14,565
He Oranga Pounamu Charitable Trust	171	171	171	171
Te Amorangi Richmond Wellness Village	8	151	8	151
Te Rito Arahi Māori Alcohol Drug & Resource Centre	228	308	228	308
Windsor House	1,952	1,778	1,952	1,778
Ryman Healthcare Ltd	6,056	4,985	6,056	4,985
TimeOut Carers	261	213	261	213
Canterbury Community Primary Health Organisation	1,450	796	1,450	796
Rural Canterbury Primary Health Organisation	9,110	6,450	9,110	6,450
Access Home Health	3,139	2,569	3,139	2,569
Deloitte	64	2	64	2
Te Puawaitanga ki Otautahi Trust	531	687	531	687
Te Rununga O Nga Maata Waka	127	-	127	-
McLeans Institute	130	192	130	192
Christchurch Resettlement Services	69	-	69	-
University of Canterbury	422	77	422	77
Christchurch Polytechnic	29	12	29	12
New Zealand College of Midwives	1	1	1	1
Cambridge Clinic (DSAC) Limited	112	110	112	110
Age Concern Canterbury	1	1	1	1
Parents Centre NZ	116	92	116	92
24 Hour Surgery Ltd	102	13	102	13
Social Services Council of the Diocese of Christchurch	4,023	3,641	4,023	3,641

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

	Group		Parent	
	As at 30/06/07 \$'000	As at 30/06/06 \$'000	As at 30/06/07 \$'000	As at 30/06/06 \$'000
Pegasus Health	130	127	130	127
Christchurch Polytech	332	313	332	313
Pegasus After Hours Ltd	4	6	4	6

16. CAPITAL CHARGE

Canterbury DHB incurs a monthly capital charge from the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2007 was 8% (8% for the year ended 30 June 2006).

17. FINANCIAL INSTRUMENTS

CREDIT RISK

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

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

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health. However, the Ministry of Health is a high credit quality entity, being the Government funded purchaser of health and disability support services. As at 30 June 2007, the Ministry of Health owed Canterbury DHB \$8.5 million (\$8.8 million at 30 June 2006).

CURRENCY RISK

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

There were no forward exchange contracts outstanding at 30 June 2007 (30 June 2006 nil).

INTEREST RATE RISK

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

There are interest rates swap and options outstanding at 30 June 2007 of \$8 million (30 June 2006 \$46 million). The valuation of these contracts at 30 June 2007 is an unrecognised loss of \$0.163 million (30 June 2006 \$0.042 million loss).

FAIR VALUES OF FINANCIAL INSTRUMENTS

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

18. SEGMENTAL REPORTING

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

19. CONTINGENCIES

Canterbury DHB has the following contingencies at year end:

Collective Employment Agreements negotiations

There are a number of collective employment agreements that expired before 30 June 2007. Negotiations are in progress at a National level and Canterbury DHB has limited influence over such negotiations. While significant industrial action may occur, due to the high degree of uncertainty, the financial impact of such events had not been allowed for in the financial results.

Outstanding Legal Proceedings

The Group has outstanding legal proceedings at year end. The Group disputes these claims and believe that it is unlikely any material financial loss will eventuate

(30 June 2006 – there was one contingency in relation to collective employment agreements negotiations.)

20. BUDGET VARIANCE

Additional personal health funding for PHO, new government health initiatives, funding for impact of property revaluation and funding for settlement of the national Public Service Association (PSA) Multi Employer Collective Agreement (MECA) were devolved during the year and were not reflected in these budgets.

21. SUBSEQUENT EVENTS

There were no events after 30 June 2007 which could have a material impact on the information in Canterbury DHB's financial statements (30 June 2006 – no events).

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2006/2007

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

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

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

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

When the DHB updates its SOI documents it continues to develop and refine the measures for its *Statement of Service Performance* that are appropriate to the needs of its stakeholders within government and within its community. Where possible, past performances for each measure are included, along with the 2006/2007 performance target and the year-end result to give the measurement context.

The targets provided by the DHB are based on the assumption that, notwithstanding funding and financial pressures, the DHB will be able to maintain current levels of service provision in the medium term. With limited funding and workforce shortage in some specialist areas the scope for service expansion can be limited; therefore performance targets in some areas tend to reflect the objective of maintaining current performance levels.

It is important to note that during 2006/07 the DHB experienced prolonged industrial action particularly around Medical Radiation Technologists (MRTs), Lab Workers (including Blood Services) and Radiation Therapists. This action was ongoing from September 2006 and had significant affect on the DHB's ability to meet performance targets associated with delivery and wait-times. The performance measure regarding the percentage of people waiting for a coronary artery bypass graft, the delivery of Cardiac Surgery for key procedures, and that for improving access to radiation therapy on page 50 and 51 are examples of the indicators directly affected by the prolonged industrial action.

Also of note is the DHB's inclusion of several indicators over which it has limited direct control. The DHB has chosen to include these indicators as important measures of the determinants of health, however it should be recognised that the DHB's ability to influence the behaviour of its community and the provision of services by third parties is limited. By including these measures the DHB is essentially recognising its role in contributing to improving health outcomes while recognising that change cannot be made through its actions alone. The DHB continues to work with other providers, external agencies and organisations to collectively improve the health of its community.

Strategic Priorities and Directions

To achieve its primary objective, to improve the health and wellbeing of people living in Canterbury, the DHB determined to focus on achieving improved outcomes in five Strategic Health Gain Priority areas. These Strategic Priorities were identified through a health needs assessment and consultation process during the development of the DHB's five-year District Strategic Plan in 2006; *A Healthier Canterbury: Directions 2010*. The Strategic Priorities chosen were:

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

In addition, Older Persons' Health, Elective Services, Mental Health, Hospital Efficiency and Effectiveness and Good Governance represented further areas of focus in 2006/2007.

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

- Improving the Health Status of our Community - improve the health outcomes for specific groups of the Canterbury population.
- Finding Better Ways of Working - to get the maximum improvement in health status for our community within the available funding and resources.
- Working Together - to ensure the right service is provided at the right time to obtain the maximum possible health gains for our community.
- Developing Our Health Care Workforce - to ensure that we have the appropriate workforce to meet the health needs of the people of Canterbury.
- Being a Leader in Health - to ensure the best possible level of care is provided to maximise outcomes for the people of Canterbury.

Overview of Performance

The indicators in this report reflect the performance measures specified in the DHB's 2006/2009 SOI (unless otherwise stated), and reflect the DHB's District Strategic Plan priorities. The performance measurements, outlined in the *Statement of Service Performance*, are loosely grouped under three output classes and these are reflected in this document:

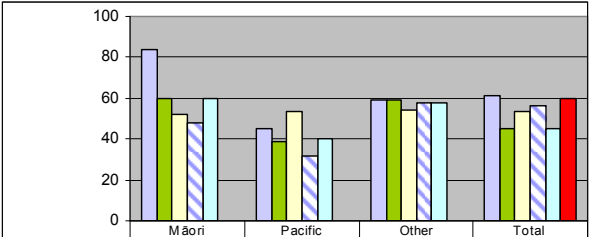
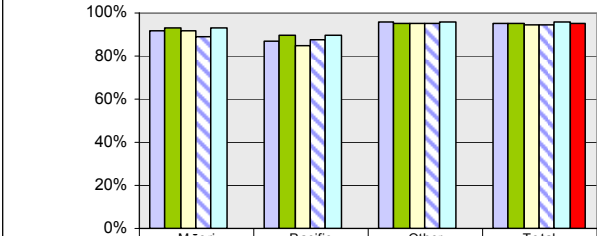
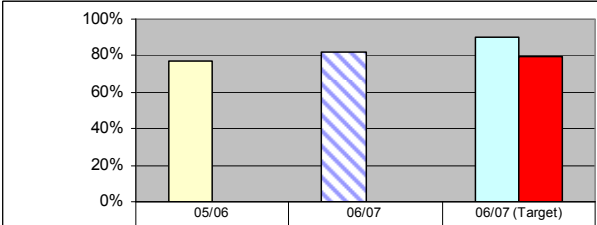
- Funding and Performance;
- Provider-arm Hospital and Specialist Services(HSS); and
- Governance.

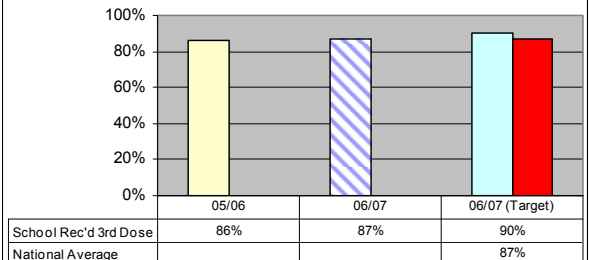
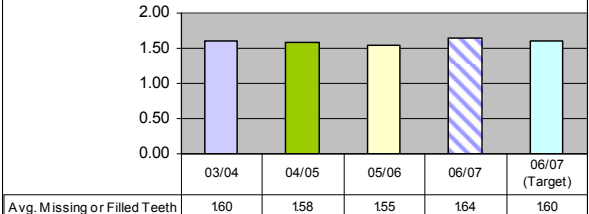
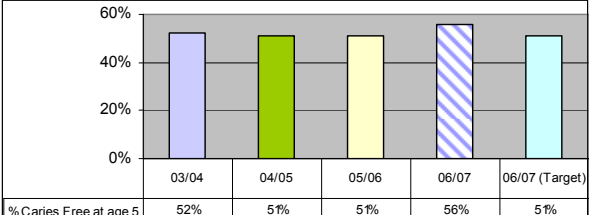
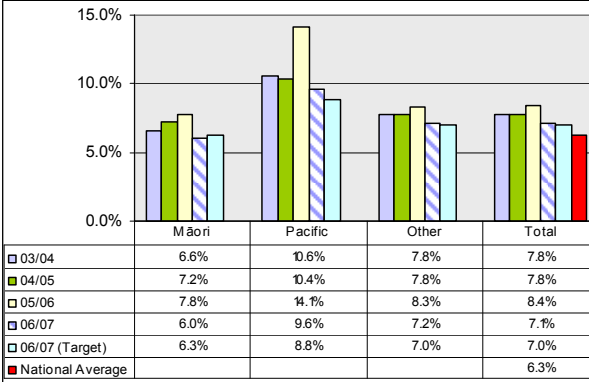
It should be noted that the number of Pacific people in the Canterbury region is small (10,476 at the 2006 Census) so the percentages shown under this ethnicity breakdown should be interpreted with caution. For some measures the results involve low numbers which may result in variability in reported results.

Where possible the DHB has included national averages for performance measures to give context to the DHB's performance. In some cases, for example, while the DHB may not have achieved the target set in 2006 the DHB may be performing well in terms of the national average and against DHBs in other regions.

1. FUNDING AND PERFORMANCE: Strategic Plan Health Gain Priorities

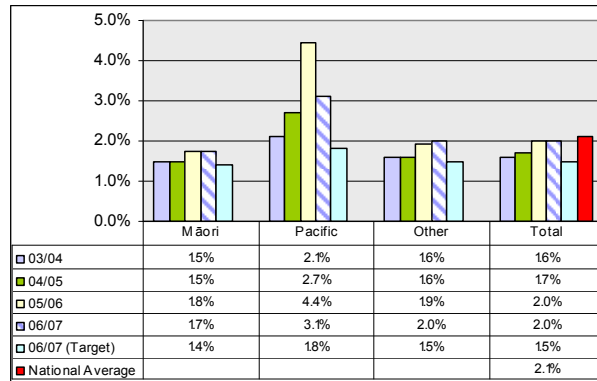
1.1 Child and Youth Health

<p>Long-term Objective: Improved health status for Canterbury's Children and Youth.</p>	<p>Brief Description: Keeping children and young people healthy gives them a better chance of becoming healthy adults. The DHB completed a Child Health and Disability Action Plan (in 2004) to address the specific health issues of children in Canterbury. The Action Plan targets ten key priorities: access, information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments. The DHB also completed a Youth Health Position Paper in April 2007 focusing on providing a safer and more supportive environment for young people, a measurable improvement in young people's mental health and a measurable improvement in their physical health.</p>																																																									
<p>Objective 2006/2007</p>	<p>Performance</p>																																																									
<p>Reduce the number of low birth weight babies. <i>Infants born under 2500gm are more likely to have poor health outcomes and increased disabilities and are more susceptible to serious illness during infancy, early childhood and adulthood.</i></p>	<p>Number of babies born in public hospital with low birth weight (rate per 1000 births).</p>  <table border="1" data-bbox="438 1064 1037 1211"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>84</td> <td>45</td> <td>59</td> <td>61</td> </tr> <tr> <td>04/05</td> <td>60</td> <td>39</td> <td>59</td> <td>45</td> </tr> <tr> <td>05/06</td> <td>52</td> <td>53</td> <td>54</td> <td>54</td> </tr> <tr> <td>06/07</td> <td>48</td> <td>32</td> <td>58</td> <td>56</td> </tr> <tr> <td>06/07 (Target)</td> <td>60</td> <td>40</td> <td>58</td> <td>45</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>59.9</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	03/04	84	45	59	61	04/05	60	39	59	45	05/06	52	53	54	54	06/07	48	32	58	56	06/07 (Target)	60	40	58	45	National Average				59.9	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>52</td> <td><60</td> <td>48</td> </tr> <tr> <td>Pacific</td> <td>53</td> <td><40</td> <td>32</td> </tr> <tr> <td>Other</td> <td>54</td> <td><58</td> <td>58</td> </tr> <tr> <td>Total</td> <td>54</td> <td><45</td> <td>56</td> </tr> </tbody> </table>		Base 05/06	Target 06/07	Result 06/07	Maori	52	<60	48	Pacific	53	<40	32	Other	54	<58	58	Total	54	<45	56	<p>While the total target has not been met the DHB is still below the National Average for this indicator and the DHB's ability to directly influence this indicator is limited. It is positive to see the rate of Maori and Pacific babies born with a low birth weight dropping against last year's results and coming in under target.</p>
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<p>Facilitate earlier detection of hearing problems in children. <i>Earlier detection of hearing problems will help facilitate early intervention and help to minimise the impact of hearing loss in children.</i></p>	<p>Percentage of children passing school entry hearing screening tests.</p>  <table border="1" data-bbox="438 1523 1037 1682"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>92%</td> <td>87%</td> <td>96%</td> <td>95%</td> </tr> <tr> <td>04/05</td> <td>93%</td> <td>90%</td> <td>95%</td> <td>95%</td> </tr> <tr> <td>05/06</td> <td>91%</td> <td>85%</td> <td>95%</td> <td>95%</td> </tr> <tr> <td>06/07</td> <td>89%</td> <td>88%</td> <td>96%</td> <td>95%</td> </tr> <tr> <td>06/07 (Target)</td> <td>93%</td> <td>90%</td> <td>96%</td> <td>96%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>95%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	03/04	92%	87%	96%	95%	04/05	93%	90%	95%	95%	05/06	91%	85%	95%	95%	06/07	89%	88%	96%	95%	06/07 (Target)	93%	90%	96%	96%	National Average				95%	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>91%</td> <td>93%</td> <td>89%</td> </tr> <tr> <td>Pacific</td> <td>85%</td> <td>90%</td> <td>88%</td> </tr> <tr> <td>Other</td> <td>95%</td> <td>96%</td> <td>96%</td> </tr> <tr> <td>Total</td> <td>95%</td> <td>96%</td> <td>95%</td> </tr> </tbody> </table>		Base 05/06	Target 06/07	Result 06/07	Maori	91%	93%	89%	Pacific	85%	90%	88%	Other	95%	96%	96%	Total	95%	96%	95%	
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<p>Implement the Meningococcal B (MeNZB) Immunisation Project. <i>Providing immunisations reduces the impact of vaccine preventable diseases.</i></p>	<p>Percentage of children between 6 weeks and 5 years of age who received their 3rd dose of the MeNZB vaccine.</p>  <table border="1" data-bbox="438 1982 1037 2029"> <thead> <tr> <th></th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Received 3rd Dose</td> <td>77%</td> <td>82%</td> <td>90%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td>80%</td> </tr> </tbody> </table>		05/06	06/07	06/07 (Target)	Received 3rd Dose	77%	82%	90%	National Average			80%	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>77%</td> <td>90%</td> <td>82%</td> </tr> </tbody> </table>		Base 05/06	Target 06/07	Result 06/07	Total	77%	90%	82%	<p>In Canterbury 82% of the DHB's under fives received dose three of the MeNZB Immunisation, slightly higher than the National Average for this indicator.</p>																																			
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	<p>Percentage of school enrolled children who received their 3rd dose of MeNZB vaccine.</p>  <table border="1" data-bbox="438 537 1029 582"> <tr> <td></td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> <tr> <td>School Rec'd 3rd Dose</td> <td>86%</td> <td>87%</td> <td>90%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td>87%</td> </tr> </table>		05/06	06/07	06/07 (Target)	School Rec'd 3rd Dose	86%	87%	90%	National Average			87%	<table border="1"> <tr> <td></td> <td>Base 05/06</td> <td>Target 06/07</td> <td>Result 06/07</td> </tr> <tr> <td>Total</td> <td>86%</td> <td>90%</td> <td>87%</td> </tr> </table> <p>The DHB's rate for school aged children meets the National Average and performance is improved on the previous year. This work continues to be a successful collaboration between the DHB, General Practice Teams, Public Health Nurses, Immunisation Coordinators, Outreach Providers, Plunket and the many organisations responsible for raising community awareness.</p>		Base 05/06	Target 06/07	Result 06/07	Total	86%	90%	87%																																			
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<p>Improve Child Oral Health.</p>	<p>Proportion of Missing or Filled (MF) teeth of year 8 children (the mean MF score).¹</p>  <table border="1" data-bbox="438 862 1029 884"> <tr> <td></td> <td>03/04</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> <tr> <td>Avg. Missing or Filled Teeth</td> <td>1.60</td> <td>1.58</td> <td>1.55</td> <td>1.64</td> <td>1.60</td> </tr> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Avg. Missing or Filled Teeth	1.60	1.58	1.55	1.64	1.60	<table border="1"> <tr> <td></td> <td>Base 05/06</td> <td>Target 06/07</td> <td>Result 06/07</td> </tr> <tr> <td>Total</td> <td>1.55</td> <td>1.60</td> <td>1.64</td> </tr> </table> <p>The public water supplies in Canterbury are not fluoridated. The oral health of children, particularly in low decile areas, is affected by this lack of fluoridation. While the DHB agreed a Position Statement on Fluoridation in 2003 and is actively promoting fluoridation, the DHB is not able to directly influence change.</p>		Base 05/06	Target 06/07	Result 06/07	Total	1.55	1.60	1.64																																			
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	<p>Percentage of children caries free (no fillings or holes in teeth), at age 5.</p>  <table border="1" data-bbox="438 1176 1029 1198"> <tr> <td></td> <td>03/04</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> <tr> <td>% Caries Free at age 5</td> <td>52%</td> <td>51%</td> <td>51%</td> <td>56%</td> <td>51%</td> </tr> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	% Caries Free at age 5	52%	51%	51%	56%	51%	<table border="1"> <tr> <td>Total</td> <td>51%</td> <td>51%</td> <td>56%</td> </tr> </table> <p>This is a positive improvement. Increased oral health promotion for under-5s is prioritised for 2007/08, but it will take 2-4 years for resultant changes to manifest.</p>	Total	51%	51%	56%																																							
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<p>Reduce Ambulatory Sensitive Admissions.</p> <p><i>Ambulatory sensitive admissions are admissions that are seen as potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care services.</i></p>	<p>Ambulatory Sensitive Admissions for those aged 0-4 years (percentage discharged per population).</p>  <table border="1" data-bbox="438 1523 1029 1668"> <tr> <td></td> <td>Māori</td> <td>Pacific</td> <td>Other</td> <td>Total</td> </tr> <tr> <td>03/04</td> <td>6.6%</td> <td>10.6%</td> <td>7.8%</td> <td>7.8%</td> </tr> <tr> <td>04/05</td> <td>7.2%</td> <td>10.4%</td> <td>7.8%</td> <td>7.8%</td> </tr> <tr> <td>05/06</td> <td>7.8%</td> <td>14.1%</td> <td>8.3%</td> <td>8.4%</td> </tr> <tr> <td>06/07</td> <td>6.0%</td> <td>9.6%</td> <td>7.2%</td> <td>7.1%</td> </tr> <tr> <td>06/07 (Target)</td> <td>6.3%</td> <td>8.8%</td> <td>7.0%</td> <td>7.0%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>6.3%</td> </tr> </table>		Māori	Pacific	Other	Total	03/04	6.6%	10.6%	7.8%	7.8%	04/05	7.2%	10.4%	7.8%	7.8%	05/06	7.8%	14.1%	8.3%	8.4%	06/07	6.0%	9.6%	7.2%	7.1%	06/07 (Target)	6.3%	8.8%	7.0%	7.0%	National Average				6.3%	<table border="1"> <tr> <td></td> <td>Base 05/06</td> <td>Target 06/07</td> <td>Result 06/07</td> </tr> <tr> <td>Maori</td> <td>7.8%</td> <td>6.3%</td> <td>6.0%</td> </tr> <tr> <td>Pacific</td> <td>14.1%</td> <td>8.8%</td> <td>9.6%</td> </tr> <tr> <td>Other</td> <td>8.3%</td> <td>7.0%</td> <td>7.2%</td> </tr> <tr> <td>Total</td> <td>8.4%</td> <td>7.0%</td> <td>7.1%</td> </tr> </table> <p>Ambulatory Sensitive Admissions are based on admissions for 37 conditions influenced primarily by services in primary care and population health initiatives. The contributing conditions include: Asthma, Dehydration, Diabetes, Ruptured Appendix, Stroke, Angina, ENT Infections, Gastroenteritis and 'Failure to Thrive'.</p> <p>While the DHB has not met targets in all population groups under this indicator, and the percentages for those aged 0-4 years still need some work to meet the National Average, it is pleasing to see the rates dropping against the previous year.</p> <p>Analysis of the DHB's rates is being undertaken, concentrating on the areas where results are above the National Average. Investigation shows child rates appear to be driven (at least in part) by admission practices for short stay patients in the Child Acute Admitting Service, which appear to differ from those used by other DHBs. Further work on this issue is being progressed.</p>		Base 05/06	Target 06/07	Result 06/07	Maori	7.8%	6.3%	6.0%	Pacific	14.1%	8.8%	9.6%	Other	8.3%	7.0%	7.2%	Total	8.4%	7.0%	7.1%
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¹ The Mean MF Score is the total permanent teeth MF due to holes divided by the number of children seen by school dental services in the period.

Ambulatory Sensitive Admissions for those aged 5-14 years (percentage discharged per population).



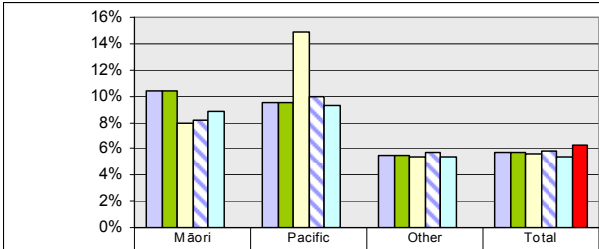
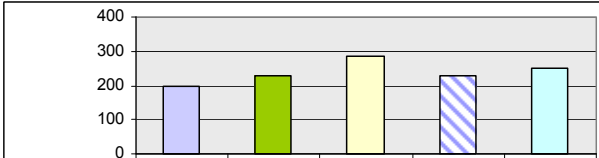
	Base 05/06	Target 06/07	Result 06/07
Maori	1.8%	1.4%	1.7%
Pacific	4.4%	1.8%	3.1%
Other	1.9%	1.5%	2.0%
Total	2.0%	1.5%	2.0%

In 2006 the targets set were primarily based on the DHB's performance in previous years rather than the National Average. Since then the Ministry of Health (Ministry) has made it clear that their expectations around Ambulatory Sensitive Admissions are based on national performance and expectations that DHBs will work to improve results if their performance is poor in comparison to other DHBs.

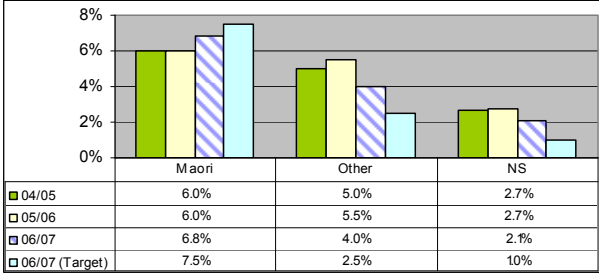
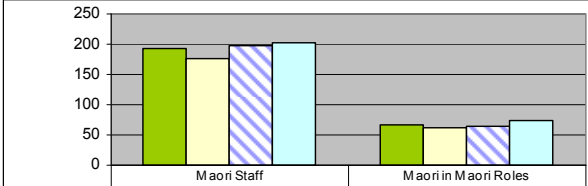
While the DHB has not reached targets for this age group, performance has improved against the previous year and the DHB is performing better than the National Average in terms of 5-14 year-olds.

Analysis of Ambulatory Sensitive Admission rates is being undertaken and this will look at the reasons for admissions and the areas where targeted activity might influence a downturn in the rates across all age groups.

1.2 Older Persons' Health

<p>Long-term Objective: Maintain/improve health and independence outcomes for older Canterbury residents within available resources.</p>	<p>Brief Description: With the demand implications of an ageing population, Older Persons' Health has been identified as an area of specific focus by the DHB going forward. In 2005/06 the DHB began the implementation of its local Aged Care Strategy; <i>Healthy Ageing, Integrated Support</i>. This work contributes to the implementation of the national Health of Older People's Strategy, is aligned with the DHB's Core Direction, Finding Better Ways of Working, and with the development of an integrated continuums of care. The emphasis is on flexible, holistic, quality and needs-based care in the community.</p>																																																					
<p>Objective 2006/2007</p>	<p>Performance</p>																																																					
<p>Reduce Ambulatory Sensitive Admissions.</p> <p><i>Ambulatory sensitive admissions are admissions that are seen as potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care services.</i></p>	<p>Ambulatory Sensitive Admissions for those aged 65-74 years (percentage discharged per population).</p>  <table border="1" data-bbox="437 943 1038 1077"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>10.4%</td> <td>9.5%</td> <td>5.5%</td> <td>5.7%</td> </tr> <tr> <td>04/05</td> <td>10.4%</td> <td>9.5%</td> <td>5.5%</td> <td>5.7%</td> </tr> <tr> <td>05/06</td> <td>8.0%</td> <td>14.9%</td> <td>5.4%</td> <td>5.6%</td> </tr> <tr> <td>06/07</td> <td>8.2%</td> <td>10.0%</td> <td>5.7%</td> <td>5.8%</td> </tr> <tr> <td>06/07 (Target)</td> <td>8.8%</td> <td>9.3%</td> <td>5.4%</td> <td>5.4%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>6.3%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	03/04	10.4%	9.5%	5.5%	5.7%	04/05	10.4%	9.5%	5.5%	5.7%	05/06	8.0%	14.9%	5.4%	5.6%	06/07	8.2%	10.0%	5.7%	5.8%	06/07 (Target)	8.8%	9.3%	5.4%	5.4%	National Average				6.3%	<table border="1"> <tr> <td>Maori</td> <td>8.0%</td> <td>8.8%</td> <td>8.2%</td> </tr> <tr> <td>Pacific</td> <td>14.9%</td> <td>9.3%</td> <td>10.0%</td> </tr> <tr> <td>Other</td> <td>5.4%</td> <td>5.4%</td> <td>5.7%</td> </tr> <tr> <td>Total</td> <td>5.6%</td> <td>5.4%</td> <td>5.8%</td> </tr> </table>	Maori	8.0%	8.8%	8.2%	Pacific	14.9%	9.3%	10.0%	Other	5.4%	5.4%	5.7%	Total	5.6%	5.4%	5.8%	<p>The DHB's admissions for the 65-74 age group are below the National Average which is reassuring, as is the drop in Pacific admissions. However the overall result has increased a little across this age group against the previous year.</p> <p>It is expected that analysis work around Ambulatory Sensitive Admissions will also assist the DHB to understand and target improvements in the rates for this age group.</p>
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<p>Build the focus on Health Promotion Services by increasing the number of older people receiving education on falls prevention through the Stay On Your Feet (SOYF) Home Exercise Programme.</p> <p><i>Falls are a major cause of injury and ongoing disability for older people in Canterbury. The DHB and the Christchurch City Council jointly fund the SOYF Programme.</i></p>	<p>The number of people referred to the SOYF Home Exercise Programme.</p>  <table border="1" data-bbox="437 1317 1038 1379"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Number Referred</td> <td>200</td> <td>230</td> <td>287</td> <td>229</td> <td>250</td> </tr> </tbody> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Number Referred	200	230	287	229	250	<table border="1"> <tr> <td></td> <td>Base 05/06</td> <td>Target 06/07</td> <td>Result 06/07</td> </tr> <tr> <td>Number Referred</td> <td>287</td> <td>250</td> <td>229</td> </tr> </table>		Base 05/06	Target 06/07	Result 06/07	Number Referred	287	250	229	<p>The project has lost two SOYF Coordinators in the past year and the DHB has just recruited to the position with the new Coordinator starting in August 2007. This disruption has impacted on the referrals and the uptake of the programme.</p> <p>However, ten new volunteers have just completed the volunteer programme and they will be ready to start with the new Coordinator which is a positive step for the 2007/08 year.</p>																															
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<p>Implement the DHB's Health of Older People Strategy including the development of performance and evaluation indicators.</p>	<p>Develop a database to assist with future capacity planning and monitoring of the progress of service and funding shifts within aged care.</p>	<table border="1"> <tr> <td>Target 06/07</td> <td>Result 06/07</td> </tr> <tr> <td>Database complete</td> <td>Complete</td> </tr> </table> <p>The DHB has developed a database which identifies entry, exit and length of stay trends in residential care which will assist with future capacity planning.</p>		Target 06/07	Result 06/07	Database complete	Complete																																															
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1.3 Maori Health

<p>Long-term Objective: Whanau Ora, Maori families supported to achieve their maximum health and wellbeing.</p>	<p>Brief Description: Evidence of Maori health disparities is well known and compelling and to address these health disparities, the DHB developed a Maori Health Plan (2002), <i>Whakamahere Hauora Maori Ki Waitaha</i>. This Plan was reviewed and updated, after consultation with Canterbury’s Maori community, and identifies a number of key areas where the DHB will focus its efforts over the coming years. These key priorities are: monitoring of Maori health outcomes, Maori participation in health planning, service provision and the workforce, effective, assurance of culturally appropriate and high quality services and working across sectors to ensure a continuum of care. The updated Maori Health Plan was approved by the Board in April 2007.</p>																																						
<p>Objective 2006/2007</p>	<p>Performance</p>																																						
<p>Improve the monitoring of Maori health outcomes. <i>Poor ethnicity data is a significant barrier to achieving this objective. Targets are set to reduce the percentages classified as ‘other’ or ‘not stated’ which contributes to under reporting of Maori (measured against Census population) and limits the DHB’s ability to monitor health outcomes.</i></p>	<p>Percentage of discharges classified by Ethnicity Groups: Maori, Other or Not Stated (NS).</p>  <table border="1" data-bbox="437 958 1038 1048"> <thead> <tr> <th></th> <th>Maori</th> <th>Other</th> <th>NS</th> </tr> </thead> <tbody> <tr> <td>04/05</td> <td>6.0%</td> <td>5.0%</td> <td>2.7%</td> </tr> <tr> <td>05/06</td> <td>6.0%</td> <td>5.5%</td> <td>2.7%</td> </tr> <tr> <td>06/07</td> <td>6.8%</td> <td>4.0%</td> <td>2.7%</td> </tr> <tr> <td>06/07 (Target)</td> <td>7.5%</td> <td>2.5%</td> <td>10%</td> </tr> </tbody> </table>		Maori	Other	NS	04/05	6.0%	5.0%	2.7%	05/06	6.0%	5.5%	2.7%	06/07	6.8%	4.0%	2.7%	06/07 (Target)	7.5%	2.5%	10%	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>6.0%</td> <td>>7.5%</td> <td>6.8%</td> </tr> <tr> <td>Other</td> <td>5.5%</td> <td><2.5%</td> <td>4.0%</td> </tr> <tr> <td>Not Stated</td> <td>2.7%</td> <td><1.0%</td> <td>2.1%</td> </tr> </tbody> </table>		Base 05/06	Target 06/07	Result 06/07	Maori	6.0%	>7.5%	6.8%	Other	5.5%	<2.5%	4.0%	Not Stated	2.7%	<1.0%	2.1%	<p>Specific measures and targets have been placed in the revised Maori Health Plan to ensure improved quality of ethnicity data collection. The targets for this indicator are long-term targets moving the ethnicity identification into alignment with the Census figures for the Canterbury population. The steady progress being made towards the longer-term goal is a positive outcome.</p>
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<p>Increase Maori participation in health planning, in service provision and in the health workforce. <i>Increasing the participation of Maori is seen as a means of improving the cultural responsiveness of our health services.</i></p>	<p>Implement a Memorandum of Understanding (MoU) between Manawhenua ki Waitaha and the DHB’s Board to increase Maori participation in developing and identifying strategies to improve Maori health.</p>	<table border="1"> <thead> <tr> <th></th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>MoU in place</td> <td></td> <td>Not achieved</td> </tr> </tbody> </table> <p>While a MoU was not progressed, formalising the relationship remains a priority. The revised Maori Health Plan requires a formal Crown-Maori Relationship Instrument agreement to be in place by June 2008.</p>			Target 06/07	Result 06/07	MoU in place		Not achieved																														
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	<p>Develop an integrated health outcome and performance monitoring framework aligning the DHB’s Maori Health Plan <i>Whakamahere Hauora Maori Ki Waitaha</i> with the Ministry’s Maori Health Strategy <i>He Korowai Oranga</i> and Maori Health Action Plan <i>Whakatataka</i>.</p>	<table border="1"> <thead> <tr> <th></th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Develop monitoring framework</td> <td></td> <td>Framework developed.</td> </tr> </tbody> </table> <p>A framework has been developed in alignment with the DHB’s revised Maori Health Plan.</p>			Target 06/07	Result 06/07	Develop monitoring framework		Framework developed.																														
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<p>Reduced health inequalities.</p>	<p>Provide Maori specific targets for indicators, particularly in areas of key concern for Maori health such as Child and Youth Health and Diabetes.</p>	<table border="1"> <thead> <tr> <th></th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Specific targets provided i.e. 1.1 Child and Youth Health and 1.8 Diabetes Indicators.</td> <td></td> </tr> </tbody> </table>			Result 06/07	Specific targets provided i.e. 1.1 Child and Youth Health and 1.8 Diabetes Indicators.																																	
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² These are long term measures and were set for achievement by 2009/10. The DHB is expecting continual progress to this point.

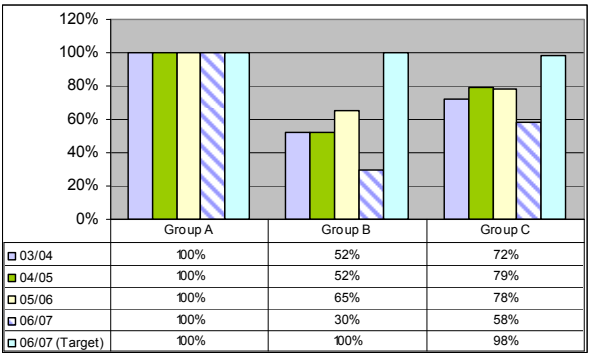
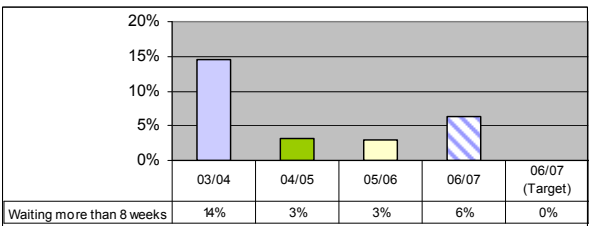
1.4 Primary Health

<p>Long-term Objective: Reduced barriers to primary health care.</p>	<p>Brief Description: Reducing the barriers to good primary health care helps people stay well resulting in improved health status. During the 2006/07 year the DHB continued to focus its primary care activities on the implementation of the national Primary Health Care Strategy, via the ongoing development of PHOs within Canterbury.</p> <p>The DHB also focused on addressing the needs of those populations with the greatest barriers to accessing primary health care through the implementation of Services to Improve Access and Health Promotion Plans and through the implementation of its Rural Health Services Action Plan ensuring equitable access for rural based communities.</p> <p>Canterbury based PHOs continue to develop and implement new services to improve access and enrolment and work together in partnership. The PHOs have worked with the DHB on the Review of Acute Demand and After Hours Cover in Primary Care and the After Hours Direction Paper. The PHOs have also begun joint planning and service implementation.</p>																																							
<p>Objective 2006/2007</p>	<p>Performance</p>																																							
<p>Continued PHO Development – ensuring improved access to services and continuums of care that are developed in line with DHB priorities and ongoing health needs assessment.</p>	<p>All PHOs have implemented Health Promotion (HP) plans and have Services to Improve Access (SIA) Plans in place. These plans are consistent with, and support, the DHB’s Strategic Priorities and are regularly reviewed.</p>	<p>3 out of five HP in place</p>	<p>5 of 5 in place</p>	<p>4 of 5 in place</p>																																				
	<p>Percentage of the population enrolled with PHOs.</p>	<p>3 out of five SIA in place</p>	<p>5 of 5 in place</p>	<p>4 of 5 in place</p>																																				
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<p>Continued retention of Rural GPs - through provision of assistance in maintaining reasonable on-call rosters.</p>	<p>Percentage of GPs with a rural ranking of greater than 35 points, who work no more than a one in four weekend roster (unless by choice).</p>	<p>Total</p>	<p>94.0%</p>	<p>>95%</p>																																				
<p>Reduce Ambulatory Sensitive Admissions. <i>Ambulatory sensitive admissions are admissions that are seen as potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care services.</i></p>	<p>Ambulatory Sensitive Admissions for those aged 15-24 years (percentage discharged per population).</p> <table border="1" data-bbox="438 1523 1040 1904"> <thead> <tr> <th>Year</th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> <th>National Average</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>1.1%</td> <td>1.3%</td> <td>1.2%</td> <td>1.2%</td> <td>1.5%</td> </tr> <tr> <td>04/05</td> <td>1.1%</td> <td>1.4%</td> <td>1.2%</td> <td>1.2%</td> <td>1.5%</td> </tr> <tr> <td>05/06</td> <td>1.2%</td> <td>1.1%</td> <td>1.3%</td> <td>1.3%</td> <td>1.5%</td> </tr> <tr> <td>06/07</td> <td>1.2%</td> <td>1.0%</td> <td>1.3%</td> <td>1.3%</td> <td>1.5%</td> </tr> <tr> <td>06/07 (Target)</td> <td>1.1%</td> <td>1.1%</td> <td>1.1%</td> <td>1.1%</td> <td>1.5%</td> </tr> </tbody> </table>	Year	Maori	Pacific	Other	Total	National Average	03/04	1.1%	1.3%	1.2%	1.2%	1.5%	04/05	1.1%	1.4%	1.2%	1.2%	1.5%	05/06	1.2%	1.1%	1.3%	1.3%	1.5%	06/07	1.2%	1.0%	1.3%	1.3%	1.5%	06/07 (Target)	1.1%	1.1%	1.1%	1.1%	1.5%	<p>Total</p>	<p>100%</p>	<p>100%</p>
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		<p>The DHB’s admission results for the 15-24 age groups are below the National Average – the performance for Maori and Pacific is also pleasing to see with the total performance remaining constant.</p>																																						

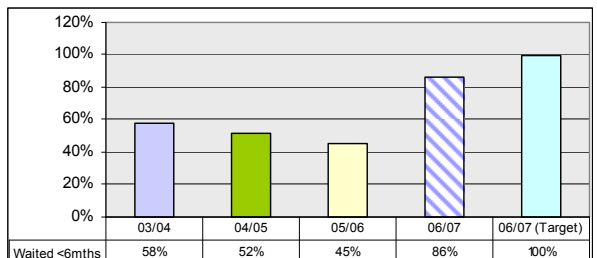
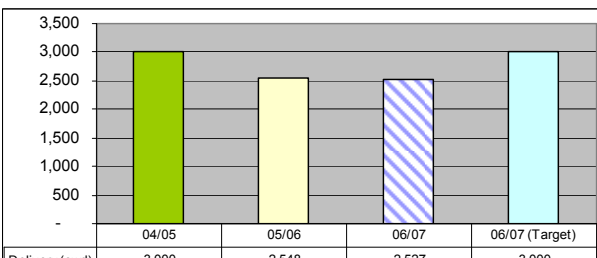
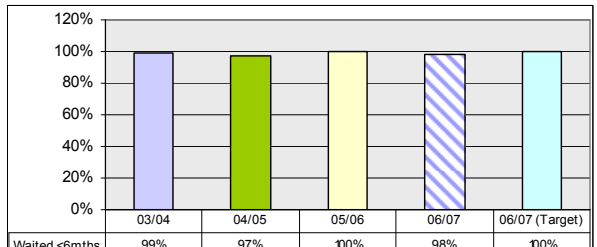
1.5 Disease Prevention and Management

<p>Long-term Objective: Reduction in the risks associated with chronic disease.</p>	<p>Brief Description: Chronic conditions are a major health burden for NZ, both now and into the foreseeable future. The DHB has identified four Disease Priorities (Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease) which it plans to give additional focus to over the next five years. However ongoing risk reduction provides an environment in which communities are supported to eat well, exercise regularly and attain and maintain healthy body weights. Ongoing risk reduction also supports smokefree environments and provides health promotion messages and programmes to encourage healthy living.</p> <p>Risk reduction and the prevention and management of disease are integrated into a continuum of care whereby the reduction of one risk assists in the reduction of another and the DHB recognises this interplay in its focus on disease prevention. Obesity and smoking cessation, for example, are a crucial component in the prevention of a number of chronic conditions.</p>																											
<p>Objective 2006/2007</p>	<p>Performance</p> <table border="1"> <thead> <tr> <th>Measure</th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>27%</td> <td>33%</td> <td>31%</td> </tr> </tbody> </table>	Measure	Base 05/06	Target 06/07	Result 06/07	Total	27%	33%	31%																			
Measure	Base 05/06	Target 06/07	Result 06/07																									
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<p>Increase the number of Health Promoting Schools (HPS) – as a means to reducing the incidence of obesity.</p> <p><i>The definition of HPS considers HPS as a framework used to address health issues. The approach is based on activities within the school setting that can impact on health: the inclusion of health education in curricula and the creation of a healthy environment. As such, HPS includes schools promoting Fruit in Schools and Active Schools.</i></p>	<p>The percentage of schools in the Canterbury region using the HPS Framework, as a percentage of the total number of schools with the DHB’s region.</p> <table border="1"> <thead> <tr> <th>Year</th> <th>% of Schools</th> </tr> </thead> <tbody> <tr> <td>04/05</td> <td>27%</td> </tr> <tr> <td>05/06</td> <td>27%</td> </tr> <tr> <td>06/07</td> <td>31%</td> </tr> <tr> <td>06/07 (Target)</td> <td>33%</td> </tr> </tbody> </table> <p>Total</p> <table border="1"> <thead> <tr> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>27%</td> <td>33%</td> <td>31%</td> </tr> </tbody> </table> <p>81 of the 262 schools (31%) are currently actively following the health promotion in schools model. These include Fruit in Schools, schools working with Community and Public Health’s Health Promoting Schools Team and Sport Canterbury’s Active Schools Team.</p> <p>Although the DHB has not met the target set in 2006; 72 additional schools are currently moving towards the Health Promoting Schools model.</p>	Year	% of Schools	04/05	27%	05/06	27%	06/07	31%	06/07 (Target)	33%	Base 05/06	Target 06/07	Result 06/07	27%	33%	31%											
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<p>Stabilise the proportion of the Canterbury population that are obese.</p> <p><i>Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Maori or Pacific.</i></p>	<p>The proportion of the Canterbury population who are obese.</p> <table border="1"> <thead> <tr> <th>Year</th> <th>% Obese</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>21%</td> </tr> <tr> <td>04/05</td> <td></td> </tr> <tr> <td>05/06</td> <td></td> </tr> <tr> <td>06/07</td> <td></td> </tr> <tr> <td>06/07 (Target)</td> <td>21%</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Base 03/04</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>21%</td> <td><21%</td> <td>n/a</td> </tr> </tbody> </table> <p>The DHB’s only measurement for this indicator is using statistics from the NZ Health Survey collected nationally by the Ministry. This survey was undertaken in 2004 and will be repeated every three years. The latest results are not yet available as the survey is currently being collected.</p>	Year	% Obese	03/04	21%	04/05		05/06		06/07		06/07 (Target)	21%	Base 03/04	Target 06/07	Result 06/07	21%	<21%	n/a									
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<p>Decrease the smoking rates in Canterbury.</p>	<p>The smoking rate for people over 15 years in Canterbury.</p> <table border="1"> <thead> <tr> <th>Year</th> <th>Males</th> <th>Females</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>22.5%</td> <td>21.5%</td> </tr> <tr> <td>04/05</td> <td></td> <td></td> </tr> <tr> <td>05/06</td> <td></td> <td></td> </tr> <tr> <td>06/07</td> <td></td> <td></td> </tr> <tr> <td>06/07 (Target)</td> <td>15%</td> <td>15%</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Base 03/04</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Males 22.5%</td> <td><15%</td> <td>n/a</td> </tr> <tr> <td>Females 21.5%</td> <td><15%</td> <td>n/a</td> </tr> </tbody> </table> <p>The DHB’s only measurement for this indicator is using statistics from the NZ Health Survey collected nationally by the Ministry. This survey was undertaken in 2004 and will be repeated every three years. The latest results are not yet available as the survey is currently being collected.</p>	Year	Males	Females	03/04	22.5%	21.5%	04/05			05/06			06/07			06/07 (Target)	15%	15%	Base 03/04	Target 06/07	Result 06/07	Males 22.5%	<15%	n/a	Females 21.5%	<15%	n/a
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Males 22.5%	<15%	n/a																										
Females 21.5%	<15%	n/a																										

1.6 Disease Prevention and Management – Cancer

<p>Long-term Objective:</p> <p><i>Improved health status for Canterbury's residents who are at risk of developing Cancer and appropriate and timely treatment for those who do.</i></p>	<p>Brief Description:</p> <p>Cancer has been identified by the DHB as a priority area for improving the health status of its population. The DHB is currently in the process of developing a health strategy for the management of Cancer in Canterbury in collaboration with the other South Island DHBs through the South Island Shared Services Agency Limited.</p> <p>The following indicators focus on reducing the impact of cancer rather than on prevention. However, actions such as making the DHB smokefree and the introduction of smokefree legislation will have positive effects as will a risk reduction focus in disease management and the development of continuums of care for chronic conditions.</p>																																																																																																												
<p>Objective 2006/2007</p>	<p align="center">Performance</p> <table border="1"> <thead> <tr> <th>Measure</th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> </table>	Measure	Base 05/06	Target 06/07	Result 06/07																																																																																																								
Measure	Base 05/06	Target 06/07	Result 06/07																																																																																																										
<p>Reduce the impact of Cancer – through the provision of improved access to Cancer treatments (specifically Radiation Therapy).</p> <p><i>Delay to radiation therapy is defined as the time between the specialist decision to commence treatment and the start of treatment. Patients are categorised into four groups:</i></p> <p><i>Group A - Ideally treated within 24 hours</i> <i>Group B - Ideally treated within 2 weeks</i> <i>Group C - Ideally treated within 4 weeks</i> <i>Group D – Patients with planned radiation treatment i.e. those taking part in a trial or having specific treatment protocols. These patients have to wait until a given time to start treatment, which is not usually within 4 weeks and they are therefore not included in the DHB's targets.</i></p>	<p>Percentage of patients in categories A, B and C treated on time.</p>  <table border="1"> <thead> <tr> <th></th> <th>Group A</th> <th>Group B</th> <th>Group C</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>100%</td> <td>52%</td> <td>72%</td> </tr> <tr> <td>04/05</td> <td>100%</td> <td>52%</td> <td>79%</td> </tr> <tr> <td>05/06</td> <td>100%</td> <td>65%</td> <td>78%</td> </tr> <tr> <td>06/07</td> <td>100%</td> <td>30%</td> <td>58%</td> </tr> <tr> <td>06/07 (Target)</td> <td>100%</td> <td>100%</td> <td>98%</td> </tr> </tbody> </table> <p>Percentage of patients in categories A, B or C who waited more than 8 weeks for treatment.</p>  <table border="1"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Waiting more than 8 weeks</td> <td>14%</td> <td>3%</td> <td>3%</td> <td>6%</td> <td>0%</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Group A</td> <td></td> <td></td> <td></td> </tr> <tr> <td>On Time</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>4-8 wks</td> <td></td> <td></td> <td></td> </tr> <tr> <td>8-12 Wks</td> <td></td> <td></td> <td></td> </tr> <tr> <td>12 wks +</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Group B</td> <td></td> <td></td> <td></td> </tr> <tr> <td>On Time</td> <td>65%</td> <td>100%</td> <td>30%</td> </tr> <tr> <td>4-8 wks</td> <td>30%</td> <td></td> <td>63%</td> </tr> <tr> <td>8-12 Wks</td> <td>4%</td> <td></td> <td>8%</td> </tr> <tr> <td>12 wks +</td> <td>1%</td> <td></td> <td></td> </tr> <tr> <td>Group C</td> <td></td> <td></td> <td></td> </tr> <tr> <td>On Time</td> <td>78%</td> <td>98%</td> <td>58%</td> </tr> <tr> <td>4-8 wks</td> <td>20%</td> <td>2%</td> <td>35%</td> </tr> <tr> <td>8-12 Wks</td> <td>2%</td> <td></td> <td>6%</td> </tr> <tr> <td>12 wks +</td> <td></td> <td></td> <td>1%</td> </tr> <tr> <td>Total</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>3% waited more than 8 weeks</td> <td>0% wait longer than 8 weeks</td> <td>6% waited more than 8 weeks</td> </tr> </tbody> </table> <p>Of those patients in Category B and C who were not seen within eight weeks 28% were due to patient preference.</p> <p>The majority of patients who were not seen 'on time' were affected by industrial action over the past year which resulted in an estimated loss in throughput of 60-80 complete treatment courses – which increased the waiting times.</p> <p>Although the DHB was able to increase treatment capacity by running an additional shift we are unable to sustain this due to staffing numbers and under resourcing of Radiation Oncologists. The DHB has recruited one Oncologist (beginning August 2007), however two other Oncologists have reduced their working hours. Recruitment efforts continue and the DHB remains fully staffed with Radiation Therapists.</p> <p>The Ministry's national Cancer Indicator is based on DHBs seeing all category A, B and C patients within 12 weeks. Under this national target the Canterbury DHB has achieved 100% for Groups A and B and 99% for Group C.</p>		Group A	Group B	Group C	03/04	100%	52%	72%	04/05	100%	52%	79%	05/06	100%	65%	78%	06/07	100%	30%	58%	06/07 (Target)	100%	100%	98%		03/04	04/05	05/06	06/07	06/07 (Target)	Waiting more than 8 weeks	14%	3%	3%	6%	0%		Base 05/06	Target 06/07	Result 06/07	Group A				On Time	100%	100%	100%	4-8 wks				8-12 Wks				12 wks +				Group B				On Time	65%	100%	30%	4-8 wks	30%		63%	8-12 Wks	4%		8%	12 wks +	1%			Group C				On Time	78%	98%	58%	4-8 wks	20%	2%	35%	8-12 Wks	2%		6%	12 wks +			1%	Total					3% waited more than 8 weeks	0% wait longer than 8 weeks	6% waited more than 8 weeks
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1.7 Cardiovascular Disease (CVD)

<p>Long-term Objective: Improved Cardiovascular health status for Canterbury residents.</p>	<p>Brief Description: In September 2004, the DHB approved its Canterbury Heart Health Strategy, which outlines key priorities in the effort to reduce the incidence and impact of CVD. These priorities include: improving access to cardiovascular services, improving information with respect to heart health, developing an information strategy and implementing training and research with respect to heart health, improving the quality of care after acute events and devolving supported impact reduction of CVD disease to primary and community care providers. The DHB continues to focus on implementing the recommendations from its Heart Health Strategy.</p>																
<p>Objective 2006/2007</p>	<p>Performance</p>																
<p>Reduce the Impact of CVD – through ensuring provision of improved access for those requiring treatment.</p>	<p>Percentage of people with certainty who waited no more than six months for a coronary artery bypass graft.</p>  <table border="1" data-bbox="438 952 1037 996"> <thead> <tr> <th>Year</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Waited <6mths</td> <td>58%</td> <td>52%</td> <td>45%</td> <td>86%</td> <td>100%</td> </tr> </tbody> </table>	Year	03/04	04/05	05/06	06/07	06/07 (Target)	Waited <6mths	58%	52%	45%	86%	100%	<p>Total</p>	<p>Base 05/06 45%</p>	<p>Target 06/07 100%</p>	<p>Result 06/07 86%</p> <p>This is a positive result considering that this is one of the services most affected by the ongoing industrial action the DHB has faced since September 2006. Industrial action has particularly affected these elective surgery levels.</p>
Year	03/04	04/05	05/06	06/07	06/07 (Target)												
Waited <6mths	58%	52%	45%	86%	100%												
<p>Delivery of Cardiac Surgery for key procedures - Cardiac Valves and Coronary Artery Bypasses Grafts.³</p>	 <table border="1" data-bbox="438 1310 1037 1332"> <thead> <tr> <th>Year</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Delivery (cwd)</td> <td>3,000</td> <td>2,548</td> <td>2,527</td> <td>3,000</td> </tr> </tbody> </table>	Year	04/05	05/06	06/07	06/07 (Target)	Delivery (cwd)	3,000	2,548	2,527	3,000	<p>Total CWD⁴</p>	<p>2,548</p>	<p>3,000</p>	<p>2,527</p> <p>Workflow issues and industrial action experienced over 2006/07 have meant a drop in CWD. A cardiac surgery agreement is currently being established with a private provider to increase delivery.</p>		
Year	04/05	05/06	06/07	06/07 (Target)													
Delivery (cwd)	3,000	2,548	2,527	3,000													
<p>Percentage of people with certainty who waited for no more than six months for an angioplasty.</p>	 <table border="1" data-bbox="438 1624 1037 1668"> <thead> <tr> <th>Year</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Waited <6mths</td> <td>99%</td> <td>97%</td> <td>100%</td> <td>98%</td> <td>100%</td> </tr> </tbody> </table>	Year	03/04	04/05	05/06	06/07	06/07 (Target)	Waited <6mths	99%	97%	100%	98%	100%	<p>Total</p>	<p>100%</p>	<p>100%</p>	<p>98%</p> <p>As at 30 June 2007 Cardiology had six patients exceeding their promise date. Two have since been treated, three are booked within the next month and one is not fit enough to undergo the procedure so will therefore be removed from the list.</p>
Year	03/04	04/05	05/06	06/07	06/07 (Target)												
Waited <6mths	99%	97%	100%	98%	100%												

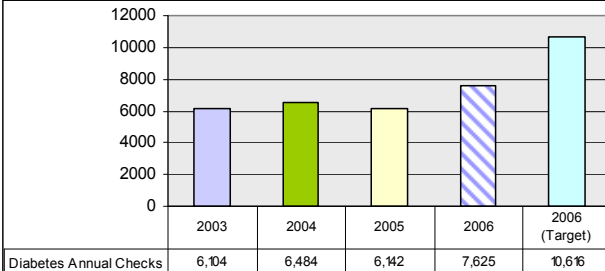
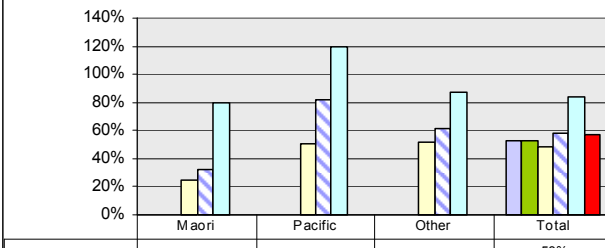
³ Cardiac Valves and Coronary Bypass Grafts are counted using Diagnostic Related Groups; F03Z, F04A, F04B, F05A, F05B, F06A, F06B.

⁴ Cost Weighted Discharges (CWD) are a relative measure of the cost of different surgeries.

Reduce the Impact of CVD – through improved quality of care after acute events.	Percentage of patients discharged after suffering an acute event, who attend a cardiac rehabilitation outpatient programme or who were admitted to organised stroke services. <table border="1"> <thead> <tr> <th></th> <th>Stroke</th> <th>Cardiac</th> <th>Combined</th> </tr> </thead> <tbody> <tr> <td>05/06</td> <td>6%</td> <td>2%</td> <td>3%</td> </tr> <tr> <td>06/07</td> <td>68%</td> <td>27%</td> <td>37%</td> </tr> <tr> <td>06/07 (Target)</td> <td></td> <td></td> <td>80%</td> </tr> </tbody> </table>		Stroke	Cardiac	Combined	05/06	6%	2%	3%	06/07	68%	27%	37%	06/07 (Target)			80%		Base 05/06	Target 06/07	Result 06/07
			Stroke	Cardiac	Combined																
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06/07 (Target)			80%																		
Cardiac	21%	80%	27% ⁵																		
Stroke	61%	80%	68%																		
The target of 80% reflects the DHB’s long-run target for rehabilitation attendance as specified in its District Strategic Plan. The reported performance for 2005/06 and for 2006/07 reflects the development of a baseline for this indicator. There are a number of smaller cardiac rehabilitation courses running in rural areas and from GP Practices and the DHB is in the process of verifying baseline data from these centres. These numbers will be included in the 2007/08 results.																					
Trial the New Zealand Heart Manual in primary care in Canterbury, beginning with six general practices.		Target 06/07	Result 06/07																		
		Heart Manual Trial underway.	Trial Underway																		
		Referrals are flowing to Maori Disease State Nurses and the six GP Practices in the trial. 17 enrolments have been counted since the programme began in March 2007 to the end of June 2007.																			
Improve Heart Health information – to improve the DHB’s ability to monitor change and evaluation programmes.	Design and implement a pilot project (in primary care) to collect a core database on CVD risk factors which will lead to the development of a Heart Health Register for Canterbury.	Target 06/07	Result 06/07																		
		Three general practices implementing the project.	Pilot Project Complete																		
		A primary care based CVD risk assessment pilot project was completed in three GP Practices and identified a number of issues around varying levels of computerisation, levels of recording information and the need to standardise methods for recording of some information. Unfortunately research funding was not secured to support the implementation of the full project and the establishment of a Heart Health Register.																			

⁵ These figures include the Maori Cardiac Outreach Programme run at Rehua Marae, the Christchurch Hospital Cardiac Rehabilitation Programme run primarily in the Canterbury Horticultural Hall and the Heart Guide Aotearoa Programme.

1.8 Disease Prevention and Management – Diabetes

<p>Long-term Objective: Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes.</p>	<p>Brief Description: To achieve improved health status with regard to Diabetes a number of accepted areas for action exist, namely: health promotion, early detection, effective treatment and improved patient awareness and information. In Canterbury the greatest benefit is considered to be gained through a range of actions, which include early diagnosis and treatment of eye problems and foot problems and improved access for Maori. The DHB intends to continue to primarily focus its activities on continuing to encourage early detection and management of diabetes within the community and improving the level of retinal screening. The DHB has also been working collaboratively to improve the collection and verification of data around diabetes screening and will continue to do so in the coming year.</p>																																	
<p>Objective 2006/2007</p>	<p>Performance</p>																																	
<p>Reduce the Impact of Diabetes – through improving Diabetes detection by increasing the proportion of people with Diabetes who receive annual Diabetic Checks and the relevant associated primary care.</p> <p>All Diabetics are entitled to an Annual Diabetes Check. The number of Checks relative to the number of expected Diabetics gives an indication of how well Diabetics are being identified and diagnosed.</p>	<p>The number of Diabetes Annual Checks undertaken in Canterbury.</p>	<p>Total</p>	<p>6,142</p>	<p>10,616</p>	<p>7,625</p>																													
	 <table border="1" data-bbox="438 1041 1045 1064"> <tr> <td>Diabetes Annual Checks</td> <td>6,104</td> <td>6,484</td> <td>6,142</td> <td>7,625</td> <td>10,616</td> </tr> </table>	Diabetes Annual Checks	6,104	6,484	6,142	7,625	10,616	<p>Investigation into data accuracy has demonstrated that the actual activity rates around Diabetes Annual Checks had been much lower than reported in past years and that the targets set were therefore unrealistic. The DHB has worked with the Local Diabetes Team (LDT) to aim for realistic targets based on actual performance and revised targets are recorded in the DHB's SOI 2007/2010. While the DHB has not met the target set, the total number of Annual Checks has increased against the previous year's performance.</p>																										
	Diabetes Annual Checks	6,104	6,484	6,142	7,625	10,616																												
	<p>The percentage of expected diabetics who have Annual Diabetes Checks/Reviews during the year.</p>	<p>Maori</p>	<p>25%</p>	<p>80%</p>	<p>33%</p>																													
 <table border="1" data-bbox="438 1422 1045 1554"> <tr> <td>2003</td> <td></td> <td></td> <td></td> <td>53%</td> </tr> <tr> <td>2004</td> <td></td> <td></td> <td></td> <td>53%</td> </tr> <tr> <td>2005</td> <td>25%</td> <td>5%</td> <td>52%</td> <td>49%</td> </tr> <tr> <td>2006</td> <td>33%</td> <td>82%</td> <td>61%</td> <td>59%</td> </tr> <tr> <td>2006 (Target)</td> <td>80%</td> <td>120%</td> <td>87%</td> <td>84%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>57%</td> </tr> </table>	2003				53%	2004				53%	2005	25%	5%	52%	49%	2006	33%	82%	61%	59%	2006 (Target)	80%	120%	87%	84%	National Average				57%	<p>Pacific</p>	<p>51%</p>	<p>120%⁷</p>	<p>82%</p>
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2006 (Target)	80%	120%	87%	84%																														
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<p>Other</p>		<p>52%</p>	<p>87%</p>	<p>61%</p>																														
<p>Total</p>		<p>49%</p>	<p>84%</p>	<p>59%</p>																														
<p>The DHB will continue to work closely with the LDT to improve and validate the accuracy of the information reported and with PHOs to draw their attention to ongoing concerns regarding data collection. The DHB will also work to gain support from PHOs to release to the DHB more detailed screening data to enable validation.⁸</p>																																		

⁶ Note these figures are collected by the Local Diabetes Team (LTD) by calendar year not by financial year.

⁷ The higher percentage for Pacific is an anomaly caused by the LDT's belief that the estimated number of Pacific People in Canterbury is too low.

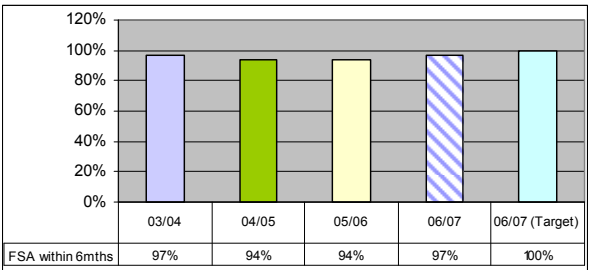
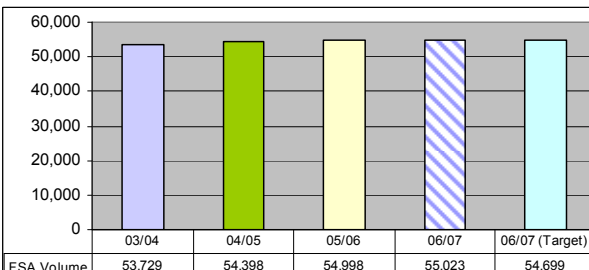
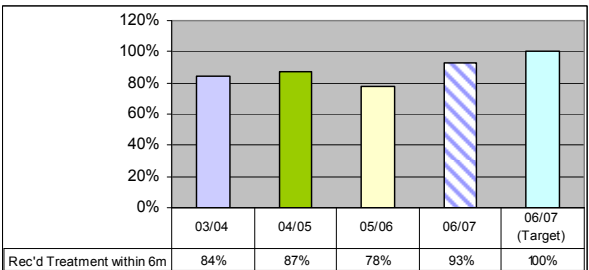
⁸ The LDT has revised its reported number of Annual Checks for 2005, 2004 and 2003. The DHB has used the figures originally provided from the LDT for 2005 as the difference between these and the revised 2005 figures were not considered materially different and the revised figures did not include ethnicity breakdowns. The DHB has reported the LDT's revised figures for 2004 and 2003 as these figures are more aligned to the invoicing by PHOs for Annual Checks over this period.

Reduce the Impact of Diabetes – through the early diagnosis and treatment of eye problems.	<p>The percentage of people having an Annual Diabetes Check who have also had a Retinal (Eye) Screen in the past two years.</p> <table border="1"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>2003</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2004</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2005</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2006</td> <td>44%</td> <td>47%</td> <td>56%</td> <td>55%</td> </tr> <tr> <td>2006 (Target)</td> <td>45%</td> <td>38%</td> <td>80%</td> <td>75%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>65%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	2003					2004					2005					2006	44%	47%	56%	55%	2006 (Target)	45%	38%	80%	75%	National Average				65%	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td></td> <td>45%</td> <td>44%</td> </tr> <tr> <td>Pacific</td> <td></td> <td>38%</td> <td>47%</td> </tr> <tr> <td>Other</td> <td></td> <td>80%</td> <td>56%</td> </tr> <tr> <td>Total</td> <td></td> <td>75%</td> <td>55%</td> </tr> </tbody> </table> <p>The DHB continues to be concerned with the reported level of retinal screens. The DHB’s provider-arm is delivering 4,500 retinal screens per annum (9000 bi annually), yet the latest LDT Annual Report shows only 55% of the 7,625 people reported as having Annual Diabetes Checks reported having had bi annual retinal screen. This would indicate that the DHB is only delivering about 2,087 screens annually (less than half of the actual volumes of screens completed).⁹</p> <p>To move forward the DHB will work with the support of PHOs to undertake more detailed analysis to allow the two currently independent datasets to be integrated so that we can understand why the level of retinal screens is different. We will look to establish the actual rate of retinal screens for those patients having Annual Checks and the number of patients outside both datasets so that PHOs can undertake further follow-up.</p>		Base 05/06	Target 06/07	Result 06/07	Maori		45%	44%	Pacific		38%	47%	Other		80%	56%	Total		75%	55%
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Reduce the Impact of Diabetes – through improved Diabetes Management.	<p>The percentage of people having an Annual Diabetes Check who have poor diabetes control (HBA1c>8%).</p> <table border="1"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>2003</td> <td></td> <td></td> <td></td> <td>26%</td> </tr> <tr> <td>2004</td> <td></td> <td></td> <td></td> <td>24%</td> </tr> <tr> <td>2005</td> <td>34%</td> <td>52%</td> <td>2%</td> <td>22%</td> </tr> <tr> <td>2006</td> <td>30%</td> <td>48%</td> <td>22%</td> <td>23%</td> </tr> <tr> <td>2006 (Target)</td> <td>39%</td> <td>45%</td> <td>20%</td> <td>23%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>27%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	2003				26%	2004				24%	2005	34%	52%	2%	22%	2006	30%	48%	22%	23%	2006 (Target)	39%	45%	20%	23%	National Average				27%	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>34%</td> <td>39%</td> <td>30%</td> </tr> <tr> <td>Pacific</td> <td>52%</td> <td>45%</td> <td>48%</td> </tr> <tr> <td>Other</td> <td>21%</td> <td>20%</td> <td>22%</td> </tr> <tr> <td>Total</td> <td>22%</td> <td>23%</td> <td>23%</td> </tr> </tbody> </table> <p>Although the results for the ‘other’ population grouping is higher than the previous years results, (therefore driving the total result up), the Maori and Pacific results have improved and these are our key risk groups for Diabetes – a positive improvement.¹⁰</p>		Base 05/06	Target 06/07	Result 06/07	Maori	34%	39%	30%	Pacific	52%	45%	48%	Other	21%	20%	22%	Total	22%	23%	23%
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⁹ The LDT has revised its reported numbers relating to Diabetes for 2005, 2004 and 2003. The DHB has reported the most recent LDT figures for bi-annual retinal screening. However the DHB is concerned with the differential between the reported number of retinal screens from the LDT and the numbers reported from our provider-arm. The DHB has chosen not to include historical figures which it believes may be inaccurate.

¹⁰ As part of its review the LDT has revised its reported percentages of those having those Annual Checks who had poor diabetes control for 2005, 2004 and 2003. The DHB has used the figures originally provided from the LDT for 2005 as the difference between these and the revised 2005 figures were not considered materially different and the revised figures did not include ethnicity breakdowns. The DHB has reported the LDT’s revised figures for 2004 and 2003 as these revised figures are more aligned to the invoicing by PHOs for Annual Checks over this period.

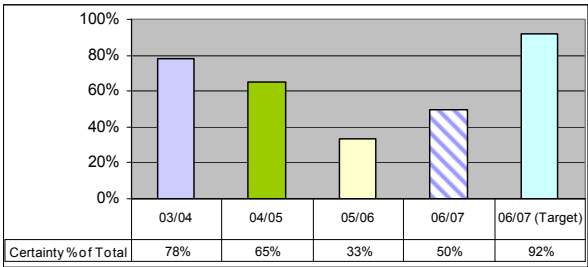
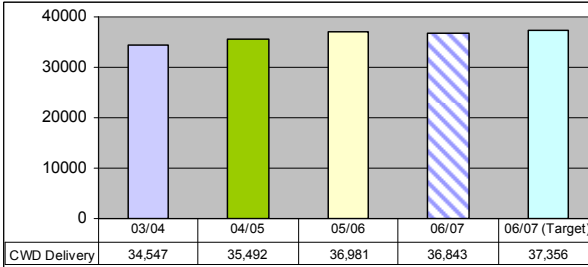
1.9 Other Performance Measures – Service Delivery Targets

<p>Long-term Objective: <i>Improved health status for Canterbury's residents via the provision of services in a timely manner, within the available resources, for those with the greatest level of need.</i></p>	<p>Brief Description: Providing access to outpatient services and elective surgery has been an ongoing issue for the DHB. The funding and human resources available are limited and are not sufficient to meet all of the demand for health services. The DHB must therefore prioritise services and has been focused on the implementation of the Ministry's national Elective Service Policy in relation to elective services. These include; the provision of timely access to specialist assessment and elective surgery and the delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress or ill health. The DHB has also been focused on elective procedures undertaken on a daycase basis, which are associated with reduced risk to the patient and cost less than the same procedures undertaken on an inpatient basis.¹¹</p>																
<p>Objective 2006/2007</p>	<p>Performance</p>																
<p>Improve access to treatment – through reducing the waiting lists for First Specialist Assessments (FSA) so that all appropriately referred patients can be assessed within appropriate timeframes. <i>A FSA is the first appointment a patient has with a specialist following referral.</i></p>	<p>Percentage of patients who receive their FSA within six months of referral.¹²</p>  <table border="1" data-bbox="438 1075 1029 1086"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>FSA within 6mths</td> <td>97%</td> <td>94%</td> <td>94%</td> <td>97%</td> <td>100%</td> </tr> </tbody> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	FSA within 6mths	97%	94%	94%	97%	100%	<p>Total</p>	<p>Base 05/06</p>	<p>Target 06/07</p>	<p>Result 06/07</p>
	03/04	04/05	05/06	06/07	06/07 (Target)												
FSA within 6mths	97%	94%	94%	97%	100%												
<p>Improve certainty of treatment – through provision of certainty to patients as to whether they will/will not receive access to publicly funded inpatient surgery and where patients are given certainty ensure this is provided in a timely manner.</p>	<p>Delivery of a level of publicly funded FSA volumes at the levels specified by contract (outlined in the DHB's DAP).</p>  <table border="1" data-bbox="438 1467 1029 1478"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>FSA Volume</td> <td>53,729</td> <td>54,398</td> <td>54,998</td> <td>55,023</td> <td>54,699</td> </tr> </tbody> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	FSA Volume	53,729	54,398	54,998	55,023	54,699	<p>Total</p>	<p>Base 05/06</p>	<p>Target 06/07</p>	<p>Result 06/07</p>
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<p>Percentage of patients provided with certainty of treatment receiving that treatment within six months.</p>	 <table border="1" data-bbox="438 1825 1029 1836"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Rec'd Treatment within 6m</td> <td>84%</td> <td>87%</td> <td>78%</td> <td>93%</td> <td>100%</td> </tr> </tbody> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Rec'd Treatment within 6m	84%	87%	78%	93%	100%	<p>Total</p>	<p>Base 05/06</p>	<p>Target 06/07</p>	<p>Result 06/07</p>
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Rec'd Treatment within 6m	84%	87%	78%	93%	100%												
<p>Percentage of patients provided with certainty of treatment receiving that treatment within six months.</p>	<p>Total FSA</p>	<p>Base 05/06</p>	<p>Target 06/07</p>	<p>Result 06/07</p>	<p>The Year-End figure shows an additional 324 FSA volumes delivered against contract and a small increase against the previous year's volumes.</p>												
<p>Percentage of patients provided with certainty of treatment receiving that treatment within six months.</p>	<p>Again these indicators have been replaced by the Ministry's national ESPIs. This indicator has been replaced by ESPI 5. Under ESPI 5 the DHB is required to see 95% of patients given a commitment to treat within six months of receiving that commitment. The DHB was compliant for ESPI 5 in June 2007.</p>	<p>Total</p>	<p>Base 05/06</p>	<p>Target 06/07</p>	<p>Result 06/07</p>												

¹¹ Day Case Procedures are cases where the patient is not admitted to hospital overnight.

¹² This indicator has been replaced by one of the Ministry's national Elective Services Patient-flow Indicators (ESPIs), as part of the Ministry's Elective Services Policy. This older indicator used slightly different parameters and business rules than the ESPI that replaced it - ESPI 2. ESPI 2 requires DHBs to see 98% of patients waiting for FSAs within six months and the Canterbury DHB was compliant under this indicator in June 2007.

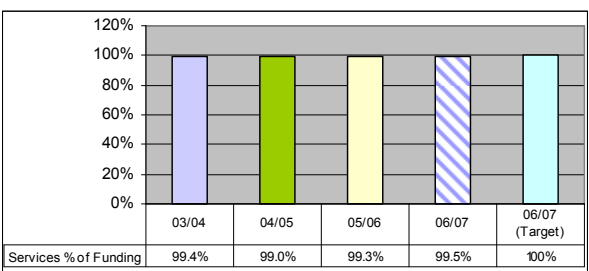
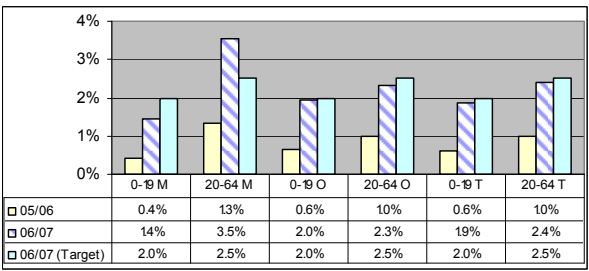
¹³ The target set in the 2006/07 SOI was not consistent with the volume specified in the 2006/07 DAP. The target has been revised to reflect the DAP target (an increase of 1,395 FSAs).

	<p>Percentage of patients given certainty who are treated within the period indicated.</p>  <table border="1" data-bbox="437 488 1027 551"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Certainty % of Total</td> <td>78%</td> <td>65%</td> <td>33%</td> <td>50%</td> <td>92%</td> </tr> </tbody> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Certainty % of Total	78%	65%	33%	50%	92%	<table border="1" data-bbox="1062 215 1543 309"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>33%</td> <td>92%</td> <td>50%</td> </tr> </tbody> </table> <p>The DHB has been focused on matching a commitment to treat (or giving certainty) with its capacity to deliver those promises. There needs to be an understanding that the DHB's capacity fluctuates. Too much emphasis on providing certainty can mean a fluctuation in capacity would see the DHB not meeting its commitment to its patients. This is an ongoing process.</p>		Base 05/06	Target 06/07	Result 06/07	Total	33%	92%	50%
	03/04	04/05	05/06	06/07	06/07 (Target)																	
Certainty % of Total	78%	65%	33%	50%	92%																	
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Total	33%	92%	50%																			
<p>Improve the Delivery of Treatment – through maintenance of surgical volume delivery, ensuring that all contracted surgery is delivered.</p>	<p>Case Weighted Discharges Delivered, as specified in the DHB DAP.¹⁴</p>  <table border="1" data-bbox="437 857 1027 898"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>CWD Delivery</td> <td>34,547</td> <td>35,492</td> <td>36,981</td> <td>36,843</td> <td>37,356</td> </tr> </tbody> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	CWD Delivery	34,547	35,492	36,981	36,843	37,356	<table border="1" data-bbox="1062 562 1543 685"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total CWD</td> <td>36,981</td> <td>37,356¹⁵</td> <td>36,843</td> </tr> </tbody> </table> <p>36,843 CWD have been delivered, this is 513 under contract and less than the previous year's performance.</p> <p>However, the DHB has faced ongoing industrial action since September 2006, which has affected elective surgery levels. This is a positive result considering the impact of the industrial action.</p> <p>In addition to the above volumes an estimated 1,990 CWD of additional surgery (734 cases) were also delivered by a range of other providers under contract to the DHB in the past year which is not reflected in this indicator.</p>		Base 05/06	Target 06/07	Result 06/07	Total CWD	36,981	37,356 ¹⁵	36,843
	03/04	04/05	05/06	06/07	06/07 (Target)																	
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Total CWD	36,981	37,356 ¹⁵	36,843																			

¹⁴ CWD delivery reflects the surgical (including Dental CWD) CWD delivery by the DHB provider-arm, against the Price Volume Schedule targets contained in the DHB's DAP. The result for 2004/05 is different from that published (34,074) as the previous number did not include Dental CWDs.

¹⁵ The target set in the DHB's 2006/07 SOI was not consistent with the volume specified in the 2006/07 DAP. The target has been revised to reflect the DAP target (an increase of 1418 CWD).

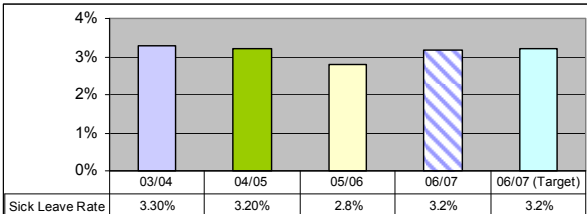
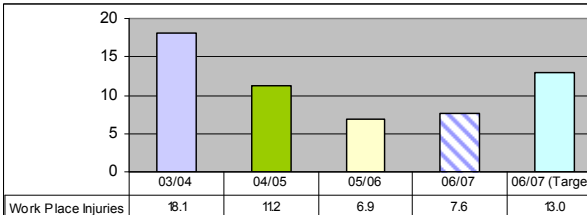
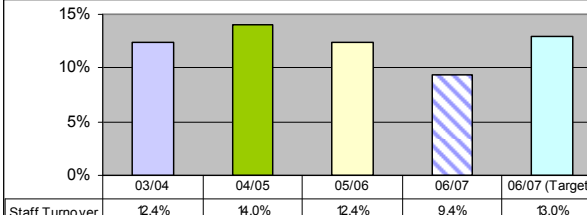
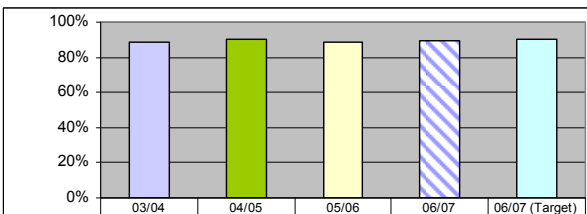
1.10 Mental Health

<p>Long-term Objective: <i>Improved Health Status for Canterbury Residents who have a serious ongoing mental illness.</i></p>	<p>Brief Description: It is estimated that 3% of New Zealanders will have a serious ongoing mental illness, which requires specialist care and treatment by a range of health and social service providers. The DHB plans to continue implementing the Mental Health Strategy, Blueprint for Mental Health Services, the Youth Suicide Strategy and national guidelines. The DHB has also completed its own Mental Health and Addictions Strategic Plan, which had its first year of implementation in 2005/06 and will continue to implement this Plan. Over the next few years the DHB will continue to focus on improving access to services (in line with the demographics and mental health needs of the people in our region) and ensuring that the services provided are provided by the right provider, in the right place and at the right time.</p>																																																																				
<p>Objective 2006/2007</p>	<p>Performance</p>																																																																				
<p>Improve the provision of Mental Health Services – through ensuring the delivery of contracted Mental Health Volumes by Hospital and Specialist Services (HSS) and ensuring services funded meet expenditure targets set by the Ministry.</p>	<p>Actual services delivered by the provider arm as a percentage of the contract with HSS, as outlined in the DHB’s DAP.¹⁶</p>  <table border="1" data-bbox="438 1019 1029 1041"> <tr> <td>Services % of Funding</td> <td>99.4%</td> <td>99.0%</td> <td>99.3%</td> <td>99.5%</td> <td>100%</td> </tr> <tr> <td></td> <td>03/04</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> </table> <p>Total contracted funding (both HSS and external Non-Government Organisations (NGOs)) as a percentage of the mental health target specified by the Ministry’s Mental Health ‘Ring-fence’.</p> <table border="1" data-bbox="1061 705 1544 1187"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>99%</td> <td>100%</td> <td>99.5%</td> </tr> <tr> <td>Total</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table>	Services % of Funding	99.4%	99.0%	99.3%	99.5%	100%		03/04	04/05	05/06	06/07	06/07 (Target)		Base 05/06	Target 06/07	Result 06/07	Total	99%	100%	99.5%	Total	100%	100%	100%																																												
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<p>Improved access to Mental Health Services through achievement of nationally set targets for access to treatment and support services for those with severe mental illness.</p> <p><i>These targets are set in line with estimated proportions of people with mental illnesses for each age group and ethnicity in Canterbury. The higher the percentage, the more people accessing services.</i></p>	 <table border="1" data-bbox="438 1400 1029 1467"> <tr> <td></td> <td>0-19 M</td> <td>20-64 M</td> <td>0-19 O</td> <td>20-64 O</td> <td>0-19 T</td> <td>20-64 T</td> </tr> <tr> <td>05/06</td> <td>0.4%</td> <td>13%</td> <td>0.6%</td> <td>10%</td> <td>0.6%</td> <td>10%</td> </tr> <tr> <td>06/07</td> <td>14%</td> <td>3.5%</td> <td>2.0%</td> <td>2.3%</td> <td>19%</td> <td>2.4%</td> </tr> <tr> <td>06/07 (Target)</td> <td>2.0%</td> <td>2.5%</td> <td>2.0%</td> <td>2.5%</td> <td>2.0%</td> <td>2.5%</td> </tr> </table> <table border="1" data-bbox="1061 1187 1544 1960"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td></td> <td></td> <td></td> </tr> <tr> <td>0-19</td> <td>0.4%</td> <td>2.0%</td> <td>1.4%</td> </tr> <tr> <td>20-64</td> <td>1.3%</td> <td>2.5%</td> <td>3.5%</td> </tr> <tr> <td>Other</td> <td></td> <td></td> <td></td> </tr> <tr> <td>0-19</td> <td>0.6%</td> <td>2.0%</td> <td>2.0%</td> </tr> <tr> <td>20-64</td> <td>1.0%</td> <td>2.5%</td> <td>2.3%</td> </tr> <tr> <td>Total</td> <td></td> <td></td> <td></td> </tr> <tr> <td>0-19</td> <td>0.6%</td> <td>2.0%</td> <td>1.9%</td> </tr> <tr> <td>20-64</td> <td>1.0%</td> <td>2.5%</td> <td>2.4%</td> </tr> </tbody> </table> <p>Although the access rates have not met target in some of the population groupings there is still a positive increase in access rates against the previous year.</p> <p>There are a number of clients seen by NGO providers in the community that are not linked in with Mental Health HSS and are therefore not reported through to the Mental Health Information National Collection (MHINC) database (where this access information is collected). The activity of many of our NGO community providers, who work with high needs and at risk groups, is not reflected under this measure. If NGO data was reported to MHINC the DHB is confident it would exceed every population target</p>		0-19 M	20-64 M	0-19 O	20-64 O	0-19 T	20-64 T	05/06	0.4%	13%	0.6%	10%	0.6%	10%	06/07	14%	3.5%	2.0%	2.3%	19%	2.4%	06/07 (Target)	2.0%	2.5%	2.0%	2.5%	2.0%	2.5%		Base 05/06	Target 06/07	Result 06/07	Maori				0-19	0.4%	2.0%	1.4%	20-64	1.3%	2.5%	3.5%	Other				0-19	0.6%	2.0%	2.0%	20-64	1.0%	2.5%	2.3%	Total				0-19	0.6%	2.0%	1.9%	20-64	1.0%	2.5%	2.4%
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¹⁶ Adjustment is made to vacant Full-time Equivalent (FTE) positions where cover has been provided.

2. PROVIDER HOSPITAL AND SPECIALIST SERVICE MEASURES

2.1 Hospital Efficiency and Effectiveness

<p>Long-term Objective: Efficient, effective and quality provision of health services to maximise the health status of Canterbury's residents within its available resources.</p>	<p>Brief Description: The DHB is a major provider (as well as the major funder) of health services to Canterbury residents. As a provider of health services the DHB must ensure that it operates in an effective and efficient manner, that the services provided are of a high quality and that patient safety is maximised.</p>																
<p>Objective 2006/2007</p>	Performance																
<p>Improve performance as a good employer – through initiating systems and processes to promote a good working environment and foster partnerships between staff and management.</p>	<p>Sick Leave Rate (as per Hospital Benchmarking Indicator (HBI)).¹⁷</p>  <table border="1" data-bbox="437 958 1026 987"> <tr> <td></td> <td>03/04</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> <tr> <td>Sick Leave Rate</td> <td>3.30%</td> <td>3.20%</td> <td>2.8%</td> <td>3.2%</td> <td>3.2%</td> </tr> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Sick Leave Rate	3.30%	3.20%	2.8%	3.2%	3.2%	<p>Total</p>	<p>Base 05/06 2.8%</p>	<p>Target 06/07 3.2%</p>	<p>Result 06/07 3.2%</p>
	03/04	04/05	05/06	06/07	06/07 (Target)												
Sick Leave Rate	3.30%	3.20%	2.8%	3.2%	3.2%												
<p>Improve Patient Satisfaction – through initiating systems and processes to ensure quality service.</p>	<p>Work Place Injuries per million hours (HBI).</p>  <table border="1" data-bbox="437 1227 1026 1256"> <tr> <td></td> <td>03/04</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> <tr> <td>Work Place Injuries</td> <td>18.1</td> <td>11.2</td> <td>6.9</td> <td>7.6</td> <td>13.0</td> </tr> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Work Place Injuries	18.1	11.2	6.9	7.6	13.0	<p>Total</p>	<p>Base 05/06 6.9</p>	<p>Target 06/07 13</p>	<p>Result 06/07 7.6</p> <p>The Workplace Injury Rate provides an indicator of the lost time injury rate over a period. There has been an overall downward trend over the last few years however recent quarters have seen a small increase in the number of lost time injuries. The result still remains well below the target set of 13 per million hours.</p>
	03/04	04/05	05/06	06/07	06/07 (Target)												
Work Place Injuries	18.1	11.2	6.9	7.6	13.0												
	<p>Staff Retention and Turnover (HBI).</p>  <table border="1" data-bbox="437 1527 1026 1556"> <tr> <td></td> <td>03/04</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> <tr> <td>Staff Turnover</td> <td>12.4%</td> <td>14.0%</td> <td>12.4%</td> <td>9.4%</td> <td>13.0%</td> </tr> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Staff Turnover	12.4%	14.0%	12.4%	9.4%	13.0%	<p>Total</p>	<p>Base 05/06 12.4%</p>	<p>Target 06/07 13%</p>	<p>Result 06/07 9.4%</p>
	03/04	04/05	05/06	06/07	06/07 (Target)												
Staff Turnover	12.4%	14.0%	12.4%	9.4%	13.0%												
	<p>Percentage of Good and Very Good responses from Inpatient Satisfaction Surveys (HBI).</p>  <table border="1" data-bbox="437 1848 1026 1877"> <tr> <td></td> <td>03/04</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>06/07 (Target)</td> </tr> <tr> <td>IP Satisfaction</td> <td>89.0%</td> <td>90.0%</td> <td>88.5%</td> <td>89.4%</td> <td>90.0%</td> </tr> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	IP Satisfaction	89.0%	90.0%	88.5%	89.4%	90.0%	<p>Total</p>	<p>Base 05/06 88.5%</p>	<p>Target 06/07 >90%</p>	<p>Result 06/07 89.4%</p> <p>There is an insignificant difference between the 2006/07 results and the target.</p>
	03/04	04/05	05/06	06/07	06/07 (Target)												
IP Satisfaction	89.0%	90.0%	88.5%	89.4%	90.0%												

¹⁷ Hospital Benchmark Indicators are national Ministry indicators used to measure national performance between DHBs.

	<p>Percentage of Good and Very Good responses from Outpatient Satisfaction Surveys (HBI).</p> <table border="1"> <thead> <tr> <th>Year</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>OP Satisfaction</td> <td>90.0%</td> <td>90.0%</td> <td>91%</td> <td>90.1%</td> <td>90.0%</td> </tr> </tbody> </table>	Year	03/04	04/05	05/06	06/07	06/07 (Target)	OP Satisfaction	90.0%	90.0%	91%	90.1%	90.0%	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>91.0%</td> <td>>90%</td> <td>90.1%</td> </tr> </tbody> </table> <p>While the 2006/07 results show a reduction against the previous year's result, the result still reaches the target set by the DHB.</p>		Base 05/06	Target 06/07	Result 06/07	Total	91.0%	>90%	90.1%
Year	03/04	04/05	05/06	06/07	06/07 (Target)																	
OP Satisfaction	90.0%	90.0%	91%	90.1%	90.0%																	
	Base 05/06	Target 06/07	Result 06/07																			
Total	91.0%	>90%	90.1%																			
<p>Continue to maintain Quality – through Quality Health New Zealand Accreditation.</p>	<p>Maintain accreditation at all major DHB provider-arm (HSS) facilities.</p>	<table border="1"> <thead> <tr> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Maintain accreditation status</td> <td>Maintained</td> </tr> </tbody> </table>	Target 06/07	Result 06/07	Maintain accreditation status	Maintained																
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<p>Maintain appropriate levels of Clinical Quality within CDHB Hospitals.</p>	<p>Hospital Acquired Bacteraemia Rate, per 100 inpatient days (excluding the Mental Health Division).</p> <table border="1"> <thead> <tr> <th>Year</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Bacteraemia Rate</td> <td>0.12</td> <td>0.13</td> <td>0.16</td> <td>0.12</td> <td>0.14</td> </tr> </tbody> </table>	Year	03/04	04/05	05/06	06/07	06/07 (Target)	Bacteraemia Rate	0.12	0.13	0.16	0.12	0.14	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>0.16</td> <td>0.14 or less</td> <td>0.12</td> </tr> </tbody> </table>		Base 05/06	Target 06/07	Result 06/07	Total	0.16	0.14 or less	0.12
Year	03/04	04/05	05/06	06/07	06/07 (Target)																	
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	<p>Patient Falls (causing moderate or serious injury) per 1000 inpatient days.¹⁸</p> <table border="1"> <thead> <tr> <th>Year</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Patient Falls</td> <td>0.20</td> <td>0.16</td> <td>0.40</td> </tr> </tbody> </table>	Year	05/06	06/07	06/07 (Target)	Patient Falls	0.20	0.16	0.40	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>0.20</td> <td>0.40 or less</td> <td>0.16</td> </tr> </tbody> </table>		Base 05/06	Target 06/07	Result 06/07	Total	0.20	0.40 or less	0.16				
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	<p>IV Medication Error Rate per 1000 inpatient days.¹⁹</p> <table border="1"> <thead> <tr> <th>Year</th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>IV Medication Error Rate</td> <td>2.0</td> <td>1.8</td> <td>1.5</td> <td>1.6</td> <td>4.0</td> </tr> </tbody> </table>	Year	03/04	04/05	05/06	06/07	06/07 (Target)	IV Medication Error Rate	2.0	1.8	1.5	1.6	4.0	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>1.3²⁰</td> <td>4 or more</td> <td>1.6</td> </tr> </tbody> </table> <p>The DHB has set a high target in response to a commitment to increase reporting of IV and medication errors.</p> <p>There are a number of initiatives in this area including: introduction of the 0800 reporting line, educating staff through orientation and quality training programmes and the introduction of key patient safety policies such as the No-Blame Incident/Accident Policy and Culture of Patient Safety Policy. The aim of these initiatives is to help reinforce the benefit of staff reporting and to pass on important safety messages.</p>		Base 05/06	Target 06/07	Result 06/07	Total	1.3 ²⁰	4 or more	1.6
Year	03/04	04/05	05/06	06/07	06/07 (Target)																	
IV Medication Error Rate	2.0	1.8	1.5	1.6	4.0																	
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Total	1.3 ²⁰	4 or more	1.6																			

¹⁸ The patient falls indicator is a patient falls rate per 1000 inpatient days. The target set in the 2006/2007 SOI document was incorrectly set at a rate per 100 days the target is reflected here per 1000 inpatient days. The Fall Rate is defined as the number of patient falls causing moderate or serious injury against the number of Inpatient Day Equivalents - these are the total inpatients days plus half the total daypatient attendances.

¹⁹ This measure is derived from incidence reports and the level of harm reported is unusually low in comparison with formal studies of adverse drug events. The target is set to increase the rate of reported errors, in line with the DHB policy of emphasising staff responsibility to report error and reflects the Institute of Healthcare Improvement recommendation that increasing reporting levels is an essential step in reducing overall harm.

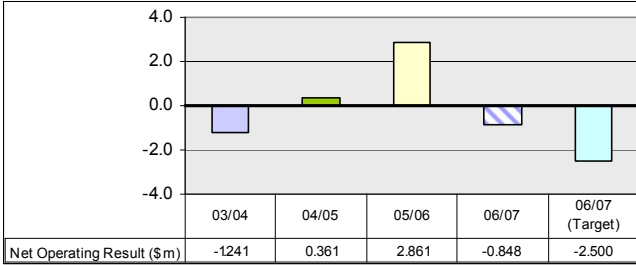
²⁰ This figure is different to that reported in the DHB's 2005/06 Annual Report (1.5) due to a data collection error (the reported figure included events not directly related to a medication error and these have been removed).

<p>Improve the continuum of care for patients – through innovation and patient orientated processes reducing unnecessary waits and delays for people attending Christchurch Hospital Emergency Department (ED).</p> <p><i>Patients coming into the ED are triaged upon presentation into one of five categories, dependant on need:</i></p> <p><i>Triage 1 should be attended to immediately</i></p> <p><i>Triage 2 within 10 mins</i></p> <p><i>Triage 3 within 30 mins.</i></p>	<p>Number of attendances at the Christchurch Hospital ED.</p> <table border="1"> <thead> <tr> <th>Year</th> <th>ED Attendances</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>65750</td> </tr> <tr> <td>04/05</td> <td>67600</td> </tr> <tr> <td>05/06</td> <td>74279</td> </tr> <tr> <td>06/07</td> <td>71952</td> </tr> </tbody> </table>	Year	ED Attendances	03/04	65750	04/05	67600	05/06	74279	06/07	71952	<table border="1"> <thead> <tr> <th></th> <th>Base 05/06</th> <th>Target 06/07</th> <th>Result 06/07</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>71,279</td> <td>n/a²¹</td> <td>71,952</td> </tr> </tbody> </table>		Base 05/06	Target 06/07	Result 06/07	Total	71,279	n/a ²¹	71,952																						
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²¹ This service is demand driven and as such no target for attendances can be set. This indicator is included for information purposes only.

3. GOVERNANCE

3.1 Good Governance

<p>Long-term 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 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 2006/2007</p>	<p>Performance</p>															
<p>Break Even – by managing expenditure (including funding to external providers) within available funding.</p>	<p>Net Operating Results.</p>  <table border="1" data-bbox="400 1055 1038 1099"> <thead> <tr> <th></th> <th>03/04</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>06/07 (Target)</th> </tr> </thead> <tbody> <tr> <td>Net Operating Result (\$m)</td> <td>-1241</td> <td>0.361</td> <td>2.861</td> <td>-0.848</td> <td>-2.500</td> </tr> </tbody> </table>		03/04	04/05	05/06	06/07	06/07 (Target)	Net Operating Result (\$m)	-1241	0.361	2.861	-0.848	-2.500	<p>\$2.861M</p>	<p>\$2.5M deficit</p>	<p>\$0.848M deficit</p>
	03/04	04/05	05/06	06/07	06/07 (Target)											
Net Operating Result (\$m)	-1241	0.361	2.861	-0.848	-2.500											
<p>Develop District Strategic Plan within set time frame.</p>	<p>Delivery against Strategic Plan monitored.</p>		<p>Regular monitoring of Strategic Plan against targets.</p>	<p>Regular activity reports presented.</p>												
<p>Provide Governance Training - good governance requires training and support, particularly for members new to governance.</p>	<p>Board members (new and existing) have received Governance training and Treaty of Waitangi training.</p>		<p>Governance and Treaty training available for all Board members.</p>	<p>Achieved.</p>												
	<p>A training register is established and maintained as required by the New Zealand Public Health and Disability Act 2000.</p>		<p>Registered established and maintained.</p>	<p>Register in place.</p>												
<p>Maintain quality of services contracted to NGO providers.</p>	<p>Contract Managers maintain ongoing working relationships with providers, monitoring service provision, making site visits and requiring monthly or quarterly monitoring reports.</p>		<p>Maintain provider monitoring processes.</p>	<p>Maintained.</p>												
	<p>Regular routine audits are carried out and issues based audits are undertaken where process indicates it is appropriate.</p>		<p>Maintain annual audit plan processes.</p>	<p>Annual audit plan complete.</p>												
	<p>The DHB leads a provider quality network which is an information sharing forum on quality related issues.</p>		<p>Continuation of this quality forum.</p>	<p>Quality forum continued.</p>												

4. Summary of Revenues and Expenses by Output Class

	Funding \$'000	Governance & Funding Admin \$'000	Provider \$'000	In-House Elimination \$'000	Total District Health Board \$'000
Revenue					
MoH Revenue	1,008,495	3,934	610,930	(572,955)	1,050,404
Patient Related Revenue			33,458		33,458
Other			27,463		27,463
Total Revenue	1,008,495	3,934	671,851	(572,955)	1,111,325
Expenditure					
Personnel		2,633	435,279		437,912
Depreciation		57	47,171		47,228
Interest			5,069		5,069
Capital Charge			22,894		22,894
Other	1,006,029	988	165,008	(572,955)	599,070
Total Expenditure	1,006,029	3,678	675,421	(572,955)	1,112,173
Net Surplus/(Deficit)	2,466	256	(3,570)	-	(848)

5. Glossary

Ambulatory Sensitive Admissions	Admissions that are seen as potentially preventable by appropriate effective and efficient primary care, preventive or therapeutic programmes.
Angioplasty	An Angioplasty is a non-invasive procedure where a balloon-tipped catheter is inflated inside a diseased blood vessel. As the balloon is inflated, the vessel opens further allowing for improved flow of blood.
Bacteraemia Rate	Hospital Acquired Bacteraemia rate measures the number of hospital acquired blood stream infections as a proportion of the number of inpatients.
Certainty	When a DHB gives a patient a commitment to treat within six months, this patient has certainty. This commitment can be given either through a certainty letter (promise of surgery date within six months) or being direct booked for treatment (given date for surgery directly).
CABG - Coronary Artery Bypass Graft	A surgical procedure which involves replacing diseased (narrowed) coronary arteries with veins obtained from the patients lower extremities. During this procedure the patient is placed on a heart bypass machine (heart-lung machine) to allow the surgeon adequate time to perform surgery on the resting (nonbeating) heart.
CWD - Case Weighted Discharges	This is a relative measure of the cost of different types of surgery. For example cataract surgery has a lower cost weight than hip replacement surgery.
FSA – First Specialist Assessment	(Outpatients only) The FSA is the first time a patient is seen by a doctor for a consultation in a particular speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
FTE - Full Time Equivalent	Full Time Equivalent means an Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
Governance	Governance, as executed by the DHB Board, is strategic oversight of the management of the DHB to ensure it delivers on its fundamental objective of working within allocated resources to improve, promote and protect the health of a defined population, and to promote the independence of people with disabilities within a defined population
HBI - Hospital Benchmark Indicator	Indicators of national DHB performance established and monitored by the Ministry of Health.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin. The level of HbA1c reflects the average blood glucose level over the past 3 months.
Mental Health Blueprint Funding or Mental Health Ring-fence	Blueprint funding is allocated by the Ministry to ensure the development of mental health services for the 3% of the total NZ population estimated to have moderate to severe mental illness. Service development is based on the service levels set out in the Mental Health Commission's <i>Blueprint for Mental Health Services in NZ: How Things Need to Be (1998)</i> . The application of a 'Ringfence Policy' for mental health services has been an important factor in ensuring progress with implementation of the Blueprint. The Ringfence serves the purpose of ensuring money allocated to mental health is used for that purpose and that service expansion is real and not eroded by demographic and price pressures.
MeNZB - Meningococcal B	Meningococcal disease is a bacterial infection. It causes severe illnesses including: meningitis (an infection of membranes that cover the brain) and septicaemia (a serious infection in the blood). There are several different strains of bacteria which cause meningococcal disease including A, B and C.
NGO - Non-Government Organisation	NGOs are defined as independent community organisations operating on a not-for-profit basis, which bring a value to society that is distinct from government and market organisations – meaning that any profits are put back into the organisation, rather than distributed to shareholders. Some organisations identify closer with other categories, for example third sector organisations, voluntary organisations or community organisation rather than a NGO. However, for the purposes of a definition a "NGO" includes all these types of organisations.
PHO - Primary Health Organisation	A new development in service delivery, PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.

Radiation Therapy	Radiation therapy is the branch of medicine that deals with the management of cancers by radiation. Commonly treated cancers are breast, lung, rectum and prostate. Radiation is often given in addition to other forms of cancer treatment, such as chemotherapy, surgery and hormonal therapy. Radiation oncology services require close linkages with medical oncology, palliative care and most surgical and medical sub-specialities.
Triage Levels - Emergency Department (ED)	Patients coming into the ED are triaged upon presentation into one of five categories. Patients may be re-triaged to a different category as the assessment and treatment process develops and particularly in response to significant changes in physiological status. Staff and other resources should be deployed so that treatment acuity thresholds are achieved progressively.

AUDIT REPORT

TO THE READERS OF
CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S
FINANCIAL STATEMENTS AND PERFORMANCE INFORMATION
FOR THE YEAR ENDED 30 JUNE 2007

The Auditor-General is the auditor of Canterbury District Health Board (the District Health Board) and group. The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand to carry out the audit on his behalf. The audit covers the financial statements and statement of service performance of the District Health Board and group for the year ended 30 June 2007.

Unqualified opinion

In our opinion:

- σ The financial statements of the District Health Board and group on pages 19 to 38:
 - comply with generally accepted accounting practice in New Zealand; and
 - fairly reflect:
 - the District Health Board and group's financial position as at 30 June 2007; and
 - the results of operations and cash flows for the year ended on that date.
- σ The statement of service performance of the District Health Board and group on pages 39 to 62:
 - complies with generally accepted accounting practice in New Zealand; and
 - fairly reflects for each class of outputs:
 - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
 - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 26 September 2007, and is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

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

Audit procedures generally include:

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

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

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

Responsibilities of the Board and the Auditor

The Board is responsible for preparing financial statements and a statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the District Health Board and group as at 30 June 2007 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the District Health Board and group's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you. This responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

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



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

Matters relating to the electronic presentation of the audited financial statements and statement of service performance

This audit report relates to the financial statements and the statement of service performance of the Canterbury District Health Board for the year ended 30 June 2007 included on the District Health Board's web-site. The District Health Board's Board is responsible for the maintenance and integrity of the web site. We have not been engaged to report on the integrity of the District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements and the statement of service performance since they were initially presented on the web site.

The audit report refers only to the financial statements and the statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and the statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 26 September 2007 to confirm the information included in the audited financial statements and statement of service performance presented on this web site.

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