

**Canterbury**

District Health Board

Te Poari Hauora o Waitaha

## **Canterbury District Health Board**

**Report For the Year Ended  
30 June 2008**

<b>TABLE OF CONTENTS</b>
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<b>DIRECTORY</b>	<b>2</b>
<b>MISSION STATEMENT</b>	<b>3</b>
<b>BOARD MEMBERS</b>	<b>3</b>
<b>STATUTORY DISCLOSURE</b>	<b>15</b>
<b>STATEMENT OF RESPONSIBILITY</b>	<b>23</b>
<b>STATEMENT OF FINANCIAL PERFORMANCE</b>	<b>24</b>
<b>STATEMENT OF CHANGES IN EQUITY</b>	<b>25</b>
<b>STATEMENT OF FINANCIAL POSITION</b>	<b>26</b>
<b>STATEMENT OF CASH FLOWS</b>	<b>27</b>
<b>NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS</b>	<b>28</b>
<b>STATEMENT OF SERVICE PERFORMANCE</b>	<b>58</b>
<b>AUDITOR'S REPORT</b>	<b>81</b>

# DIRECTORY

## Board Members

Alister James - Chair

Olive Webb – Deputy Chair

Andrew Dickerson

Anna Crighton

Chris Ryan

David Morrell

Eleanor Carter

Elizabeth Cunningham

Jo Kane

Matea Gillies

Peter Ballantyne

Heather Carter \*

Karen Guilliland \*

Laurence Malcolm \*

Neville Fagerlund \*

Norm Dewes \*

Robin Booth \*

Syd Bradley \*

(\* Board Member retired in December 2007)

## Chief Executive

Gordon Davies (Chief Executive Officer)

## Registered Office

2nd Floor, H Block

The Princess Margaret Hospital

Cashmere Road

Christchurch

## Auditor

Audit New Zealand on behalf of the Auditor-General

## Banker

Westpac Banking Corporation

## MISSION STATEMENT

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

## BOARD MEMBERS

- Alister James - Chair** Alister served 20 years as a Christchurch City Councillor and is a lawyer with a particular interest in adolescent health, mental health, and alcohol and drug treatment services. He is keen to improve DHB and community relations.
- Olive Webb - Deputy Chair** Olive is a Clinical Psychologist and independent Health and Disability Consultant with more than 35 years experience. She has served on the Board for seven years and is committed to rural health issues and delivery.
- Andrew Dickerson\*\*** Andrew has 20 years experience in the health and disability sector and is Chief Executive of Age Concern Canterbury. He would like to see improved access to elective surgery, better integration between hospital and General Practice services.
- Anna Crighton \*\*** Anna intends to use her 15 years as a Christchurch City Councillor and Community Board member, to help improve governance and accountability. She has a record of being effective, vocal, publicly accessible and accountable.
- Chris Ryan \*\*** An Ashburton GP for 18 years, Chris has been Chair of the Ashburton District Health Committee, GP representative Rural Canterbury PHO Board, Secretary of the Canterbury Faculty of the Royal NZ College of GPs and a GP education facilitator. Chris believes health professionals should be involved in planning and management at every level.
- David Morrell** David has been a member of the District Health Board for six years and has been Christchurch City Missioner. He is committed to more accessible and affordable services for all. David is Chair of the CDHB Hospital Advisory Committee, member of the Finance Audit & Risk Committee and Chair of Brackenridge Estate.
- Eleanor Carter \*\*** Eleanor is an advocate for patient needs. Previously a Health Cuts Hurt spokesperson, Eleanor believes that health services should be funded according to community need in a transparent and effective manner.
- Elizabeth Cunningham \*\*** Elizabeth Cunningham, who is of Ngāi Tahu and Ngati Mutunga descent, is a research manager (Māori) at the University of Otago, Christchurch School of Medicine. She has worked at all levels of the health sector, including as a health professional; a service manager; and as an advisor to Ministers of Health on Māori health issues. She is also a longstanding member of the Māori Women's Welfare League. In her current role with the University of Otago, her role is to manage and develop strategies to ensure university researchers' work responds to the needs and aspirations of Māori.
- Jo Kane** In her second term on the Board, Jo is keen to follow through on community focused health initiatives. Jo believes early intervention and healthy lifestyle choices will assist our health system.
- Matea Gillies \*\*** Matea has been a GP for 30 years. He is of Ngai Tahu descent and Chairperson of the Ngai Tahu Runanga Health collective - Manawhenua ki Waitaha. He believes primary and secondary health services need to work together more efficiently.
- Peter Ballantyne \*\*** Peter is Chair of the CDHB's Finance Audit & Risk Committee and is a retired Chartered Accountant in a consultancy role. He is involved in the aged care sector and has financial accounting and auditing experience.

**BOARD MEMBERS – continued**

- Heather Carter \* Heather Carter is devoted to accessible and affordable health care for all New Zealanders. Heather runs Life Masters, a personal development and workplace counselling consultancy. In addition, Heather serves on the Council of the Christchurch Polytechnic Institute of Technology, and Health Cuts Hurt (a group aimed at improving healthcare for the people of Canterbury).
- Karen Guilliland \* Karen Guilliland is Chief Executive of the New Zealand College of Midwives. Karen has served on the Minister of Health's Health Advisory Group and the NZ Nursing Council. She is currently a member of the PHARMAC Board. She also provides consultancy to Parents Centre NZ.
- Laurence Malcolm \* Laurence Malcolm is a medical graduate, Professor Emeritus and former Professor of Community Health at the Wellington School of Medicine. He currently works as a consultant in health services research and development, is a member of the Council and Executive of Age Concern Canterbury, and has been on many national and international boards and committees. He has a special interest in primary health care and the quality of clinical services.
- Neville Fagerlund \* Neville Fagerlund is a Chartered Accountant in public practice with over 25 years experience. He has provided financial and commercial advice to Pegasus Health Ltd since its inception in 1993 and advises The 24-Hour Surgery Ltd. Neville is a Director of Cambridge Clinic Ltd, a charitable company in the health arena.
- Norm Dewes \* Norm Dewes is the Chief Executive of the urban Māori authority based in Canterbury (Te Runanga o Nga Maata Waka). Norm is a member of the New Zealand Advertising Standards Authority, Canterbury Museum Advisory Committee, and Canterbury Community Primary Health Organisation. He is the Chairperson of Te Rito Arahi Māori Alcohol, Drug and Resource Centre, Otautahi Social Services, Māori Legal Services and Capital Planning and Development, and is the Manager of Nga Hau e Wha National Marae. He has a background in education, social work, sport and recreation and is particularly experienced in helping unemployed into the workforce.
- Robin Booth \* Robin Booth has previously served on the Christchurch City Council, and is a self-employed builder, manufacturer and author. Robin has a strong interest in community health and preventative medicine.
- Syd Bradley \* Syd Bradley is a professional Company Director based in Christchurch and is the Chairman of the Canterbury DHB. Syd has served on a number of boards since resigning as General Manager Commercial Operations (International) with New Zealand Post in 1996. Over the last decade he has been closely involved with the administration of the health sector, first as a director of Canterbury Health Ltd and subsequently as director of Healthlink South Ltd and Healthcare Otago Ltd. He was also Chairman of Healthlink South Ltd and Canterbury Health Ltd. Following this Syd was Chairman of the Health Funding Authority and also chaired the Crown Health Association (CHA) representing public health and hospital services. Syd is interested in adding value through the development and application of management systems that measure performance against standards.

\* retired during the year

\*\* appointed/elected during the year

## BOARD'S REPORT & STATUTORY DISCLOSURE

To the stakeholders on the affairs of the Board for the year ended 30 June 2008.

### PRINCIPAL ACTIVITIES

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

### RESULTS

During the year, Canterbury DHB Group recorded a net deficit of \$16.766 million against a budgeted breakeven position. (2006/07 result was a net deficit of \$2.249 million).

### BOARD FEES

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

	<b>Board Fees</b> Year ended 30/06/08 \$'000	<b>Committee Fees</b> Year ended 30/06/08 \$'000
Alister James	39	2
Olive Webb	32	5
Syd Bradley*	26	1
Jo Kane	26	4
David Morrell	26	5
Robin Booth*	13	1
Heather Carter*	13	3
Norman Dewes*	13	3
Neville Fagerlund*	13	1
Karen Guilliland*	13	1
Laurence Malcolm*	13	3
Anna Crighton	13	1
Andrew Dickerson	13	3
Christopher Ryan	13	2
Eleanor Carter	13	1
Peter Ballantyne	13	5
Matea Gillies	13	3
Elizabeth Cunningham	2	1
Alison Wilkie	-	1
David Kerr	-	3
John Musgrove	-	1
Tuari Potiki	-	1
Trevor Read	-	3
William Tate	-	3
Margaret Schwass	-	2
Wendy Dallas-Katoa	-	1
	<b><u>307</u></b>	<b><u>60</u></b>

\*retired during the year

Total fees paid for the year were \$367,000 (2006/07 - \$357,000). The limit of fees authorised for the year ended 30 June 2008 was \$392,875 (2006/07 - \$385,000).

## DIRECTOR FEES

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

	<b>Year Ended 30/06/08 \$'000</b>	<b>Year Ended 30/06/07 \$'000</b>
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

Alister James

Barrister and Youth Advocate - acting for clients including young persons with mental health, alcohol and drug issues and dealing with Mental Health Services, in particular Youth Specialty Services.

Home Made Partnership Trust (Christchurch Supergrans) – Chair - sometime recipient of funding grants from Community and Public Health for courses run by the organisation.

Legal Services Agency (Crown Entity) - Board Member - Legal Services Agency provides legal services and funding, including granting legal aid for persons who may be involved in any proceedings against the Canterbury DHB, and in respect to mental health reviews.

State Housing Appeal Authority – Deputy Principal Member - This relates to appeals relating to the allocation of State houses and the assessment of income related rentals. Conflicts of interest are not likely.

The McLean Institute – Board of Governors - The Chair of the Canterbury DHB is an ex-officio member of the Board of Governors pursuant to the will of Allan McLean and Act of Parliament. The McLean Institute operates Holly Lea, a rest home and some commercial property which supports its charitable purpose. The Institute provides residential aged care services under contract with the Canterbury DHB.

Spouse, Sue James is an employee with the Community and Public Health Division.

Olive Webb

Health Practitioners Disciplinary Tribunal – Member

Potentially a member of a tribunal panel when a clinical psychologist is before the panel. The tribunal has procedures for dealing with potential conflicts of interests for tribunal members. Should an issue of conflict arise, this will be disclosed at the time.

Institute of Applied Human Services Limited (IAHS) – Chairperson

Provides individual consultation, service advice and workforce training in the intellectual disability area, on contract to various individuals and providers in Australasia. New Zealand providers of intellectual disability services are usually funded by the Ministry of Health. IAHS has no contracts with Canterbury DHB.

Special Olympics New Zealand – Trustee

As well as providing sporting events, also provides health screening and assistance.

Access Home Health Limited – Director

Provides home based healthcare and personal support on contract to the Accident Compensation Corporation, Ministry of Health and several DHBs, including Canterbury DHB.

Alison Wilkie	<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>
Andrew Dickerson **	<p>Health Care of the Elderly Education Trust – Chair - Promotes and supports teaching and research in the area of care of older people. Recipients of financial assistance for research, education or training could include employees of the Canterbury DHB.</p> <p>Age Concern Canterbury Inc. - Chief Executive - Provides social support services and advocacy services to approximately 13,500 older people per annum in the Canterbury area. Does not have any contracts with the Canterbury District Health Board but does have contracts with:</p> <ul style="list-style-type: none"> <li>▪ Ministry of Health (through Age Concern New Zealand) for Health Promotion Services</li> <li>▪ Capital &amp; Coast District Health Board (through Age Concern New Zealand) for Visiting Services</li> <li>▪ Partnership Health PHO for the Winter Warmth Project</li> <li>▪ Ministry of Social Development (through Age Concern New Zealand) for Elder Abuse &amp; Neglect Prevention Services.</li> </ul> <p>Canterbury Medical Research Foundation – Member - Provides financial assistance for medical research and research facilities in Christchurch. Recipients of financial assistance for research, education or training could include employees of the Canterbury DHB.</p> <p>Elder Care Canterbury Reference Group – Member - Intersectorial community group that works collaboratively to identify, discuss and make recommendations on issues affecting older person’s health services. Funded by the Canterbury District Health Board, on contract to Presbyterian Support Services.</p> <p>NZ Historic Places Trust – Member - The Trust promotes the identification, preservation and conservation of the historical &amp; cultural heritage of New Zealand. Canterbury District Health Board owns buildings that may be considered by the Trust to have historical significance.</p> <p>No Conflicts of Interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time.</p> <ul style="list-style-type: none"> <li>▪ NZ Gerontology Association – Member - Professional association that promotes the interests of older people and an understanding of ageing.</li> <li>▪ Hope Foundation for Research on Ageing – Member - Promotes research on New Zealand’s ageing population and its implications for the future.</li> <li>▪ Osteoporosis (Canterbury) Inc. – Member - Provides support, information and advice to people with osteoporosis.</li> <li>▪ Neurological Foundation of New Zealand Inc. – Member - Provides support and information to people with diseases and disorders of the brain and nervous system.</li> <li>▪ Abbeyfield New Zealand Inc. – Member - Promotes and establishes community housing for lonely and socially isolated older people using the Abbeyfield model.</li> <li>▪ Mayors Welfare Fund Trust Board – Member - Provides assistance in cases of extreme hardship.</li> </ul> <p>Ministry of Social Development Home Equity Conversion Reference Group – Member - Provides advice to the Minister for Senior Citizens (through the Office for Senior Citizens) on Home Equity Conversion.</p>

Anna Crighton **	<p>University of Canterbury Council – Council Member - Governance of University.</p> <p>New Zealand Historic Places Trust – Board Member - Governance of New Zealand Heritage. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance.</p> <p>Christchurch Heritage Trust and Director – Director - Governance of Christchurch Heritage. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance.</p> <p>No Conflicts of Interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time.</p> <ul style="list-style-type: none"> <li>▪ The Art Registry Co. Limited – Director - Principal Registrar and Director of collections management.</li> <li>▪ Theatre Royal Charitable Foundation – Director - Governance of theatre operations.</li> <li>▪ Lottery Canterbury / Kaikoura Community Distribution Committee- Member - Distribution of profits from NZ Lotteries for funding of Community projects.</li> </ul>
Bob Lineham	<p>Civic Assurance (Local Government Insurance Corporation Ltd) – Director - This is a specialist Insurance Company servicing Local Government</p> <p>Riskpool – Director - This is a mutual fund covering Liability Insurance for Local Government members</p> <p>Christchurch City Networks Ltd – Director - This involves the installation of Broadband Infrastructure in Christchurch. There is a possibility that it could offer services to the Canterbury DHB in the future.</p> <p>Local Government Finance Corp Ltd – Director - This involves investing and borrowing on behalf of Local authorities (currently in wind down mode).</p> <p>Christchurch City Holdings – Chief Executive - This is an infrastructure Investment Company.</p>
Chris Ryan **	<p>Southlink Health IPA - member - Southlink Health provides managerial support for PHOs, who are contracted to the DHB and intends to advocate on behalf of health practitioners.</p> <p>General Practitioner - Contracted to the Rural Canterbury PHO, with capitation payments and other payments, such as Performance Management Payments coming from the DHB through the PHO.</p> <p>Royal New Zealand College of GPs - Fellow and member of Canterbury Faculty Board - The RNZCGP prepares statements and advocates at times on Workforce, Recruitment and Quality issues.</p>
David Kerr	<p>Centercare Limited – Chair - Centercare purchases supplies for Medical Practitioners.</p> <p>General Medical Practitioner - Doctor providing primary care services.</p> <p>Health Education Trust – Trustee - Health Education Trust develops and provides educational materials and training programmes for those caring for the elderly within the health sector.</p> <p>Medical Protection Society – Advisor - Organisation that advises and provides legal support to doctors. The MPS role is to support the doctor, which can occasionally conflict with the DHB. Should an issue of conflict arise, that will be disclosed at the time.</p> <p>Pegasus Health – Advisor - Provides a management services organisation for primary medical providers and other primary care providers.</p> <p>Ryman Healthcare Limited – Chair - Provides residential aged care services under contracts with the Canterbury DHB.</p> <p>Pharmaceutical Management Agency (Pharmac) – Board Member - Pharmac purchases pharmaceuticals to New Zealand (including on behalf of DHB's) within New Zealand for the New Zealand Pharmaceutical schedule.</p> <p>New Zealand Medical Association - President - The New Zealand Medical</p>

Association is the largest medical organisation in New Zealand. Members come from all disciplines within the medical profession, and include specialists, general practitioners, doctors-in-training and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values and the health of New Zealanders. The key roles of the NZMA are to provide advocacy on behalf of doctors and their patients; to provide support and services to members and their practices; to publish and maintain the Code of Ethics for the profession; and to publish the New Zealand Medical Journal.

David Morrell

Brackenridge Estate Limited – Chairman (appointed by Canterbury DHB) - wholly owned subsidiary of the Canterbury DHB - provides intellectual disability services under contracts with the Ministry of Health, Work and Income New Zealand, Accident Compensation Corporation and the Child, Youth and Family Service.

Honorary British Consul - Interest relates to my supporting British visitors who may be hospitalised arising from injury related accidents

Social Services Council of the Diocese of Christchurch (Anglican Aged Care) - Committee Member - provides residential aged care services (rest home and hospital) under contracts with the Canterbury DHB.

Historic Places Trust – Subscribing Member - The Trust's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. The Trust identifies records and acts in respect of significant ancestral sites and buildings. The Trust has already been involved with Canterbury DHB buildings.

Eleanor Carter \*\*

Health Cuts Hurts- Member – Patient Lobby Group.

Elizabeth Cunningham\*\*

University of Otago, Christchurch – Research Manager, Māori (0.6FTE) - part of Senior Management Team. The University has various relationships with the Canterbury DHB, including medical training, research, the provision of library services, and leasing of premises.

Otautahi Runaka – Member - Includes Māori community groups and representatives of government agencies, including Canterbury DHB staff.

Te Runanga o Ngai Tahu (TRONT) – Alternate Member - Governance body for Ngai Tahu

Te Runanga o Koukorarata (Port Levy) – Runanga member - A Runanga of Ngai Tahu, and a signatory for the Memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB.

Manawhenua ki Waitaha – Member - Representative of Te Runanga o Koukorarata. Manawhenua ki Waitaha is a collective of health representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB.

Māori Women's Welfare League – Member -The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori.

Kawa Whakaruruhau Roopu Bachelor of Nursing/Midwifery Christchurch Polytechnic – Chair - A committee of Christchurch Polytechnic, Department of health services, providing input and oversight in relation to course programmes.

Avon Heathcote Estuary Ihutai Trust – Member - The Trust has an interest in improving water quality within the estuary.

Special Education Strategy Committee – Member - A committee of the Ministry of Education.

Registered Resource Management Act (RMA) Commissioner - From time to time asked to sit on these panels given involvement with the Regional Council and in particular understanding the Māori issues around Section 8 of the RMA Act. If conflicts arise they will be advised.

Son, Manaia Cunningham, is a Board member of the Christchurch Primary Health

	<p>Organisation.</p>
Heather Carter *	<p>Christchurch Polytechnic Institute of Technology (CPIT) – Council Member</p> <p>Health Cuts Hurt Incorporated (Health Lobby Organisation) - Member</p> <p>LifeMasters (Life skills and personal development) – Company Owner and Consultant</p> <p>Otautahi Education Development Trust (OEDT) – Trustee - this trust is related to CPIT activities.</p>
Jo Kane	<p>Environment Canterbury – Deputy Chairperson - Environment Canterbury is involved in the promotion of sustainable management of natural and physical resources and ensures safe and efficient movement of people and goods for the benefit of people, communities and future generations. As part of its role Environment Canterbury is responsible for the health and well-being of its community, as part of its key priorities. Intersectorial collaboration is a key focus, where potential conflicts arise these will be disclosed at the time. One area of potential conflict is with issues surrounding the proposed Central Plains Water Scheme.</p> <p>Te Kohaka o Tuhaitara Trust – Chairperson - Provides for a range of cultural, historical, recreational and educational opportunities for the community within the Coastal Reserve. It is not envisaged any potential Conflicts of Interest, but will be disclosed at the appropriate time.</p> <p>Health North Canterbury – Steering Group Member - Involved in a community trust that is looking at a future use of land at the Rangiora Hospital site, which is likely to involve putting a proposal to the Canterbury DHB for consideration (including potential commercial negotiations).</p> <p>Council of Social Services – member (no voting rights) - Intersectorial/Community Group whose predominate role is the health, safety and well being of our community. Provides social support services, advocacy and works collaboratively with multiple agencies including the determinates of health that are faced by the community.</p>
John Musgrove	<p>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.</p>
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>
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 Māori Health planning.</p> <p>Age Concern Canterbury, Council and Executive – Member - advocacy and support group for older people.</p>

- Matea Gillies \*\* Partnership Health “Te Kei o te Waka” - Board Member - Partnership Health Canterbury is a Primary Health Organisation (PHO). The PHO has entered into an agreement with the Canterbury DHB under which the PHO agreed to provide a range of health care services and the management tasks associated with the delivery and funding of these services. The PHO has the power to subcontract the delivery of any or all such services and associated management tasks.
- Pegasus Health (Charitable) Ltd – Member - Pegasus Health is an Independent Practice Association (IPA) that supports General Practitioners delivering care to approximately 290,000 patients. Pegasus Health is part of Partnership Health Canterbury PHO. Much of the organisation’s work is funded either from the Ministry of Health and the DHB via Partnership Health.
- Taupunga Ltd - Director - Taupunga Ltd provides General Medical Services. I am employed by Taupunga Ltd to provide General Practitioner services. Taupunga has a contract with the Pegasus 24 Hrs Clinic and Dr James Shanks.
- Manawhenua ki Waitaha – Chairperson - Manawhenua ki Waitaha is a collective of health representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB.
- Te Hapu o Ngati Wheke Inc – Chairperson - Te Hapu o Ngati Wheke Inc is the legal body of Te Hapu o Ngati Wheke , one of the 18 Papatipu Runanga that make up Ngai Tahu.
- Te Poho o Tamatea - Board Member - Te Poho o Tamatea is a charitable company which is the investment company for Te Hapu o Ngati Wheke, distributing money for primarily education, health, and cultural purposes.
- MIHI ( Māori /Indigenous Health Institute) - Senior Clinical Lecture - University of Otago Christchurch School of Medicine
- Neville Fagerlund \* Cambridge Clinic (DSAC) Limited - Director of a company which holds a contract with the Canterbury DHB for the delivery of medical services to victims of sexual abuse.
- Pegasus Health (Charitable) Limited - Financial Advisor to a company which holds a contract with the Canterbury DHB for observation and continuing care nurse co-ordination, and a contract in the co-ordination role of immunisation services. The 24 hour clinic in Bealey Avenue is 100% owned by Pegasus Health (Charitable) Limited, who hold the observation contract.
- A wide range of trusts and private companies as a result of private accountancy practice (where potential conflicts arise these will be disclosed individually)
- Norm Dewes \* Te Runanga o Nga Maata Waka – Chief Executive Officer - this Runanga provides a range of advocacy, community and social services. These services include a contract for the Canterbury DHB to deliver mother & pepi services. The Runanga also provides a range of education services which are NZQA registered and accredited under the Education Act. The Runanga is a part of a national body, the National Urban Māori Authority.
- Nga Hau e Wha, National Marae – Manager - there is a proposal that an oral health service clinic be located on part of the land held by the trust.
- Canterbury Community Primary Health Organisation (Access PHO) – Member - one of the PHOs within the Canterbury DHB’s area – contracts with the DHB for primary services.
- Te Runanga o Ngati Kahungunu ki Waitaha – Secretary
- Te Rito Arahi Māori Alcohol, Drug and Resource Centre – Chair
- Otautahi Social Services – Chair
- Otautahi Sports Association - Secretary

Peter Ballantyne **	<p>Bishop Julius Hall of Residence - Trust Board Member - University of Canterbury Audit and Risk Committee – Member</p> <p>Social Service Council of the Diocese of Christchurch – Trust Board Member, Chair Aged Care Division.</p> <p>Deloitte – Consultant - Deloitte carries out certain consulting assignments for the Canterbury DHB from time to time.</p> <p>Spouse, Claire Ballantyne is a Canterbury DHB employee</p>
Syd Bradley *	<p>Christchurch International Airport Co Limited – Chair</p> <p>Waipara Hills Wine Estate – Advisor</p> <p>McLeans Institute – Board Member (Canterbury DHB representative) - provides residential aged care services under contract with the Canterbury DHB.</p>
Trevor Read	<p>Francis Group Consultants - Consultant</p> <p>South Canterbury District Health Board - Contracted to provide advice and consultancy services. The service can involve facilitation and discussion with Canterbury DHB exploring how Canterbury and South Canterbury DHBs may work together, particularly in the development of shared services in the provision of information services, related clinical and administrative support areas. Also provide assistance with strengthening IT strategy and systems planning.</p> <p>Ministry of Health - Undertaking a review on addressing the Disincentive Fund Pilots – the Canterbury District Health Board was one of the pilots</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>
Wendy Dallas-Katoa	<p>Pegasus Health – Māori Health Advisor</p> <p>IPA – Primary Health Care working with General Practice.</p> <p>MIHI ( Māori/Indigenous Health Institute) - Research Fellow Lecturer - University of Otago – Christchurch School of Medicine</p> <p>Research Projects – International Indigenous Resilience health worker – cross study between Canadian Indigenous &amp; Māori. Lecturer undergraduate 4 &amp; 5 yr medical students.</p> <p>Ka Wahine Board – Board Member - Women’s Whare – newly released women from prison halfway house.</p> <p>Partnership Health PHO – Board Member – iwi/manawhenua representative - Partnership Health Canterbury is a Primary Health Organisation (PHO). The PHO has entered into an agreement with the Canterbury DHB under which the PHO agreed to provide a range of health care services and the management tasks associated with the delivery and funding of these services. The PHO has the power to subcontract the delivery of any or all such services and associated management tasks.</p>
William Tate	<p>Global Catering Limited-Director</p> <p>Pulp Kitchen- Director</p> <p>Pulp Kitchen Catering Limited-Director</p> <p>New Zealand Institute of Management Foundation-Trustee</p> <p>New Zealand Institute of Management Life Fellows Committee</p>

\* retired during the year

\*\* appointed / elected during the year

## SUBSIDIARY AND ASSOCIATED COMPANIES

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

\* resigned during the year

**DIRECTORS' AND BOARD MEMBERS' LOANS**

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

**DIRECTORS' AND BOARD MEMBERS' INSURANCE**

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

**USE OF BOARD OR SUBSIDIARIES' INFORMATION**

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

**PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT**

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

The total payments made by Canterbury DHB were \$16,915 (2006/07 – 1 employee totalling \$32,130) comprising negotiated settlements with all of the former employees.

Number of Employees	TOTAL \$
4	16,915
<u>4</u>	<u>16,915</u>

## REMUNERATION OF EMPLOYEES

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

	30/06/08 (including benefits)				30/06/07 (including benefits)			
	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total
100,000-109,000	3	14	59	76	4	17	77	98
110,000-119,000	2	11	59	72	1	3	73	77
120,000-129,000		4	54	58		3	51	54
130,000-139,000	1	4	44	49		3	39	42
140,000-149,000		3	26	29		5	29	34
150,000-159,000			30	30			33	33
160,000-169,000		1	33	34		4	18	22
170,000-179,000		2	23	25			23	23
180,000-189,000		2	25	27			25	25
190,000-199,000			15	15			16	16
200,000-209,000		1	17	18		2	24	26
210,000-219,000		1	23	24		1	20	21
220,000-229,000			25	25			11	11
230,000-239,000			18	18			17	17
240,000-249,000			11	11			7	7
250,000-259,000		1	7	8			8	8
260,000-269,000			6	6			3	3
270,000-279,000			2	2		1	4	5
280,000-289,000			3	3			2	2
290,000-299,000			2	2			1	1
300,000-309,000							1	1
310,000-319,000			1	1			2	2
320,000-329,000			2	2			1	1
330,000-339,000			1	1				
350,000-359,000			1	1				
360,000-370,000							1	1
370,000-379,000			1	1				
410,000-419,000			1	1				
450,000-459,000		1 <sup>1</sup>	1	2				
460,000-469,000			1	1		1 <sup>1*</sup>		1
<b>Total</b>	<b>6</b>	<b>45</b>	<b>491</b>	<b>542</b>	<b>5</b>	<b>40</b>	<b>486</b>	<b>531</b>

Of the 542 (2006/07 531) positions identified above, 497 (2006/07 491) positions were predominantly clinical and 45 (2006/07 40) positions were management/administrative.

### OTHER ENTITLEMENTS (employees earning over \$100,000)

	Allied Health	Mgmt / Admin	Nursing	RMO	SMO
Annual leave pa	5 wks	4.4 wks	5 wks	6 wks	6 wks
Long Service Leave	1 wk after every 5 yrs	2 wks after 15 yrs	1 wk after every 5 yrs	No	2 wks after 15 yrs
CME** - 10 days pa up to maximum of 30 days accumulated	No	No	No	\$3,000	\$12,000
Conference leave - maximum pa	No	No	3 days PDRP**	6 wks	30 days
Sabbatical eligibility (not as of right)	No	No	No	No	3 mths every 6 yrs
Gratuity	No	No	No	No	Grandparented
Professional membership	Yes	Not for majority	Yes	Yes	Yes
Overtime and penal rates	Yes	No	Yes	Yes	Yes
Professional protection membership	No	No	No	Yes	Yes

<sup>1</sup> CEO remuneration and other benefits are included in these bands

\* includes arrears from previous years

\*\* CME – Continuing Medical Education; PDRP – Professional Development and Recognition Programme

# STATUTORY DISCLOSURE

## Legislative Responsibilities

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

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

The following information reports Canterbury DHB's performance for the year ended 30 June 2008, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 58.

<b>Section 42(3)(b) – Report on the extent CDHB has met the objectives under Section 22</b>	
<b>Objective:</b>	<b>Extent objectives met</b>
(a) To improve, promote, and protect the health of people and communities:	<p>The DHB funds and delivers a range of services including health promotion and protection services, primary care, secondary care, specialist and tertiary services to meet the needs of its population. The key areas of focus for the DHB are: Child and Youth Health, Older Persons' Health, Māori Health, Primary Health, Disease Prevention and Management, Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease.</p> <p>The Minister of Health's expectations see an additional focus on implementation of the national Mental Health and Disability Strategies and a focus on information systems and services, workforce development, elective services, service delivery, collaboration, productivity and value for money.</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>The DHB's local commitment to the national Health Eating Healthy Activity (HEHA) Strategy recognises that all sectors and groups have a role to play in improving community health and wellbeing, whether their specific focus is older person's health, child and youth health, education, recreation, transport or any other aspect of city life.</p> <p>Some of the HEHA initiatives which involve collaboration with community groups and government agencies to improve and promote the health of our population include:</p> <ul style="list-style-type: none"> <li>▪ Training for more than 50 practice nurses/community support workers to facilitate Appetite for Life programmes in Canterbury. The Appetite for life course is a 6-week programme focused on helping women overcome barriers to adopting healthy behaviours, and aims to provide them with the skills, knowledge and confidence to make positive sustainable change to food choices and activity levels.</li> <li>▪ The trial of smokefree children's playgrounds. A child is seven times more likely to take up smoking later in life if they are exposed to parental smoking and smokefree children's playgrounds aim to reduce the number of times children see adults smoking and therefore the chances of them taking it up in later life. The emphasis is on peer pressure and social change rather</li> </ul>

	<p>than a ban or a bylaw. It is hoped that the trial will lead to a city-wide policy that promotes smokefree children's playgrounds across Christchurch.</p>
<p>(b) To promote the integration of health services, especially primary and secondary health services:</p>	<p>Together Canterbury's five 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"> <li>▪ The Review of Acute Demand and After Hours Cover in Primary Care, undertaken in 2006, continues to be implemented. This Review outlined a number of key recommendations and identified ten projects for implementation. These included a primary health care public education and information programme, enhanced telephone advice for the general public, alternative rapid response service or pathways, a variety of community based acute care services and an After Hours Direction Paper.</li> <li>▪ PHO enrolments cover 95.6% of the Canterbury population;</li> <li>▪ 84% of two year olds are fully immunised.</li> <li>▪ Services to Improve Access programmes continue to be implemented including: longer GP consultations, school health clinics and community nursing services;</li> <li>▪ Collaboration continues around health promotion programmes including smoking cessation, youth oral health promotion, flu vaccinations for over 65s and programmes such as Appetite for Life</li> </ul> <p>The DHB has also worked over the past year on the challenge to create shared vision and ownership across Canterbury's health sector in order to create capacity and improve access to electives services.</p> <p>The (Canterbury Community-based) Referrals Project was established to provide a platform for delivering the DHB's electives goals in an objective and collaborative way. It is jointly sponsored by the DHB's Elective Services Steering Group and Canterbury's five PHOs and involves wide representation from primary and secondary care and the community. The aim is to design a consistent electives referral management process and pathway that informs alternative models of care and increases access to services. Unmet need in the community will be more appropriately measured by a specific focus on the gaps as determined by the community and general practice, which in turn will inform funding decisions and application of electives initiative funding allocations.</p> <p>GPs and hospital specialists are providing clinical input and leadership in the design and implementation of the pathways and new models of care with a project methodology of constant communication. The aim is to enable evaluation of new pathways where the need for a referral or hospital visit is avoided by ready access to diagnostics, enabling patients to remain in the care of general practise.</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 include:</p> <ul style="list-style-type: none"> <li>▪ Development of a new model of CARE for the delivery of specialist community health services for older people. The CARE model aims to strengthen the primary/secondary interface and ensure older people receive appropriate and effective care in a home-based or community setting.</li> <li>▪ The InterRAI (International Home-based Assessment Instrument)</li> </ul>

	<p>roll-out in the DHB's Hospital and Specialist Service division with the aim of providing consistency in the assessment process and evidence based evaluation. The tool also has potential for improving care planning in residential care settings.</p> <ul style="list-style-type: none"> <li>▪ Collaboration with community pharmacies to roll-out the Medicines Use Review Service. This Service targets patients with long term conditions, those on multiple medications and those with multiple prescribers to ensure safe medication use and reduce avoidable hospital admissions.</li> <li>▪ Supporting Canterbury PHOs to increase the enrolment of patients in CarePlus programmes and work towards a target of 75% of their enrolled populations receiving the flu vaccine in the over 65 age group. Patients over the age of 65 are more at risk of contracting the flu virus and complications from this.</li> </ul>
<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 an Action Plan for Disability that outlines the steps it is taking to implement the NZ Disability Strategy. The Action Plan involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring.</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 Māori Health Action Plan over the past year. The key objectives include reducing health inequalities and supporting Māori participation in health and Māori health workforce development. Over the past year progress has been made in implementing projects that support the DHB's Māori Health Plan including:</p> <ul style="list-style-type: none"> <li>▪ Signing of a formal Memorandum of Understanding with Manawhenua Ki Waitaha in March 2008. This agreement aims to establish a clear relationship between the two groups and to improve Māori input into the planning and development of health and disability services in Canterbury.</li> <li>▪ An Ethnicity Data Collection Project was introduced with the aim of improving the accuracy of ethnicity data collection. The Project focused on updating codes for all patients coded as Not Stated or Other and raising the awareness of the importance of accurate ethnicity code collection. Over 2,000 patients who previously had the codes Not Stated or Other have had their codes updated.</li> <li>▪ Collaboration around strategies that promote healthy nutrition and increased physical activity for Māori through community-based projects have been a successful focus including: Kaikoura's Positive Vibration (focusing on overweight children) and the Hundie Club (focusing on overweight/obese adults). Training of Māori health workers in breastfeeding and nutrition issues has also been positive in ensuring that front line workers are providing consistent HEHA messages.</li> <li>▪ Smokefree lifestyles have been promoted to improve Māori health status through Auahi Kore initiatives and the Aukati Kai Paipa programme. The Auahi Kore and Aukati Kai Paipa both use a social marketing emphasis recognising local champions to promote and reinforce smokefree lifestyles. There is also an emphasis on Marae with three Marae in Canterbury now smokefree.</li> </ul>

<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 strategic priority areas where the DHB will focus its efforts to reduce health inequalities: Child and Youth Health, Older Persons’ Health, Māori Health, Primary Health, Disease Prevention and Management, Cancer, Cardiovascular, Diabetes and Respiratory Disease.</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 age groups. Specific work has been undertaken in the past 6 months to increase the number of general practices in Canterbury who have adopted the under 6s subsidies and provide free services for under 6 year olds. At present 50% of all children under the age of 6 have access to free fees. The DHB also continues to work with PHOs to implement Services to Improve Access to primary care.</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, Education and Social Development, ACC and the Department of Corrections. The DHB works collaboratively with the TLAs and regional council in the Canterbury region along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other Non-Government Organisations (NGOs) in our region. The DHB also actively supports a number of collaborative ventures which endeavour to improve the environment and the health of our residents.</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 community and providers. This may be in the form of providing opportunities for input on early development of papers/ideas or involvement in working parties.</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 plans and strategies. This includes a number of Māori and Pacific groups to ensure Māori and Pacific input into decision making to improve delivery of health and disability services and to reduce inequalities in health status.</p> <p>In 2007, as part of the DHB’s focus on long-term health services planning, the DHB established a Consumer Council to provide input into decision making as part of its Health Services Planning Programme.</p> <p>The Consumer Council consists of representatives nominated by consumers and consumer lobby/advocacy groups and covers nine key areas; family health, older persons’ health, disabilities, Māori health, Pacific health, chronic conditions, mental health, rural communities and primary care. The Consumer Council will give focus to a true partnership model that will provide a strong and viable voice for the community and consumers in health service planning and service delivery.</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 has embarked on the development of a Health Services Plan which will be linked to a workforce strategy and facilities master-plan. If the DHB intends to ensure effective utilisation of resources and delivery of the best possible health outcomes within the funding allocated we need to ensure that health resources are protected, sustainable and supported long-term. The Health Services Planning</p>

	<p>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 which includes the establishment of the DHB’s Consumer Council.</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. In 2002 the DHB established its Quality and Patient Safety Council to promote quality improvement within the DHB. The Council provides governance for the organisation with respect to quality and patient safety and provides advice to the Chief Executive.</p> <p>The Quality and Patient Safety Council facilitates continuous improvement and looks to offer support and guidance to positively influence quality care. The Council also identifies key issues for quality improvement and promotes the development of appropriate information systems for monitoring and reporting on quality and supports and promotes training and education programmes.</p> <p>The Council sponsors both the DHB’s Quality Strategic Plan and the DHB’s Quality and Innovation Awards and has developed key policies, which promote quality and patient safety (the culture of patient safety policy, open disclosure policy and the no blame incident/accident reporting policy).</p> <p>Alongside quality and patient safety, clinical governance places a responsibility on the Chief Executive to have effective mechanisms in place for planning, monitoring and managing the quality of clinical care and for meeting identified targets for quality and budget objectives.</p> <p>The DHB’s Clinical Board was established in 2003 to give a focus to clinical leadership and to take a lead in developing clinical governance systems.</p> <p>The Clinical Board is a multi-disciplinary DHB-wide clinical forum consisting of clinical representatives from the primary, secondary and community sectors. The Board provides oversight of the DHB’s clinical activity and advice to the Chief Executive and is charged with having a proactive role in setting clinical policy and standards and encouraging best practice and innovation. The Clinical Board also supports the DHB’s vision and values and provides a leadership role for the organisation.</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>(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 has in place, as appropriate, a number of organisational policies and procedures (to promote a healthy and safe workplace) including the DHB’s Equal Opportunities and Harassment Policy.</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>

<p><b>Section 42(3)(i) – Statement of how the CDHB has given effect and intends to give effect to its functions specified in Section 23 (1) (b)-(e)</b></p>	
<p><b>Function:</b></p>	<p><b>What has been done to meet function</b></p>
<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>	<p>The DHB has involved stakeholders in selection of its strategic priority areas for the District Strategic Plan and actively involves relevant groups and individuals in planning specific service areas including its current Health Services Planning Programme.</p> <p>The DHB has established joint arrangements with external providers for the provision of some additional surgical services, such as orthopaedic and cardiac surgery.</p> <p>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.</p> <p>The DHB has a Memorandum of Understanding with the West Coast DHB which assists in the development of closer clinical collaboration.</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, Education and Social Development, ACC and the Department of Corrections.</p> <p>The DHB also works with the Ministry of Health in a number of joint/collaborative ways participating in national projects including national benchmarking exercises and national pricing projects and on the implementation of a number of national screening programmes such as B4 School Checks.</p>

<p>(c) To issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):</p>	<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, community and group enquires. The DHB also provides written media to inform the community and other sectors of current activity including Healthfirst (a community newsletter), Healthbeat (a newsletter for DHB staff and community providers) and Health Promoting Schools (a newsletter for Canterbury schools).</p> <p>The DHB has developed a website, which includes community based health information and its primary planning documents. The DHB also circulates and makes available significant documents and plans for its population in summary and comprehensive form either at libraries, via groups or individually and on it website.</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>In the past the DHB has had an informal relationship with groups such as Manawhenua Ki Waitaha and Te Rūnanga o Ngā Maata Waka and has engaged at many levels with Māori providers and other Māori community organisations. The outcomes of these meetings are fed directly into the DHB planning process.<sup>2</sup></p> <p>In March 2008 the DHB signed a Memorandum of Understanding with Manawhenua Ki Waitaha as a first formal step to enabling the participation of Māori in DHB decision making and in the planning and delivery of health and disability services. The Memorandum of Understanding commits the DHB to regular meetings with, and reporting to, Manawhenua Ki Waitaha as a pathway to shared decision making.</p> <p>The DHB's Māori Health Plan, approved in 2007, also commits the DHB to establishing formal relationships with Māori representative groups beyond Manawhenua Ki Waitaha, such as Taura Here community groups.<sup>3</sup></p> <p>In collaboration with Manawhenua Ki Waitaha the DHB will explore mechanisms to facilitate greater participation of Māori at a governance level. Possibilities for such participation may include a Māori governance/advice board providing advice to the DHB's Board and allowing Māori opportunities to engage with the Board of the DHB.</p> <p>The DHB will continue to consult with Māori communities at appropriate levels of operations and to provide Māori with opportunities to engage and feedback to the DHB.</p>

<sup>2</sup> *Manawhenua ki Waitaha is a representative group which comprises of seven Ngāi Tahu Rūnanga.*

<sup>3</sup> *Taura Here refers to all other collective pan-tribal Māori groups.*

<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 Māori Managers Network), where a number of projects have been developed to support Māori service provision in Canterbury. These include:</p> <ul style="list-style-type: none"> <li>▪ The development of a Māori Health Workforce Development Plan, <i>Te Waipounamu</i>;</li> <li>▪ The development of a South Island regional Māori workforce recruitment project to enhance the Māori health workforce in our region; and</li> <li>▪ The development of a Māori health training and education opportunities directory, currently being distributed to Māori health providers.</li> </ul>
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For and on behalf of the Board

**Alister James**  
*Chair*  
10 October 2008

**Olive Webb**  
*Board Member*  
10 October 2008

## STATEMENT OF RESPONSIBILITY

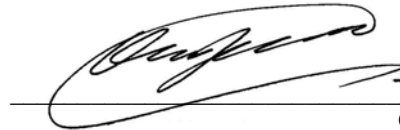
Pursuant to Section 155 of the Crown Entities Act 2004, we acknowledge that:

- a) The preparation of financial statements and statement of service performance of Canterbury DHB and the judgements used therein, are our responsibility.
- b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2008, are our responsibility.
- c) In our opinion, the financial statements and statement of service performance for the year under review fairly reflect the financial position and operations of Canterbury DHB.



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**Alister James**  
*Chair*  
10 October 2008



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**Olive Webb**  
*Board Member*  
10 October 2008

## STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2008

	Notes	Group			Parent	
		Actual 30/06/2008 \$'000	Budget 30/06/2008 \$'000	Actual 30/06/2007 \$'000	Actual 30/06/2008 \$'000	Actual 30/06/2007 \$'000
<b>Income</b>						
Ministry of Health revenue		1,116,673	1,096,676	1,050,170	1,107,697	1,042,064
Patient related revenue	2	36,545	33,536	33,458	36,972	33,876
Other operating income	3	19,011	22,513	22,317	16,538	19,999
Interest income		8,819	3,746	5,146	9,040	5,278
<b>Total income</b>		<u>1,181,048</u>	<u>1,156,471</u>	<u>1,111,091</u>	<u>1,170,247</u>	<u>1,101,217</u>
<b>Operating expenses</b>						
Employee benefit costs	4	472,445	444,945	439,146	462,320	430,517
Treatment related costs		105,008	115,187	105,727	108,493	108,864
External service providers		480,389	462,314	433,074	480,389	433,074
Depreciation and amortisation		47,808	50,405	47,228	46,439	46,046
Interest expenses on loans		5,584	5,932	5,069	5,745	5,140
Other Expenses	5	65,963	55,992	60,202	62,743	57,232
<b>Total operating expenses</b>		<u>1,177,197</u>	<u>1,134,775</u>	<u>1,090,446</u>	<u>1,166,129</u>	<u>1,080,873</u>
Operating surplus before capital charge		3,851	21,696	20,645	4,118	20,344
Capital charge expense	6	(20,617)	(21,696)	(22,894)	(20,617)	(22,894)
<b>Net surplus/(deficit)</b>		<u>(16,766)</u>	<u>-</u>	<u>(2,249)</u>	<u>(16,499)</u>	<u>(2,550)</u>

## STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 30 JUNE 2008

	Notes	Group		Parent		
		Actual 30/06/2008 \$'000	Budget 30/06/2008 \$'000	Actual 30/06/2007 \$'000	Actual 30/06/2008 \$'000	Actual 30/06/2007 \$'000
Total equity at beginning of the period		268,142	269,972	272,252	266,240	270,651
Net surplus/(deficit) for the period		(16,766)	-	(2,249)	(16,499)	(2,550)
Amounts recognised directly in equity						
Revaluation of property, plant and equipment		-	-	-	-	-
Total recognised revenues and expenses		(16,766)	-	(2,249)	(16,499)	(2,550)
Other movements						
Contribution from/(back to) Crown		(1,861)	-	(1,861)	(1,861)	(1,861)
<b>Total equity at end of the period</b>		<b>249,515</b>	<b>269,972</b>	<b>268,142</b>	<b>247,880</b>	<b>266,240</b>

# STATEMENT OF FINANCIAL POSITION

## AS AT 30 JUNE 2008

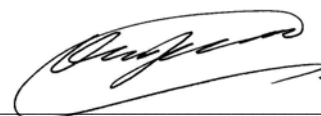
	Notes	Actual as at 30/06/2008 \$'000	Group Budget as at 30/06/2008 \$'000	Actual as at 30/06/2007 \$'000	Parent Actual as at 30/06/2008 \$'000	Actual as at 30/06/2007 \$'000
<b>CROWN EQUITY</b>						
General Funds	7	122,452	124,313	124,313	122,590	124,451
Revaluation Reserve	7	184,477	184,477	184,477	184,477	184,477
Retained earnings/(losses)	7	(57,414)	(38,818)	(40,648)	(59,187)	(42,688)
<b>TOTAL EQUITY</b>		<b>249,515</b>	<b>269,972</b>	<b>268,142</b>	<b>247,880</b>	<b>266,240</b>
<b>REPRESENTED BY:</b>						
<b>CURRENT ASSETS</b>						
Cash and cash equivalents	8	42,339	14,282	50,633	40,240	49,282
Trade and other receivables	9	36,009	25,800	24,282	35,441	23,913
Inventories	10	8,963	7,000	8,175	8,894	8,110
Investments	11	-	-	5,000	-	5,000
<b>TOTAL CURRENT ASSETS</b>		<b>87,311</b>	<b>47,082</b>	<b>88,090</b>	<b>84,575</b>	<b>86,305</b>
<b>CURRENT LIABILITIES</b>						
Trade and other payables	12	86,411	65,377	80,110	86,160	80,786
Owing to the Ministry of Health		7,229	4,500	13,852	7,229	13,852
Employee benefits due within 1 year	13	109,932	76,744	100,545	108,663	99,535
<b>TOTAL CURRENT LIABILITIES</b>		<b>203,572</b>	<b>146,621</b>	<b>194,507</b>	<b>202,052</b>	<b>194,173</b>
<b>NET WORKING CAPITAL</b>		<b>(116,261)</b>	<b>(99,539)</b>	<b>(106,417)</b>	<b>(117,477)</b>	<b>(107,868)</b>
<b>NON CURRENT ASSETS</b>						
Investments	11	9,170	29,375	6,338	12,378	9,508
Property, plant and equipment	14	430,657	437,295	455,446	427,005	451,606
Intangible assets	15	1,283	-	701	1,283	701
Surplus property		8,250	-	8,250	8,250	8,250
Restricted assets	16	11,522	8,110	10,931	11,402	10,825
<b>TOTAL NON CURRENT ASSETS</b>		<b>460,882</b>	<b>474,780</b>	<b>481,666</b>	<b>460,318</b>	<b>480,890</b>
<b>NON CURRENT LIABILITIES</b>						
Employee benefits	13	8,584	9,509	8,326	8,559	8,307
Provisions	17	-	-	200	-	-
Restricted funds	16	11,522	8,110	10,931	11,402	10,825
Borrowings	18	75,000	87,650	87,650	75,000	87,650
<b>TOTAL NON CURRENT LIABILITIES</b>		<b>95,106</b>	<b>105,269</b>	<b>107,107</b>	<b>94,961</b>	<b>106,782</b>
<b>NET ASSETS</b>		<b>249,515</b>	<b>269,972</b>	<b>268,142</b>	<b>247,880</b>	<b>266,240</b>

For and on behalf of the Board

**Alistar James**  
*Chair*  
10 October 2008



**Olive Webb**  
*Deputy Chair*  
10 October 2008



## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2008

	Notes	Actual 30/06/2008 \$'000	Group Budget 30/06/2008 \$'000	Actual 30/06/2007 \$'000	Parent Actual 30/06/2008 \$'000	Actual 30/06/2007 \$'000
<b>CASH FLOW FROM OPERATING ACTIVITIES</b>						
Cash was provided from:						
Receipts from Ministry of Health		1,105,160	1,096,676	1,051,140	1,096,410	1,042,109
Other Receipts		55,691	48,049	49,715	53,652	48,595
Interest Received		8,819	3,746	5,146	9,040	5,278
		<u>1,169,670</u>	<u>1,148,471</u>	<u>1,106,001</u>	<u>1,159,102</u>	<u>1,095,982</u>
Cash was applied to:						
Payments to Employees		462,833	449,945	424,411	452,940	416,000
Payments to Suppliers		646,530	637,492	593,671	647,565	594,120
Interest Paid		5,602	5,932	4,883	5,772	4,953
Capital Charge		27,240	21,697	12,780	27,240	12,780
GST - net		(320)	-	728	(316)	751
		<u>1,141,885</u>	<u>1,155,066</u>	<u>1,036,473</u>	<u>1,133,201</u>	<u>1,028,604</u>
<b>NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES</b>	19	27,785	33,405	69,528	25,901	67,378
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>						
Cash was provided from:						
Sale of property, plant & equipment		67	10,800	11,315	17	11,297
Receipt from sale of investments		2,168	-	-	2,130	-
		<u>2,235</u>	<u>10,800</u>	<u>11,315</u>	<u>2,147</u>	<u>11,297</u>
Cash was applied to:						
Purchase of Investments & Restricted Assets		-	14,500	11,314	-	12,204
Purchase of property, plant & equipment		23,803	30,000	38,873	22,579	36,598
		<u>23,803</u>	<u>44,500</u>	<u>50,187</u>	<u>22,579</u>	<u>48,802</u>
<b>NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES</b>		(21,568)	(33,700)	(38,872)	(20,432)	(37,505)
<b>CASH FLOWS FROM FINANCING ACTIVITIES</b>						
Cash was provided from:						
Loans Raised		-	-	15,000	-	15,000
		<u>-</u>	<u>-</u>	<u>15,000</u>	<u>-</u>	<u>15,000</u>
Cash was applied to:						
Loans Repaid		12,650	-	6,000	12,650	6,000
Equity repaid to Crown		1,861	-	1,861	1,861	1,861
		<u>14,511</u>	<u>-</u>	<u>7,861</u>	<u>(14,511)</u>	<u>7,861</u>
<b>NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES</b>		(14,511)	-	7,139	(14,511)	7,139
Net increase/(decrease) in cash and cash equivalents		(8,294)	(295)	37,795	(9,042)	37,012
Cash and cash equivalents at beginning of year		50,633	14,577	12,838	49,282	12,270
<b>Cash and cash equivalents at end of year</b>	8	<u>42,339</u>	<u>14,282</u>	<u>50,633</u>	<u>40,240</u>	<u>49,282</u>

# NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2008

## 1. Statement of accounting policies

### REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB (“Canterbury DHB”) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Canterbury DHB is a Reporting Entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, Public Finance Act 1989, and the Crown Entities Act 2004.

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand International Accounting Standard 1 (NZ IAS 1).

Canterbury DHB’s primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community.

The consolidated financial statements of Canterbury DHB consists of Canterbury DHB, its subsidiaries, Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entity South Island Shared Service Agency Ltd (47% owned).

The financial statements of CDHB are for the year ended 30 June 2008 and were authorised for issue by the Board on 10 October 2008.

### BASIS OF PREPARATION

#### Statement of compliance

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Section 154 of the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP). In accordance with NZ GAAP, the consolidated financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are Canterbury DHB’s first NZ IFRS financial statements. NZ IFRS 1 has been applied, and comparatives for the year ended 30 June 2008 have been restated to NZ IFRS accordingly. An explanation of how the transition to NZ IFRS has affected the reported financial position and financial performance of Canterbury DHB for the year ended 30 June 2007 is provided in note 28.

#### Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, and land and buildings.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value.

#### Functional and presentation currency

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand. The functional currency of Canterbury DHB is New Zealand dollars.

#### Changes in accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZ IFRS statement of financial position at 1 July 2006 for the purposes of the transition to NZ IFRS.

**Standards, amendments and interpretations issued that are not yet effective and have not been early adopted**

Standards, amendments and interpretations issued but not yet effective that have not been early adopted and which are relevant to Canterbury DHB include:

- NZ IAS 1 *Presentation of Financial Statements (revised 2007)* replaces NZ IAS 1 *Presentation of Financial Statements (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as “owner”. The revised standard gives Canterbury DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). Canterbury DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.
- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. Canterbury DHB intends to adopt this standard for the year ending 30 June 2010 and has not yet determined the potential impact of the new standard.
- NZ specific amendment to NZ IAS 2 *Inventories*. In November 2007 the New Zealand Accounting Standards Review Board approved an amendment to NZ IAS 2 *Inventories*, which requires public benefit entities to measure inventory held for distribution at cost, adjusted when applicable for any loss of service potential. Prior to the amendment, public benefit entities were required to measure inventories held for distribution at the lower of cost and current replacement cost. Application of the amendment is mandatory for reporting periods beginning on or after 1 January 2008. Canterbury DHB will adopt the amended standard for the year ending 30 June 2009 and expects the impact of adopting the new standard to be minimal.

**SIGNIFICANT ACCOUNTING POLICIES****Basis for Consolidation**

The purchase method is used to prepare the consolidated financial statements, which involves adding together like items of assets, liabilities, equity, income and expenses on a line-by-line basis. All significant intragroup balances, transactions, income and expenses are eliminated on consolidation.

Canterbury DHB’s investments in its subsidiaries are carried at cost in the Canterbury DHB’s own “parent entity” financial statements.

**Subsidiaries**

Subsidiaries are entities controlled by Canterbury DHB. Control exists when Canterbury DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Canterbury DHB measures the cost of a business combination as the aggregate of the fair values, at the date of exchange, of assets given, liabilities incurred or assumed, in exchange for control of subsidiary plus any costs directly attributable to the business combination.

**Associates**

Associates are those entities in which Canterbury DHB has significant influence, but not control, over the financial and operating policies.

The consolidated financial statements include Canterbury DHB’s share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When Canterbury DHB’s share of losses exceeds its interest in an associate, Canterbury DHB’s carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Canterbury DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Canterbury DHB's investments in associates are carried at cost in Canterbury DHB's own "parent entity" financial statements.

#### *Transactions eliminated on consolidation*

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates are eliminated to the extent of Canterbury DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

#### **Foreign currency**

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of financial performance.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

#### **Budget figures**

The budget figures are those approved by the Canterbury DHB in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ IFRS, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

#### **Property, plant and equipment**

##### *Classes of property, plant and equipment*

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings and building fitout
- leasehold building
- plant, equipment and vehicles
- work in progress

##### *Owned assets*

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance. Additions to land and buildings between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

##### *Fixed Assets Vested from the Hospital and Health Service*

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

*Additions*

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Canterbury DHB and the cost of the item can be measured reliably.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

*Subsequent costs*

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Canterbury DHB. All other costs are recognised in the statement of financial performance as an expense is incurred.

*Disposal of Property, Plant and Equipment*

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

*Donated Assets*

Donated assets are recorded at the best estimate of fair value and recognised as income. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

*Depreciation*

Depreciation is charged to the statement of financial performance using the straight line method so as to write off the cost or valuation of fixed assets above \$2,000 to their estimated residual value over their expected economic life. Assets below \$2,000 are written off in the month of purchase. Land is not depreciated.

The estimated useful lives of major classes of assets and resulting rates are as follows:

<b>Class of Asset</b>	<b>Years</b>	<b>Depreciation Rate</b>
Freehold Buildings & Fitout	10 – 50	2-10%
Leasehold Building	3 – 20	5-33%
Plant, Equipment and Vehicles	3 – 12	8.3-33%

The residual value of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

**Intangible assets***Software development and acquisition*

Expenditure on software development activities, whereby the new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the statement of financial performance as an expense as incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

*Amortisation*

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

<b>Type of asset</b>	<b>Estimated life</b>	<b>Amortisation rate</b>
Software	2 years	50%

### Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the statement of financial performance.

Other financial assets held are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the statement of financial performance. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the statement of financial performance.

Financial assets classified as held for trading or available-for-sale are recognised/derecognised on the date the DHB commits to purchase/sell the investments.

### Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified.

### Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at the lower of cost (calculated using the weighted average cost method) and current replacement cost. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Other inventories are stated at the lower of cost (calculated using the weighted average method) and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

### Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

### Impairment

The carrying amounts of Canterbury DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset, at which point it is recognised in the statement of financial performance.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on asset's ability to generate net cash inflows and where Canterbury DHB would, if deprived of the asset, replace its reminding future economic benefits or service potential.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the statement of financial performance, a reversal of the impairment loss is also recognised in the statement of financial performance.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

### **Borrowings**

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

### **Employee benefits**

#### *Defined contribution plans*

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of financial performance as incurred.

#### *Defined benefit plans*

Canterbury DHB makes contributions to the DBP Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounts, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocations. The scheme is therefore accounted for as a defined contribution scheme.

#### *Long service leave, sabbatical leave, retirement gratuities and sick leave*

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the year end date. Canterbury DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. Sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date; to the extent Canterbury DHB anticipates it will be used by staff to cover those future absences.

#### *Annual leave, conference leave and medical education leave*

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

### **Provisions**

A provision is recognised when Canterbury DHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

#### *ACC Partnership Programme*

Canterbury DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme the DHB is liable for all its claims costs for a period of two years up to a specified maximum. At the end of the two year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

**Trade and other payables**

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate.

**Derivative financial instruments**

Canterbury DHB uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational and financing activities. The DHB does not hold these financial instruments for trading purposes and has not adopted hedge accounting.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are remeasured to fair value at each balance date. The gain or loss on remeasured to fair value is recognised immediately in the statement of financial performance.

**Income tax**

DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

**Goods and services tax**

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

**Revenue**

Revenue is measured at the fair value of consideration received or receivable.

*Revenue relating to service contracts*

Canterbury DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Canterbury DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability

*Services rendered*

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Canterbury DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Canterbury DHB.

*Interest income*

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

**Operating lease payments**

Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

**Non-current assets held for sale**

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the statement of financial performance.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of disposal group) are not depreciated or amortised while they are classified as held for sale.

**Borrowing costs**

Borrowing costs are recognised as an expense in the period in which they are incurred.

### **Critical judgements in applying CDHB's accounting policies**

The preparation of financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. These estimates and assumptions may differ from the actual results. The estimates and underlying assumptions are reviewed on an ongoing basis.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

#### *Property, plant and equipment useful lives and residual value*

At each balance date Canterbury DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, and expected disposal proceeds from the future sale of the assets.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. Canterbury DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets;
- Asset replacement programs;
- Review of second hand market prices for similar assets; and
- Analysis of prior asset sales.

Canterbury DHB has not made significant changes to past assumption concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 14.

#### *Retirement and long service leave*

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any change in these assumptions will impact on the carrying amount of the liability.

#### *Leases classification*

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Canterbury DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased assets, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Canterbury DHB has exercised its judgement on the appropriate classification of its leases and, has determined all leases arrangements are operating leases.

#### *Non-government grants*

Canterbury DHB must exercise judgement when recognising grant income to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

## 2. Patient related revenue

	Group		Parent	
	30/06/08 \$'000	30/06/07 \$'000	30/06/08 \$'000	30/06/07 \$'000
ACC Revenue	21,512	19,565	21,512	19,565
Other patient related revenue	15,033	13,893	15,460	14,311
<b>Total patient related revenue</b>	<b>36,545</b>	<b>33,458</b>	<b>36,972</b>	<b>33,876</b>

## 3. Other operating income

	Group		Parent	
	30/06/08 \$'000	30/06/07 \$'000	30/06/08 \$'000	30/06/07 \$'000
Gain/(loss) on sale of property, plant and equipment	(135)	6,162	(142)	6,178
Donations and bequests received	783	649	797	649
Other	18,363	15,506	15,883	13,172
	<b>19,011</b>	<b>22,317</b>	<b>16,538</b>	<b>19,999</b>

## 4. Employee benefit costs

	Group		Parent	
	30/06/08 \$'000	30/06/07 \$'000	30/06/08 \$'000	30/06/07 \$'000
Wages and salaries	455,007	419,016	445,147	410,606
Contributions to defined contribution plans	7,793	5,394	7,793	5,394
Increase/(decrease) in employee benefit provisions	9,645	14,736	9,380	14,517
	<b>472,445</b>	<b>439,146</b>	<b>462,320</b>	<b>430,517</b>

## 5. Other operating expenses

	Group		Parent	
	30/06/08 \$'000	30/06/07 \$'000	30/06/08 \$'000	30/06/07 \$'000
Remuneration of auditor:				
Audit fees for financial statement audit	172	166	148	137
Audit fees for NZ IFRS transition	35	14	18	14
Board members' fees	307	300	307	300
Directors' fees	23	23	-	-
Operating lease costs	4,343	4,211	3,858	3,773
Other	61,083	55,488	58,412	53,008
	<b>65,963</b>	<b>60,202</b>	<b>62,743</b>	<b>57,232</b>

## 6. Capital charge

CDHB pays capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the year. The capital charge rate for the period ended June 2008 was 8%. ( June 2007 8%).

## 7. Capital and reserves

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>General Funds</b>				
Opening Balance	124,313	126,174	124,451	126,312
Equity repayment to Ministry of Health	(1,861)	(1,861)	(1,861)	(1,861)
	<b>122,452</b>	<b>124,313</b>	<b>122,590</b>	<b>124,451</b>
<b>Retained earnings</b>				
Opening balance	(40,648)	(38,399)	(42,688)	(40,138)
Operating surplus/(deficit)	(16,766)	(2,249)	(16,499)	(2,550)
Transfer from/(to) trust reserve	-	-	-	-
Closing balance	(57,414)	(40,648)	(59,187)	(42,688)
Represented by:				
Accumulated deficit in parent and subsidiary	(57,492)	(40,726)	(59,265)	(42,766)
Accumulated surplus in associates	78	78	78	78
	<b>(57,414)</b>	<b>(40,648)</b>	<b>(59,187)</b>	<b>(42,688)</b>
<b>Revaluation reserve</b>				
Opening balance	184,477	184,477	184,477	184,477
Current year movement	-	-	-	-
Closing balance	184,477	184,477	184,477	184,477
Represented by:				
Revaluation of land	68,603	68,603	68,603	68,603
Revaluation of building including fitout	114,374	114,374	114,374	114,374
Revaluation of reversionary interest in buildings	1,500	1,500	1,500	1,500
	<b>184,477</b>	<b>184,477</b>	<b>184,477</b>	<b>184,477</b>

## 8. Cash and cash equivalents

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Bank balances and call deposits	29,004	50,633	26,905	49,282
Term deposits less than 3 months	13,335	-	13,335	-
Cash and cash equivalents	42,339	50,633	40,240	49,282
Bank overdrafts	-	-	-	-
<b>Cash and cash equivalents at end of year</b>	<b>42,339</b>	<b>50,633</b>	<b>40,240</b>	<b>49,282</b>

The carrying value of short-term deposits with maturity dates of three months or less approximates their fair value.

## 9. Trade and other receivables

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Trade receivables	9,303	7,516	8,733	7,323
Receivable from the Ministry of Health	15,372	8,620	14,927	8,480
Prepayments	872	658	863	622
Other receivables	10,462	7,488	10,918	7,488
	<b>36,009</b>	<b>24,282</b>	<b>35,441</b>	<b>23,913</b>

The carrying value of receivables approximates their fair value.

Movements in the provision for impairment of receivables are as follows:

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Balance at 1 July	2,549	1,742	2,549	1,742
Additional provisions made during the year	(173)	1,183	(173)	1,183
Receivables written-off during period	(214)	(376)	(214)	(376)
<b>Balance at 30 June</b>	<b>2,162</b>	<b>2,549</b>	<b>2,162</b>	<b>2,549</b>

As at 30 June 2008 and 2007, all overdue receivables have been assessed for impairment and appropriate provisions have been applied. The net ageing of trade receivables are:

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Current	6,752	6,029	6,182	5,836
1-30 days	1,538	795	1,538	795
31-60 days	546	175	546	175
> 61 days	467	517	467	517
<b>Balance at 30 June</b>	<b>9,303</b>	<b>7,516</b>	<b>8,733</b>	<b>7,323</b>

## 10. Inventory

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Pharmaceuticals	2,998	2,538	2,998	2,538
Surgical and Medical Supplies	4,944	4,716	4,944	4,716
Other Supplies	1,654	1,532	1,585	1,467
	9,596	8,786	9,527	8,721
Provision for Obsolescence	(633)	(611)	(633)	(611)
	<b>8,963</b>	<b>8,175</b>	<b>8,894</b>	<b>8,110</b>

No inventories are pledged as security for liabilities, however some inventories are subject to retention of title clauses.

## 11. Investments

Canterbury DHB has the following investments :

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Investment in Associates	-	168	-	168
Investment in Subsidiaries	-	-	3,208	3,170
Other Investments	9,170	11,170	9,170	11,170
	<b>9,170</b>	<b>11,338</b>	<b>12,378</b>	<b>14,508</b>

### Investment in Associates

#### a) General information

Name of entity	Principal activities	Interest held at 30 June 2008	Balance date
South Island Shared Service Agency Limited	Provision of support services relating to contracting to DHBs for their funding arm	47%	30 June

#### b) Investment in associate entities

	2008 Actual \$'000	2007 Actual \$'000
Carrying amount at beginning of year	168	168
Investment realised through sale of assets and liabilities of NZCRM	(168)	-
<b>Carrying amount at end of year</b>	<b>-</b>	<b>168</b>

#### c) Share of associates' contingent liabilities and commitments

Canterbury DHB is not jointly or severally liable for the liabilities owing at balance date by South Island Shared Service Agency Limited. South Island Shared Service Agency Limited is incorporated in New Zealand.

### Investments in subsidiaries

	Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Equity - Canterbury Laundry Service Ltd	394	394
Advances - Canterbury Laundry Service Ltd	2,716	2,776
Advances - Brackenridge Estate Ltd	98	-
	<b>3,208</b>	<b>3,170</b>

At 30 June 2008 subsidiary companies comprise:

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

Both Canterbury Laundry Service Ltd and Brackenridge Estate Ltd are incorporated in New Zealand. Canterbury Laundry Service Ltd provides laundry services. Brackenridge Estate Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

**Other investments**

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Current investments are represented by:</b>				
Term deposits	-	5,000	-	5,000
<i>Total current portion</i>	-	5,000	-	5,000
<b>Non-current investments are represented by:</b>				
Bonds	9,170	6,170	9,170	6,170
Total non-current portion	9,170	6,170	9,170	6,170
<b>Total other investments</b>	<b>9,170</b>	<b>11,170</b>	<b>9,170</b>	<b>11,170</b>

The fair value of equity investments are determined by reference to published price quotations in an active market.

**Maturity analysis and effective interest rates of term deposits**

The maturity dates and weighted average effective interest rates for term deposits are as follows:

	30/06/08 \$'000	30/06/07 \$'000
Term deposits with maturities of 6-12 months	-	5,000
<i>Weighted average effective interest rates</i>	-	8.30%

The carrying amounts of term deposits with maturities less than 12 months approximate their fair value.

**12. Trade and other payables**

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Trade payables	10,680	11,268	10,410	11,944
Other payables	75,731	68,842	75,750	68,842
<b>Total trade and other payables</b>	<b>86,411</b>	<b>80,110</b>	<b>86,160</b>	<b>80,786</b>

Trade and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of trade and other payables approximates their fair value.

### 13. Employee benefits

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Non-current liabilities</b>				
Liability for long service leave	3,877	4,172	3,852	4,153
Liability for retirement gratuities	4,707	4,154	4,707	4,154
	<b>8,584</b>	<b>8,326</b>	<b>8,559</b>	<b>8,307</b>
<b>Current liabilities</b>				
Annual leave accruals	38,932	35,007	38,353	34,466
Unpaid days accruals	5,795	12,226	5,733	11,946
ACC accruals	6,431	4,641	6,357	4,554
Conference/Sabbatical leave and expenses	11,839	14,059	11,839	14,059
Sick leave	7,313	7,978	7,192	7,878
Other	39,622	26,634	39,189	26,632
<b>Staff entitlement due within 1 year</b>	<b>109,932</b>	<b>100,545</b>	<b>108,663</b>	<b>99,535</b>

The present value of the retirement and long service leave obligation depends on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating the liability include the discount rate and the salary inflation factor. Any changes in these assumptions will impact on the carrying amount of the liability.

### 14. Property, plant and equipment

#### Movements for each class of property, plant and equipment for the Group

07/08 Financial year	Freehold land \$'000	Freehold buildings & fitout \$'000	Plant, equipment & vehicles \$'000	Leasehold buildings \$'000	Revisionary interest in buildings \$'000	Work in progress \$'000	Total \$'000
<b>Cost or valuation</b>							
Balance at 1 July 2007	100,083	313,912	144,776	894	1,500	21,529	582,694
Additions	-	18,928	15,887	-	-	(13,206)	21,609
Disposals/transfers	-	-	(2,658)	-	-	-	(2,658)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2008</b>	<b>100,083</b>	<b>332,840</b>	<b>158,005</b>	<b>894</b>	<b>1,500</b>	<b>8,323</b>	<b>601,645</b>
<b>Depreciation and impairment losses</b>							
Balance at 1 July 2007	-	29,730	96,624	894	-	-	127,248
Depreciation charge for the year	-	29,564	16,632	-	-	-	46,196
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	-	(2,456)	-	-	-	(2,456)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2008</b>	<b>-</b>	<b>59,294</b>	<b>110,800</b>	<b>894</b>	<b>-</b>	<b>-</b>	<b>170,988</b>

The disposal of certain properties may be subject to the Ngai Tahu Claims Settlement Act 1995, or the provision of section 40 of the Public Works Act 1981.

06/07 Financial year	Freehold land \$'000	Freehold buildings & fitout \$'000	Plant, equipment & vehicles \$'000	Leasehold buildings \$'000	Revisionary interest in buildings \$'000	Work in progress \$'000	Total \$'000
<b>Cost or valuation</b>							
Balance at 1 July 2006	99,913	300,816	129,659	1,281	1,500	15,841	549,010
Additions	-	12,803	19,525	27	-	5,688	38,043
Disposals/Transfers	170	293	(4,408)	(414)	-	-	(4,359)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2007</b>	<b>100,083</b>	<b>313,912</b>	<b>144,776</b>	<b>894</b>	<b>1,500</b>	<b>21,529</b>	<b>582,694</b>
<b>Depreciation and impairment losses</b>							
Balance at 1 July 2006	-	-	82,847	891	-	-	83,738
Depreciation charge for the year	-	29,794	16,313	85	-	-	46,192
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	(64)	(2,536)	(82)	-	-	(2,682)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2007</b>	<b>-</b>	<b>29,730</b>	<b>96,624</b>	<b>894</b>	<b>-</b>	<b>-</b>	<b>127,248</b>
<b>Carrying amounts</b>							
At 1 July 2007	100,083	284,182	48,152	-	1,500	21,529	455,446
At 30 June 2008	100,083	273,546	47,205	-	1,500	8,323	430,657

#### Movements for each class of property, plant and equipment for the Parent

07/08 Financial year	Freehold land \$'000	Freehold buildings & fitout \$'000	Plant, equipment & vehicles \$'000	Leasehold buildings \$'000	Revisionary interest in buildings \$'000	Work in progress \$'000	Total \$'000
<b>Cost or valuation</b>							
Balance at 1 July 2007	100,083	313,625	137,427	894	1,500	21,483	575,012
Additions	-	18,768	14,772	-	-	(13,187)	20,353
Disposals/transfers	-	-	(1,899)	-	-	-	(1,899)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2008</b>	<b>100,083</b>	<b>332,393</b>	<b>150,300</b>	<b>894</b>	<b>1,500</b>	<b>8,296</b>	<b>593,466</b>
<b>Depreciation and impairment losses</b>							
Balance at 1 July 2007	-	29,691	92,823	894	-	-	123,408
Depreciation charge for the year	-	29,414	15,409	-	-	-	44,823
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	-	(1,770)	-	-	-	(1,770)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2008</b>	<b>-</b>	<b>59,105</b>	<b>106,462</b>	<b>894</b>	<b>-</b>	<b>-</b>	<b>166,461</b>

06/07 Financial year	Freehold land \$'000	Freehold buildings & fitout \$'000	Plant, equipment & vehicles \$'000	Leasehold buildings \$'000	Reversionary interest in buildings \$'000	Work in progress \$'000	Total \$'000
<b>Cost or valuation</b>							
Balance at 1 July 2006	99,913	300,816	123,957	894	1,500	15,727	542,807
Additions	-	12,803	17,223	-	-	5,756	35,782
Disposals/transfers	170	6	(3,753)	-	-	-	(3,575)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2007</b>	<b>100,083</b>	<b>313,625</b>	<b>137,427</b>	<b>894</b>	<b>1,500</b>	<b>21,483</b>	<b>575,012</b>
<b>Depreciation and impairment losses</b>							
Balance at 1 July 2006	-	-	79,509	808	-	-	80,317
Depreciation charge for the year	-	29,764	15,158	86	-	-	45,008
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals/transfer	-	(74)	(1,845)	-	-	-	(1,919)
Revaluations	-	-	-	-	-	-	-
<b>Balance at 30 June 2007</b>	<b>-</b>	<b>29,690</b>	<b>92,822</b>	<b>894</b>	<b>-</b>	<b>-</b>	<b>123,406</b>
<b>Carrying amounts</b>							
At 1 July 2007	100,083	283,935	44,605	-	1,500	21,483	451,606
At 30 June 2008	100,083	273,288	43,838	-	1,500	8,296	427,005

### Revaluation

Canterbury DHB revalued its land, buildings and fitout plants as at 30 June 2006. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of Telfer Young (Canterbury) Ltd), which is consistent with NZ IAS 16 Property Plant & Equipment, and resulted in the net increases in the value of land (\$41,072,000), buildings and fitout (\$65,177,000) and reversionary interest in a car park building (\$510,000). This increase had been recognised in the Revaluation Reserve. The total optimised depreciated replacement cost of Canterbury DHB's land and buildings including fitout as at 30 June 2006 was \$400,729,000.

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

## 15. Intangible assets

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Software</b>				
<b>Cost</b>				
Opening balance	16,267	15,418	16,267	15,418
Additions	2,211	849	2,211	849
Disposals	-	-	-	-
Closing balance	18,478	16,267	18,478	16,267
<b>Amortisation and impairment losses</b>				
Opening balance	15,566	14,545	15,566	14,545
Amortisation charge for the year	1,616	1,035	1,616	1,035
Impairment losses	13	(14)	13	(14)
Reversal of impairment losses	-	-	-	-
Disposals	-	-	-	-
Closing balance	17,195	15,566	17,195	15,566
<b>Carrying amounts</b>	<b>1,283</b>	<b>701</b>	<b>1,283</b>	<b>701</b>

## 16. Trust / Special funds

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. An amount equal to the trust fund assets is reflected as a non-current liability.

All trust funds are held in bank accounts that are separate from Canterbury DHB's normal banking facilities.

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Balance at beginning of year</b>	10,931	9,907	10,825	9,818
Interest received	1,121	731	1,099	703
Donations and funds received	683	1,589	683	1,589
Funds spent	(1,213)	(1,296)	(1,205)	(1,285)
<b>Balance at end of year</b>	<b>11,522</b>	<b>10,931</b>	<b>11,402</b>	<b>10,825</b>
<b>Residents' trust accounts</b>				
<b>Residents' trust account balance</b>	<b>846</b>	<b>870</b>	<b>302</b>	<b>400</b>

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

## 17. Provisions

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Provisions due within 1 year	-	-	-	-
Provisions due after 1 year	-	200	-	-
<b>Total provisions</b>	<b>-</b>	<b>200</b>	<b>-</b>	<b>-</b>
Movements in provisions				
Opening balance	200	254	-	-
Additional provisions made during the year	-	-	-	-
Now included in other payables	(200)	-	-	-
Charged against provisions for the year	-	(54)	-	-
<b>Closing balance</b>	<b>-</b>	<b>200</b>	<b>-</b>	<b>-</b>

Brackenridge has a refurbishment provision in regard to its legal obligation to the Housing Corporation to keep the premises at 150 Madisons Road in the same condition that they were in at the start of their lease in December 1999. The lease will finish in 2019.

## 18. Borrowings

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Non-current</b>				
Crown Health Financing Agency loans	75,000	87,650	75,000	87,650
Total non-current borrowings	75,000	87,650	75,000	87,650
<b>Total borrowings</b>	<b>75,000</b>	<b>87,650</b>	<b>75,000</b>	<b>87,650</b>

The Crown Health Financing Agency loans are issued at fixed rates of interest. The carrying amounts of borrowings approximate their fair values. The details of terms and conditions are as follows:

### Interest rates

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

	Group		Parent	
	30/06/08	30/06/07	30/06/08	30/06/07
<b>Crown Health Financing Agency loans</b>				
Later than one year but not more than five years	60,000	72,650	60,000	72,650
<i>Weighted average effective interest rate</i>	<i>6.39%</i>	<i>6.34%</i>	<i>6.39%</i>	<i>6.34%</i>
Later than five years	15,000	15,000	15,000	15,000
<i>Weighted average effective interest rate</i>	<i>6.13%</i>	<i>6.13%</i>	<i>6.13%</i>	<i>6.13%</i>

### Security

The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent Canterbury DHB cannot perform the following actions:

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any of its assets except disposals at full value in the ordinary course of business

## 19. Reconciliation of Net Surplus/(Deficit) for the period with net cash flows from operating activities

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Net surplus/deficit</b>	(16,766)	(2,249)	(16,499)	(2,550)
<b>Add back non-cash items:</b>				
Depreciation and amortisation	47,808	47,228	46,439	46,046
<b>Add back items classified as investing activity:</b>				
(Gain) / loss on asset sale	135	(6,162)	142	(6,178)
	<u>31,177</u>	<u>38,817</u>	<u>30,082</u>	<u>37,318</u>
Movement in term portion provisions/staff entitlements	258	(929)	252	(924)
<b>Movements in working capital:</b>				
Decrease/(increase) in receivables & prepayments	(11,727)	1,315	(11,528)	1,191
Decrease/(increase) in stocks	(788)	(979)	(784)	(977)
Increase/(decrease) in creditors & other accruals	6,301	5,579	5,374	5,215
Increase/(decrease) in capital charge due to crown	(6,623)	10,114	(6,623)	10,114
Increase/(decrease) in staff entitlements	9,387	15,665	9,128	15,441
Increase/(decrease) in provisions	(200)	(54)	-	-
<b>Net cash inflow/(outflow) from operating activities</b>	<u><b>27,785</b></u>	<u><b>69,528</b></u>	<u><b>25,901</b></u>	<u><b>67,378</b></u>

## 20. Commitments

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Capital Commitments</b>				
Property, plant and equipment	11,201	16,996	11,201	16,996
Intangible assets	4,174	22,204	4,174	22,204
Other capital commitments	11,198	-	11,198	-
<b>Total capital commitments at Balance Date</b>	<b>26,573</b>	<b>39,200</b>	<b>26,573</b>	<b>39,200</b>
<b>Non Cancellable Operating Lease Commitments</b>				
Accommodation leases	8,939	9,481	4,754	4,996
Vehicle leases	-	-	-	-
Other	11	11	-	-
	<b>8,950</b>	<b>9,492</b>	<b>4,754</b>	<b>4,996</b>
<b>For Expenditure Within:</b>				
Not later than one year	1,879	1,634	1,352	1,136
Later than one year and not later than five years	3,181	3,554	1,763	2,140
Later than five years	3,890	4,304	1,639	1,720
	<b>8,950</b>	<b>9,492</b>	<b>4,754</b>	<b>4,996</b>

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

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

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

Operating leases as lessee

Canterbury DHB leases a number of properties in the normal course of its business. The majority of these leases contain normal clauses in relation to regular rent reviews at current market rates.

## 21. Contingent liabilities

Canterbury DHB has the following contingencies at year end:

a. Collective Employment Agreements negotiations

There are a number of collective employment agreements that expired before 30 June 2008. Negotiations are in progress at a National level and Canterbury has limited influence over such negotiations. While significant industrial action may occur, due the high degree of uncertainty, the financial impact of such events had not been allowed for in the financial results.

b. Outstanding Legal Proceedings

The Group has outstanding legal proceedings at year end. The Group disputes these claims and believe that it is unlikely any material financial loss will eventuate. Not all information disclosed as this may prejudice the legal position of the DHB.

c. Defined Benefit Contribution Schemes

Canterbury DHB is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, the DHB could be responsible for an increased share of the deficit.

## 22. Categories of financial assets and liabilities

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Investments in subsidiaries and associates	-	168	3,208	3,338
<b>Loans and receivables</b>				
Cash and cash equivalents	42,339	50,633	40,240	49,282
Debtors and other receivables	36,009	24,282	35,441	23,913
Bonds	9,170	6,170	9,170	6,170
Term deposits (term>3 months)	-	5,000	-	5,000
<b>Total loans and receivables</b>	<b>87,518</b>	<b>86,085</b>	<b>84,851</b>	<b>84,365</b>
<b>Fair value through profit and loss</b>				
Restricted assets	11,522	10,931	11,402	10,825
Restricted liabilities	11,522	10,931	11,402	10,825
<b>Other financial liabilities</b>				
Creditors and other payables	93,640	93,962	93,389	94,638
Borrowings- CFA loans	75,000	87,650	75,000	87,650
<b>Total other financial liabilities</b>	<b>168,640</b>	<b>181,612</b>	<b>168,389</b>	<b>182,288</b>

## 23. Financial Instrument Risks

### Credit risk

Credit risk is the risk that a third party will default on its obligation to the Group, causing the Group to incur a loss.

Financial instruments which potentially subject the Group to credit risk consist mainly of cash and short-term investments, accounts receivable, interest rate swaps and foreign currency forward contracts. The Group only invest funds with those entities which have a specified Standard and Poor's credit rating.

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2008, the Ministry of Health owed Canterbury DHB \$14.9 million (\$8.5 million at 30 June 2007).

At the balance sheet date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

### Market risk

#### Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. Canterbury DHB is exposed to equity securities price risk on its investments. This price risk arises due to market movements in listed companies. The price risk is managed by diversification of Canterbury DHB's investment portfolio in accordance with the limits set out in Canterbury DHB's investment policy.

#### Interest rate risk

The interest rates on the Group's investments are disclosed in note 11 and on the Group borrowings in note 18.

*Fair value interest rate risk*

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. Borrowing issued at fixed rate and term deposits held at fixed rates expose the Group to fair value interest rate risk.

The group has adopted a policy of having a mixture of long term fixed rate and floating rate debt to fund ongoing activities. Canterbury DHB uses interest rate swaps and options in order to manage interest rate risk. The notional principal or contract amount of interest rate swaps and options outstanding at 30 June 2008 was nil (2007: \$8 million).

*Cash flow interest rate risk*

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The Group currently has no variable interest rate investments or borrowings.

*Currency risk*

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

The group has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2008 (30 June 2007 nil)

**Liquidity risk**

Liquidity risk is the risk that the Group will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of funding through an adequate amount of committed credit facilities and the ability to close out market positions.

The table below analyses trade and other payables into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date, based on undiscounted cash flows:

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Less than 6 months	86,411	80,110	86,160	80,786
<b>Total</b>	<b>86,411</b>	<b>80,110</b>	<b>86,160</b>	<b>80,786</b>

**24. Capital management**

Canterbury DHB's capital is its equity, which comprises accumulated funds and other reserves. Equity is represented by net assets.

Canterbury DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

Canterbury DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure Canterbury DHB effectively achieves its objectives and purpose, whilst remaining a going concern.

## 25. Related parties

### Government funding

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

### Inter-group transactions

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

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Revenue</b>				
Interest on advance and director's fees from/to Canterbury Laundry Service Ltd	-	-	235	202
Service fees to Brackenridge Estate Ltd	-	-	48	45
Services to Canterbury Laundry Service Ltd	-	-	427	427
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	27	58	27	58
<b>Expenses</b>				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	3,927	4,073
Interest on advance from Brackenridge Estate Ltd	-	-	18	70
Services from New Zealand Centre for Reproductive Medicine Ltd	1,224	1,940	1,224	1,940
Services from South Island Shared Service Agency Ltd	994	553	994	553

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

The amounts outstanding for all related party transactions as at 30 June 2008 are as follows:

	Group		Parent	
	As at 30/06/08 \$'000	As at 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
<b>Amount receivable owing by associates</b>				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	103	351	103	384
<b>Amount payable owing to associates</b>				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	-	-	-	33
<b>Amount payable owing to subsidiaries</b>				
Brackenridge Estate Ltd – advance	-	-	-	713
Canterbury Laundry Service Ltd	-	-	372	346
<b>Amount receivable owing by subsidiaries</b>				
Canterbury Laundry Service Ltd – debtor	-	-	87	80
Canterbury Laundry Service Ltd – advance	-	-	2,750	2,750
Brackenridge Estate Ltd – advance	-	-	98	-

**Board and Committee members**

Below are the aggregate value of purchase transactions and outstanding balances which Canterbury DHB and its subsidiaries have made during the financial year on an arm's length basis with the organisations which fall within the related party definition. Balances outstanding are per the Accounts Payable Ledger, and exclude any provisions made.

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/08 \$'000	Year ended 30/06/07 \$'000	As at 30/06/08 \$'000	As at 30/06/07 \$'000
Pegasus Health	2,063	2,716	-	-
He Oranga Pounamu Charitable Trust	191	171	-	-
Te Amorangi Richmond Wellness Village	-	8	-	-
Te Rito Arahi Māori Alcohol Drug & Resource Centre	(57)	228	-	-
Windsor House	2,198	1,952	-	-
Ryman Healthcare Ltd	6,845	6,056	-	-
TimeOut Carers	24	261	-	-
Canterbury Community Primary Health Organisation	4,698	1,450	-	-
Rural Canterbury Primary Health Organisation	12,165	9,110	-	-
Access Home Health	3,946	3,139	-	-
Deloitte	98	64	-	-
Te Puawaitanga ki Otautahi Trust	784	531	-	-
Te Rununga O Nga Maata Waka	166	127	-	-
McLeans Institute	133	130	-	-
Christchurch Resettlement Services	75	69	-	-
University of Canterbury	112	422	4	313
Christchurch Polytechnic Institute of Technology (CPIT)	23	29	-	-
New Zealand College of Midwives	-	1	-	-
Cambridge Clinic (DSAC) Ltd	236	112	-	-
Age Concern Canterbury	1	1	-	-
Parents Centre NZ	121	116	-	-
24 Hour Surgery Ltd	8	102	-	-
Social Services Council of the Diocese of Christchurch	4,262	4,023	-	-
Christchurch Primary Health Organisation	4,181	2,634	-	-
The Nurse Maude Association	22,247	21,162	-	-
Medical Protection Society	102	206	1	-
Partnership Health Primary Health Organisation	63,362	50,268	-	-
Hurunui-Kaikoura Primary Health Organisation	3,429	2,530	-	-
Amuri Health Centre Ltd	3	-	-	-
City Care Limited	27	5	-	1
Orion New Zealand Limited	-	173	-	-
Red Bus Limited	8	6	-	1
Christchurch International Airport Limited	1	2	-	-

Below are the aggregate value of revenue transactions and outstanding balances which Canterbury DHB and its subsidiaries have made during the financial year on an arm's length basis with the organisations which fall within the related party definition. Balances outstanding are per the Accounts Receivable ledger, and exclude any provisions made. A provision for impairment of receivables from related parties of \$22,482 has been made (2007 \$71,261).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended	Year ended	As at	As at
	30/06/08	30/06/07	30/06/08	30/06/07
	\$'000	\$'000	\$'000	\$'000
Pegasus Health	138	130	15	28
He Oranga Pounamu Charitable Trust	38	29	4	4
Rural Canterbury Primary Health Organisation	71	-	-	-
University of Canterbury	55	25	3	(2)
Christchurch Polytechnic Institute of Technology (CPIT)	340	332	20	21
Christchurch Primary Health Organisation	38	-	-	-
The Nurse Maude Association	56	93	19	72
Canterbury Medical Research Foundation	111	98	21	19
Partnership Health Primary Health Organisation	128	289	-	16
Hurunui-Kaikoura Primary Health Organisation	2	3	1	-
24 Hour Surgery Ltd	31	4	-	3
City Care Limited	1	-	-	-
Lyttelton Port Company Limited	3	3	-	-
Orion New Zealand Limited	-	4	-	-

### Key Management Personnel

Below are the aggregate value of transactions and outstanding balances relating to key management personnel and entities over which they have control or significant influence. Balances outstanding are per the Accounts Payable and the Accounts Receivable ledgers, and exclude any provisions made. No provision has been required, nor any expense recognised, for impairment of receivables from related parties (2007 \$nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended	Year ended	As at	As at
	30/06/08	30/06/07	30/06/08	30/06/07
	\$'000	\$'000	\$'000	\$'000
<b>Services purchased by Canterbury DHB:</b>				
Heart Centre at St George's	728	554	-	-
Christchurch Polytechnic Institute of Technology	23	29	-	-
<b>Services purchased from Canterbury DHB:</b>				
Heart Centre at St George's	45	29	4	1
Christchurch Polytechnic Institute of Technology	340	332	20	21

Heart Centre at St George's is an unincorporated joint venture between St George's Hospital and Heart Centre (2003) Ltd. When clinical demand requires, "excess" cardiac surgery services are outsourced to this joint venture. These services are provided at St George's Hospital. Graham (Jock) Muir is both a director and shareholder of Heart Centre (2003) Ltd.

Hector Matthews is the Chair of the Christchurch Polytechnic Institute of Technology Council.

**Compensation of key management personnel:**

	<b>Group</b>		<b>Parent</b>	
	<b>Year ended</b>	<b>Year ended</b>	<b>Year ended</b>	<b>Year ended</b>
	<b>30/06/08</b>	<b>30/06/07</b>	<b>30/06/08</b>	<b>30/06/07</b>
	<b>\$'000</b>	<b>\$'000</b>	<b>\$'000</b>	<b>\$'000</b>
Salaries & other short term employee benefits	1,609	1,777	1,609	1,777
Post-employment benefits	245	183	245	183
<b>Total key management personnel compensation</b>	<b>1,854</b>	<b>1,960</b>	<b>1,854</b>	<b>1,960</b>

**26. Subsequent events**

There were no events after 30 June 2008 which could have a material impact on the information in Canterbury DHB's financial statements (30 June 2007 – no events).

**27. Budget variance**

Additional personal health funding for aged related care and home based support, and additional funding for settlements of Multi Employer Collective Agreement (MECA), were devolved during the year and were not reflected in these budgets.

**28. Explanation of transition to NZ IFRS**

These are Canterbury DHB's first consolidated financial statements prepared in accordance with NZ IFRS.

The accounting policies set out in note 1 to the financial statements have been applied in preparing financial statements for the year ended 30 June 2007, and in the preparation of an opening NZ IFRS Balance Sheet at 1 July 2006 (Canterbury DHB's date of transition).

Canterbury DHB's transition date is 1 July 2006 and the opening NZ IFRS balance sheet has been prepared as at that date. Canterbury DHB's NZ IFRS adoption date is 1 July 2007.

In preparing these financial statements in accordance with NZ IFRS 1, Canterbury DHB has not applied any optional and mandatory exemptions to full retrospective application of NZ IFRS.

In preparing its opening NZ IFRS Balance Sheet, Canterbury DHB has adjusted amounts reported previously in financial statements prepared in accordance with its old basis of accounting (previous GAAP). An explanation of how the transition from previous GAAP to NZ IFRS has affected Canterbury DHB's financial position, financial performance and cash flows is set out in the following tables and the notes that accompany the tables.

The following tables show the changes in equity, resulting from the transition from previous NZ GAAP to NZ IFRS as at 1 July 2006 and 30 June 2007 for the group and parent.

### Reconciliation of equity – Group

	Note	Transition Balance Sheet 1 July 2006			Comparative Balance Sheet 30 June 2007		
		Previous GAAP	Effect of transition to NZIFRS	NZ IFRS	Previous GAAP	Effect of transition to NZIFRS	NZ IFRS
		\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Investment	a	375	(207)	168	6,689	(351)	6,338
Property, plant and equipment	b	466,145	(873)	465,272	456,147	(701)	455,446
Intangible assets	b	-	873	873	0	701	701
Surplus property		11,760	-	11,760	8,250	-	8,250
Restricted assets	c	8,110	2,199	10,309	8,100	2,831	10,931
<b>Total non-current assets</b>		<b>486,390</b>	<b>1,992</b>	<b>488,382</b>	<b>479,186</b>	<b>2,480</b>	<b>481,666</b>
Cash and cash equivalents		12,838	-	12,838	50,633	-	50,633
Trade and other receivables	a&d	25,391	29	25,420	24,132	150	24,282
Inventories		7,196	-	7,196	8,175	-	8,175
Investment		-	-	0	5,000	-	5,000
<b>Total current assets</b>		<b>45,425</b>	<b>29</b>	<b>45,454</b>	<b>87,940</b>	<b>150</b>	<b>88,090</b>
<b>Total assets</b>		<b>531,815</b>	<b>2,021</b>	<b>533,836</b>	<b>567,126</b>	<b>2,630</b>	<b>569,756</b>
<b>Equity</b>							
Crown equity		126,174	-	126,174	124,313	-	124,313
Other reserves		184,477	-	184,477	184,477	-	184,477
Retained earning/(losses)	c,d,g,h&i	(31,435)	(6,964)	(38,399)	(32,273)	(8,375)	(40,648)
Trust/Special funds	e	8,110	(8,110)	-	8,100	(8,100)	-
<b>Total equity</b>		<b>287,326</b>	<b>(15,074)</b>	<b>272,252</b>	<b>284,617</b>	<b>(16,475)</b>	<b>268,142</b>
<b>Liabilities</b>							
Employee benefits	f,g&h	-	9,255	9,255	-	8,326	8,326
Patient and restricted funds	c&e	-	10,309	10,309	-	10,931	10,931
Provisions	f	9,509	(9,255)	254	8,526	(8,326)	200
Borrowings		78,650	-	78,650	87,650	-	87,650
<b>Total non-current liabilities</b>		<b>88,159</b>	<b>10,309</b>	<b>98,468</b>	<b>96,176</b>	<b>10,931</b>	<b>107,107</b>
Trade and other payables	a&i	74,456	42	74,498	79,914	196	80,110
Owing to the Ministry of Health		3,738	-	3,738	13,852	-	13,852
Employee benefits		48,919	35,961	84,880	56,475	44,070	100,545
Provisions		29,217	(29,217)	-	36,092	(36,092)	-
<b>Total current liabilities</b>		<b>156,330</b>	<b>6,786</b>	<b>163,116</b>	<b>186,333</b>	<b>8,174</b>	<b>194,507</b>
<b>Total liabilities</b>		<b>244,489</b>	<b>17,095</b>	<b>261,584</b>	<b>282,509</b>	<b>19,105</b>	<b>301,614</b>
<b>Total equity and liabilities</b>		<b>531,815</b>	<b>2,021</b>	<b>533,836</b>	<b>567,126</b>	<b>2,630</b>	<b>569,756</b>

## Reconciliation of equity – Parent

	Note	Transition Balance Sheet 1 July 2006			Comparative Balance Sheet 30 June 2007		
		Previous GAAP	Effect of transition to NZIFRS	NZIFRS	Previous GAAP	Effect of transition to NZIFRS	NZIFRS
		\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Investment	a	2,592	(2,030)	562	9,796	(288)	9,508
Property, plant and equipment	b	463,364	(873)	462,491	452,307	(701)	451,606
Intangible assets	b	-	873	873	-	701	701
Surplus property		11,760	-	11,760	8,250	-	8,250
Restricted assets	c	7,993	2,199	10,192	7,994	2,831	10,825
Total non-current assets		485,709	169	485,878	478,347	(2,543)	480,890
Cash and cash equivalents		12,270	-	12,270	49,282	-	49,282
Trade and other receivables	a&d	24,898	2,207	27,105	23,529	384	23,913
Inventories		7,133	-	7,133	8,110	-	8,110
Investment		-	-	-	5,000	-	5,000
Total current assets		44,301	2,207	46,508	85,921	384	86,305
<b>Total assets</b>		<b>530,010</b>	<b>2,376</b>	<b>532,386</b>	<b>564,268</b>	<b>2,927</b>	<b>567,195</b>
<b>Equity</b>							
Crown equity		126,312	-	126,312	124,451	-	124,451
Other reserves		184,477	-	184,477	184,477	-	184,477
Retained earning/(losses)	c,d,g,h&i	(33,170)	(6,968)	(40,138)	(34,547)	(8,141)	(42,688)
Trust/Special funds	e	7,993	(7,993)	-	7,994	(7,994)	-
Total equity		285,612	(14,961)	270,651	282,375	(16,135)	266,240
<b>Liabilities</b>							
Employee benefits	f,g&h	-	9,231	9,231	-	8,307	8,307
Patient and restricted funds	c&e	-	10,192	10,192	-	10,825	10,825
Provisions	f	9,231	(9,231)	-	8,307	(8,307)	-
Borrowings		78,650	-	78,650	87,650	-	87,650
Total non-current liabilities		87,881	10,192	98,073	95,957	10,825	106,782
Trade and other payables	a&i	75,433	397	75,830	80,527	259	80,786
Owing to the Ministry of Health		3,738	-	3,738	13,852	-	13,852
Employee benefits		48,157	35,937	84,094	55,509	44,026	99,535
Provisions		29,189	(29,189)	-	36,048	(36,048)	-
Total current liabilities		156,517	7,145	163,662	185,936	8,237	194,173
Total liabilities		244,398	17,337	261,735	281,893	19,062	300,955
<b>Total equity and liabilities</b>		<b>530,010</b>	<b>2,376</b>	<b>532,386</b>	<b>564,268</b>	<b>2,927</b>	<b>567,195</b>

## Explanatory notes – reconciliation of equity

## a. Reclassification of advances to/from associates

Advances to/from associates were classified as part of investment under previous NZ GAAP. Advances to associates are reclassified as part of trade and other receivables and advances from associates are included in trade and other payables under NZ IFRS.

## b. Intangible assets

Computer software was classified as part of property, plant and equipment under previous NZ GAAP. The net book value of computer software reclassified as an intangible asset on transition to NZ IFRS is \$873,000 and at 30 June 2007 is \$701,000.

- c. Restricted assets and liabilities**  
Trust asset/ liabilities have been designated as fair value through P&L under NZ IAS 39. They were recorded at cost under previous NZ GAAP and the increase in carrying value as a result of adopting fair value.
- d. Impairment of trade receivables**  
NZ IAS 39 requires impairment of receivables to be based upon a review of individual debtors, not a general provision as was applied under previous NZ GAAP. The impact of the change has resulted in an increase in the provision for doubtful debts on the date of transition, but there is no impact on the provision as at 30 June 2007.
- e. Trust / special funds**  
Trust/ special funds were classified as part of equity under previous NZ GAAP. In accordance with NZ IAS 37, Appendix E, trust funds are accessed as non-discretionary grants. Therefore trust / special funds were reclassified as patients / restricted funds under liability section.
- f. Employee benefits**  
Employee related benefits were provided by general provision under previous NZ GAAP. NZ IAS 1 recommends employee related benefits to be split out from the provision line and to be reclassified as employee benefits.
- g. Sick leave**  
Sick leave was not recognised as a liability under previous NZ GAAP. NZ IAS 19 requires Canterbury DHB to recognise employees unused sick leave entitlement that can be carried forward at balance date, to the extent that Canterbury DHB anticipates it will be used by staff to cover future absences.
- h. ACC partnership programme**  
The ACC Partnership Programme is accounted for under NZ IFRS 4. An actuarial valuation is used to determine the liability for the present value of future costs to be incurred by Canterbury DHB relating to accidents that have happened. The impact of the change has resulted in an increase in ACC accrual on the date of transition, but there is no impact on the provision as at 30 June 2007.
- i. Loss on interest rate swaps**  
Loss on interest rate swaps was only disclosed in the notes to the financial statements under previous NZ GAAP. NZ IAS 39 requires interest rate swaps to be recognised in the statement of position at their fair value.

**Reconciliation of surplus for the year ended 30 June 2007**

	Note	Group 30 June 2007			Parent 30 June 2007		
		Previous NZ GAAP	Effect of transition to NZ IFRS	NZIFRS	Previous NZ GAAP	Effect of transition to NZ IFRS	NZIFRS
		\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Ministry of Health revenue	a	1,050,404	(234)	1,050,170	1,042,064	-	1,042,064
Patient related revenue		33,458	-	33,458	33,876	-	33,876
Other operating income		22,317	-	22,317	19,999	-	19,999
Interest income		5,146	-	5,146	5,278	-	5,278
Total income		1,111,325	(234)	1,111,091	1,101,217	-	1,101,217
Employee benefit costs	b&c	437,912	1,234	439,146	429,287	1,230	430,517
Treatment related costs		105,727	-	105,727	108,864	-	108,864
Depreciation and amortisation expenses		47,228	-	47,228	46,046	-	46,046
External service providers		433,074	-	433,074	433,074	-	433,074
Other operating expenses	d&e	60,269	(67)	60,202	57,288	(56)	57,232
Interest expenses		5,069	-	5,069	5,140	-	5,140
Capital charge		22,894	-	22,894	22,894	-	22,894
Total expenses		1,112,173	1,167	1,113,340	1,102,593	1,174	1,103,767
<b>Surplus before and after tax</b>		<b>(848)</b>	<b>(1,401)</b>	<b>(2,249)</b>	<b>(1,376)</b>	<b>(1,174)</b>	<b>(2,550)</b>

**Explanatory notes – reconciliation of surplus****a. Ministry of Health revenue provision**

\$234,000 represents an adjustment within one of the Subsidiaries made in the IFRS accounts, but not recognised in the GAAP accounts.

**b. Employee benefits costs – sick leave**

\$1,687,000 represents the increase in the sick leave provision for the group (\$1,683,000 for the parent), which were not recognised under previous NZ GAAP.

**c. ACC partnership programme**

NZ IFRS 4 requires the liability for the ACC partnership programme is calculated using actuarial techniques. This represents the additional provision (\$453,000) for ACC partnership programme liability on transition to NZ IFRS (1 July 2006).

**d. Loss on interest rate swaps**

\$121,000 represents the net movement in fair value of interest rate swaps, which were not recognised under previous NZ GAAP.

**e. Impairment of trade receivables**

NZ IAS 39 requires impairment of receivables to be based upon a review of individual debtors, not a general provision as was applied under previous NZ GAAP. This represents change in the measurement basis of the provision for doubtful debts on transition to NZ IFRS, which has impacted on the movement in the provision for doubtful debts recognised in the statement of financial performance by \$178,000.

**Statement of cash flows**

There have been no material adjustments to the statement of cash flows for the year ended 30 June 2007, on transition to NZ IFRS.

# STATEMENT OF SERVICE PERFORMANCE

## DHB Priorities and Accountability

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

- *A District Strategic Plan* - This is a long-term strategic document outlining the DHB's intended direction and vision for the next five to ten years. This document is produced through a public consultation and health needs assessment process and enables the DHB to determine key objectives and set its long-term strategic priorities;
- *A Statement of Intent* - This is a three-year document requiring DHBs to demonstrate at a high-level how its activities will contribute to achieving the long-term vision outlined in its District Strategic Plan. Included is a 'Forecast of Service Performance' which presents a set of performance measures against which the DHB will evaluate its performance, with targets set for each performance measure.
- *A District Annual Plan* - This is a more detailed document outlining the intended actions and activity the DHB has planned over the coming year to progress the long-term direction and achieve the objectives and performance targets outlined in the other two documents.

The Canterbury DHB's business covers the funding and provision of population health intervention, primary and secondary services, community care and specialist and secondary services – across all population groups. However, the strategic priorities identified by the DHB in 2004, while developing its District Strategic Plan A Healthier Canterbury Directions 2010, are a mix of population, service and disease based approaches. These represent areas where the Canterbury DHB believes there is potential to make improvements in the health status of its population and in the delivery or effectiveness of the services provided.

Five Health Gain Priorities and four Disease Priorities were selected:

- Child and Youth Health;
- Older Person's Health
- Primary Health;
- Māori Health;
- Disease Prevention and Management;
- Cancer;
- Cardiovascular Disease;
- Diabetes; and
- Respiratory Disease.

The DHB updates its Statement of Intent annually and continues to develop and refine the measures for its Forecast Statement of Service Performance to ensure they appropriately reflect the activity and direction of the DHB and meet the needs of its stakeholders, both in government and in the community.

The performance measures included by the DHB in its Forecast of Service Performance reflect activity in the long-term strategic priority areas identified in its District Strategic Plan. As a major provider of health and disability services and the largest employer in the South Island the DHB also includes additional performance measure around areas of performance focus of interest to its stakeholders. These include; improved service delivery around elective and mental health services, hospital efficiency and effectiveness, clinical quality, patient satisfaction and being a good employer.

Also of note is the inclusion in the DHB's mix of performance measure of several measures over which it has does not have direct control. The DHB chooses to include these indicators as an important measure of the determinants of health however its ability to influence the behaviour of its community and the provision of services by third parties is limited. By including these performance measures the DHB is essentially acknowledging that change cannot be made through its actions alone. The DHB continues to work with other providers, external agencies and organisations to collectively improve the health of its community and these performance measures provide an indication of the success of that collective approach.

Sponsors are identified against each of the performance measurements, identifying one of the three output classes (or roles) of the DHB: Governance; Funder; or Provider. It is the outputs where the DHB is the Provider of the service where it has the most control. Where the DHB is the Funder (and therefore contracts with external providers to deliver

the service) control is limited to influencing change through contracting, support and encouragement, partnership or leadership. Those outputs where the DHB is Funder present more of a risk for the DHB in terms of reliance on a third party to deliver the outputs needed to achieve the desired outcomes or objective.

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

Where possible past performance and national averages are included against each performance measure, to give the performance target context and to better enable evaluation of DHB performance.

At the end of the year the DHB produces the *Statement of Service Performance*, reporting against all of the performance measures and targets set out in its Forecast of Service Performance at the beginning of the year. This Statement of Service Performance provides an indication of how well the DHB's activity over the past year contributed to improving the health and well-being of the Canterbury population and to progressing the DHB's vision, direction and strategic priorities.

### **Overview of Performance for 2007/08**

The indicators that follow are from the DHB's 2007/2010 Statement of Intent with the targets being those set for the 2007/08 year.

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

Over the past year the DHB's approach to making progress in all areas has been consistent:

- Promote messages related to improved lifestyle choices, physical activity and nutrition and the reduction of risk behaviours, obesity and smoking cessation to promote and improve the health status of the community;
- Work collaboratively with primary and community sectors, the community and external organisations to find better ways of working through an integrated and patient centred approach to care and the development of robust long-term disease continuums;
- Work together with providers and community agencies to reduce inequalities in health status through increased equity of access and improved uptake of services across population groups, particularly those more at risk and with the highest need;
- Develop Canterbury's health care workforce to ensure the capacity and capability to meet the changing needs of the population and growing demand for health and disability services; and
- Be a leader in health, working to ensure the best possible level of quality care is provided to maximise outcomes for the population.

The DHB notes that the following set of performance measures does not include measures around Respiratory Disease, one of the DHB's identified Disease Priorities. The DHB is currently scoping the developing of key indicators for this priority area for use in future Statements of Intent.

**Child and Youth Health**

**Long-Term Objective:** Improve the health status of Canterbury’s child and youth populations. By keeping young people healthy we give them a better chance of becoming healthy adults.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08																																																				
Maintain the number of babies born with a low birth weight, at below the national average – as a mean of reducing a major cause and association of infant mortality. <sup>4</sup>	The rate of babies born (in public hospitals) with low birth weight - rate per 1000 births. <table border="1"> <thead> <tr> <th></th> <th>Māori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <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>07/08</td> <td>82</td> <td>45</td> <td>62</td> <td>63</td> </tr> <tr> <td>07/08 (Target)</td> <td>62</td> <td>62</td> <td>62</td> <td>62</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>61</td> </tr> </tbody> </table>		Māori	Pacific	Other	Total	04/05	60	39	59	45	05/06	52	53	54	54	06/07	48	32	58	56	07/08	82	45	62	63	07/08 (Target)	62	62	62	62	National Average				61	<table border="1"> <thead> <tr> <th></th> <th>Base 06/07</th> <th>Target 07/08</th> <th>Result 07/08</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>48</td> <td>&lt;62</td> <td>82</td> </tr> <tr> <td>Pacific</td> <td>32</td> <td>&lt;62</td> <td>45</td> </tr> <tr> <td>Other</td> <td>58</td> <td>&lt;62</td> <td>62</td> </tr> <tr> <td>Total</td> <td>56</td> <td>&lt;62</td> <td>63</td> </tr> </tbody> </table> <p>The results for low-birth weight babies are influenced by a complex mix of social, environmental and behaviour factors, out the direct control of the DHB. Smoking rates, ethnicity mix and maternal age all influence outcomes. Contributors to the increased rate include an increase in premature rates and admissions of 32-35 week babies and multiple pregnancies with an increase in twin rates. This result is not surprising and is reflected in international as well as national trends.</p>		Base 06/07	Target 07/08	Result 07/08	Māori	48	<62	82	Pacific	32	<62	45	Other	58	<62	62	Total	56	<62	63
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Improve Breastfeeding Rates – as a means of maximising children’s health and providing a positive start to life.	Percentage of children exclusively/fully breastfed at 6 weeks, 3 months and 6 months. <sup>5</sup> <table border="1"> <thead> <tr> <th></th> <th>6 Weeks</th> <th>3 Months</th> <th>6 Months</th> </tr> </thead> <tbody> <tr> <td>05/06</td> <td>67%</td> <td>57%</td> <td>32%</td> </tr> <tr> <td>06/07</td> <td>67%</td> <td>57%</td> <td>37%</td> </tr> <tr> <td>07/08</td> <td>67%</td> <td>55%</td> <td>31%</td> </tr> <tr> <td>07/08 (Target)</td> <td>74%</td> <td>57%</td> <td>27%</td> </tr> <tr> <td>National Average</td> <td>67%</td> <td>55%</td> <td>25%</td> </tr> </tbody> </table>		6 Weeks	3 Months	6 Months	05/06	67%	57%	32%	06/07	67%	57%	37%	07/08	67%	55%	31%	07/08 (Target)	74%	57%	27%	National Average	67%	55%	25%	<table border="1"> <thead> <tr> <th></th> <th>Base 06/07</th> <th>Target 07/08</th> <th>Result 07/08</th> </tr> </thead> <tbody> <tr> <td>6 weeks</td> <td>67%</td> <td>&gt;74%</td> <td>67%</td> </tr> <tr> <td>3 months</td> <td>-</td> <td>&gt;57%</td> <td>55%</td> </tr> <tr> <td>6 months</td> <td>37%</td> <td>&gt;27%</td> <td>31%</td> </tr> </tbody> </table>		Base 06/07	Target 07/08	Result 07/08	6 weeks	67%	>74%	67%	3 months	-	>57%	55%	6 months	37%	>27%	31%															
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Improve Vaccination Rates – as a means of reducing the impact of vaccine preventable disease.	The percentage of children fully immunised on day they turned 6 months, 12 months, 18 months and 2 years. <table border="1"> <thead> <tr> <th></th> <th>05/06</th> <th>06/07</th> <th>07/08</th> <th>07/08 (Target)</th> </tr> </thead> <tbody> <tr> <td>6mths</td> <td>74%</td> <td>71%</td> <td>71%</td> <td>88%</td> </tr> <tr> <td>12mths</td> <td>87%</td> <td>87%</td> <td>89%</td> <td>88%</td> </tr> <tr> <td>18mths</td> <td>75%</td> <td>75%</td> <td>75%</td> <td>85%</td> </tr> <tr> <td>24mths</td> <td>33%</td> <td>33%</td> <td>84%</td> <td>85%</td> </tr> <tr> <td>2 Yr National Average</td> <td></td> <td></td> <td></td> <td>73%</td> </tr> </tbody> </table>		05/06	06/07	07/08	07/08 (Target)	6mths	74%	71%	71%	88%	12mths	87%	87%	89%	88%	18mths	75%	75%	75%	85%	24mths	33%	33%	84%	85%	2 Yr National Average				73%	<table border="1"> <thead> <tr> <th></th> <th>Base 06/07</th> <th>Target 07/08</th> <th>Result 07/08</th> </tr> </thead> <tbody> <tr> <td>6 months</td> <td>71%</td> <td>88-92%</td> <td>71%</td> </tr> <tr> <td>12 mths</td> <td>87%</td> <td>88-92%</td> <td>89%</td> </tr> <tr> <td>18 mths</td> <td>75%</td> <td>85-88%</td> <td>75%</td> </tr> <tr> <td>2 years</td> <td>33%</td> <td>85-88%</td> <td>84%</td> </tr> </tbody> </table> <p>The DHB has maintained or improved immunisation performance across all age groups in the past year.</p> <p>A collaborative immunisation direction has been developed to improving timeliness of vaccinations over the coming year which is expected to improve the 6 and 18 month results.</p>		Base 06/07	Target 07/08	Result 07/08	6 months	71%	88-92%	71%	12 mths	87%	88-92%	89%	18 mths	75%	85-88%	75%	2 years	33%	85-88%	84%					
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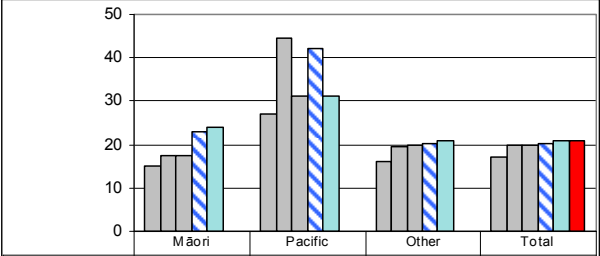
<sup>4</sup> Infants born with a low birth weight (under 2500gm) are more likely to have poor health outcomes and increased disabilities and are more susceptible to serious illness during infancy, early childhood and adulthood. This information comes from the Ministry of Health (Ministry) from their National Minimum Data Set (NMDS) and are the most recent results available covering the yearly average to December 2007.

<sup>5</sup> These targets reflect our commitment to nationally accepted rates for breastfeeding, in line with Ministry expectations. Although some are already above national expectations, the aim is to reflect the intention to focus on the age groups where performance can be improved. This information is provided by Plunket.

Objective 2007/2008	Performance Measure		Base 2006	Target 2007	Result 2007																																			
Improve Oral Health Rates – as a means of maximising on-going health.	The percentage of adolescents utilising oral health services. <sup>6</sup> <table border="1"> <tr> <td>Utilising Oral Hlth Services</td> <td>68.8%</td> <td>69.9%</td> <td>67.2%</td> <td>67.0%</td> <td>74.2%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td></td> <td>58.3%</td> </tr> </table>	Utilising Oral Hlth Services	68.8%	69.9%	67.2%	67.0%	74.2%	National Average					58.3%	Total	67.2%	74.2%	67%																							
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National Average					58.3%																																			
		The DHB has not met the target for this indicator but performance continues to be above the national average.																																						
	The percentage of children caries free, (i.e. no holes or fillings) at age five. <table border="1"> <tr> <td>% Caries Free at age 5</td> <td>5%</td> <td>5%</td> <td>56%</td> <td>58%</td> <td>5%</td> </tr> </table>	% Caries Free at age 5	5%	5%	56%	58%	5%		Base 2006	Target 2007	Result 2007																													
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Results have continued to improve and Māori and Pacific results are within confidence level. The complex mix of environmental, biological and behavioural factors effecting dental caries mean that reasons for change can be difficult to influence and identify. However, dental enrolment levels for preschool children have been steadily improving and results may demonstrate benefits from the early intervention.																																								
	The average proportion of Decayed, Missing or Filled (DMF) teeth of Year-8 children. <table border="1"> <tr> <td>Avg. Missing or Filled Teeth</td> <td>1.58</td> <td>1.55</td> <td>1.64</td> <td>1.56</td> <td>1.60</td> </tr> </table>	Avg. Missing or Filled Teeth	1.58	1.55	1.64	1.56	1.60		Base 2006	Target 2007	Result 2007																													
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Other	1.51	1.46	1.46																																					
Total	1.64	1.60	1.56																																					
The rate of DMF teeth of Year-8 children has improved, dropping across all population groups over the past year.																																								
Reduce Ambulatory Sensitive Admission Rates - as an indication of improved access to, and effectiveness of, primary care services. <sup>7</sup>	Ambulatory Sensitive Admissions for those aged 0-4 years (rate per 1000 population). <table border="1"> <tr> <td></td> <td>Māori</td> <td>Pacific</td> <td>Other</td> <td>Total</td> </tr> <tr> <td>04/05</td> <td>72</td> <td>104</td> <td>78</td> <td>78</td> </tr> <tr> <td>05/06</td> <td>78</td> <td>141</td> <td>83</td> <td>84</td> </tr> <tr> <td>06/07</td> <td>60</td> <td>96</td> <td>72</td> <td>71</td> </tr> <tr> <td>07/08</td> <td>71</td> <td>115</td> <td>69</td> <td>71</td> </tr> <tr> <td>07/08 (Target)</td> <td>76</td> <td>114</td> <td>74</td> <td>73</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>60</td> </tr> </table>		Māori	Pacific	Other	Total	04/05	72	104	78	78	05/06	78	141	83	84	06/07	60	96	72	71	07/08	71	115	69	71	07/08 (Target)	76	114	74	73	National Average				60		Base 06/07	Target 07/08	Result 07/08
			Māori	Pacific	Other	Total																																		
		04/05	72	104	78	78																																		
		05/06	78	141	83	84																																		
06/07	60	96	72	71																																				
07/08	71	115	69	71																																				
07/08 (Target)	76	114	74	73																																				
National Average				60																																				
Māori	60	<76	71																																					
Pacific	96	<114	115																																					
Other	72	<74	69																																					
Total	71	<73	71																																					
The DHB has met its targets in all population groups except Pacific, where very small population numbers (128 Pacific children were admitted in 2007/08) make a disproportionate difference in results. Work is still needed across all population groups to achieve rates closer to the national average. The DHB is working on 'Improving the Child Journey' within its services and anticipates this will improve results in the coming year.																																								

<sup>6</sup> Oral health results are provided by calendar year, from the Ministry. The 2006 result differs from that in the 2006/07 Annual Report, reflecting updated information provided by the Ministry after the report was printed.

<sup>7</sup> Ambulatory Sensitive Admissions are based on admissions for 37 combined conditions including: Asthma, Dehydration, Diabetes, Ruptured Appendix, Stroke, Angina, Gastroenteritis and 'Failure to Thrive'. The information comes from the Ministry's NMDS and covers the year to December 2007 – which are the latest results available.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08																																			
	Ambulatory Sensitive Admissions for those aged 5-14 years (rate per 1000 population).	Māori	17	<24	23																																			
	Pacific	31	<31	42																																				
	Other	20	<21	20																																				
	Total	20	<21	20																																				
																																								
	<table border="1"> <thead> <tr> <th></th> <th>Māori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>04/05</td> <td>15</td> <td>27</td> <td>16</td> <td>17</td> </tr> <tr> <td>05/06</td> <td>18</td> <td>44</td> <td>19</td> <td>20</td> </tr> <tr> <td>06/07</td> <td>17</td> <td>31</td> <td>20</td> <td>20</td> </tr> <tr> <td>07/08</td> <td>23</td> <td>42</td> <td>20</td> <td>20</td> </tr> <tr> <td>07/08 (Target)</td> <td>24</td> <td>31</td> <td>21</td> <td>21</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>21</td> </tr> </tbody> </table>		Māori	Pacific	Other	Total	04/05	15	27	16	17	05/06	18	44	19	20	06/07	17	31	20	20	07/08	23	42	20	20	07/08 (Target)	24	31	21	21	National Average				21				
		Māori	Pacific	Other	Total																																			
	04/05	15	27	16	17																																			
	05/06	18	44	19	20																																			
	06/07	17	31	20	20																																			
07/08	23	42	20	20																																				
07/08 (Target)	24	31	21	21																																				
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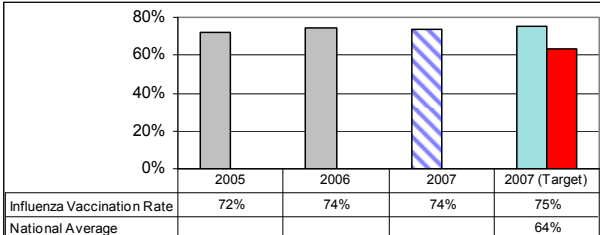
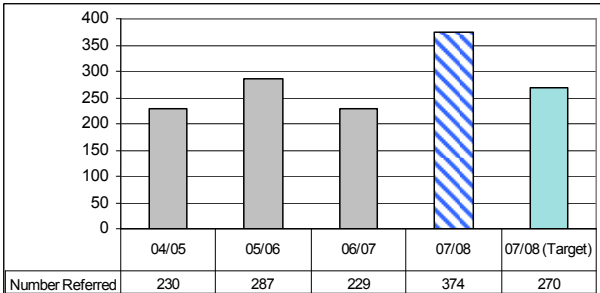
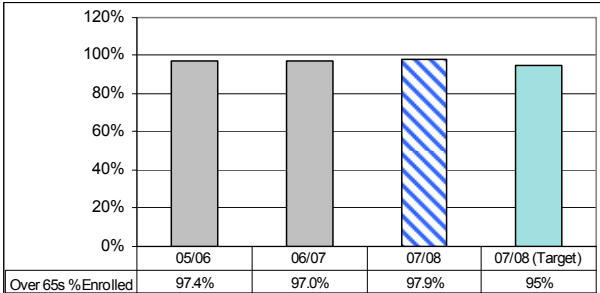
Again the DHB has met its targets in all population groups except Pacific (there was a total of 78 Pacific children admitted in 2007/08 out of a total of 1,030). The overall results match the national average for this indicator.

The DHB's 'Improving the Child Journey' work should also see some further improvement within this age grouping in the coming year.

**Older Person's Health**

**Long-Term Objective:** Maintain/improve the health and independence of our older population, within available resources.

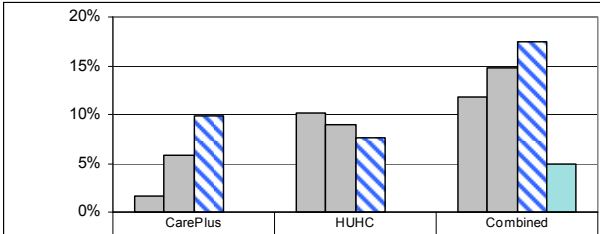
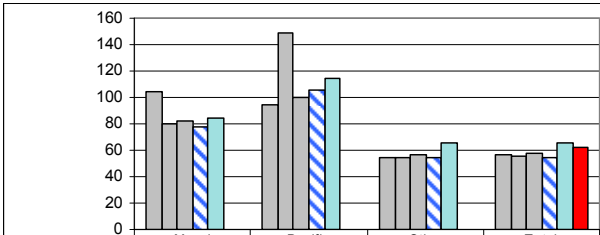
*In defining Older People the DHB refers to 65+ for European and Other and to 50+ for Māori and Pacific Populations.*

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08										
Build the Focus on Health Promotion – as a means of maximising the health of older people and helping them to staying healthy in their own homes.	The percentage of the enrolled PHO population over 65 receiving the influenza vaccination. <sup>8</sup>  <table border="1" data-bbox="403 678 1005 739"> <tr> <td>Influenza Vaccination Rate</td> <td>72%</td> <td>74%</td> <td>74%</td> <td>75%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>64%</td> </tr> </table>	Influenza Vaccination Rate	72%	74%	74%	75%	National Average				64%	Total	74%	> 75%	74%
	Influenza Vaccination Rate	72%	74%	74%	75%										
National Average				64%											
While the DHB has missed this target, the result reflects an overall increase in the actual number of vaccinations delivered, as the enrolled over 65 population increased between 2006 and 2007.															
Maintain Access to Primary Care Services as a means of maximising ongoing health and well-being. <sup>10</sup>	The numbers referred to the Stay On Your Feet (SOFY) Home Exercise Programme. <sup>9</sup>  <table border="1" data-bbox="403 1048 1005 1115"> <tr> <td>Number Referred</td> <td>230</td> <td>287</td> <td>229</td> <td>374</td> <td>270</td> </tr> </table>	Number Referred	230	287	229	374	270		Base 06/07	Target 07/08	Result 07/08				
	Number Referred	230	287	229	374	270									
Referrals to the Stay on Your Feet home exercise programme steadily increased over the past year and the DHB has achieved and exceeded its target.	Total	229	>270	374											
			Base 06/07	Target 07/08	Result 07/08										
	The percentage of the Canterbury population over 65, enrolled with PHOs.  <table border="1" data-bbox="403 1444 1005 1489"> <tr> <td>Over 65s % Enrolled</td> <td>97.4%</td> <td>97.0%</td> <td>97.9%</td> <td>95%</td> </tr> </table>	Over 65s % Enrolled	97.4%	97.0%	97.9%	95%	Total	97%	> 95%	97.9%					
Over 65s % Enrolled	97.4%	97.0%	97.9%	95%											
Enrolments have remained steady over the past several years, and the DHB has achieved its target for this indicator.															

<sup>8</sup> These results are provided through the PHO Performance Management Programme (PMP) and they relate to the calendar year January – December 2007.

<sup>9</sup> Falls are a major cause of injury and ongoing disability for older people in Canterbury.

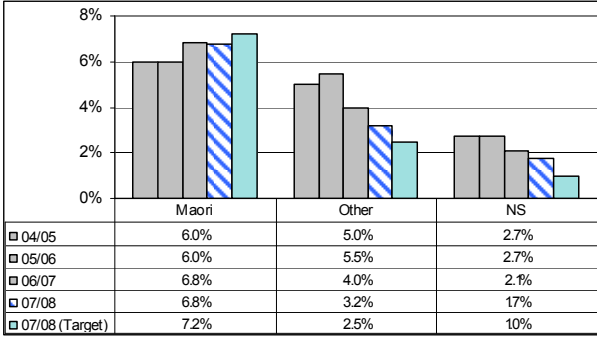
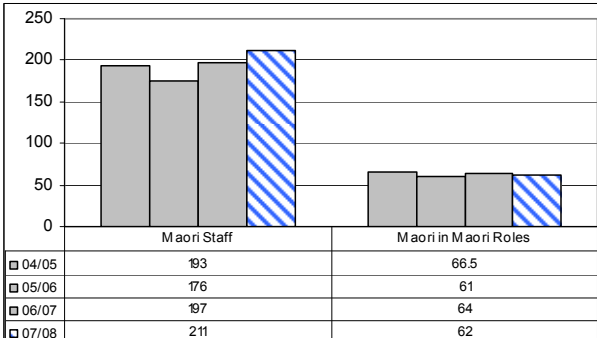
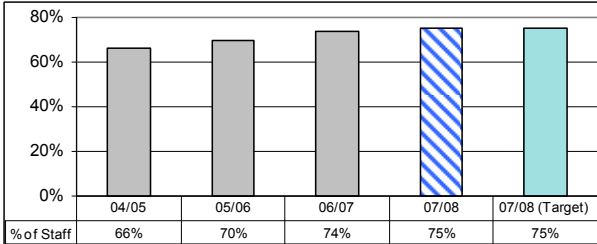
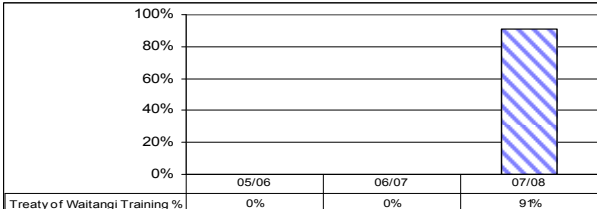
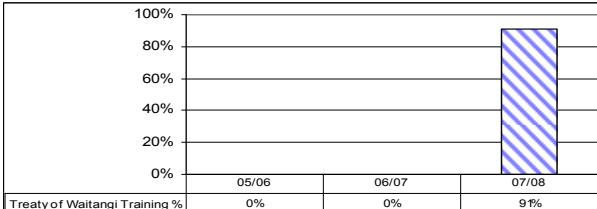
<sup>10</sup> Older People face particular barriers to accessing primary care services. They are more likely to lack transport and to have difficulty meeting user part charges, reducing barriers to access is expected to result in improved health outcomes.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08																																																			
	<p>The percentage of the PHO enrolled population over 65, accessing High User or CarePlus services. <sup>11</sup></p>  <table border="1" data-bbox="403 584 1005 672"> <thead> <tr> <th></th> <th>CarePlus</th> <th>HUHC</th> <th>Combined</th> </tr> </thead> <tbody> <tr> <td>05/06</td> <td>17%</td> <td>10.1%</td> <td>11.8%</td> </tr> <tr> <td>06/07</td> <td>5.8%</td> <td>9.0%</td> <td>14.8%</td> </tr> <tr> <td>07/08</td> <td>9.8%</td> <td>7.6%</td> <td>17.5%</td> </tr> <tr> <td>07/08 (Target)</td> <td></td> <td></td> <td>5.0%</td> </tr> </tbody> </table>		CarePlus	HUHC	Combined	05/06	17%	10.1%	11.8%	06/07	5.8%	9.0%	14.8%	07/08	9.8%	7.6%	17.5%	07/08 (Target)			5.0%	<table border="1"> <tr> <td>High User</td> <td>9.0%</td> <td>-</td> <td>7.6%</td> </tr> <tr> <td>Care+</td> <td>5.8%</td> <td>-</td> <td>9.8%</td> </tr> <tr> <td>Total</td> <td>14.8%</td> <td>&gt;5%</td> <td>17.5%</td> </tr> </table>	High User	9.0%	-	7.6%	Care+	5.8%	-	9.8%	Total	14.8%	>5%	17.5%																						
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<p>Reduce Ambulatory Sensitive Admission Rates – as an indication of improved access to, and effectiveness of primary care services.</p>	<p>Ambulatory Sensitive Admissions for those aged 65-74 years (rate per 1000 population).</p>  <table border="1" data-bbox="403 987 1005 1137"> <thead> <tr> <th></th> <th>Māori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>04/05</td> <td>104</td> <td>95</td> <td>55</td> <td>57</td> </tr> <tr> <td>05/06</td> <td>80</td> <td>149</td> <td>54</td> <td>56</td> </tr> <tr> <td>06/07</td> <td>82</td> <td>100</td> <td>57</td> <td>58</td> </tr> <tr> <td>07/08</td> <td>78</td> <td>106</td> <td>54</td> <td>55</td> </tr> <tr> <td>07/08 (Target)</td> <td>84</td> <td>114</td> <td>66</td> <td>66</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>62</td> </tr> </tbody> </table>		Māori	Pacific	Other	Total	04/05	104	95	55	57	05/06	80	149	54	56	06/07	82	100	57	58	07/08	78	106	54	55	07/08 (Target)	84	114	66	66	National Average				62	<table border="1"> <tr> <td>Māori</td> <td>82</td> <td>&lt;84</td> <td>78</td> </tr> <tr> <td>Pacific</td> <td>100</td> <td>&lt;114</td> <td>106</td> </tr> <tr> <td>Other</td> <td>57</td> <td>&lt;66</td> <td>54</td> </tr> <tr> <td>Total</td> <td>58</td> <td>&lt;66</td> <td>55</td> </tr> </table>	Māori	82	<84	78	Pacific	100	<114	106	Other	57	<66	54	Total	58	<66	55			
	Māori	Pacific	Other	Total																																																				
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		<p>Admissions for the 65-74 age group are better than the national average and the DHB has achieved its targets across all population groups. Low Pacific numbers again cause the appearance of disproportionate performance results. While the rate moved from 74 to 106 there were actually 20 Pacific people admitted in 2006/07 and 22 in 207/08, an increase of only two admissions.</p>																																																						

<sup>11</sup> The goal of Careplus is to develop individualised programmes for those people with two or more chronic conditions, specific goals are then set for each person and monitored on a quarterly basis – older people tend to have more complicated conditions.

**Māori Health**

**Long-Term Objective:** Whanau Ora, Māori are supported to achieve their maximum health and wellbeing.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08	
Improve Ethnicity Data Collection – as a means of reducing barriers to identifying inequalities in health status and monitoring Māori health outcomes.	The percentage of Inpatients with ethnicity recorded. <sup>12</sup> 	Māori	6.8%	>7.2%	6.8%	
		Other	4.0%	<2.5%	3.2%	
		Not Stated	2.1%	<1.0%	1.7%	
		While the DHB has not met the targets for this indicator, however these have been set as long-term goals to move ethnicity identification into alignment with Census figures for the Canterbury population. Steady progress is being made, a positive outcome.				
Increase Māori participation in service provision and the health workforce – as a means of improving the cultural responsive of health services.	The number of DHB (i) staff identifying as Māori (ii) Māori staff working in Māori roles. 		<b>Base 06/07</b>	<b>Target 07/08</b>	<b>Result 07/08</b>	
		(i)	197	-	211	
		(ii)	64	-	62	
		The DHBs focus is on monitoring staffing levels and on increasing the number of staff with disclosed ethnicity to improve the robustness of this data over time – hence no targets have been set for increasing staffing levels as this is for information only. The DHB is undertaking a number of Roadshows and offering scholarships in 2008/09 to promote health as a career to Māori students.				
Increase Māori engagement and participation in health planning and decision making – as a means of improving the cultural responsive of health services.	Implement a Memorandum of Understanding (MOU or formal relationship agreement) with Manawhenua ki Waitaha. The percentage of DHB staff with ethnicity disclosed. 		<b>Base 06/07</b>	<b>Target 07/08</b>	<b>Result 07/08</b>	
		Total	74%	>75%	75%	
		The DHB has met its target for this indicator.				
Increase Māori engagement and participation in health planning and decision making – as a means of improving the cultural responsive of health services.	Implement a Memorandum of Understanding (MOU or formal relationship agreement) with Manawhenua ki Waitaha. The percentage of Board members receiving Treaty of Waitangi training. 		<b>Target 07/08</b>	<b>Result 07/08</b>		
			Complete	Achieved		
		The DHB has agreed and signed an MOU with Manawhenua, a key Māori Health Plan goal.				
Increase Māori engagement and participation in health planning and decision making – as a means of improving the cultural responsive of health services.	The percentage of Board members receiving Treaty of Waitangi training. 		<b>Base 06/07</b>	<b>Target 07/08</b>	<b>Result 07/08</b>	
		Total	0%	100%	91%	
		One person missed the Treaty Training; further updates are planned for the coming year.				

<sup>12</sup> Targets are set to reduce the percentages classified as 'other' or 'not stated' which contributes to under reporting of Māori (measured against Census population) and limits the DHB's ability to monitor health outcomes.

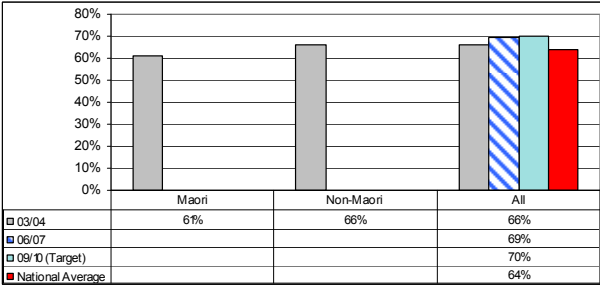
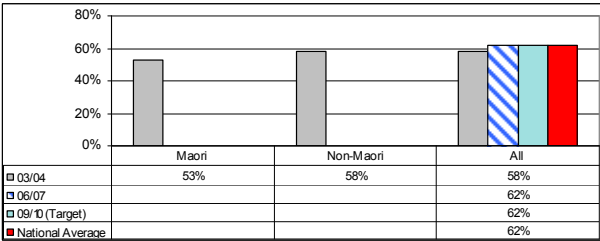
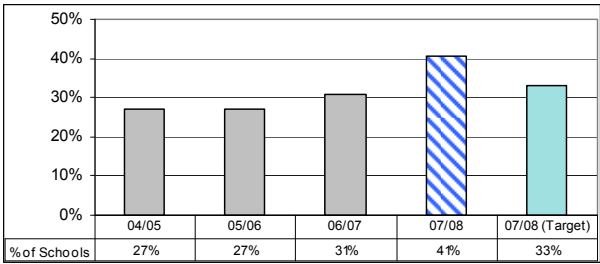
Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08										
	<p>The percentage of PHOs with Māori Health Plans.</p> <table border="1" data-bbox="405 327 1007 577"> <thead> <tr> <th></th> <th>05/06</th> <th>06/07</th> <th>07/08</th> <th>07/08 (Target)</th> </tr> </thead> <tbody> <tr> <td>%PHOs with Maori HP</td> <td>0%</td> <td>60%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table>		05/06	06/07	07/08	07/08 (Target)	%PHOs with Maori HP	0%	60%	100%	100%	Total	60%	100%	100%
	05/06	06/07	07/08	07/08 (Target)											
%PHOs with Maori HP	0%	60%	100%	100%											
		<p>The DHB has met its target with all PHOs having Māori Health Plans approved and now beginning implementation of those plans, in consultation with the DHB.</p>													

Primary Health																																							
Long-Term Objective: Reduce barriers to primary health care services and improve the utilisation of services.																																							
Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08																																		
Continue PHO Development – as a means of ensuring continuums of care are developed in line with DHB priorities and ongoing health needs assessment.	The percentage of PHOs with Health Promotion and Services to Improve Access.	Total	80%	100%	100%																																		
		The DHB has met its target for this indicator with all PHOs having Health Promotion Plans and Services to Improve Access Plan in place.																																					
	<table border="1"> <tr> <td>HP/SIA Plan in Place</td> <td>80%</td> <td>60%</td> <td>80%</td> <td>100%</td> <td>100%</td> </tr> </table>	HP/SIA Plan in Place	80%	60%	80%	100%	100%																																
HP/SIA Plan in Place	80%	60%	80%	100%	100%																																		
Reduce Barriers to Primary Care – as a means of maximising ongoing health and wellbeing.	The percentage of the population enrolled in PHOs.		Base 06/07	Target 07/08	Result 07/08																																		
		Māori	75.7%	-	75.1%																																		
		Pacific	99.0%	-	91.2%																																		
		Other	95.6%	-	97.5%																																		
		Total	94.3%	>95%	95.6%																																		
The DHB has achieved its target for PHO enrolment.																																							
	<table border="1"> <tr> <td>% PHO Enrolment</td> <td>92.8%</td> <td>94.0%</td> <td>94.3%</td> <td>95.6%</td> <td>95.0%</td> </tr> </table>	% PHO Enrolment	92.8%	94.0%	94.3%	95.6%	95.0%																																
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Reduce Ambulatory Sensitive Admission Rates - as an indication of improved access to, and effectiveness of, primary care services.	The percentage of the eligible enrolled PHO population, enrolled in Careplus services.	Total	86%	>80%	98%																																		
		The DHB has achieved and exceeded the target set for this indicator.																																					
	<table border="1"> <tr> <td>CarePlus Enrol. %</td> <td>47%</td> <td>86%</td> <td>98%</td> <td>80%</td> </tr> </table>	CarePlus Enrol. %	47%	86%	98%	80%																																	
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Reduce Ambulatory Sensitive Admission Rates - as an indication of improved access to, and effectiveness of, primary care services.	Ambulatory Sensitive Admissions for those aged 15-24 years (rate per 1000 population).		Base 06/07	Target 07/08	Result 07/08																																		
		Māori	12	<20	14																																		
		Pacific	10	<27	48																																		
		Other	13	<15	13																																		
		Total	13	<15	14																																		
The DHB's admission results for the 15-24 age groups are better than the national average and the DHB has met the set targets for all population groups, except for Pacific.																																							
	<table border="1"> <tr> <td></td> <td>Māori</td> <td>Pacific</td> <td>Other</td> <td>Total</td> </tr> <tr> <td>04/05</td> <td>11</td> <td>14</td> <td>12</td> <td>12</td> </tr> <tr> <td>05/06</td> <td>12</td> <td>11</td> <td>13</td> <td>13</td> </tr> <tr> <td>06/07</td> <td>12</td> <td>10</td> <td>13</td> <td>13</td> </tr> <tr> <td>07/08</td> <td>14</td> <td>48</td> <td>13</td> <td>14</td> </tr> <tr> <td>07/08 (Target)</td> <td>20</td> <td>27</td> <td>15</td> <td>15</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>15</td> </tr> </table>		Māori	Pacific	Other	Total	04/05	11	14	12	12	05/06	12	11	13	13	06/07	12	10	13	13	07/08	14	48	13	14	07/08 (Target)	20	27	15	15	National Average				15			
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04/05	11	14	12	12																																			
05/06	12	11	13	13																																			
06/07	12	10	13	13																																			
07/08	14	48	13	14																																			
07/08 (Target)	20	27	15	15																																			
National Average				15																																			

**Disease Prevention and Management**

**Long-Term Objective:** Reduce the risks associated with chronic conditions, improve the management of long-term illness and promote well-being.<sup>13</sup>

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08
Increase the number of Canterbury schools working within the Health Promotion in Schools Framework – as a means to reducing the incidence of obesity, lowering smoking rates and improving overall health and well-being.	The percentage of Canterbury schools, working within the Health Promoting Schools framework. <sup>14</sup>	Total	31%	>33%	41%
		The DHB has achieved and exceeded the target set for this indicator. A positive momentum is being demonstrated in the uptake of the framework by Canterbury schools.			
Increase the proportion of fruit and vegetables consumed per day by adults (15 years+) in the Canterbury region – as a means to reducing the incidence of obesity and improving overall health and well-being.	The percentage of the population having two or more servings of fruit per day.		Base 03/04	Target 09/10	Result 06/07
		Māori	53%		
		Non-Māori	58%		
		All	58%	>62%	62%
The latest results from the 2006/07 NZ Health Survey released in 2007, demonstrate a positive increase in fruit consumption in Canterbury – already meeting the DHB’s long-term target.					
Increase the proportion of fruit and vegetables consumed per day by adults (15 years+) in the Canterbury region – as a means to reducing the incidence of obesity and improving overall health and well-being.	The percentage of the population having three or more servings of vegetables a day.		Base 03/04	Target 09/10	Result 06/07
		Māori	61%		
		Non-Māori	66%		
		All	66%	>70%	69%
The latest results from the 2006/07 NZ Health Survey released in 2008, demonstrate a positive increase in vegetable consumption in Canterbury.					



<sup>13</sup>The DHB sees the indicators listed below as important measures to monitor the health and wellbeing of its population. However (with the exception of the Health Promoting Schools Indicator) the DHB’s only means of measuring progress is the national NZ Health Survey collected by the Ministry of Health every three years. The DHB has therefore set long-term targets against these indicators with the aim to move towards these goals over the next three to five years. The Surveys were undertaken in 2003/04 and 2006/07.

<sup>14</sup>The DHBs Health Promoting Schools approach is based on activities within the school setting that can impact on health: the provision of health services, the inclusion of health education in curricula, and the creation of a healthy environment. As such, the definition includes schools promoting Fruit in Schools and Active Schools.

Objective 2007/2008	Performance Measure		Base 03/04	Target 09/10	Result 06/07																				
Increase the proportion of the Canterbury population undertaking regular physical activity – as a means to reducing the trend in obesity rates and improving health and well-being.	The percentage of the population who are regularly active. <sup>15</sup>  <table border="1" data-bbox="422 593 1024 689"> <thead> <tr> <th></th> <th>Maori</th> <th>Non-Maori</th> <th>All</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>50%</td> <td>51%</td> <td>51%</td> </tr> <tr> <td>06/07</td> <td></td> <td></td> <td>50%</td> </tr> <tr> <td>09/10 Target</td> <td></td> <td></td> <td>56%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td>5%</td> </tr> </tbody> </table>		Maori	Non-Maori	All	03/04	50%	51%	51%	06/07			50%	09/10 Target			56%	National Average			5%	Māori	50%		
			Maori	Non-Maori	All																				
		03/04	50%	51%	51%																				
		06/07			50%																				
09/10 Target			56%																						
National Average			5%																						
Non-Māori	51%																								
All	51%	>56%	50%																						
The latest results indicate that more work is needed to meet the DHB's long-term target.																									
Reduce the trend in obesity rates – as a means of reducing a key risk factor for chronic conditions.	The proportion of the population who are obese. <sup>16</sup>  <table border="1" data-bbox="422 958 1024 1003"> <thead> <tr> <th></th> <th>03/04</th> <th>06/07</th> <th>09/10 (Target)</th> </tr> </thead> <tbody> <tr> <td>% Obese</td> <td>21%</td> <td>25%</td> <td>21%</td> </tr> </tbody> </table>		03/04	06/07	09/10 (Target)	% Obese	21%	25%	21%		Base 03/04	Target 09/10	Result 06/07												
			03/04	06/07	09/10 (Target)																				
		% Obese	21%	25%	21%																				
Total	21%	<21%	25%																						
The latest results indicate that more work is needed to meet the DHB's long-term target.																									
Decrease the smoking rates for people 15 years and above - as a means of reducing a key risk factor for chronic conditions.	The smoking rates in Canterbury.  <table border="1" data-bbox="422 1317 1024 1361"> <thead> <tr> <th></th> <th>03/04</th> <th>06/07</th> <th>09/10 (Target)</th> </tr> </thead> <tbody> <tr> <td>Males</td> <td>22.5%</td> <td>18.3%</td> <td>15%</td> </tr> <tr> <td>Females</td> <td>21.5%</td> <td>18.3%</td> <td>15%</td> </tr> </tbody> </table>		03/04	06/07	09/10 (Target)	Males	22.5%	18.3%	15%	Females	21.5%	18.3%	15%		Base 03/04	Target 09/10	Result 07/08								
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Females	21.5	<15%	18.3%																						
The latest results indicate positive momentum towards the DHB's long-term targets.																									

<sup>15</sup> Regular Activity is defined as at least 30 minutes of moderate physical activity on five or more days of the week.

<sup>16</sup> Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Māori or Pacific.

<b>Cancer</b>																	
<b>Long-Term Objective:</b> Improved health status for those at risk of developing cancer and appropriate and timely treatment for those that do develop cancer.																	
<b>Objective 2007/2008</b>	<b>Performance Measure</b>		<b>Base 06/07</b>	<b>Target 07/08</b>	<b>Result 07/08</b>												
Improve access to Radiation Therapy treatment – as a means of reducing the impact of Cancer. <sup>17</sup>	Patients waiting no more than eight weeks for Radiation Therapy treatment (excluding category D).	Total	94%	100%	93%												
		<p>The DHB has not met the target set for radiation therapy treatment waiting-times.</p> <p>Plans are in place to address issues of capacity which will help the DHB to meet its targets in the coming year, including increased shifts to address wait-lists and submission of a business case to replace the DHB's aged Linear Accelerator and seeking to add an additional fourth Linear Accelerator.</p>															
		<table border="1"> <thead> <tr> <th>Year</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>07/08</th> <th>07/08 (Target)</th> </tr> </thead> <tbody> <tr> <td>Waiting less than 8 weeks</td> <td>97%</td> <td>97%</td> <td>94%</td> <td>93%</td> <td>100%</td> </tr> </tbody> </table>				Year	04/05	05/06	06/07	07/08	07/08 (Target)	Waiting less than 8 weeks	97%	97%	94%	93%	100%
Year	04/05	05/06	06/07	07/08	07/08 (Target)												
Waiting less than 8 weeks	97%	97%	94%	93%	100%												

<sup>17</sup>The delay to radiotherapy is defined as the time between the specialist decision to commence radiotherapy and the start of treatment. The measure reflects categories A, B and C - category D patients have planned treatment (either as part of a trial or because of given protocols) and therefore may have to wait to start treatment these patients are not included in targets.

**Cardiovascular Disease (CVD)**

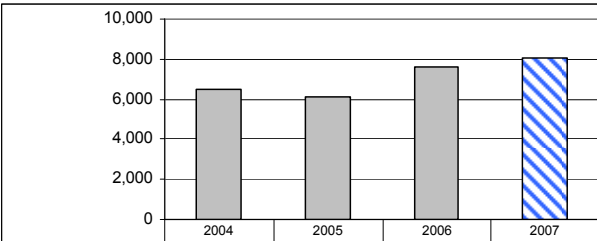
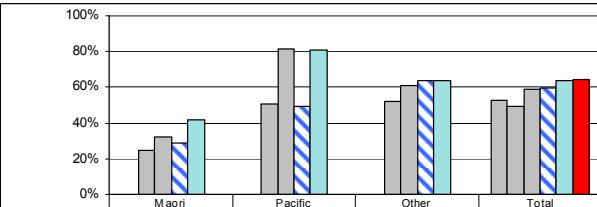
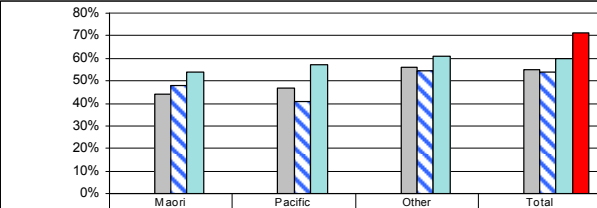
**Long-Term Objective:** Improved health status for those at risk of developing CVD and appropriate and timely treatment for those that do develop CVD.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08														
Maintain access for those requiring treatment - as a means of reducing the impact of CVD.	The Standardised Discharge Rates for Coronary Artery Bypass Grafts (CABGs) and for Angioplasties (APs).	CABGs	1.28	>1	1.14														
		APs	1.35	>1	1.42														
		<table border="1" data-bbox="422 772 1024 898"> <thead> <tr> <th></th> <th>CABGs</th> <th>Angioplasties</th> </tr> </thead> <tbody> <tr> <td>04/05</td> <td>123</td> <td>146</td> </tr> <tr> <td>05/06</td> <td>108</td> <td>137</td> </tr> <tr> <td>06/07</td> <td>128</td> <td>135</td> </tr> <tr> <td>07/08</td> <td>114</td> <td>142</td> </tr> <tr> <td>07/08 (Target)</td> <td>100</td> <td>100</td> </tr> </tbody> </table>		CABGs	Angioplasties	04/05	123	146	05/06	108	137	06/07	128	135	07/08	114	142	07/08 (Target)	100
	CABGs	Angioplasties																	
04/05	123	146																	
05/06	108	137																	
06/07	128	135																	
07/08	114	142																	
07/08 (Target)	100	100																	
Improve the quality of care after acute events – as a means of reducing the impact of CVD.  <i>These indicators are seen as good measures for this priority area, the aim for 2007/08 was to establish clear definitions and baselines for these indicators and to set targets for achievement in the 2008/09 SOI.</i>	The percentage of patients who suffered an acute event and attended outpatient cardiac rehabilitation.		Base 06/07	Target 07/08	Result 07/08														
	<table border="1" data-bbox="422 1198 1024 1240"> <thead> <tr> <th></th> <th>05/06</th> <th>06/07</th> <th>07/08</th> </tr> </thead> <tbody> <tr> <td>Cardiac</td> <td>2%</td> <td>27%</td> <td>34%</td> </tr> </tbody> </table>		05/06	06/07	07/08	Cardiac	2%	27%	34%	Total	27%	-	34%						
		05/06	06/07	07/08															
Cardiac	2%	27%	34%																
The percentage of patient who suffered an event and where admitted to an organised stroke service. <sup>18</sup>		Base 06/07	Target 07/08	Result 07/08															
<table border="1" data-bbox="422 1534 1024 1599"> <thead> <tr> <th></th> <th>05/06</th> <th>06/07</th> <th>07/08</th> </tr> </thead> <tbody> <tr> <td>Stroke</td> <td>6%</td> <td>68%</td> <td>65%</td> </tr> </tbody> </table>		05/06	06/07	07/08	Stroke	6%	68%	65%	Total	68%	-	65%							
	05/06	06/07	07/08																
Stroke	6%	68%	65%																

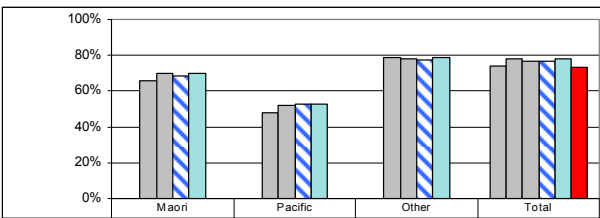
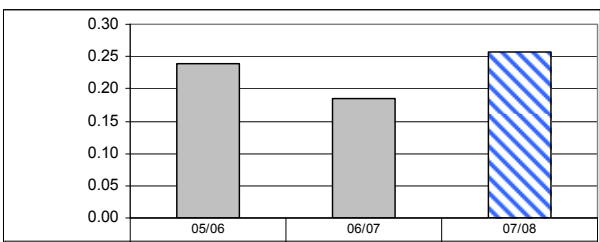
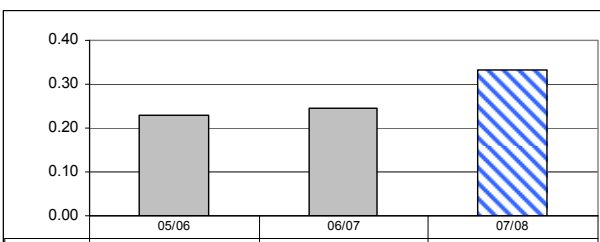
<sup>18</sup>Note that although the DHB is working on combining data from all its sites, at this time the Stroke Service results do not include Princess Margaret Hospital data.

**Diabetes**

**Long-Term Objective:** Improved health status for those at risk of developing diabetes and appropriate and timely treatment for those that do develop diabetes.<sup>19</sup>

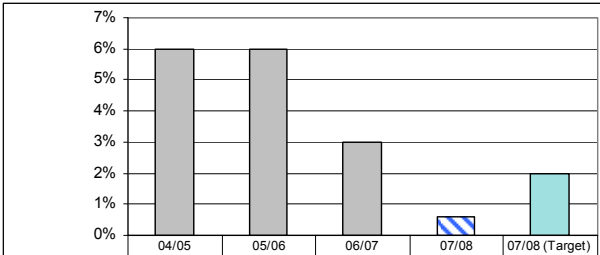
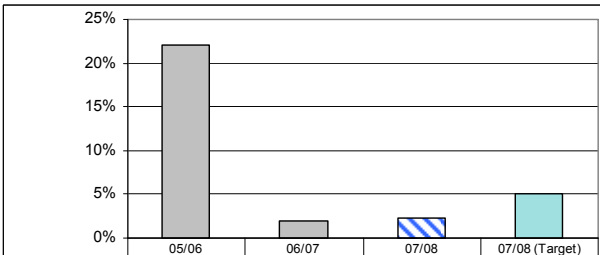
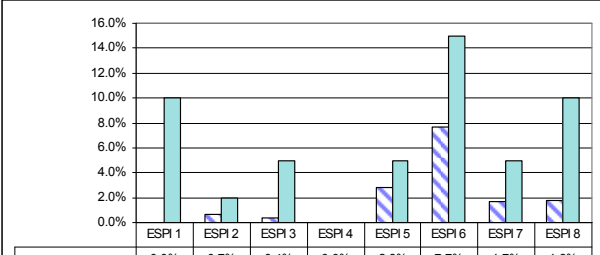
Objective 2007/2008	Performance Measure		Base 2006	Target 2007	Result 2007																																			
<p>Improve the detection and review of those at risk of Diabetes - as a means of reducing the impact of Diabetes.</p> <p><i>All those people with diabetes are entitled to a free Annual Diabetes Review or Annual Check. The number of reviews relative to the number of expected diabetics gives an indication of how well diabetes is being identified and diagnosed.</i></p>	<p>The number of Annual Reviews (for information only).</p>  <table border="1" data-bbox="424 705 1023 734"> <thead> <tr> <th>Year</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> </tr> </thead> <tbody> <tr> <td>Diabetes Annual Checks</td> <td>6,484</td> <td>6,142</td> <td>7,625</td> <td>8,032</td> </tr> </tbody> </table>	Year	2004	2005	2006	2007	Diabetes Annual Checks	6,484	6,142	7,625	8,032	<p>Total</p>	<p>7,625</p>	<p>-</p>	<p>8,032</p> <p>The total number of annual diabetes checks provided in Canterbury has increased by an additional 407 checks, against the previous year.</p>																									
	Year	2004	2005	2006	2007																																			
Diabetes Annual Checks	6,484	6,142	7,625	8,032																																				
<p>The percentage of expected diabetics who received their Annual Review.</p>  <table border="1" data-bbox="424 1019 1023 1137"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <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>6%</td> <td>59%</td> </tr> <tr> <td>2007</td> <td>29%</td> <td>49%</td> <td>64%</td> <td>60%</td> </tr> <tr> <td>2007 (Target)</td> <td>42%</td> <td>8%</td> <td>64%</td> <td>64%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>64%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	2004				53%	2005	25%	5%	52%	49%	2006	33%	82%	6%	59%	2007	29%	49%	64%	60%	2007 (Target)	42%	8%	64%	64%	National Average				64%		<p>Base 2006</p>	<p>Target 2007</p>	<p>Result 2007</p> <p>Māori 33% &gt;42% 29%</p> <p>Pacific 82% &gt;81% 49%</p> <p>Other 61% &gt;64% 64%</p> <p>Total 59% &gt;64% 60%</p> <p>The DHB has not met the targets for this indicator and the DHB's performance currently sits below the national average.</p> <p>The DHB has outlined several key areas of collaborative focus around diabetes in 2008/09, working with PHOs, hospital and specialist services and the Local Diabetes Team, to improve pathways and raise diabetes awareness in order to improve outcomes in the coming year.</p>	
	Maori	Pacific	Other	Total																																				
2004				53%																																				
2005	25%	5%	52%	49%																																				
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2007 (Target)	42%	8%	64%	64%																																				
National Average				64%																																				
	<p>The percentage of those having Annual Reviews who have also had a Retinal Screen (eye check) in the past two years.</p>  <table border="1" data-bbox="424 1523 1023 1641"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <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>2007</td> <td>48%</td> <td>4%</td> <td>55%</td> <td>54%</td> </tr> <tr> <td>2007 (Target)</td> <td>54%</td> <td>57%</td> <td>6%</td> <td>60%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>7%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	2004					2005					2006	44%	47%	56%	55%	2007	48%	4%	55%	54%	2007 (Target)	54%	57%	6%	60%	National Average				7%		<p>Base 2006</p>	<p>Target 2007</p>	<p>Result 2007</p> <p>Māori 44% 54% 48%</p> <p>Pacific 47% 57% 41%</p> <p>Other 56% 61% 55%</p> <p>Total 55% 60% 54%</p> <p>The DHB has not met the targets for this indicator and the DHB's performance sits below the national average.</p> <p>The DHB continues to be concerned with the reported level of retinal screens. The DHB's provider-arm delivered 5,156 screens in 2007/08 (10,107 biannually), yet the latest results shows only half of those people having Annual Reviews also had a bi annual retinal screen. This would indicate delivery of around 2,000 screens annually (less than a half of the actual volumes of screens completed).</p> <p>To move forward the DHB has been working with PHOs to identify the patients outside the two independent datasets, enabling PHOs to undertake further follow-up.</p>
	Maori	Pacific	Other	Total																																				
2004																																								
2005																																								
2006	44%	47%	56%	55%																																				
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National Average				7%																																				

<sup>19</sup>Diabetes Results are provided by individual PHOs to the Local Diabetes Team who then produce an Annual Report and provide aggregated results to the DHB – the results are provided by calendar year and relate to January – December 2007.

Objective 2007/2008	Performance Measure		Base 2006	Target 2007	Result 2007																															
Improve the management of Diabetes - as a means of reducing the impact and complications of Diabetes.	The percentage of people having Annual Reviews who have good diabetes control (HBA1c<=%).	Māori	70%	70%	69%																															
		Pacific	52%	53%	53%																															
		Other	78%	79%	78%																															
		Total	77%	78%	77%																															
	 <table border="1" data-bbox="422 560 1024 678"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>2004</td> <td></td> <td></td> <td></td> <td>74%</td> </tr> <tr> <td>2005</td> <td>66%</td> <td>48%</td> <td>79%</td> <td>78%</td> </tr> <tr> <td>2006</td> <td>70%</td> <td>52%</td> <td>78%</td> <td>77%</td> </tr> <tr> <td>2007</td> <td>69%</td> <td>53%</td> <td>78%</td> <td>77%</td> </tr> <tr> <td>2007 (Target)</td> <td>70%</td> <td>53%</td> <td>79%</td> <td>78%</td> </tr> <tr> <td>National Average</td> <td></td> <td></td> <td></td> <td>73%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	2004				74%	2005	66%	48%	79%	78%	2006	70%	52%	78%	77%	2007	69%	53%	78%	77%	2007 (Target)	70%	53%	79%	78%	National Average				73%
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2007 (Target)	70%	53%	79%	78%																																
National Average				73%																																
Reduce the complications of Diabetes – as a means of maximising health and wellbeing.	Rate of admissions due to short-term diabetes complications (per 1000 population, aged 19+).		Base 06/07	Target 07/08	Result 07/08																															
	 <table border="1" data-bbox="422 985 1024 1014"> <thead> <tr> <th></th> <th>05/06</th> <th>06/07</th> <th>07/08</th> </tr> </thead> <tbody> <tr> <td>Short-Term Admits</td> <td>0.24</td> <td>0.18</td> <td>0.26</td> </tr> </tbody> </table>		05/06	06/07	07/08	Short-Term Admits	0.24	0.18	0.26	<p>Total</p> <table border="1" data-bbox="1046 745 1524 779"> <thead> <tr> <th></th> <th>Base 06/07</th> <th>Target 07/08</th> <th>Result 07/08</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>0.18</td> <td>-</td> <td>0.26</td> </tr> </tbody> </table> <p>These are new indicators developed through the DHB's Quality and Patient Safety Council. While a positive addition to the set of measures for this priority area, no targets have been set as baseline data is still being confirmed.</p>		Base 06/07	Target 07/08	Result 07/08	Total	0.18	-	0.26																		
	05/06	06/07	07/08																																	
Short-Term Admits	0.24	0.18	0.26																																	
	Base 06/07	Target 07/08	Result 07/08																																	
Total	0.18	-	0.26																																	
	Rate of lower extremity amputations due to diabetes complications (per 1000 population, aged 19+).		Base 06/07	Target 07/08	Result 07/08																															
	 <table border="1" data-bbox="422 1321 1024 1344"> <thead> <tr> <th></th> <th>05/06</th> <th>06/07</th> <th>07/08</th> </tr> </thead> <tbody> <tr> <td>Amputations</td> <td>0.23</td> <td>0.25</td> <td>0.33</td> </tr> </tbody> </table>		05/06	06/07	07/08	Amputations	0.23	0.25	0.33	<p>Total</p> <table border="1" data-bbox="1046 1081 1524 1115"> <thead> <tr> <th></th> <th>Base 06/07</th> <th>Target 07/08</th> <th>Result 07/08</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>0.25</td> <td>-</td> <td>0.33</td> </tr> </tbody> </table> <p>As above.</p>		Base 06/07	Target 07/08	Result 07/08	Total	0.25	-	0.33																		
	05/06	06/07	07/08																																	
Amputations	0.23	0.25	0.33																																	
	Base 06/07	Target 07/08	Result 07/08																																	
Total	0.25	-	0.33																																	

**Other Priority Areas - Improved Service Delivery**

**Long-Term Objective:** Improved health status for Canterbury residents through the provision of services in a timely manner, within available resources, and for those with the greatest level of need.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08																										
Improve delivery of Elective Services through continued compliance with the Ministry's eight ESPIs - as a means of improving expectation, clarity and access issues around treatment and services.	Compliance with ESPI 2 – The percentage of patients waiting longer than six months for their FSA. <sup>20</sup>	Total	3%	<2%	0.6%																										
	 <table border="1" data-bbox="422 750 1024 779"> <tr> <td>ESPI 2 Compliance</td> <td>04/05</td> <td>05/06</td> <td>06/07</td> <td>07/08</td> <td>07/08 (Target)</td> </tr> <tr> <td></td> <td>6%</td> <td>6%</td> <td>3%</td> <td>0.6%</td> <td>2%</td> </tr> </table>	ESPI 2 Compliance	04/05	05/06	06/07	07/08	07/08 (Target)		6%	6%	3%	0.6%	2%	The DHB has achieved the target set for this indicator and has significantly exceeded the performance of previous years.																	
	ESPI 2 Compliance	04/05	05/06	06/07	07/08	07/08 (Target)																									
	6%	6%	3%	0.6%	2%																										
Compliance with ESPI 5 – The percentage of patients given a commitment but not treated within six months.	Total	2%	<5%	2.3%																											
 <table border="1" data-bbox="422 1108 1024 1137"> <tr> <td>ESPI 5 Compliance</td> <td>05/06</td> <td>06/07</td> <td>07/08</td> <td>07/08 (Target)</td> </tr> <tr> <td></td> <td>22%</td> <td>2.00%</td> <td>2.3%</td> <td>5%</td> </tr> </table>	ESPI 5 Compliance	05/06	06/07	07/08	07/08 (Target)		22%	2.00%	2.3%	5%	The DHB has achieved the target set for this indicator and continues to meet its commitment to patients.																				
ESPI 5 Compliance	05/06	06/07	07/08	07/08 (Target)																											
	22%	2.00%	2.3%	5%																											
Monthly compliance with all eight of the Ministry's ESPIs.	Total	100%	100%	100%																											
 <table border="1" data-bbox="422 1444 1024 1498"> <tr> <td></td> <td>ESPI 1</td> <td>ESPI 2</td> <td>ESPI 3</td> <td>ESPI 4</td> <td>ESPI 5</td> <td>ESPI 6</td> <td>ESPI 7</td> <td>ESPI 8</td> </tr> <tr> <td>June 2008</td> <td>0.0%</td> <td>0.7%</td> <td>0.4%</td> <td>0.0%</td> <td>2.8%</td> <td>7.7%</td> <td>1.7%</td> <td>1.8%</td> </tr> <tr> <td>Target (less than)</td> <td>10%</td> <td>2%</td> <td>5%</td> <td>0%</td> <td>5%</td> <td>15%</td> <td>5%</td> <td>10%</td> </tr> </table>		ESPI 1	ESPI 2	ESPI 3	ESPI 4	ESPI 5	ESPI 6	ESPI 7	ESPI 8	June 2008	0.0%	0.7%	0.4%	0.0%	2.8%	7.7%	1.7%	1.8%	Target (less than)	10%	2%	5%	0%	5%	15%	5%	10%	The DHB continues to maintain compliance with the Ministry's ESPIs.			
	ESPI 1	ESPI 2	ESPI 3	ESPI 4	ESPI 5	ESPI 6	ESPI 7	ESPI 8																							
June 2008	0.0%	0.7%	0.4%	0.0%	2.8%	7.7%	1.7%	1.8%																							
Target (less than)	10%	2%	5%	0%	5%	15%	5%	10%																							

<sup>20</sup> FSA is the first appointment a patient has with a specialist following referral.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08																																	
Improve the delivery of Mental Health Services – as a means of improving access to treatment and support services for those with severe mental illness.	The percentage within each age group, accessing mental health treatment and support services. <sup>21</sup>		<b>Māori</b>																																			
		0-19	1.4%	2%	1.6%																																	
		20-64	3.5%	2.5%	3.5%																																	
		<b>Other</b>																																				
		0-19	2.0%	2%	1.9%																																	
		20-64	2.3%	2.5%	2.3%																																	
		<b>Total</b>																																				
		0-19	1.9%	2%	1.8%																																	
		20-64	2.4%	2.5%	2.4%																																	
		<table border="1"> <thead> <tr> <th></th> <th>0-19 M</th> <th>20-64 M</th> <th>0-19 O</th> <th>20-64 O</th> <th>0-19 T</th> <th>20-64 T</th> </tr> </thead> <tbody> <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>07/08</td> <td>16%</td> <td>3.5%</td> <td>1.9%</td> <td>2.3%</td> <td>18%</td> <td>2.4%</td> </tr> <tr> <td>07/08 (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> </tbody> </table>		0-19 M	20-64 M	0-19 O	20-64 O	0-19 T	20-64 T	05/06	0.4%	13%	0.6%	10%	0.6%	10%	06/07	14%	3.5%	2.0%	2.3%	19%	2.4%	07/08	16%	3.5%	1.9%	2.3%	18%	2.4%	07/08 (Target)	2.0%	2.5%	2.0%	2.5%	2.0%	2.5%	The data for this indicator is collected through the Mental Health Information National Collection (MHINC) database that covers DHB's hospital and specialist services and a limited number of community providers. The activity of many other community providers, who work with high needs and at risk groups, is not fed into this database and therefore not reflected under this measure. While the DHB has set targets to increase access levels, the current focus is on flexible service delivery and increased access to community based services - outside those covered by this indicator.
			0-19 M	20-64 M	0-19 O	20-64 O	0-19 T	20-64 T																														
		05/06	0.4%	13%	0.6%	10%	0.6%	10%																														
		06/07	14%	3.5%	2.0%	2.3%	19%	2.4%																														
		07/08	16%	3.5%	1.9%	2.3%	18%	2.4%																														
		07/08 (Target)	2.0%	2.5%	2.0%	2.5%	2.0%	2.5%																														
Although not all access rate targets have been met, the rates are positive considering the focus on services outside those covered by the indicator.																																						

<sup>21</sup> The data for this indicator is collected through the MHINC database and results lag by three months, the results are the latest available and are for the year up to March 2008.

**Improved Efficiency, Effectiveness and Quality**

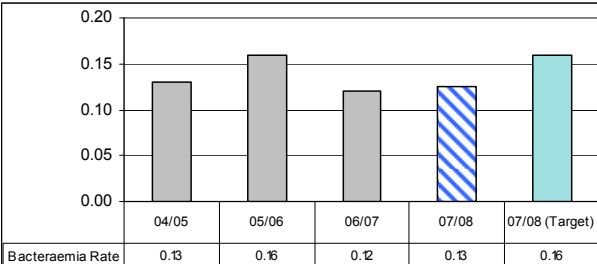
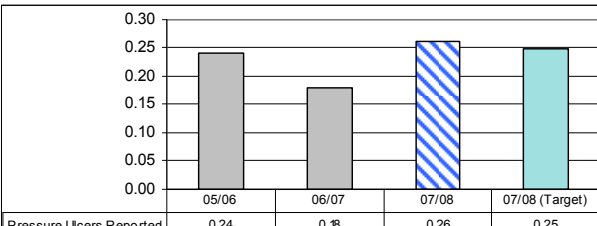
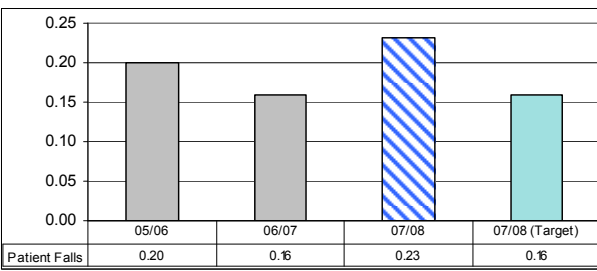
**Long-Term Objective:** Provision of efficient, effective and quality health services and optimal use of available resources to maximise the health status of Canterbury residents.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08																		
Initiating Systems and Processes to Ensure Quality Service Provision – as a means of maintaining patient satisfaction with services.	The percentage of Overall Inpatient Satisfaction. The percentage of Overall Outpatient Satisfaction.	Total	89.4%	>90%	89.2%																		
		Total	90.1%	>90%	91.0%																		
		The DHB has achieved the target set for outpatient satisfaction, and has delivered only 0.8% below target for inpatient satisfaction. Performance with respect to overall patient satisfaction at a national level has remained high and the most recent national data ranks the Canterbury DHB 6 <sup>th</sup> out of all DHBs for overall patient satisfaction, a positive result.																					
		<table border="1"> <thead> <tr> <th></th> <th>Inpatient</th> <th>Outpatient</th> </tr> </thead> <tbody> <tr> <td>04/05</td> <td>90.0%</td> <td>90.0%</td> </tr> <tr> <td>05/06</td> <td>88.5%</td> <td>91.1%</td> </tr> <tr> <td>06/07</td> <td>89.4%</td> <td>90.1%</td> </tr> <tr> <td>07/08</td> <td>89.2%</td> <td>91.0%</td> </tr> <tr> <td>07/08 (Target)</td> <td>90.0%</td> <td>90.0%</td> </tr> </tbody> </table>			Inpatient	Outpatient	04/05	90.0%	90.0%	05/06	88.5%	91.1%	06/07	89.4%	90.1%	07/08	89.2%	91.0%	07/08 (Target)	90.0%	90.0%		
	Inpatient	Outpatient																					
04/05	90.0%	90.0%																					
05/06	88.5%	91.1%																					
06/07	89.4%	90.1%																					
07/08	89.2%	91.0%																					
07/08 (Target)	90.0%	90.0%																					

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08												
Maintain Performance as a Good Employer – as a means of establishing a healthy working environment and fostering positive partnerships between staff and management.	The DHB's Sick Leave Rate.	Total	3.2%	<3.2%	3.2%												
		The DHB has maintained its sick leave rate.															
		<table border="1"> <thead> <tr> <th></th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>07/08</th> <th>07/08 (Target)</th> </tr> </thead> <tbody> <tr> <td>Sick Leave Rate</td> <td>3.2%</td> <td>2.8%</td> <td>3.2%</td> <td>3.2%</td> <td>3.2%</td> </tr> </tbody> </table>			04/05	05/06	06/07	07/08	07/08 (Target)	Sick Leave Rate	3.2%	2.8%	3.2%	3.2%	3.2%		
	04/05	05/06	06/07	07/08	07/08 (Target)												
Sick Leave Rate	3.2%	2.8%	3.2%	3.2%	3.2%												

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08												
	Workplace Injuries (per million hours).	Total	7.6	<10	7.3												
		The DHB has achieved the target set and improved performance against the previous year.															
		<table border="1"> <thead> <tr> <th></th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>07/08</th> <th>07/08 (Target)</th> </tr> </thead> <tbody> <tr> <td>Work Place Injuries</td> <td>11.2</td> <td>6.9</td> <td>7.6</td> <td>7.3</td> <td>10.0</td> </tr> </tbody> </table>			04/05	05/06	06/07	07/08	07/08 (Target)	Work Place Injuries	11.2	6.9	7.6	7.3	10.0		
	04/05	05/06	06/07	07/08	07/08 (Target)												
Work Place Injuries	11.2	6.9	7.6	7.3	10.0												

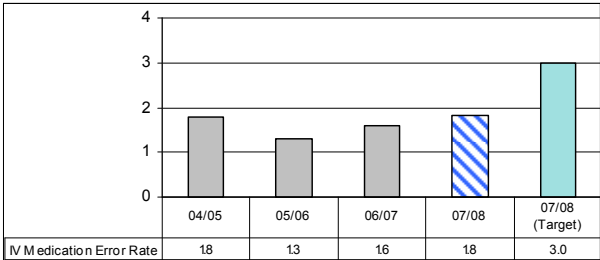
Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08												
	The percentage of Staff Turnover.	Total	9.4%	<13%	10.5%												
		The DHB has achieved the target set.															
		<table border="1"> <thead> <tr> <th></th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>07/08</th> <th>07/08 (Target)</th> </tr> </thead> <tbody> <tr> <td>Staff Turnover</td> <td>14.0%</td> <td>12.4%</td> <td>9.4%</td> <td>10.5%</td> <td>13.0%</td> </tr> </tbody> </table>			04/05	05/06	06/07	07/08	07/08 (Target)	Staff Turnover	14.0%	12.4%	9.4%	10.5%	13.0%		
	04/05	05/06	06/07	07/08	07/08 (Target)												
Staff Turnover	14.0%	12.4%	9.4%	10.5%	13.0%												

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08						
Maintain Appropriate Levels of Clinical Quality – as a means to maintain patient safety and quality within our Hospital and Specialist Services.	Hospital Acquired Bacteraemia rate per 100 inpatients. <sup>22</sup>  <table border="1" data-bbox="424 562 1023 584"> <tr> <td>Bacteraemia Rate</td> <td>0.13</td> <td>0.16</td> <td>0.12</td> <td>0.13</td> <td>0.16</td> </tr> </table>	Bacteraemia Rate	0.13	0.16	0.12	0.13	0.16	Total	0.12	=<0.16	0.13
	Bacteraemia Rate	0.13	0.16	0.12	0.13	0.16					
	The DHB has achieved the target for this indicator.	Pressure Ulcers rate per 1000 inpatient days.  <table border="1" data-bbox="424 842 1023 864"> <tr> <td>Pressure Ulcers Reported</td> <td>0.24</td> <td>0.18</td> <td>0.26</td> <td>0.25</td> </tr> </table>	Pressure Ulcers Reported	0.24	0.18	0.26	0.25	Total	0.18	<0.25	0.26
Pressure Ulcers Reported	0.24	0.18	0.26	0.25							
The DHB has missed this target only by 0.01. Given the education programmes occurring around pressure ulcers and skin integrity, the increase in the rate is not surprising. An ongoing increase in the number of pressure ulcers is expected as the education programmes continue, reflecting improved reporting and providing a more accurate picture of pressure ulcer occurrence. Both are seen as positive quality outcomes by the DHB.	Patient Fall rate (falls causing moderate or serious injury) per 1000 inpatient day equivalents. <sup>23 24</sup>  <table border="1" data-bbox="424 1267 1023 1290"> <tr> <td>Patient Falls</td> <td>0.20</td> <td>0.16</td> <td>0.23</td> <td>0.16</td> </tr> </table>	Patient Falls	0.20	0.16	0.23	0.16	Total	0.16	=<0.16	0.23	
Patient Falls	0.20	0.16	0.23	0.16							
The DHB has missed this target and overall there has been an unexpected increase in the serious and moderate falls rate. A multidisciplinary falls prevention review was undertaken and initiatives implemented include; modification of the falls risk assessment tool, introduction of an environmental audit tool, development of education pamphlets and a falls prevention self directed leaning package for staff, development of information leaflets for patients, and sourcing of non-slip footwear. There has been a decrease in the patient falls rate in the later part of the year, which may be a direct result of the work being undertaken.											

<sup>22</sup> Excludes DHB's Mental Health Division.

<sup>23</sup> Past analysis of total falls has included many minor events that cause little or no harm; the CDHB includes only those falls associated with moderate or serious injury to provide a direct measure of injury caused.

<sup>24</sup> Inpatient Day Equivalents reflect the total inpatient days plus half the total day patient attendances.

Objective 2007/2008	Performance Measure		Base 06/07	Target 07/08	Result 07/08												
	IV Medication Error rate per 1000 inpatient day equivalents. <sup>25</sup>  <table border="1" data-bbox="422 548 1024 607"> <thead> <tr> <th>IV Medication Error Rate</th> <th>04/05</th> <th>05/06</th> <th>06/07</th> <th>07/08</th> <th>07/08 (Target)</th> </tr> </thead> <tbody> <tr> <td></td> <td>18</td> <td>13</td> <td>16</td> <td>18</td> <td>3.0</td> </tr> </tbody> </table>	IV Medication Error Rate	04/05	05/06	06/07	07/08	07/08 (Target)		18	13	16	18	3.0	Total	1.6	>3	1.8
IV Medication Error Rate	04/05	05/06	06/07	07/08	07/08 (Target)												
	18	13	16	18	3.0												
		<p>The DHB has set a high target in response to its commitment to increase reporting of IV and medication errors and this target has not been met, it is positive to see an increase in the reporting rate against the previous year.</p> <p>Ongoing initiatives include: introduction of an 0800 reporting line, educating staff through orientation and quality training programmes and the introduction of key patient safety policies such as the No-Blame Incident/Accident Policy and Culture of Patient Safety Policy. The aim of these initiatives is to help reinforce the benefit of staff reporting and to pass on important safety messages.</p>															

<sup>25</sup>The targets are set to increase the rate of reported errors, in line with DHB policy of emphasising the responsibility of staff to report error - previously set at 6 or more the target has been adjusted to reflect a more achievable increase in reporting levels

## Summary of Revenues and Expenses by Output Class

	Funding \$'000	Governance & Funding Admin \$'000	Provider \$'000	In House Elimination \$'000	Total DHB \$'000
<b><u>ACTUAL 07/08</u></b>					
<b>Revenue</b>					
MoH revenue	1,071,753	3,596	633,653	(592,329)	1,116,673
Patient Related Revenue			36,545		36,545
Other			27,830		27,830
Total Revenue	<b>1,071,753</b>	<b>3,596</b>	<b>698,028</b>	<b>(592,329)</b>	<b>1,181,048</b>
<b>Expenditure</b>					
Personnel		2,860	469,585		472,445
Depreciation		15	47,793		47,808
Interest			5,584		5,584
Capital Charge			20,617		20,617
Other	1,072,718	616	170,355	(592,329)	651,360
Total Expenditure	<b>1,072,718</b>	<b>3,491</b>	<b>713,934</b>	<b>(592,329)</b>	<b>1,197,814</b>
<b>Net Surplus/(Deficit)</b>	<b>(965)</b>	<b>105</b>	<b>(15,906)</b>	<b>-</b>	<b>(16,766)</b>
<b><u>BUDGET 07/08</u></b>					
<b>Revenue</b>					
MoH revenue	1,056,985	3,751	630,611	(594,671)	1,096,676
Patient Related Revenue			33,536		33,536
Other			26,259		26,259
Total Revenue	<b>1,056,985</b>	<b>3,751</b>	<b>690,406</b>	<b>(594,671)</b>	<b>1,156,471</b>
<b>Expenditure</b>					
Personnel		2,507	442,438		444,945
Depreciation		50	50,355		50,405
Interest			5,932		5,932
Capital Charge			21,697		21,697
Other	1,056,985	1,194	169,984	(594,671)	633,492
Total Expenditure	<b>1,056,985</b>	<b>3,751</b>	<b>690,406</b>	<b>(594,671)</b>	<b>1,156,471</b>
<b>Net Surplus/(Deficit)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b><u>VARIANCE TO 07/08 BUDGET</u></b>					
<b>Revenue</b>					
MoH revenue	14,768	(155)	3,042	2,342	19,997
Patient Related Revenue	-	-	3,009	-	3,009
Other	-	-	1,571	-	1,571
Total Revenue	<b>14,768</b>	<b>(155)</b>	<b>7,622</b>	<b>2,342</b>	<b>24,577</b>
<b>Expenditure</b>					
Personnel	-	353	27,147	-	27,500
Depreciation	-	(35)	(2,562)	-	(2,597)
Interest	-	-	(348)	-	(348)
Capital Charge	-	-	(1,080)	-	(1,080)
Other	15,733	(578)	371	2,342	17,868
Total Expenditure	<b>15,733</b>	<b>(260)</b>	<b>23,528</b>	<b>2,342</b>	<b>41,343</b>
<b>Net Surplus/(Deficit)</b>	<b>(965)</b>	<b>105</b>	<b>(15,906)</b>	<b>-</b>	<b>(16,766)</b>

## Glossary

	Access	Ability of people to reach or use health care services. Barriers to access can be: (1) a persons locality, income or knowledge of services available; or (2) the acceptability or availability of existing services
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
	Ambulatory Sensitive Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
	Blueprint Funding	Blueprint funding is allocated by Government to work to ensure the development of mental health services for the 3% of the total NZ population with moderate to severe mental illness. Service development is based on the service levels set out in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).
CCC	Christchurch City Council	Local Council in the Christchurch region.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
ESPIs	Elective Services Patient flow Indicators	The ESPIs have been developed by the Ministry to assess whether or not DHBs are on the right track with the Government policies on elective services.
FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
FTE	Full Time Equivalent	Means an Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin.	The level of HbA1c reflects the average blood glucose level over the past 3 months.
HEAL	Healthy Eating Active Living 'Action Plan'	This Plan provides us with the platform to implement the national HEHA Strategy at a local level.
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other or others with respects to an issue over which the organisations have concurrent jurisdiction.
MHINC	Mental Health Information National Collection	The national database of mental health information held by the NZ Health Information Service (NZHIS) to support policy formation, monitoring and research.
	Morbidity	Illness, sickness.
	Mortality	Death.
NIR	National Immunisation Register	The NIR is a computerised information system that has been developed to hold immunisation details of NZ children and assist to improve immunisation rates.
PHO	Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Risk Factor	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.
	Treaty of Waitangi	NZ's founding document. It establishes the relationship between the Crown and Māori as tangata whenua and requires both the Crown and Māori to act reasonably toward each other and with utmost good faith
YTD	Year to Date	The 12 month period immediately prior to the date given.

**TO THE READERS OF**  
**CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S**  
**FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE**  
**FOR THE YEAR ENDED 30 JUNE 2008**

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, A P Burns, using the staff and resources of Audit New Zealand, to carry out the audit on his behalf. The audit covers the financial statements and statement of service performance of the Health Board and group for the year ended 30 June 2008.

**Unqualified Opinion**

In our opinion:

- The financial statements of the Health Board and group on pages 24 to 57:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health Board and group's financial position as at 30 June 2008; and
    - the results of operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board and group on pages 58 to 79:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects for each class of outputs:
    - its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 10 October 2008, and is the date at which our opinion is expressed.

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

**Basis of Opinion**

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

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

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

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

Audit procedures generally include:

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

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

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

### **Responsibilities of the Board and the Auditor**

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board and group as at 30 June 2008 and the results of operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board and group's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

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

## Independence

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

In addition to the audit we have carried out one assignment during the reporting period in the area of an independent review of aspects of the Health Board's supply chain enhancement initiative. This assignment is compatible with those independence requirements. Other than the audit and this assignment, we have no relationship with or interests in the Health Board or any of its subsidiaries.



A P Burns  
Audit New Zealand  
On behalf of the Auditor-General  
Christchurch, New Zealand

### **Matters Relating to the Electronic Presentation of the Audited Financial Statements and Statement of Service Performance**

This audit report relates to the financial statements and statement of service performance of Canterbury District Health Board (the Health Board) for the year ended 30 June 2008 included on the Health Board's website. The Canterbury District Health Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 10 October 2008 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

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