Canterbury District Health Board

Report for the Year Ended 30 June 2009

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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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

Chief Executive
David Meates

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

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.

REPORT FROM THE CHAIR AND CHIEF EXECUTIVE

We are pleased to present our Annual Report for the 2008/09 financial year. This is our main document of accountability to the people of Canterbury and describes what we have been doing in the last year to improve the health and well being of the people in our region.

Significant changes in the world economy have impacted on our organisation as they have done on all sectors of society, making us think harder about how we provide a high level of healthcare to our community within tight fiscal constraints.

After an initial potential deficit of $20 million, this DHB worked particularly hard to end the year with a group deficit of $12.361 million. This represented major progress towards living within our means long term. At the same time important gains were made in the health care we provided and the health outcomes for Canterbury people.

At the heart of many of our improvements has been a new way of looking at the way we provide services across the entire Canterbury health system from primary care to tertiary level hospital facilities. This is encompassed in our Vision 2020 that will shortly be communicated to everyone in the region.

This vision charts a course that will require Canterbury DHB to work with other DHBs, the Ministry of Health, Primary Health Organisations, local health and disability providers, community and primary organisations and other government agencies to re-orient the Canterbury Health system over the next three years.

The 'Improving the Patient Journey' initiative that has been part of our DHB since 2004 epitomises what Canterbury DHB is trying to achieve. 'Improving the Patient Journey' focuses on the patient as the person whose time is most valuable. Through this endeavour, variability in the system is being removed to eliminate delays or blocks to the delivery of effective care. At the same time as meeting the needs of patients, a more efficient and effective way of working is developed. One of our big successes for our patients in the last year has been the transformation of our Radiology Department from ordinary to internationally leading edge. This was through a collaborative effort between Canterbury DHB's Radiology Department and Business Development Unit that focussed on the patient journey through radiology.

Canterbury is also one of seven DHBs working together towards an all-encompassing health record for individuals. At present, different health professionals hold different records on the same person. The proposed system will be password protected with the individual able to access it, keep it updated and control who sees what parts of the record. Our Chief Medical Officer Dr Nigel Millar says this is an essential step in transforming the health system.

We are also working to assist Canterbury Maori to have more of a voice in health. In May the first official meeting between Manawhenua Ki Waitaha and Canterbury DHB since the signing of our Memorandum of Understanding was held. It was a significant event and presented a number of opportunities to grow our relationship for the future.

'The Canterbury Initiative' is another development that has emerged in the last year and is promoting leadership and engagement of clinicians from primary and secondary sectors in actively transforming the way services are delivered to patients. It is forging a way for

Primary and Secondary Care and a relationship-focused Planning and Funding team to re-orientate the health system.

We are also looking within our organisation for ways to improve. By working together to get the basics right, we are making it better. The EQuIP4 quality improvement programme is an example of getting the basics right. It challenges us to prove how we evaluate and subsequently improve the way Canterbury DHB delivers its core business – looking after consumers/patients. Accreditation and certification is being undertaken across all aspects of the DHB.

Our Xcelr[8] programme provides a set of tools for staff to help them see opportunities and develop a sense of where they can make an impact as leaders. The purpose of the programme is to empower clinical leaders to make positive effective changes across the spectrum of care for their patients. It does not seek to alter clinical practices but does encourage change in how services are delivered and administered. Having informed and focused clinical leadership is critical, and we believe that in our DHB we have some of the best leadership potential in Australasia.

Linked to our introspective analysis is our goal to improve the way we do things. Substantial improvements have been made within our Emergency Department which has risen to the challenge of meeting the six hour deadline for patients to be seen and treated. Canterbury DHB has continued to build on the success of a range of initiatives including our Acute Medical Assessment Unit (AMAU), Surgical Assessment and Review Area (SARA) and community-based acute demand management service. As a result, on average over the last six months 90% of people waited less than six hours in the Christchurch Hospital ED. Seventy two per cent waited less than four.

Other patient flow initiatives at the hospital have included the introduction of a meet and greet service for patients, involving community groups; the implementation of two ward rounds a day by general medical clinicians; extra acute theatres and changes to the surgical team's roster.

An additional acute theatre opened at Christchurch Hospital in early February. The new theatre was opened to reduce the wait times for patients requiring acute general, plastic or orthopaedic surgery. It is our goal that no patient should wait longer than 24 hours for acute surgery. Patients receiving operations in the new theatre are also allocated to special acute streams to help make theatre teams more efficient.

Our annual Quality Improvement and Innovation Awards continue to highlight and reward other successful programmes. A project streamlining the patient journey through our health services for hip and knee surgery was the Supreme Winner at the 2008 Canterbury DHB Quality Improvement and Innovation Awards. The project attracted considerable interest nationally and is fast evolving into a world leading service.

Improvements have also led to a dramatic reduction in time from referral to treatment for plastic surgery patients. The Burwood Outpatient Unit was set up in August 2008 to reduce the time it takes patients with skin lesions to progress from referral to treatment. Instead of a patient with a skin lesion visiting their GP, being referred to a consultant and then having to return for treatment, the unit operates on a "see and treat basis". The referral from the GP is triaged by a consultant plastic surgeon. Once the triage process has been completed

the patient is either referred back to the GP for the lesion to be removed by a GP or the patient will be seen at the Burwood Outpatient Unit. Key benefits from this initiative are the reduction of turnaround time from identification to treatment for patients being reduced from four to five months to same day in most cases and a reduction in waiting lists for plastic surgery by two-thirds. The service is on target to treat 2,300 patients in its first year which is a significant improvement.

The level of support provided to older people wishing to stay in their own homes has increased. We have met with aged residential care providers from across the region to explain our plans to offer increased support to help older people to stay in their homes. Residential care will continue to be an important option for older people who are unable to remain at home, but we are planning to focus more closely on provision of home-based support services for older people to ensure they have the opportunity to remain at home until they need residential care. All older people will be regularly reviewed to make sure services are tailored and adjusted to meet their needs. As the average age of the Canterbury population continues to increase it will be important that we ensure the right mix of services are in place to support older people.

There is no doubt, however, that we still face some very real challenges.

These include:

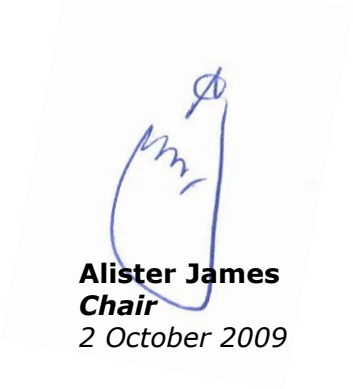
- *Cancer waiting times*. Although we have exceeded our 2008/09 target of 81% of patients waiting less than six weeks from the decision to treat to the start of treatment (we in fact have reached 91%) we are still striving for a 100% rate.
- *Oral health*. Despite our best efforts we have poor oral health status due to the lack of fluoridation in Canterbury. Canterbury DHB will spend $13.3 million over the next three years upgrading its Community Dental Service for children at primary and intermediate school. The upgrade will see most of the region's 120 school dental clinics replaced by 12 'multi-chair' community clinics, supported by 18 campervan-style mobile clinics. We will continue to work towards our target of 85% of adolescents accessing oral health services.
- *Improving Diabetes Services*. Canterbury is below the national average in terms of the number of annual diabetes checks being delivered for our population. Results from a consumer study undertaken over the past year will help us to better understand perceived barriers to attending the free annual checks.

As we look ahead, there are ongoing efforts to make our health services more efficient and effective and reduce waste in the system. We are always looking at ways to save money across the organisation. This includes tightening up delegations, which allows us to more easily determine who is spending what within the organisation, and making changes to the way we order supplies, including stationery, household goods needed in hospital wards to treatment-related goods, such as drugs and radiology film.

In order to discover other ways of developing a more sustainable and effective health service we have embarked on a major planning exercise, looking at all of our facilities and land to determine what needs to be done for the future. A Health Services Plan, which involved community and key stakeholder consultation in 2007, has been made to inform the development of Canterbury health services through to 2020 and work is now underway to

develop a Facilities Master Plan to identify physical infrastructure needs for the next 50 years.

Given our financial constraints we know we won't be able to tackle everything we want to achieve at once but we need a robust plan and timeline so that we know we can meet the future health needs of Canterbury people. We are committed to delivering effective health services while living within our financial means and are looking at all aspects of our business to determine how we can be more cost effective and efficient, while working towards the health goals for our region.



Alister James
Chair
2 October 2009

David Meates
Chief Executive
2 October 2009

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 36 years experience. She has served on the Board for eight years and is committed to rural health issues and delivery.
Andrew Dickerson	Andrew has 20 years experience in the health and disability sector and was a former Chief Executive of Age Concern Canterbury. He would like to see improved access to elective surgery and 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 19 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 Canterbury DHB Board for seven years and has been Christchurch City Missioner. He is committed to more accessible and affordable services for all. David is Chair of the Canterbury DHB Hospital Advisory Committee, a member of the Quality, Finance, Audit & Risk Committee and Chair of Brackenridge Estate Limited.
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 an advisor to Minister 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 over 31 years. He is of Ngai Tahu descent and is 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 Canterbury DHB's Quality, Finance, Audit & Risk Committee and is a Chartered Accountant. Formerly a partner in Deloitte he now acts in a consultancy role. He has experience in the aged care sector and has financial accounting and auditing experience.

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2009.

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, the Canterbury DHB Group recorded a net deficit of $12.361 million against an original budgeted breakeven position. In November 2008 the 2008/09 operating target was revised to a deficit of $13 million as agreed with the incoming Minister of Health. (2007/08 result was a net deficit of $16.766 million).

BOARD FEES

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

	Board Fees Year ended 30/06/09 $'000	Committee Fees Year ended 30/06/09 $'000
Alister James	52	3
Olive Webb	32	5
Jo Kane	26	4
David Morrell	26	5
Anna Crighton	26	2
Andrew Dickerson	26	7
Chris Ryan	26	5
Eleanor Carter	26	2
Peter Ballantyne	26	6
Matea Gillies	26	4
Elizabeth Cunningham	26	6
David Kerr	-	2
Trevor Read	-	2
William Tate	-	6
Margaret Schwass	-	2
Wendy Dallas-Katoa	-	2
Teresa Chalecki	-	2
Richard Davison	-	2
Bob Lineham	-	3
Stephen Lowndes	-	2
	318	**72**

Total fees paid for the year were $390,000 (2007/08 - $367,000). The limit of fees authorised for the year ended 30 June 2009 was $395,375 (2007/08 - $392,785).

DIRECTOR FEES

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

	Year Ended 30/06/09 $'000	Year Ended 30/06/08 $'000
David Morrell	10	10
Graham Heenan	13	13
	23	**23**

BOARD AND COMMITTEE MEMBERS' INTEREST

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

CANTERBURY DHB

Alister James	Barrister and Youth Advocate - acts 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 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 Canterbury DHB.
	Holly Lea Village Ltd - Director – this company is a fully owned subsidiary of the McLean Institute and is a provider of residential aged care services.
	Spouse, Sue James is an employee with the Community and Public Health division of Canterbury DHB.
Olive Webb	Health Practitioners Disciplinary Tribunal – Member - potentially a member of a tribunal panel when a clinical psychologist is before the panel. The tribunal has procedures for dealing with potential conflicts of interests for tribunal members. Should an issue of conflict arise, this will be disclosed at the time.
	Institute of Applied Human Services Limited (IAHS) – Chairperson - provides individual consultation, service advice and workforce training in the intellectual disability area on contract to various individuals and providers in Australasia. New Zealand providers of intellectual disability services are usually funded by the Ministry of Health. IAHS has no contracts with Canterbury DHB.

	Special Olympics New Zealand – Trustee - as well as providing sporting events, also provides health screening and assistance. Access Home Health Limited – Director - provides home based healthcare and personal support on contract to the Accident Compensation Corporation, Ministry of Health and several DHBs, including Canterbury DHB. IDEA Services - assist in introducing government funded annual health checks for people with intellectual disabilities, promoting this with GPs and other primary health care professionals and working to achieve funding for this.
Andrew Dickerson	Health Care of the Elderly Education Trust – Chair - promotes and supports teaching and research in the area of care of older people. Recipients of financial assistance for research, education or training could include employees of Canterbury DHB. 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 Canterbury DHB. NZ Historic Places Trust – Member - the Trust promotes the identification, preservation and conservation of the historical & cultural heritage of New Zealand. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance. No conflicts of interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time. ▪ NZ Gerontology Association – Member - professional association that promotes the interests of older people and an understanding of ageing. ▪ Hope Foundation for Research on Ageing – Member - promotes research on New Zealand's ageing population and its implications for the future. ▪ Osteoporosis (Canterbury) Inc. – Member - provides support and advice to people with osteoporosis. ▪ Neurological Foundation of New Zealand Inc. – Member - provides support and information to people with diseases and disorders of the brain and nervous system. ▪ Abbeyfield New Zealand Inc. – Member - promotes and establishes community housing for lonely and socially isolated older people using the Abbeyfield model. ▪ Private Consultant - specialising in management consultancy services (including communication management, communication strategy and marketing) to the not for profit sector, professional associations, social service and public sector agencies. ▪ Masters Degree dissertation - undertaking the following Masters Degree dissertation: 'The Extent to Which Communication Failures Contribute to Sentinel Events in Public Hospitals in New Zealand'. ▪ Supervisor: Associate Professor Frank Sligo, Head of the Department of Communication, Journalism & Marketing, Massey University (Wellington). The study will include sentinel events at all District Health Boards in New Zealand, including Canterbury DHB. No conflicts of interest are envisaged as all the research material used for this study is publicly available (e.g. sentinel event reports, coroners' reports, internal enquiries, media statements, media reports, etc). Partner, Shona Powell, is the Executive Officer for the NZ Speech Language Therapist's Association. Canterbury DHB is an employer of

	speech therapists.
Anna Crighton	University of Canterbury Council – Council Member - governance of University.
	New Zealand Historic Places Trust – Board Member - governance of New Zealand Heritage. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance.
	Christchurch Heritage Trust and Director – Director - governance of Christchurch Heritage.
	The Art Registry Co. Limited – Director - principal Registrar and Director of collections management.
	Theatre Royal Charitable Foundation – Director - governance of theatre operations.
	Lottery Canterbury / Kaikoura Community Distribution Committee- Member - distribution of profits from NZ Lotteries for funding of Community projects.
Bob Lineham	Civic Assurance (Local Government Insurance Corporation Ltd) – Director - this is a specialist insurance company servicing local government.
	Christchurch City Networks Ltd – Director - this involves the installation of broadband infrastructure in Christchurch. There is a possibility that it could offer services to Canterbury DHB in the future.
	Local Government Finance Corp Ltd – Director - this involves investing and borrowing on behalf of local authorities (currently in wind down mode).
	Christchurch City Holdings – Chief Executive - this is an infrastructure investment company.
Chris Ryan	Southlink Health IPA - Member - Southlink Health provides managerial support for PHOs, who are contracted to the DHB and intends to advocate on behalf of health practitioners.
	General Practitioner - contracted to the Rural Canterbury PHO, with capitation payments and other payments, such as Performance Management Payments coming from the DHB through the PHO.
	Royal New Zealand College of GPs - Fellow and Member of Canterbury Faculty Board - the RNZCGP prepares statements and advocates at times on workforce, recruitment and quality issues.
	Spouse, Maireed Ryan, is a member of the IHC. Parent of a child with Down Syndrome.
David Kerr	Centercare Limited – Chair - Centercare purchases supplies for Medical Practitioners.
	General Medical Practitioner - Doctor providing primary care services.
	Health Education Trust – Trustee - Health Education Trust develops and provides educational materials and training programmes for those caring for the elderly within the health sector.
	Medical Protection Society – Advisor - organisation that advises and provides legal support to doctors. The MPS role is to support the doctor, which can occasionally conflict with the DHB. Should an issue of conflict arise, that will be disclosed at the time.
	Partnership Health PHO – Contractor - contracted to Partnership Health PHO to assist in developing an improved Hospital referral process and interface between Hospital and community providers.
	Pegasus Health – Advisor - provides a management services organisation for primary medical providers and other primary care

	providers.
	Ryman Healthcare Limited – Chair - provides residential aged care services under contracts with Canterbury DHB.
	Pharmaceutical Management Agency (Pharmac) – Board Member - Pharmac purchases pharmaceuticals to New Zealand (including on behalf of DHBs) within New Zealand for the New Zealand Pharmaceutical schedule.
	New Zealand Medical Association - President - the New Zealand Medical Association is the largest medical organisation in New Zealand. Members come from all disciplines within the medical profession, and include specialists, general practitioners, doctors-in-training and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values and the health of New Zealanders. The key roles of the NZMA are to provide advocacy on behalf of doctors and their patients; to provide support and services to members and their practices; to publish and maintain the Code of Ethics for the profession; and to publish the New Zealand Medical Journal.
	Canterbury Initiative Project - involved with this project which is a joint Canterbury DHB/Canterbury PHO initiative focused on the elective services interface between general practice and hospital clinicians.
David Morrell	Brackenridge Estate Limited – Chairman (appointed by Canterbury DHB) – (wholly owned subsidiary of 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 supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of Canterbury DHB, including Mental Health Services. In addition a conflict of interest may arise from time to time in respect to Coroners' Inquest hearings involving British nationals.
	Nurses Memorial Chapel Trust – Trustee - (Canterbury DHB appointee) Trust responsible for Memorial on the Christchurch Hospital site.
	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 Hurt- Member – Patient Lobby Group.
Elizabeth Cunningham	University of Otago, Christchurch – Research Manager, Māori (0.6FTE) – part of the Senior Management Team. The University has various relationships with 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 Canterbury DHB.
	Manawhenua ki Waitaha – Member - representative of Te Runanga o Koukourata. Manawhenua ki Waitaha is a collective of health

	representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a Memorandum of Understanding between Manawhenua ki Waitaha and Canterbury DHB.
	Māori Women's Welfare League – Member - the Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori.
	Kawa Whakaruruhau Roopu Bachelor of Nursing/Midwifery Christchurch Polytechnic – Chair - a committee of Christchurch Polytechnic, Department of Health Services, providing input and oversight in relation to course programmes.
	Avon Heathcote Estuary Ihutai Trust – Member - the Trust has an interest in improving water quality within the estuary.
	Special Education Strategy Committee – Member - a committee of the Ministry of Education.
	Registered Resource Management Act (RMA) Commissioner - from time to time asked to sit on these panels given involvement with the Regional Council and in particular understanding the Māori issues around Section 8 of the RMA Act. If conflicts arise they will be advised.
	Son, Manaia Cunningham, is a Board member of the Christchurch Primary Health Organisation.
Jo Kane	Environment Canterbury – Deputy Chairperson - Environment Canterbury is involved in the promotion of sustainable management of natural and physical resources and ensures safe and efficient movement of people and goods for the benefit of people, communities and future generations. As part of its role Environment Canterbury is responsible for the health and wellbeing 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 and the greater Christchurch Urban Design Strategy which includes Christchurch City Council, Selwyn District Council and Waimakariri District Council planning process.
	Resource Management Act (RMA) Commissioner - from time to time sits on hearing panels for consenting and regulatory functions under the RMA process. If conflicts arise they will be advised.
	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 will exist, but these would be disclosed at the appropriate time.
	Health North Canterbury – Steering Group Member - involved in a community trust that is looking at a future use of land at the Rangiora Hospital site, which is likely to involve putting a proposal to Canterbury DHB for consideration (including potential commercial negotiations).
	Royal Humane Society of New Zealand – Member - Court of Directors.
Margaret Schwass	IHC New Zealand-Employee.
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 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 - employed by Taupunga Ltd (which provides general medical services) 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 Canterbury DHB.
	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 Lecturer - University of Otago Christchurch School of Medicine.
Peter Ballantyne	Bishop Julius Hall of Residence - Trust Board Member.
	University of Canterbury - Audit and Risk Committee Member.
	Deloitte – Consultant - Deloitte carries out certain consulting assignments for Canterbury DHB from time to time.
	Spouse, Claire Ballantyne is a Canterbury DHB employee.
Richard Davison	Ag Research Ltd – Director - Crown Research Institute involved in animal and plant research.
	Mossman and Davison Ltd – Partner - Registered Valuers involved in property valuation.
	Amuri Community Trust – Trustee - Community Trust for benefit of Amuri citizens – not for profit trust.
	Amuri Health Centre Ltd – Chairman - not for profit community owned general medical practice funded in part by Canterbury DHB.
	Hurunui-Kaikoura Primary Health Organisation – Chairman - Primary Health Organisation funded by Canterbury DHB.
	Central Plains Water Trust - Trustee - Trustee appointed by the Christchurch City Council and Selwyn District Council.
	Toraja Rural Development Trust – Trustee - privately funded aid project in Indonesia.
	Canterbury DHB Consumer Council – Member - recently established Canterbury DHB Council.
Stephen Lowndes	Canterbury Aoraki Conservation Board – Member.
	Aoraki Civic Board Trust – Member.
	It is not considered that membership of the above two organisations would constitute any direct conflict of interest. Should any future conflict of interest arise this will be disclosed at that time.
Trevor Read	Francis Group Consultants – Consultant - working with South Canterbury DHB to investigate an interim patient management system solution under a shared service arrangement with Southern Alliance DHBs. This is part of a risk management strategy until the procurement of a new generation application being undertaken collectively by seven DHBs, including Canterbury DHB.

	Capital and Coast DHB - Costing Unit - Acting Team Leader. Nelson Marlborough and West Coast DHBs - participating in the development of an operating model as part of the strategic collaboration initiatives between these DHBs. It is not considered that any of these activities present a general conflict of interest but should a conflict arise this will be discussed at the time.
Theresa Chalecki	Nurse Maude – Community Services Manager - non government, not for profit, organisation providing community and specialist nursing, home support, hospice and palliative care and aged care hospital services in Canterbury. Holds contracts with Canterbury DHB, Ministry of Health and ACC. - responsible for the operational management of the Home Support Services. - member of the organisations senior management team. Potential conflicts would involve decisions relating to funding services currently or potentially to be contracted to community service providers.
Wendy Dallas-Katoa	Ka Wahine Board – Board Member - Women's Whare – newly released women from prison halfway house. Te Runanga O Ngai Tahu – Health and Social Development Programme Leader. Partnership Health PHO – Board Member – iwi/manawhenua representative. The PHO has entered into an agreement with Canterbury DHB under which the PHO agreed to provide a range of health care services and the management tasks associated with the delivery and funding of these services. The PHO has the power to subcontract the delivery of any or all such services and associated management tasks.
William Tate	Global Catering Limited-Director. Pulp Kitchen- Director. Pulp Kitchen Catering Limited-Director. New Zealand Institute of Management Foundation - Trustee. New Zealand Institute of Management Life Fellows Committee - Member.

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.

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 $92,319 (2007/08 – 4 employees totalling $16,915) comprising negotiated settlements with all of the former employees.

Number of Employees	TOTAL $
8	92,319
8	**92,319**

REMUNERATION OF EMPLOYEES

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

	30/06/09 (including benefits)				30/06/08 (including benefits)			
	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total
100,000-109,000	22	23	60	**105**	3	14	59	**76**
110,000-119,000	7	9	63	**79**	2	11	59	**72**
120,000-129,000	4	7	64	**75**		4	54	**58**
130,000-139,000	2	5	59	**66**	1	4	44	**49**
140,000-149,000	1	4	41	**46**		3	26	**29**
150,000-159,000		2	37	**39**			30	**30**
160,000-169,000		1	23	**24**		1	33	**34**
170,000-179,000		1	31	**32**		2	23	**25**
180,000-189,000			19	**19**		2	25	**27**
190,000-199,000		2	27	**29**			15	**15**
200,000-209,000		1	19	**20**		1	17	**18**
210,000-219,000		1	27	**28**		1	23	**24**
220,000-229,000		2	17	**19**			25	**25**
230,000-239,000			23	**23**			18	**18**
240,000-249,000			19	**19**			11	**11**
250,000-259,000			15	**15**		1	7	**8**
260,000-269,000			11	**11**			6	**6**
270,000-279,000			13	**13**			2	**2**
280,000-289,000			5	**5**			3	**3**
290,000-299,000		1	8	**9**			2	**2**
300,000-309,000			4	**4**				
310,000-319,000			6	**6**			1	**1**
320,000-329,000			3	**3**			2	**2**
330,000-339,000		1	2	**3**			1	**1**
350,000-359,000			4	**4**			1	**1**
360,000-370,000			3	**3**				
370,000-379,000			1	**1**			1	**1**
380,000-389,000			1	**1**				
410,000-419,000			1	**1**			1	**1**
450,000-459,000						1	1	**2**
460,000-469,000							1	**1**
470,000-479,000			1	**1**				
Total	**36**	**60**	**607**	**703**	**6**	**45**	**491**	**542**

Of the 703 (2007/08 542) positions identified above, 643 (2007/08 497) positions were predominantly clinical and 60 (2007/08 45) positions were management/administrative. The increase in number of positions was due to the impact of MECA settlements with RMOs accounting for 53% of the increase.

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	$16,000
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

*** 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 2009, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Objectives and Service Performance on page 59.

Section 42(3)(b) – Report on the extent Canterbury DHB has met the objectives under Section 22	
Objective:	**Extent objectives met**
(a) To improve, promote, and protect the health of people and communities:	Canterbury DHB activity is focused on improving health outcomes for the Canterbury population, reducing inequalities in health status and improving the delivery and effectiveness of the services provided. Added to this is the imperative that any initiatives or programmes developed will enable the DHB to build the foundations essential to drive transformational change and improvements in our challenging environment. The DHB takes a consistent approach to improving the health of its community and: ▪ Promotes messages related to improve lifestyle choices, physical activity and nutrition and reduce risk behaviours, including obesity and smoking cessation, to improve population health; ▪ Works collaboratively with the primary and community sectors to provide an integrated and patient centred approach to service delivery and develop continuums of care and patient pathways that help to better manage long-term conditions and reduce acute demand and unnecessary hospital admissions; ▪ Works with its hospital and specialist services to provide timely and appropriate quality services to its population and improve productivity, efficiency and effectiveness; and ▪ Implements a more restorative focus through improved access to home and community-based support, rehabilitation services and respite care to support people to better manage their conditions and to improve wellbeing and the quality of life. Over the past year a number of key improvements have been made in improving the health and promoting the well-being of the Canterbury population: ▪ 86% of all Canterbury two-year-olds have been fully immunised, a 2% increase on 2007/08; ▪ 64% of all age five children have no holes or fillings in their teeth, a 6% improvement; ▪ 64% of all Year-10 students have 'never smoked' a 6% improvement on 2007/08; ▪ 96.5% of the population is enrolled with primary care with a 2% improvement in Māori enrolment rates;

	▪ 70% of people are now seen in under four hours in the Emergency Department, a 2% improvement on last year, and in the last six months of 2008/09, 90% of people are waiting less than six hours – this is despite more than 5,500 additional people presenting to emergency; ▪ 91% of patients wait less than six weeks for radiation oncology (cancer) treatment, a 10% improvement; ▪ 14,809 elective surgery discharges were delivered, 1,888 more than in 2007/08; ▪ 89% of all long-term mental health clients have relapse prevention or crisis plans in place, 3% more than the previous year; and ▪ A Restorative Based Model of Care for Older People has been introduced including supportive discharge models and improvements in assessment and needs co-ordination services. As part of its Health Services Planning work, the DHB has also developed a patient centred model of care to manage long-term conditions irrespective of the specific diagnosis. The model identifies different groupings of services, such as prevention, early intervention, treatment and support that will be delivered by a range of service providers on an individual or population-wide basis. These services can be for a specific group of people (older people) or a particular disease or condition (diabetes or mental illness) and the model ensures continuums of care across the whole of the health system and supports a strengthening of workforce capacity and capability and the best use of available resources. The model explicitly acknowledges the roles of other organisations, groups or individuals who have a key part to play in helping people to be healthy and describes how health services are linked together and how people can receive the care they need. It also presents a flexible approach so that people of differing cultures, ages and needs can get equitable and appropriate levels of help and support. The model considers the patient journey, starting with health promotion and prevention, and prompts a series of questions: ▪ What do we need to do to keep people well in the community? ▪ What do we need to do to ensure early detection and early intervention? ▪ How can we better manage people in the community and primary care to avoid unnecessary hospital admissions and improve the quality of life? ▪ How do we ensure that when people do require specific interventions such as hospital care, specialist advice or diagnostics, they are available in the right place, at the right time and are provided by the right people? ▪ How do we provide appropriate and restorative support services so people can quickly return to their normal lifestyles and avoid further complications? ▪ Does the health system respect people dying with dignity; do we listen and meet their needs? The key focus is on ensuring patients receive the right treatment, at the right time and in the most appropriate setting. The model supports the DHB's vision of a joined-up health system, focused around patient services and clinical outcomes from 'end to end' where the patient journey through the health system will be timely,

	seamless between providers, provide consistent quality, and offer the best quality outcomes.
(b) To promote the integration of health services, especially primary and secondary health services:	In July 2007 the Canterbury Initiative commenced as a joint initiative between general practice, Canterbury PHOs and Canterbury DHB. In line with the shared vision of one 'whole' health system the Canterbury Initiative brings together GPs and hospital specialists to identify challenges and design solutions to improve patient care in the form of consistent clinically-led pathways across the primary/secondary sectors. These pathways inform alternative patient-centred models of care and provide service access in line with best practice under a project methodology of constant communication. The approach removes traditional boundaries by ensuring services are delivered in the most appropriate and convenient settings. GPs and hospital specialists provide clinical input and leadership in the design and implementation of new pathways and models of care all aimed at improving the patient journey through the system. The new pathways aim to avoid needless referrals and hospital visits, provide more accurate referrals, more ready access to diagnostics and quicker more convenient services and support in primary and community settings. The overall objective is to provide better outcomes for patients, develop effective and constructive relationships between general practice and hospital specialists and establish effective integration of services across the primary/secondary sectors. Although in its infancy, the alternative provision of care in primary settings has already increased the availability of procedures that had previously been difficult to access and is freeing up secondary care to address more complex health issues. The Canterbury Initiative has also developed a mechanism for GP to GP referrals, widening access to expertise in the community. In the last six months of 2008/09, 1,151 GP subsidised procedures have been delivered in the community and not hospital settings including: ▪ 857 excisions of skin lesions; ▪ 51 sleep assessments; ▪ 28 Pipelle biopsies; ▪ 169 steroid injections; and ▪ 44 Mirena insertions. The face of the Canterbury Initiative is presented online via www.healthpathways.org.nz which contains information and resources specifically to help Canterbury general practice navigate the established clinical pathways including information on referrals, specialist advice, diagnostic tools, GP to GP referral and GP procedure subsidies.
(c) To promote effective care or support for those in need of personal health services or disability support services:	Canterbury DHB has developed a restorative model of care for Older Persons Health Services with the underlying objective to maintain older people's independence for as long as possible, reduce the period and levels of dependence and provide effective, integrated services when they are required. This local strategy is aligned with the vision of integrated continuums of care and clinical pathways that reach across the whole of health system to enable better management of long-term conditions. The emphasis is on flexible, responsive, needs-based care provided in the community to assist older people to stay well and to remain in their own homes. Providing people have the adequate supports and have a manageable level of need, ageing in

	place will likely result in much higher quality of life and people may remain healthier for longer as a result of staying active and positively connected to their communities. The DHB is focused on effective health promotion and disease prevention to support people to maintain good health for longer. Effective primary health care services are also important in keeping people well and reducing unnecessary hospital admissions, including effective screening, long-term conditions management programmes and medication management. Over the past year a number of key improvements have been made in promoting the well-being of the Canterbury population: ▪ 98.4% of people over 65 are now enrolled with general practice in Canterbury; ▪ 18.7% of those people are accessing CarePlus or High User Health Card services ensuring low cost access to enhance primary care services for older people, particularly those with two or more long-term (chronic) conditions, an increase on the previous year; and ▪ 73% of people over 65 received an influenza vaccination in 2008, 9% higher than the national average. Aged residential care services are the greatest challenge for the DHB. Compared to other DHBs Canterbury has the fifth highest age standardised per capita utilisation of aged residential care services and a higher than national average utilisation of home based support services. This level of additional expenditure is not sustainable and also means fewer resources are available for other services including those which may better support older people to stay well in their own homes. The DHB is focused on improving referral pathways, ensuring coordinated and consistent needs assessment, building a strong community base and increasing stand-alone day support and respite care services. Coordination and assessment services will be augmented to improve integration of access for different service areas and to ensure people receive appropriate and timely review of their care. This work is being done in partnership with primary and community providers to provide a smooth transition between services and to emphasise a restorative/rehabilitation approach by better supporting hospital discharge. Home based support services will be focused on supporting those people assessed as having a range of priority needs. This will help ensure that service provision levels going forward can be sustainably provided and targeted to supporting people with a range of needs to age in place. Appropriate service provision and any changes to service provision will be determined for individuals only after comprehensive evidence based assessment, using the InterRAI (International Assessment Instrument) tool and service users will have their needs reviewed annually or more frequently as required.[1] The DHB will also continue to focus on improving the quality of care for older people and will work collaboratively with providers around ensuring the safety and wellbeing of older people and building the capacity of residential care to support residents in episodes of acute or end of life care. Over the past year the DHB has implemented: ▪ Additional funding (as agreed nationally) to support supervision

[1] *InterRAI – the International Resident Assessment Instrument is a comprehensive geriatric assessment tool.*

	and improved nursing quality in rest homes; ▪ InterRAI to ensure that people receive the most appropriate services and to assist in measuring service quality; and Increased access to assessment services to ensure timely assessment.
(d) To promote the inclusion and participation in society and independence of people with disabilities:	Canterbury DHB aims to ensure it contributes to a 'non-disabling' society through its actions, and the actions of the providers with whom it contracts. The DHB has 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 and is currently being updated. The Plan is monitored by the Board's Disability Support Advisory Committee. All new building and facility developments are also assessed for meeting the needs of people with disabilities.
(e) To reduce health disparities by improving health outcomes for Māori and other population groups:	Canterbury DHB has a Māori Health Action Plan. The key objectives include reducing health inequalities and supporting Māori participation in health and Māori health workforce development. Progress has been made in implementing projects that support the DHB's Māori Health Plan including: ▪ Signing of a formal Memorandum of Understanding with Manawhenua Ki Waitaha establishing a clear relationship between the two groups to improve Māori input into the planning and development of health and disability services in Canterbury; ▪ An Ethnicity Data Collection Project with the aim of improving the accuracy of ethnicity data collection. Steady improvements in ethnicity data collection continue to be made; ▪ Collaboration around strategies that promote healthy nutrition and increased physical activity through community-based projects have been a successful focus including training of Māori health workers in breastfeeding and nutrition issues and support for peer support groups which have been positive in ensuring consistent healthy messages; and ▪ 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 smokefree Marae with three Marae in Canterbury now smokefree.
(f) To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those	Canterbury DHB's local Health Needs Assessment (completed in 2005) has identified areas of health inequality within the Canterbury community. The DHB's Strategic Plan identifies a number of strategic priority areas where the DHB focuses its efforts to reduce health inequalities: Child and Youth Health, Older Persons' Health and Māori Health. The DHB also works with general practice in Canterbury to reduce barriers to primary care including financial barriers through the reduction of general practice co-payments. The DHB also continues to work with Primary Health Organisations to implement services to improve access to primary care. The DHB also supports smoking cessation through its Tobacco Action Plan, ABC smoking cessation programme and Māori smoking cessation programmes (referred to above). Tobacco smoking is inextricably linked to a number of health inequalities and remains the foremost opportunity to target improvement in the health of

of other New Zealanders:	the population with high needs and to improve Māori health. The DHB will undertake an update of its Health Needs Assessment in the coming twelve months and will also complete a specific Māori Health Needs Profile for Canterbury. Over the past year a number of key improvements have been made in reducing outcome disparities between various population groups in Canterbury: ▪ 84% of all Māori and 86% of all Pacific two-year-olds were immunised in Canterbury, a higher percentage increase than for the total population over the same period; ▪ A reduction in the rate of avoidable hospital admissions for Māori and Pacific 0-4 year-olds over the past year to below the national average and the rate for the total population; ▪ 43% of all age five Māori children have no holes or fillings in their teeth, a 7% improvement on the previous year; ▪ 94.9% of the Pacific population are enrolled with primary care, up 6% on the previous year; and ▪ 100% of PHOs have Māori Health Plans in place and 100% of the DHB's Board and Statutory Committee have Māori representation in their membership.
(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:	Canterbury 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 local and regional council in the Canterbury region along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other Non-Government Organisations (NGOs) in our region. The DHB also actively supports a number of collaborative ventures which endeavour to improve the environment and the health of our residents. The DHB actively engages with providers of health services working with them in a cooperative way for the benefit of our population. In important areas of policy development or for significant projects the DHB seeks input from community and providers. This may be in the form of providing opportunities for input on early development of papers/ideas or involvement in working parties. The DHB has established, or is involved with a number of consumer and community reference groups, working parties and advisory groups which provide advice and input on the development of plans and strategies and in 2007 a formal Consumer Council was established. This Council supports a partnership model that will provide a strong and viable voice for the community and consumers in health service planning and service delivery. The Consumer Council consists of 15 representatives nominated by consumers and consumer lobby and advocacy groups. The Council's advice and input assists in developing DHB plans and strategies, and improving the delivery of health and disability services.
(h) To foster community participation in health improvement, and in planning for the provision of	In the past year Canterbury DHB worked on the development of a Health Services Plan to ensure that health resources are protected, sustainable and supported long-term. The Health Services Planning has focused on progressing 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.

services and for significant changes to the provision of services:	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. Through its Health Services Planning work the DHB introduced a 'participatory model' to involve staff, providers, consumers and the community in the Health Services Planning and extensive participatory workshops and 'design teams' established to drive the thinking and planning which includes the establishment of the DHB's Consumer Council. The DHB has continued this momentum and the collaborative journey towards a whole of system approach to change and transformation within the health system with its Vision 2020 workshops which will feed into the review of its Strategic Plan in the coming year.
(i) To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	Canterbury DHB has a Quality and Patient Safety Council and a Clinical Board to provide advice to the CEO on quality and clinical issues and promote quality improvement within the DHB. These clinical leadership groups facilitate continuous improvement and provide support and guidance to positively influence the quality of care. They also identify key issues for quality improvement and promote the development of appropriate information systems for monitoring and reporting on quality. 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 patient safety policy, open disclosure policy and the no blame incident/accident reporting policy). The Clinical Board is a multi-disciplinary DHB-wide clinical forum consisting of clinical representatives from the primary, secondary and community sectors. The Board takes a proactive role in setting clinical policy and standards and encouraging best practice and innovation. The DHB has processes in place to maintain and improve quality including Quality Health New Zealand and EQuIP 4 accreditation processes for its hospitals and performance targets and measures to maintain appropriate levels of clinical quality. The DHB has also recently reviewed its prioritisation framework and agreed an updated set of prioritisation principles based on best practice and consistent with its strategic direction. These principles will assist the DHB in making decisions about which competing services or interventions to fund with the limited resources available and will be applied as the DHB reviews all existing health investments to ensure funding is directed into the most effective and highest value patient services. The prioritisation principles that guide DHB decision making are: ▪ Effectiveness: Publicly funded health and disability services should be effective. Effective services are those that produce more of the outcomes desired, such as a reduction in pain, maintenance of daily activity, greater independence and the prevention of premature death. ▪ Equity: Services should reduce significant inequalities in the health and independence of our population. ▪ Value for Money: Our population should receive the greatest possible value (in terms of effectiveness and equity) from public spending on health and disability services. ▪ Whanau Ora: Services should have a positive impact on the holistic health and wellbeing of the person and their family and

	whanau. This has particular significance for Māori, but relevance for all cultures. ▪ Acceptability: Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service. ▪ Ability to implement: Ability to implement services is carefully considered, including workforce capacity, impact on the whole of the health system and any risk and change management requirements.
(j) To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:	Canterbury DHB has shown a sense of environmental responsibility via its waste management programme and in relation to its rebuilding programme. The DHB is also aware of the interaction of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work collaboratively to set goals and objectives for our community's health and to provide a healthy environment for our population.
(k) To be a good employer	Canterbury DHB is committed to the principles of being a good employer and has in place, as appropriate, a number of organisational policies and procedures (to promote a healthy and safe workplace) including the DHB's Equal Opportunities and Harassment Policy. The DHB also provides a safe and health promoting environment through safe handling programmes and membership of the ACC Partnership Programme. The DHB also encourages its workforce to lead by example in terms of healthier lifestyles and practices. Over the past year: ▪ Staff turnover rates have dropped from 10.5% to 7.4%; ▪ Sick leave rates have remained low at 3.3%; and ▪ 55% of all Canterbury DHB staff took up free influenza vaccinations.

Section 42(3)(i) – Statement of how Canterbury DHB has given effect and intends to give effect to its functions specified in Section 23 (1) (b)-(e)	
Function:	**What has been done to meet function**
(b) To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in	Canterbury DHB has involved stakeholders in selection of its strategic priority areas for its current Strategic Plan and will do so again in the next twelve months as it looks to review this Strategic Plan. The DHB has also been working across the sector in the development of its Health Services Planning Programme and Vision 2020 looking to the future development of health services. The DHB has joint arrangements with external providers for the provision of some surgical services, such as orthopaedic and cardiac surgery and participates in a number of regional initiatives with other DHBs such as the South Island Cancer Control Network and the implementation of national information systems. The DHB has established inter-agency relationships with a wide range of government agencies including the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, Education and Social Development, ACC and the Department of Corrections. The DHB also works with the Ministry of Health in a number of

society and independence of people with disabilities:	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. Most recently the DHB has established formal working relationships with clinical leaders across the whole of the health system in the development of patient pathways to improve health outcomes for our population. This work is taking place primarily through the Canterbury Initiative (referred to above) but is also in place across a number of areas throughout the health system. The DHB also has key clinical networks in place and fosters and supports clinical leaderships and participation in the development of arrangements and initiatives to improve health outcomes. The DHB ensures that strategic and operational decisions are fully informed through appropriate clinical involvement and support at all levels of the decision making process. Clinical input into decision making is facilitated by having a model of shared management and clinician leadership at all levels within the DHB. This model is replicated across the whole of the health system with a framework of primary/secondary clinical leadership seen as essential to drive the change and transformation needed to improve the delivery of health services. Clinical leaders provide support to the Chief Executive and the Board in their decision making processes and the model is supported by formal and informal clinical networks across the whole of the health system. This clinical leadership can be seen driving a number of key improvement programmes across the DHB including the Canterbury Initiative and the DHB's Improving the Patient Journey Programme.
(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):	Canterbury DHB uses a variety of written media, TV and radio work to outline general issues and priorities to the community and responds directly to media, personal, community and group enquiries. The DHB also provides written media to inform the community and other sectors of current activity including Healthfirst (a community newsletter), Healthbeat (a newsletter for DHB staff and community providers) and Health Promoting Schools (a newsletter for Canterbury schools). The DHB has developed a website, which includes community based health information and its primary planning documents. The DHB also circulates and makes available significant documents and plans for its population in summary and comprehensive form either at libraries, via groups or individually and on its website. The DHB has also supported the development of HealthPathways a collaborative website designed for general practice which contains active and current information on referral pathways, assessment, other patient management information and information which can be provided to patients. The DHB continues to provide health promotion information through its Community Health Information Centre, open to the public five days a week. Supplies of health education resources are held and a number of satellite health information stands have been developed - there are currently 20 of these sites with particular emphasis being placed on Marae, TLA service centres, hospitals, and other appropriate settings for target communities.
(d) To establish and maintain processes to enable Māori to	Canterbury DHB has a Memorandum of Understanding with Manawhenua Ki Waitaha signed in 2008 to formally support the participation of Māori in DHB decision making and in the planning

participate in, and contribute to, strategies for Māori health improvement:	and delivery of health and disability services.[2] The DHB also has a number of informal relationships with Māori groups and engages at many levels with Māori providers and Māori community organisations. The DHB's Māori Health Plan, approved in 2007, also commits the DHB to establishing formal relationships with Māori representative groups beyond Manawhenua Ki Waitaha, such as Taura Here community groups.[3] In collaboration with Manawhenua Ki Waitaha the DHB is exploring mechanisms to facilitate greater participation of Māori at a governance level. Possibilities for such participation include a Māori governance/advice board providing advice to the DHB's Board and allowing Māori further opportunities to engage with the Board of the DHB. The DHB will continue to consult with Māori communities at appropriate levels of operations and provide Māori with opportunities to engage and feedback to the DHB.
(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:	Canterbury DHB continues to work on capacity and capability issues through Te Herenga Hauora o te Waka a Maui (the South Island Māori Managers Network), where a number of projects have been developed to support Māori service provision in Canterbury. These include: ▪ The development of a Māori Health Workforce Development Plan, *Te Waipounamu*; ▪ The development of a South Island regional Māori workforce recruitment project to enhance the Māori health workforce in our region; ▪ The development of a Māori health training and education opportunities directory, currently being distributed to Māori health providers; ▪ Road shows to encourage health as a career; and ▪ Scholarships to support Māori wanting to study to work in primary care settings. There were eight successful applicants for the scholarships in the first year.

For and on behalf of the Board

Alister James
Chair
2 October 2009

Olive Webb
Deputy Chair
2 October 2009

[2] *Manawhenua ki Waitaha is a representative group which comprises of seven Ngāi Tahu Rūnanga.*
[3] *Taura Here refers to all other collective pan-tribal Māori groups.*

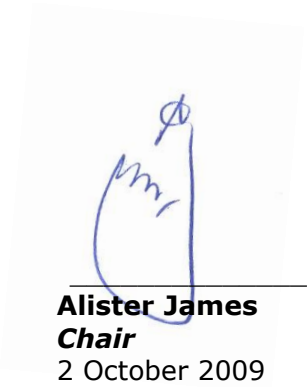
STATEMENT OF RESPONSIBILITY

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 2009, are our responsibility.

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



Alister James
Chair
2 October 2009

Olive Webb
Deputy Chair
2 October 2009

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2009

	Notes	Group Actual 30/06/09 $'000	Group Budget 30/06/09 $'000	Group Actual 30/06/08 $'000	Parent Actual 30/06/09 $'000	Parent Actual 30/06/08 $'000
Income						
Ministry of Health revenue		1,201,899	1,168,742	1,116,673	1,191,204	1,107,697
Patient related revenue	2	43,285	38,303	36,545	43,213	36,972
Other operating income	3	28,123	27,376	19,011	25,928	16,538
Interest income		5,544	8,510	8,819	5,599	9,040
Total income		1,278,851	1,242,931	1,181,048	1,265,944	1,170,247
Operating expenses						
Employee benefit costs	4	512,629	504,946	472,445	501,743	462,320
Treatment related costs		112,786	102,002	105,008	115,774	108,493
External service providers		525,784	497,076	480,389	525,784	480,389
Depreciation and amortisation		45,100	47,214	47,808	43,786	46,439
Interest expenses on loans		4,698	5,632	5,584	4,692	5,745
Other Expenses	5	72,424	64,364	65,963	69,005	62,743
Total operating expenses		1,273,421	1,221,234	1,177,197	1,260,784	1,166,129
Operating surplus before capital charge		5,430	21,697	3,851	5,160	4,118
Capital charge expense	6	(17,791)	(21,697)	(20,617)	(17,791)	(20,617)
Net surplus/(deficit)		**(12,361)**	**-**	**(16,766)**	**(12,631)**	**(16,499)**

In November 2008 the 2008/09 operating target was revised to a deficit of $13 million as agreed with the incoming Minister of Health.

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2009

	Notes	Group			Parent	
		Actual 30/06/09 $'000	Budget 30/06/09 $'000	Actual 30/06/08 $'000	Actual 30/06/09 $'000	Actual 30/06/08 $'000
Total equity at beginning of the period		249,515	253,281	268,142	247,880	266,240
Net surplus/(deficit) for the period		(12,361)	-	(16,766)	(12,631)	(16,499)
Amounts recognised directly in equity:						
Impairment of property, plant and equipment	14	(19,802)	-	-	(19,802)	-
Total recognised revenues and expenses		(32,163)	-	(16,766)	(32,433)	(16,499)
Other movements:						
Contribution back to Crown		(1,861)	-	(1,861)	(1,861)	(1,861)
Contribution from Crown		432	-	-	432	-
Total equity at end of the period	7	**215,923**	**253,281**	**249,515**	**214,018**	**247,880**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2009

	Notes	Group Actual as at 30/06/09 $'000	Group Budget as at 30/06/09 $'000	Group Actual as at 30/06/08 $'000	Parent Actual as at 30/06/09 $'000	Parent Actual as at 30/06/08 $'000
CROWN EQUITY						
General Funds	7	121,023	124,313	122,452	121,161	122,590
Revaluation Reserve	7	164,675	184,477	184,477	164,675	184,477
Retained earnings/(losses)	7	(69,775)	(55,509)	(57,414)	(71,818)	(59,187)
TOTAL EQUITY		**215,923**	**253,281**	**249,515**	**214,018**	**247,880**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and cash equivalents	8	47,497	48,716	42,339	45,870	40,240
Trade and other receivables	9	47,939	25,800	36,009	47,264	35,441
Inventories	10	9,641	8,000	8,963	9,534	8,894
Investments	11	3,895	-	-	3,624	-
TOTAL CURRENT ASSETS		108,972	82,516	87,311	106,292	84,575
CURRENT LIABILITIES						
Trade and other payables	12	90,758	76,400	86,411	90,378	86,160
Owing to the Ministry of Health		5,194	5,425	7,229	5,194	7,229
Employee benefits due within 1 year	13	115,967	102,000	109,932	114,440	108,663
TOTAL CURRENT LIABILITIES		211,919	183,825	203,572	210,012	202,052
NET WORKING CAPITAL		(102,947)	(101,309)	(116,261)	(103,720)	(117,477)
NON CURRENT ASSETS						
Investments	11	8,171	26,170	9,170	10,299	12,378
Property, plant and equipment	14	387,902	424,396	430,657	384,625	427,005
Intangible assets	15	1,962	-	1,283	1,962	1,283
Surplus property	16	5,460	-	8,250	5,460	8,250
Restricted assets	17	12,483	10,931	11,522	12,357	11,402
TOTAL NON CURRENT ASSETS		415,978	461,497	460,882	414,703	460,318
NON CURRENT LIABILITIES						
Employee benefits	13	9,625	8,326	8,584	9,608	8,559
Restricted funds	17	12,483	10,931	11,522	12,357	11,402
Borrowings	18	75,000	87,650	75,000	75,000	75,000
TOTAL NON CURRENT LIABILITIES		97,108	106,907	95,106	96,965	94,961
NET ASSETS		**215,923**	**253,281**	**249,515**	**214,018**	**247,880**

For and on behalf of the Board

Alister James
Chair
2 October 2009

Olive Webb
Deputy Chair
2 October 2009

This statement is to be read in conjunction with the Notes on pages 33 to 58 and the Audit Report on page 83

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2009

	Notes	Group Actual 30/06/09 $'000	Group Budget 30/06/09 $'000	Group Actual 30/06/08 $'000	Parent Actual 30/06/09 $'000	Parent Actual 30/06/08 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,190,244	1,168,742	1,105,160	1,179,665	1,096,410
Other Receipts		61,099	57,679	55,691	58,841	53,652
Interest Received		5,544	8,510	8,819	5,599	9,040
		1,256,887	1,234,931	1,169,670	1,244,105	1,159,102
Cash was applied to:						
Payments to Employees		505,553	504,946	462,833	494,917	452,940
Payments to Suppliers		707,104	663,442	646,530	706,781	647,565
Interest Paid		4,422	5,632	5,602	4,407	5,772
Capital Charge		19,826	21,697	27,240	19,826	27,240
GST - net		772	-	(320)	773	(316)
		1,237,677	1,195,717	1,141,885	1,226,704	1,133,201
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	19,210	39,214	27,785	17,401	25,901
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant & equipment		13,108	10,790	67	13,097	17
Receipt from sale of investments		-	-	2,168	-	2,130
		13,108	10,790	2,235	13,097	2,147
Cash was applied to:						
Purchase of Investments & Restricted Assets		2,896	15,000	-	1,545	-
Purchase of property, plant & equipment		22,835	30,000	23,803	21,894	22,579
		25,731	45,000	23,803	23,439	22,579
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		(12,623)	(34,210)	(21,568)	(10,342)	(20,432)
CASH FLOW FROM FINANCING ACTIVITIES						
Cash was provided from:						
Equity injection		432	-		432	
		432	-	-	432	-
Cash was applied to:						
Loans Repaid		-	-	12,650	-	12,650
Equity repaid to Crown		1,861	-	1,861	1,861	1,861
		1,861	-	14,511	1,861	14,511
NET CASH INFLOW/ (OUTFLOW) FROM FINANCING ACTIVITIES		(1,429)	-	(14,511)	(1,429)	(14,511)
Net increase/(decrease) in cash and cash equivalents		5,158	5,004	(8,294)	5,630	(9,042)
Cash and cash equivalents at beginning of year		42,339	43,712	50,633	40,240	49,282
Cash & cash equivalents at end of year	8	**47,497**	**48,716**	**42,339**	**45,870**	**40,240**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2009

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 Canterbury DHB are for the year ended 30 June 2009 and were authorised for issue by the Board on 2 October 2009.

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.

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.

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)* relaces NZ IAS 1 *Presentation of Financial Statements (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive

income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as "owner". The revised standard gives Canterbury DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). Canterbury DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.

- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. Canterbury DHB intends to adopt this standard for the year ending 30 June 2010 and has determined that the potential impact of 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 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 Canterbury DHB in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ IFRS, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

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

Fixed Assets Vested from the Hospital and Health Service

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

Additions

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

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

Depreciation

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

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

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

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

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

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

Amortisation

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

Type of asset	Estimated life	Amortisation rate
Software	2 years	50%

Investments

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

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

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

Trade and other receivables

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

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. 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 cost (calculated using the weighted average method).

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 remaining 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.

Restricted assets and liabilities

Donations and bequests received with restrictive conditions are treated as liability until the specific terms from which the funds were derived are fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

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 five years up to a specified maximum. At the end of the five 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

Canterbury DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

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 Canterbury DHB'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 assumptions concerning useful lives and residual values, other than a reduction in the useful lives of certain buildings for which Canterbury DHB has recognised an impairment to their carrying amounts as 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 asset, 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 lease 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	
	30/06/09 $'000	30/06/08 $'000	30/06/09 $'000	30/06/08 $'000
ACC Revenue	22,641	21,512	22,641	21,512
Other patient related revenue	20,644	15,033	20,572	15,460
	43,285	**36,545**	**43,213**	**36,972**

3. OTHER OPERATING INCOME

	Group		Parent	
	30/06/09 $'000	30/06/08 $'000	30/06/09 $'000	30/06/08 $'000
Gain/(loss) on sale of property, plant and equipment	10,309	(135)	10,300	(142)
Donations and bequests received	603	783	602	797
Other	17,211	18,363	15,026	15,883
	28,123	**19,011**	**25,928**	**16,538**

4. EMPLOYEE BENEFIT COSTS

	Group		Parent	
	30/06/09 $'000	30/06/08 $'000	30/06/09 $'000	30/06/08 $'000
Wages and salaries	500,506	455,007	489,870	445,147
Contributions to defined contribution plans	5,047	7,793	5,047	7,793
Increase/(decrease) in employee benefit provisions	7,076	9,645	6,826	9,380
	512,629	**472,445**	**501,743**	**462,320**

5. OTHER OPERATING EXPENSES

	Group		Parent	
	30/06/09 $'000	30/06/08 $'000	30/06/09 $'000	30/06/08 $'000
Remuneration of auditor:				
Audit fees for financial statement audit	197	172	160	148
Audit fees for NZ IFRS transition	-	35	-	18
Board members' fees	318	307	318	307
Directors' fees	23	23	-	-
Operating lease costs	4,589	4,343	4,044	3,858
Other	67,297	61,083	64,483	58,412
	72,424	**65,963**	**69,005**	**62,743**

6. CAPITAL CHARGE

Canterbury DHB 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 2009 was 8%. (June 2008 8%).

7. CAPITAL AND RESERVES

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
General Funds				
Opening Balance	122,452	124,313	122,590	124,451
Equity repayment to Ministry of Health	(1,861)	(1,861)	(1,861)	(1,861)
Equity injection by Ministry of Health	432	-	432	-
	121,023	**122,452**	**121,161**	**122,590**
Retained earnings				
Opening balance	(57,414)	(40,648)	(59,187)	(42,688)
Operating surplus/(deficit)	(12,361)	(16,766)	(12,631)	(16,499)
Closing balance	(69,775)	(57,414)	(71,818)	(59,187)
Represented by:				
Accumulated deficit in parent and subsidiary	(69,853)	(57,492)	(71,896)	(59,265)
Accumulated surplus in associates	78	78	78	78
	(69,775)	**(57,414)**	**(71,818)**	**(59,187)**
Revaluation reserve				
Opening balance	184,477	184,477	184,477	184,477
Impairment charges	(19,802)	-	(19,802)	-
Closing balance	164,675	184,477	164,675	184,477
Represented by:				
Revaluation of land	68,603	68,603	68,603	68,603
Revaluation of building including fitout	94,572	114,374	94,572	114,374
Revaluation of reversionary interest in buildings	1,500	1,500	1,500	1,500
	164,675	**184,477**	**164,675**	**184,477**
Total Equity	**215,923**	**249,515**	**214,018**	**247,880**

8. CASH AND CASH EQUIVALENTS

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Bank balances and call deposits	43,959	29,004	42,670	26,905
Term deposits less than 3 months	3,538	13,335	3,200	13,335
	47,497	**42,339**	**45,870**	**40,240**

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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Trade receivables	11,719	9,303	11,564	8,733
Receivable from the Ministry of Health	27,422	15,372	26,942	14,927
Prepayments	1,147	872	1,147	863
Other receivables	7,651	10,462	7,611	10,918
47,939	**36,009**	**47,264**	**35,441**	

The carrying value of receivables approximates their fair value.

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

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Balance at 1 July	2,162	2,549	2,162	2,549
Additional provisions made during the year	2,129	(173)	2,129	(173)
Receivables written-off during period	(363)	(214)	(363)	(214)
Balance at 30 June	**3,928**	**2,162**	**3,928**	**2,162**

As at 30 June 2009 and 2008, 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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Current	6,822	6,752	6,697	6,182
1-30 days	1,643	1,538	1,598	1,538
31-60 days	2,155	546	2,155	546
> 61 days	1,099	467	1,114	467
Balance at 30 June	**11,719**	**9,303**	**11,564**	**8,733**

10. INVENTORY

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Pharmaceuticals	2,755	2,998	2,755	2,998
Surgical and Medical Supplies	5,347	4,944	5,347	4,944
Other Supplies	2,149	1,654	2,042	1,585
	10,251	9,596	10,144	9,527
Provision for Obsolescence	(610)	(633)	(610)	(633)
9,641	**8,963**	**9,534**	**8,894**	

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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Current investments are represented by:				
Investment in Subsidiaries	-	-	300	-
Term deposits	2,896	-	2,325	-
Bonds	999	-	999	-
Total current portion	3,895	-	3,624	-
Non-current investments are represented by:				
Investment in Subsidiaries	-	-	2,128	3,208
Bonds	8,171	9,170	8,171	9,170
Total non-current portion	8,171	9,170	10,299	12,378
	12,066	**9,170**	**13,923**	**12,378**

Investment in Associates

a) General information

Name of entity	Principal activities	Interest held at 30/06/09	Balance date
South Island Shared Service Agency Limited	Provision of support services relating to South Island DHBs funding arm contracting	47%	30 June

b) Investment in associate entities

	2009 Actual $'000	2008 Actual $'000
Carrying amount at beginning of year	-	168
Investment realised through sale of assets and liabilities of NZCRM	-	(168)
Carrying amount at end of year	**-**	**-**

c) Summarised financial information of associate entity

	2009 Actual $'000	2008 Actual $'000
Assets	2,059	1,566
Liabilities	1,319	1,178
Revenues	3,351	2,473
Surplus/(deficit)	352	56
Group's interest	47%	47%

d) 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 30/06/09 $'000	As at 30/06/08 $'000
Equity - Canterbury Laundry Service Ltd	394	394
Advances - Canterbury Laundry Service Ltd	2,404	2,716
Advances - Brackenridge Estate Ltd	(370)	98
	2,428	**3,208**

At 30 June 2009 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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Term deposits	2,896	-	2,325	-
Bonds	9,170	9,170	9,170	9,170

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

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

	30/06/09 $'000	30/06/08 $'000
Term deposit with maturities of 6-12 months	571	-
Weighted average effective interest rates	*3.53%*	-
Foreign currency deposit with maturities of 6-12 months	2,325	-
Weighted average effective interest rates	*0.97%*	-

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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Trade payables	15,167	10,680	14,900	10,410
Other payables	75,591	75,731	75,478	75,750
	90,758	**86,411**	**90,378**	**86,160**

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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Non-current liabilities				
Liability for long service leave	4,849	3,877	4,832	3,852
Liability for retirement gratuities	4,776	4,707	4,776	4,707
	9,625	**8,584**	**9,608**	**8,559**
Current liabilities				
Annual leave accruals	45,334	38,932	44,540	38,353
Unpaid days accruals	7,166	5,795	7,102	5,733
ACC accruals	7,899	6,431	7,852	6,357
Conference/Sabbatical leave and expenses	16,197	11,839	16,197	11,839
Sick leave	8,842	7,313	8,706	7,192
Other	30,529	39,622	30,043	39,189
Staff entitlement due within 1 year	**115,967**	**109,932**	**114,440**	**108,663**

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

08/09 Financial year	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Revisionary interest in buildings $'000	Work in progress $'000	Total $'000
Cost or valuation							
Balance at 1 July 2008	100,083	332,840	158,005	894	1,500	8,323	601,645
Additions	-	5,001	11,877	-	-	3,402	20,280
Disposals/transfers	-	-	(3,416)	-	-	-	(3,416)
Balance at 30 June 2009	**100,083**	**337,841**	**166,466**	**894**	**1,500**	**11,725**	**618,509**
Depreciation and impairment losses							
Balance at 1 July 2008	-	59,294	110,800	894	-	-	170,988
Depreciation charge for the year	-	27,935	15,098	-	-	-	43,033
Impairment losses	-	19,802	-	-	-	-	19,802
Disposals/transfer	-	(49)	(3,167)	-	-	-	(3,216)
Balance at 30 June 2009	**-**	**106,982**	**122,731**	**894**	**-**	**-**	**230,607**

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.

07/08 Financial year	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Revisionary interest in buildings $'000	Work in progress $'000	Total $'000
Cost or valuation							
Balance at 1 July 2007	100,083	313,912	144,776	894	1,500	21,529	582,694
Additions	-	18,928	15,887	-	-	(13,206)	21,609
Disposals/transfers	-	-	(2,658)	-	-	-	(2,658)
Balance at 30 June 2008	**100,083**	**332,840**	**158,005**	**894**	**1,500**	**8,323**	**601,645**
Depreciation and impairment losses							
Balance at 1 July 2007	-	29,730	96,624	894	-	-	127,248
Depreciation charge for the year	-	29,564	16,632	-	-	-	46,196
Disposals/transfer	-	-	(2,456)	-	-	-	(2,456)
Balance at 30 June 2008	**-**	**59,294**	**110,800**	**894**	**-**	**-**	**170,988**
Carrying amount							
At 1 July 2008	**100,083**	**273,546**	**47,205**	**-**	**1,500**	**8,323**	**430,657**
At 30 June 2009	**100,083**	**230,859**	**43,735**	**-**	**1,500**	**11,725**	**387,902**

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

08/09 Financial year	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Revisionary interest in buildings $'000	Work in progress $'000	Total $'000
Cost or valuation							
Balance at 1 July 2008	100,083	332,393	150,300	894	1,500	8,296	593,466
Additions	-	4,926	11,036	-	-	3,383	19,345
Disposals/transfers	-	-	(2,331)	-	-	-	(2,331)
Balance at 30 June 2009	**100,083**	**337,319**	**159,005**	**894**	**1,500**	**11,679**	**610,480**
Depreciation and impairment losses							
Balance at 1 July 2008	-	59,105	106,462	894	-	-	166,461
Depreciation charge for the year	-	27,900	13,819	-	-	-	41,719
Impairment losses	-	19,802	-	-	-	-	19,802
Disposals/transfer	-	-	(2,127)	-	-	-	(2,127)
Balance at 30 June 2009	**-**	**106,807**	**118,154**	**894**	**-**	**-**	**225,855**

07/08 Financial year	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Revisionary interest in buildings $'000	Work in progress $'000	Total $'000
Cost or valuation							
Balance at 1 July 2007	100,083	313,625	137,427	894	1,500	21,483	575,012
Additions	-	18,768	14,772	-	-	(13,187)	20,353
Disposals/transfers	-	-	(1,899)	-	-	-	(1,899)
Balance at 30 June 2008	**100,083**	**332,393**	**150,300**	**894**	**1,500**	**8,296**	**593,466**
Depreciation and impairment losses							
Balance at 1 July 2007	-	29,691	92,823	894	-	-	123,408
Depreciation charge for the year	-	29,414	15,409	-	-	-	44,823
Disposals/transfer	-	-	(1,770)	-	-	-	(1,770)
Balance at 30 June 2008	**-**	**59,105**	**106,462**	**894**	**-**	**-**	**166,461**
Carrying amount							
At 1 July 2008	**100,083**	**273,288**	**43,838**	**-**	**1,500**	**8,296**	**427,005**
At 30 June 2009	**100,083**	**230,512**	**40,851**	**-**	**1,500**	**11,679**	**384,625**

Revaluation

Canterbury DHB revalued its land, buildings and plant fitouts 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 is in the process of preparing its Facilities Management Plan. As part of this process, a number of buildings have been identified as no longer suitable for use as clinical facilities, and consideration is being given to replacing these with modern clinical facilities. As a result of this process, the carrying amount of these buildings has been reviewed, and an impairment of $19,802,056 has been recognised as a reduction in the revaluation reserve. The value of the impairment was based on the value in use of the buildings, determined as the depreciated cost of each building.

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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Software				
Cost				
Opening balance	18,478	16,267	18,478	16,267
Additions	2,819	2,211	2,812	2,211
Disposals	(47)	-	(47)	-
Closing balance	21,250	18,478	21,243	18,478
Amortisation and impairment losses				
Opening balance	17,195	15,566	17,195	15,566
Amortisation charge for the year	2,067	1,616	2,067	1,616
Impairment losses	26	13	19	13
Closing balance	19,288	17,195	19,281	17,195
Carrying amounts	**1,962**	**1,283**	**1,962**	**1,283**

16. SURPLUS PROPERTY

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

17. 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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Balance at beginning of year	11,522	10,931	11,402	10,825
Interest received	846	1,121	840	1,099
Donations and funds received	2,326	683	2,326	683
Funds spent	(2,211)	(1,213)	(2,211)	(1,205)
Balance at end of year	**12,483**	**11,522**	**12,357**	**11,402**

Residents' trust accounts	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Residents' trust account balance	**893**	**846**	**310**	**302**

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.

18. BORROWINGS

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Non-current				
Crown Health Financing Agency loans	75,000	75,000	75,000	75,000
Total non-current borrowings	75,000	75,000	75,000	75,000
Total borrowings	**75,000**	**75,000**	**75,000**	**75,000**

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	
	30/06/09 $'000	30/06/08 $'000	30/06/09 $'000	30/06/08 $'000
Crown Health Financing Agency loans				
Later than one year but not more than five years	60,000	60,000	60,000	60,000
Weighted average effective interest rate	*6.22%*	*6.39%*	*6.22%*	*6.39%*
Later than five years	15,000	15,000	15,000	15,000
Weighted average effective interest rate	*6.13%*	*6.13%*	*6.13%*	*6.13%*

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

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

19. RECONCILIATION OF NET SURPLUS/(DEFICIT) FOR THE PERIOD WITH NET CASH FLOWS FROM OPERATING ACTIVITIES

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Net surplus/deficit	(12,361)	(16,766)	(12,631)	(16,499)
Add back non-cash items:				
Depreciation and amortisation	45,100	47,808	43,786	46,439
Add back items classified as investing activity:				
(Gain) / loss on asset sale	(10,309)	135	(10,300)	142
	22,430	31,177	20,855	30,082
Movement in term portion provisions/staff entitlements	1,041	258	1,049	252
Movements in working capital:				
Decrease/(increase) in receivables & prepayments	(11,930)	(11,727)	(11,823)	(11,528)
Decrease/(increase) in stocks	(678)	(788)	(640)	(784)
Increase/(decrease) in creditors & other accruals	4,347	6,301	4,218	5,374
Increase/(decrease) in capital charge due to crown	(2,035)	(6,623)	(2,035)	(6,623)
Increase/(decrease) in staff entitlements	6,035	9,387	5,777	9,128
Increase/(decrease) in provisions	-	(200)	-	-
Net cash inflow/(outflow) from operating activities	**19,210**	**27,785**	**17,401**	**25,901**

20. COMMITMENTS

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Capital Commitments				
Property, plant and equipment	15,845	11,201	15,845	11,201
Intangible assets	2,562	4,174	2,562	4,174
Other capital commitments	16,408	11,198	16,370	11,198
Total Capital Commitments at Balance Date	**34,815**	**26,573**	**34,777**	**26,573**
Non Cancellable Operating Lease Commitments				
Accommodation leases	7,463	8,939	3,614	4,754
Vehicle leases	-	-	-	-
Other	11	11	-	-
	7,474	**8,950**	**3,614**	**4,754**
For Expenditure Within:				
Not later than one year	1,590	1,879	1,053	1,352
Later than one year and not later than five years	2,621	3,181	1,211	1,763
Later than five years	3,263	3,890	1,350	1,639
	7,474	**8,950**	**3,614**	**4,754**

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 ongoing 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 Group'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. 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. Information is not disclosed on these claims, as this may prejudice the legal position of the DHB.

b. 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.

c. Legal decisions with flow-on implications
A recent ruling in an employment court case to which Canterbury DHB was not a party may have flow-on implications for the DHB, depending on decisions and actions by the Crown. Accordingly at this stage, there is an unquantified contingent liability for the DHB.

22. CATEGORIES OF FINANCIAL ASSETS AND LIABILITIES

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Investments in subsidiaries and associates	-	-	2,428	3,208
Loans and receivables				
Cash and cash equivalents	47,497	42,339	45,870	40,240
Debtors and other receivables	47,939	36,009	47,264	35,441
Bonds	9,170	9,170	9,170	9,170
Term deposits (term>3 months)	2,896	-	2,325	-
Total loans and receivables	**107,502**	**87,518**	**104,629**	**84,851**
Fair value through profit and loss				
Restricted assets	12,483	11,522	12,357	11,402
Restricted liabilities	12,483	11,522	12,357	11,402
Other financial liabilities				
Creditors and other payables	95,952	93,640	95,572	93,389
Borrowings- CFA loans	75,000	75,000	75,000	75,000
Total other financial liabilities	**170,952**	**168,640**	**170,572**	**168,389**

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 invests 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 2009, the Ministry of Health owed Canterbury DHB $26.9 million ($14.9 million at 30 June 2008).

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 2009 was nil (2008: nil).

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 2009 (30 June 2008 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 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Less than 6 months	90,758	86,411	90,378	86,160
Total	**90,758**	**86,411**	**90,378**	**86,160**

24. CAPITAL MANAGEMENT

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

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

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

25. RELATED PARTIES

Government funding

Canterbury DHB is a wholly owned entity of the Crown. The government significantly influences the role of 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	
	30/06/09 $'000	30/06/08 $'000	30/06/09 $'000	30/06/08 $'000
Revenue				
Interest on advance and director's fees from/to Canterbury Laundry Service Ltd	-	-	190	235
Interest on advance to Brackenridge Estate Ltd	-	-	6	-
Service fees to Brackenridge Estate Ltd	-	-	48	48
Services to Canterbury Laundry Service Ltd	-	-	427	427
Service fees to Canterbury Laundry Service Ltd	-	-	11	11
Services to South Island Shared Service Agency Ltd	80	-	80	-
Services to New Zealand Centre for Reproductive Medicine Ltd and interest on advance	-	27	-	27
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	4,420	3,927
Interest on advance from Brackenridge Estate Ltd	-	-	6	18
Services from New Zealand Centre for Reproductive Medicine Ltd	-	1,224	-	1,224
Services from South Island Shared Service Agency Ltd	1,351	994	1,351	994

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.

Canterbury DHB pays for items such as power and insurance on behalf of Canterbury Laundry Service Ltd, and is reimbursed the full amount. These amounts are not included in the above numbers

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

	Group		Parent	
	As at 30/06/09 $'000	As at 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Amount receivable owing by associates				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	196	103	196	103
Amount payable owing to associates				
South Island Shared Service Agency Ltd	567	-	567	-
Amount payable owing to subsidiaries				
Brackenridge Estate Ltd – advance	-	-	370	-
Canterbury Laundry Service Ltd	-	-	456	372
Amount receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – debtor	-	-	51	87
Canterbury Laundry Service Ltd – advance	-	-	2,450	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 30/06/09 $'000	Year ended 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Pegasus Health (Charitable) Ltd	1,403	2,063	18	-
Ryman Healthcare Ltd	8,348	6,845	-	-
Access Home Health	4,538	3,946	-	-
Deloitte	32	98	-	-
McLeans Institute	173	133	-	-
University of Canterbury	117	112	2	4
Age Concern Canterbury	2	1	1	-
Social Services Council of the Diocese of Christchurch	4,859	4,262	-	-
Nurse Maude	24,162	22,247	3	-
Medical Protection Society	105	102	1	1
Partnership Health Primary Health Organisation	69,714	63,362	478	-
Hurunui-Kaikoura Primary Health Organisation	3,623	3,429	-	-
Amuri Health Centre Ltd	2	3	2	-
Te Runanga O Ngai Tahu	4	-	-	-
University of Otago	8,419	7,635	336	929
Environment Canterbury	19	20	-	-

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 $92,050 has been made (2008 $22,482).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/09 $'000	Year ended 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Pegasus Health	19	138	6	15
University of Canterbury	324	55	33	3
Christchurch Polytechnic Institute of Technology (CPIT)	392	340	27	20
Nurse Maude	60	56	51	19
Canterbury Medical Research Foundation	83	111	35	21
Partnership Health Primary Health Organisation	129	128	(22)	-
Hurunui Kaikoura Primary Health Organisation	1	2	-	1
24 Hour Surgery Ltd	3	31	-	-
Environment Canterbury	3	2	-	-
Southlink Health	9	42	-	6
University of Otago	3,513	2,700	543	779

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 (2008 $nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/09 $'000	Year ended 30/06/08 $'000	As at 30/06/09 $'000	As at 30/06/08 $'000
Services purchased by Canterbury DHB:				
Heart Centre at St George's	1,328	728	-	-
Te Kura Kaupapa Māori o Te Whanau Tahi	7	2	-	-
Christchurch Polytechnic Institute of Technology	23	23	-	-
Heart Vision Ltd	2	-	-	-
Services purchased from Canterbury DHB:				
Heart Centre at St George's	31	45	2	4
Te Kura Kaupapa Māori o Te Whanau Tahi	-	-	-	-
Christchurch Polytechnic Institute of Technology	392	340	27	20
Heart Vision Ltd	-	-	-	-

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. He is also the Chair, Board of Trustees, Te Kura Kaupapa Māori o Te Whanau Tahi.

Compensation of key management personnel:

	Group		Parent	
	Year ended 30/06/09 $'000	Year ended 30/06/08 $'000	Year ended 30/06/09 $'000	Year ended 30/06/08 $'000
Salaries & other short term employee benefits	1,851	1,609	1,851	1,609
Post-employment benefits	255	245	255	245
Total key management personnel compensation	**2,106**	**1,854**	**2,106**	**1,854**

The above compensation of key management personnel does not include Board and Committee members' fees. For Board and Committee members' fees see page 8.

26. SUBSEQUENT EVENTS

There were no events after 30 June 2009 which could have a material impact on the information in Canterbury DHB's financial statements (30 June 2008 – no events).

27. BUDGET VARIANCE

Additional personal health funding for HPV, elective initiatives, Care Plus and further one-off funding contracts were devolved during the year and were not reflected in these budgets.

STATEMENT OF SERVICE PERFORMANCE

OVERVIEW

In 2004 Canterbury DHB developed its District Strategic Plan, A Healthier Canterbury Directions 2010, and identified mix of population, service and disease based Strategic Priorities for Canterbury. The Strategic Priorities represent areas where 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.

Nine Strategic Priorities were identified:

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

This Statement of Service Performance describes the DHB's non-financial performance under each Strategic Priority area and provides an indication of how well activity over the past year contributed to improving the health and well-being of the Canterbury population. The Statement of Service Performance also measures governance and operational performance, ensuring the DHB is delivering sustainable and quality services effectively and efficiently.

The DHB updates its Forecast Statement of Service Performance annually and continues to develop and refine the associated performance measures it uses, to ensure they appropriately reflect the objectives and activity of the DHB and meet the expectations of the Minister of Health.

The performance measures include national measures, which are consistent across all 21 DHBs, along with local measures and targets. The national 'Health Targets' are the measures that reflect the Minister of Health's expectation for 2008/09 and these are mixed through the Statement of Service Performance and also summarised on the following page.

While the DHB provides a large volume of hospital and specialist services the DHB is also often the funder of service for its community and works in partnership with other health and disability service providers, external agencies and organisations to collectively improve the health of its community. As the funder, the DHB is reliant on a third party to deliver the outputs needed to achieve the desired outcomes or objective and its role is in influencing and enabling change through partnership, leadership and supportive contracting. A number of the associated performance measures in the 2008/09 Statement of Service Performance were chosen to provide an indication of the success of that collective and collaborative approach.

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

HEALTH TARGETS

HEALTH TARGET	GOAL	RESULT 2008/09
Improving Immunisation Coverage	Progress towards 95% of two year olds fully immunised. Target 88%	***Partially Achieved.*** Total coverage 86%. An increase of 2% on the previous year and 6% above the national average.
Improving Oral Health	Progress towards 85% of adolescents reached by oral health services. Target 70%	***Partially Achieved.*** 68.2%, 216 more than in the previous year and 9.9% above the national average of 58.3%
Improving Elective Services	Maintain compliance with Elective Services Patient Flow Indicators (ESPIs). Deliver an agreed increase in the number of elective services discharges provided. Target 14,180 discharges	***Achieved.*** The DHB was compliant for the 2008/09 year. 14,809 elective discharges were delivered, 1,888 more than the previous year.
Reducing Cancer Waiting Times	Progress towards 100% of patients waiting less than six weeks from the decision to treat to the start of treatment. Target 81%	***Achieved.*** 91% of all patients started radiation treatment within six weeks – a 10% improvement on the previous year.
Reducing Ambulatory Sensitive (Avoidable) Hospital Admissions	A decline in the number of admissions to hospital that are avoidable or preventable.	***Achieved.*** Of the three targets for this indicator two were achieved and one partially achieved. This is an improved result on the previous year.
Improving Diabetes Services and Cardiovascular Disease	An increase in proportion of the population expected to have diabetes having free annual diabetes checks. Target 43% An increase in the proportion of those receiving free annual checks that have good diabetes management. Target 77%	***Not Achieved.*** 38% of the population expected to have diabetes received a free annual check. ***Achieved.*** 78% of those people receiving a free diabetes check had good diabetes control.
Improving Mental Health Services	National target - 90% of long-term mental health clients have up-to-date relapse prevention plans. Target 95%	***Partially Achieved.*** A total of 89% of all clients have current plans. We have exceeded this target for adult clients and are slightly below for child and youth. Long term service users in this area include a number of children who require specialist prescribing only.
Improving Nutrition Increasing Physical Activity and Reducing Obesity	Increase the proportion of babies fully or exclusively breastfed. Target 6wks74% 3mths57% 6mths27% Increase the proportion of adults having three servings of vegetable and two servings of fruit a day. Target veg70% fruit 62%	***Partially Achieved.*** 6wks 68%, 3mths 57% and 6mths 28% ***Not Achieved.*** 69% of adults ate 3+ servings of vegetables. ***Achieved.*** 62% of adults ate 2+ servings of fruit a day.
Reducing the Harm Caused by Tobacco	Increase the proportion of 'never smokers' amongst Year 10 students. Target 61% Reduce the prevalence of exposure of non-smokers to second-hand smoke inside the home. National Target 5%	***Achieved.*** 64% of all Year 10 students are 'never smokers'. ***Partially Achieved.*** 7.1% of non-smokers are exposed to second-hand smoke inside their home. This is an improvement on 8.4% in 2007/08.

MANAGING ORGANISATIONAL HEALTH: GOVERNANCE OF THE DHB

The DHB is effectively and efficiently governed by its Board.

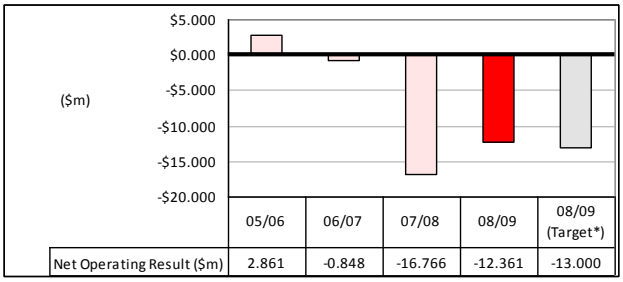
The DHB is responsible for identifying needs, allocating funding and providing services to improve health outcomes for the Canterbury population. The performance of these responsibilities must be guided, overseen and monitored by an effective governance Board.

Our long term objective is to improve the DHB's capability and capacity to meet the needs of its population and deliver against national expectations and national objectives by providing effective leadership and governance for the Canterbury Health System.

MAINTAIN SUSTAINABILITY

The DHB meets its financial targets and maintains financial breakeven.

Measure - Net Operating Results compared with expected.



	05/06	06/07	07/08	08/09	08/09 (Target*)
Net Operating Result ($m)	2.861	-0.848	-16.766	-12.361	-13.000

*Approved Revised Target

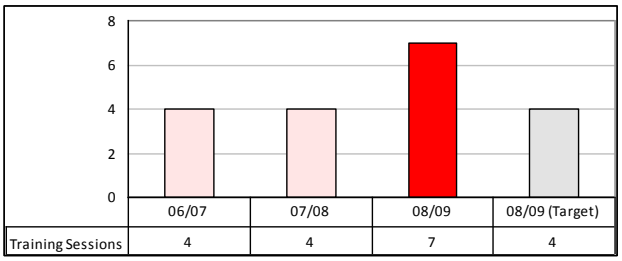
Achieved.

The DHB result reflects achievement of the modified target agreed in November 2008 with the incoming Minister of Health. This target differs from the earlier one published in the Statement of Intent. This is a positive move towards a sustainable breakeven position in 2010/11 and includes significant unexpected H1N1 pandemic costs of around $900,000.

MAINTAIN QUALITY OF LEADERSHIP

Achieve and Maintain ongoing Board and Committee Training Sessions (governance and operational).

Measure - Board and Committee training sessions delivered.



	06/07	07/08	08/09	08/09 (Target)
Training Sessions	4	4	7	4

Achieved.

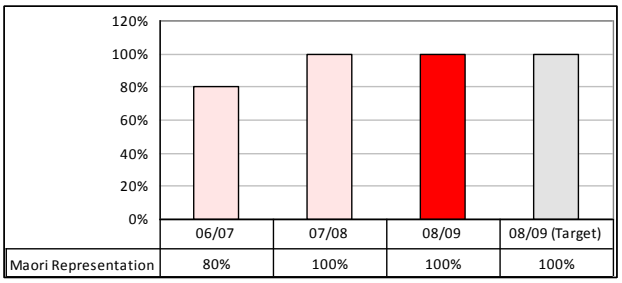
The DHB has achieved this target and delivered seven different governance training sessions or forums over the past year.

The DHB has also continued to monitor organisational results and performance through review of monthly and quarterly reports to the Board and has delivered its accountability documents to the Ministry and Parliament within required timeframes and in accordance with legislative guidelines.

MAINTAIN PARTNERSHIPS WITH LOCAL IWI AND MĀORI GROUPS

Māori representation is achieved and maintained on the DHB's Board and Statutory Committees.

Measure – Percentage (%) of Board and Statutory Committees with current Māori representation.



	06/07	07/08	08/09	08/09 (Target)
Maori Representation	80%	100%	100%	100%

Achieved.

100% of the DHB's Board and its Statutory Committees currently have Māori representative members.

Over the past year the DHB has agreed Terms of Reference with Manawhenua Ki Waitaha in line with its Memorandum of Understanding to allow for increased participation by Māori in the development and delivery of health and disability services.[4]

The DHB has also sought to maintain public participation by advertising all Board and Statutory Committee meetings and providing for public attendance. The DHB provides all public meeting agendas and papers on its website.

[4] *Manawhenua ki Waitaha is a representative group which comprises the seven Ngai Tahu Runanga.*

CHILD AND YOUTH HEALTH

Build healthy foundations for our child and youth populations to ensure long-term wellbeing.

Higher rates of ambulatory sensitive (avoidable or unnecessary) hospital admissions can indicate poor access to effective primary and social services. Canterbury's rates are higher than the national average for the 0-4 year old age group and a reduction in these rates will indicate improvements in health that will lead to healthier young people and healthier adults.

Partnerships across the health system will assist in facilitating the provision of high quality preventative care and early intervention; reducing unnecessary admissions and building solid foundations for life-long good health, particularly around:

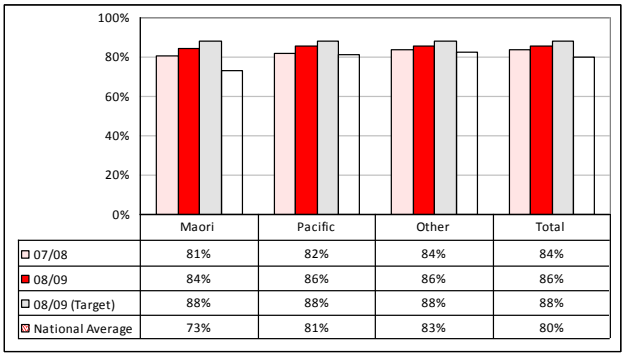
- Immunisation which is one of the most cost-effective and successful preventative health interventions known and an important component in keeping both children and adults free from vaccine preventable disease;
- Regular dental care which has life-long benefits for improved health and is recognised as a precursor of ongoing health and wellbeing in adulthood; and
- Breastfeeding which contributes positively to infant and maternal health and influences the likelihood of adult obesity.

Our long-term objective is improved health status for our child and youth populations, particularly for those with high needs or those living in environmentally disadvantaged situations. We aim to demonstrate the establishment of good foundations for wellbeing, establishment of healthy behavioural patterns and improved access to health and disability services in order to reduce unnecessary or avoidable hospital admissions.

IMPROVE UTILISATION OF SERVICES

Families and young people have regular contact with primary and community health care services.

Measure – The % of children fully immunised at age two. [5]



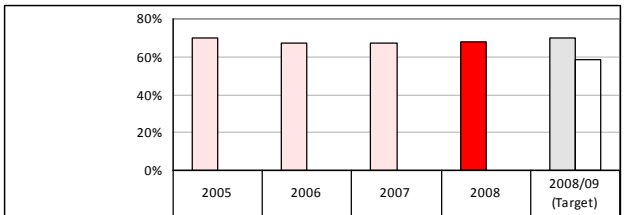
	Maori	Pacific	Other	Total
07/08	81%	82%	84%	84%
08/09	84%	86%	86%	86%
08/09 (Target)	88%	88%	88%	88%
National Average	73%	81%	83%	80%

Partially Achieved.

5,718 two year olds were immunised in 2008/09; bringing the total coverage to 86%. While the target was not reached there has been steady improvement and Canterbury rates are currently 6% above the national average.

Of note is that 5% of the eligible population are not fully immunised as a result of having 'opted-off' the national immunisation register or having 'declined' one or more of the immunisations being offered to them. Including those people 91% of the eligible population are being reached.

Measure - The % of adolescents (13-17) utilising oral health services. [6]



	2005	2006	2007	2008	2008/09 (Target)
Utilising Oral Hlth Services	69.9%	67.2%	67.4%	68.2%	70.0%
National Average					58.3%

Partially Achieved.

Using 2001 population projections against which the target was set 68.2% of the eligible adolescent population utilised oral health services in Canterbury. An additional 216 adolescents seen than in the previous year.

Canterbury access rates continue to be above the national average and the DHB will maintain high rates of transfer for child oral health services, good relationships with dentists in private practice and work in lower decile high schools; all to continue to improve utilisation.

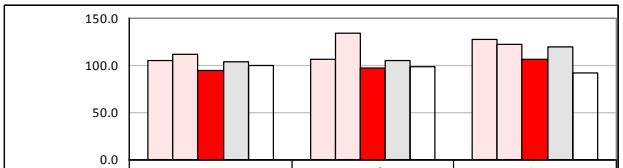
[5] *Immunisation data comes from the National Immunisation Register (NIR) rolled-out in 2005, it was not until November 2007 that Canterbury children, registered on the NIR at birth, reached age two and hence there is no data prior to this date.*

[6] *Oral health data is provided by calendar year, from the Ministry of Health's payment agency HealthPac. During 2008/09 the population projection was changed nationally from 29,315 eligible adolescents to 30,490. Using the higher population projections 65.6% of eligible population utilised dental services - which is still a positive increase against the previous year which (using the same population) was 64.9%.*

IMPROVE THE QUALITY OF TREATMENT

A reduction in avoidable adverse events or outcomes.

Measure - Ambulatory Sensitive Hospital Admissions (ASH) for those aged 0-4 years (ISR).[7]



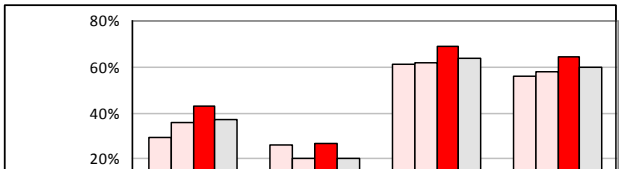
	Māori	Pacific	Other
06/07	105.6	106.5	127.9
2007	111.9	134.0	122.5
2008	94.6	97.8	106.0
08/09 (Target)	104.0	105.0	120.0
National Average	100.1	98.1	92.4

Achieved.

The DHB has met its target across all ethnicity groups for this age group and has achieved better than the national average for Māori and Pacific groups. A much improved result against the previous year.

The DHB has implemented a number of nationally funded screening programmes to improve early intervention and reduce unnecessary hospital admissions including Newborn Hearing Testing, B4 School Checks and the national Violence Intervention Guidelines and has also implemented its local Improving the Patient Journey programme in its child health service.

Measure - The % of children with no holes or fillings 'in their teeth' (caries free) at age five. [8]



	Maori	Pacific	Other	Total
2006	29%	26%	61%	56%
2007	36%	20%	62%	58%
2008	43%	27%	69%	64%
08/09 (Target)	37%	20%	64%	60%

Achieved.

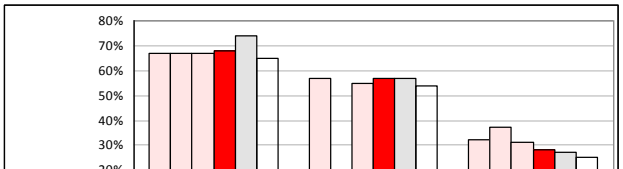
The DHB has exceeded the target for all ethnicity groups a positive achievement, particularly considering that water fluoridation can significantly reduce tooth decay and less than 5% of children in Canterbury have access to fluoridated water.

The DHB continues the implementation of the national Oral Health Reform, improving the oral health service provided to children and young people in the Canterbury region. The DHB will implement its Oral Health Business case in the coming year including a new service model and mobile oral health service and further improvement is likely.

IMPROVE PATHWAYS BETWEEN SERVICES

Mothers are supported to breastfeed their babies in hospital and on their return home.

Measure – The % of children exclusively/fully breastfed. [9]



	6 Weeks	3 Months	6 Months
05/06	67%	57%	32%
06/07	67%		37%
07/08	67%	55%	31%
08/09	68%	57%	28%
08/09 (Target)	74%	57%	27%
National Average	65%	54%	25%

Partially Achieved.

The results for 2008/09 demonstrate that 68% of babies were fully or exclusively breastfed at age 6 weeks, 57% at age 3 months and 28% at age 6 months. This is an achievement of the 3 and 6 month targets and a slight improvement at 6 weeks. Canterbury's results are above the national average for all age groups.

The DHB has progressed key projects around breastfeeding including the establishment of a Breastfeeding Advocacy Service, peer support programmes to support breastfeeding, the appointment of a community-based lactation consultants and a successful collaborative breastfeeding Hui.

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[7] *ASH Admissions are admission to hospital that are seen as potentially preventable by access to appropriate community and primary health care and reflect a mix of 37 conditions including: Asthma, Dehydration, Diabetes, Ruptured Appendix, Vaccine Preventable Disease, Dental Conditions, Gastroenteritis and Failure to Thrive (poor nutrition). The expected rate is the age-group specific national average admission rate and if actual matches expected the ratio equals 100 – a ratio greater than 100 indicates performance below the national average. 2006/07 figures were for the year end June 2007. 2007 and 2008 figures were for the year end December.*

[8] *Small population numbers for Māori and Pacific age groups make it difficult to set targets for these populations and therefore confidence intervals were built into the 2008/09 targets.*

[9] *Breastfeeding data is provided by Plunket – no data was provided for the 3 month age group in 2006/07. The targets emphasising the aim to focus on increasing rates at 6 wks and 3mths and maintain rates at 6mths where Canterbury is already higher than the national average.*

OLDER PERSON'S HEALTH

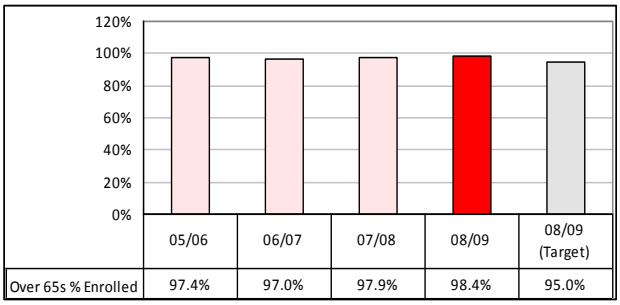
Ensure our older population remain healthier and are appropriately supported in the community.

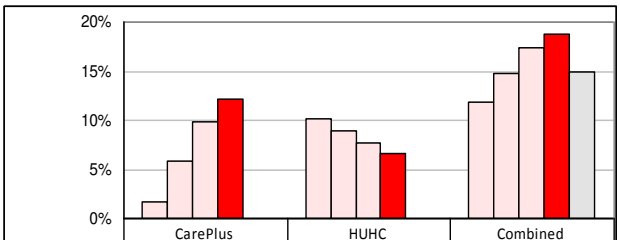
As people get older their health needs usually increase, are likely to be more complex with longer and more severe impacts and they are more likely to suffer from long-term (chronic) conditions.

Effective health and disability support services are important in keeping people well and avoiding unnecessary hospital and residential care admissions. Increasing access to primary and preventative care (such as flu vaccination and falls prevention programmes) is expected to improve health outcomes and reduce avoidable admissions for older people.

Older people also require more disability support services and generally they prefer to receive these services in their own homes, rather than entering hospital or residential care. Research shows people supported in their own homes have better health outcomes than those admitted to residential care, however this 'ageing in place' philosophy requires people to be safe in their homes and to maintain good health for longer.

The long term objective is to improve health outcomes for older Canterbury residents, deliver positive outcomes and meet increasing demand, all within available resources. The DHB also aims to demonstrate an emphasis on flexible, holistic, high quality and needs-based care provided in the community to assist older people to stay well and to age in their own home.

<table>
<tr><th colspan="2">IMPROVE ACCESS TO TREATMENT</th></tr>
<tr><td colspan="2">Older people have regular contact with primary and community health care services.</td></tr>
<tr><td>Measure - The % of the Canterbury population over 65 enrolled with a Primary Health Organisation (PHO).
 

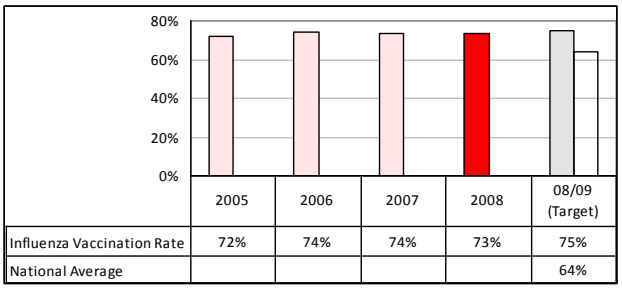
<table>
<tr><th></th><th>05/06</th><th>06/07</th><th>07/08</th><th>08/09</th><th>08/09 (Target)</th></tr>
<tr><td>Over 65s % Enrolled</td><td>97.4%</td><td>97.0%</td><td>97.9%</td><td>98.4%</td><td>95.0%</td></tr>
</table></td><td>Achieved.
The percentage of the population enrolled with PHOs continues to be maintained at high percentages, in excess of the target.</td></tr>
<tr><td>Measure – The % of people over 65 enrolled with a PHO and accessing CarePlus or High User Health Card services.
 

<table>
<tr><th></th><th>CarePlus</th><th>HUHC</th><th>Combined</th></tr>
<tr><td>05/06</td><td>1.7%</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>08/09</td><td>12.1%</td><td>6.6%</td><td>18.7%</td></tr>
<tr><td>08/09 (Target)</td><td></td><td></td><td>15.0%</td></tr>
</table></td><td>Achieved.
Steady progress continues to be made with appropriate emphasis being placed on the new CarePlus programme rather than the older High User Health Card system.
CarePlus provides low cost enhanced primary care for people with two or more long-term (chronic) conditions. People over 65 are more likely to have more complicated and multiple long-term conditions and enrolments are indicative of people with long-term conditions accessing appropriate primary care.</td></tr>
</table>

IMPROVE THE QUALITY OF TREATMENT

Older people are supported to stay well and healthy through appropriate and targeted early intervention.

Measure – The % of people over 65 receiving influenza vaccinations. [10]



	2005	2006	2007	2008	08/09 (Target)
Influenza Vaccination Rate	72%	74%	74%	73%	75%
National Average					64%

Not Achieved.

The steady growth in Canterbury's over 65 population means more vaccinations must be delivered just to maintain current percentages. While there has been a slight drop-off in the end of year results against last year, the actual number of vaccinations delivered has increased with 942 more people having been vaccinated in 2008/09.

Canterbury rates continue to be well above national rates.

IMPROVE THE PATHWAYS BETWEEN PRIMARY AND SECONDARY SERVICES

People are supported to stay in their own homes through accessible pathways and the provision of integrated service delivery.

Measure - The number of people referred to community-based Stay on Your Feet fall prevention programmes.

	05/06	06/07	07/08	08/09	08/09 (Target)
Number Referred	287	229	374	287	270

Achieved.

The DHB has also implemented an internal falls prevention programme to reduce and minimise falls in its Older Person's Health Hospital and Specialist Service.

[10] *This data is provided through the PHO Performance Programme and relates to the calendar year 2008*

MĀORI HEALTH

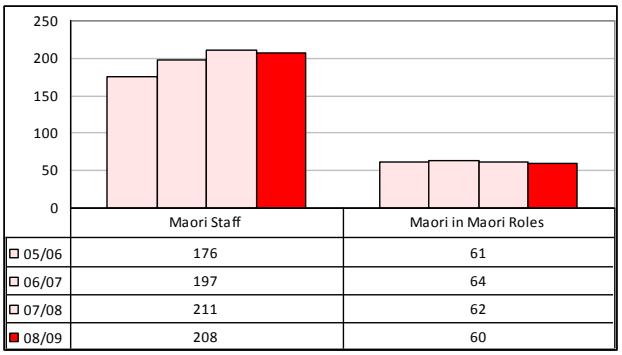
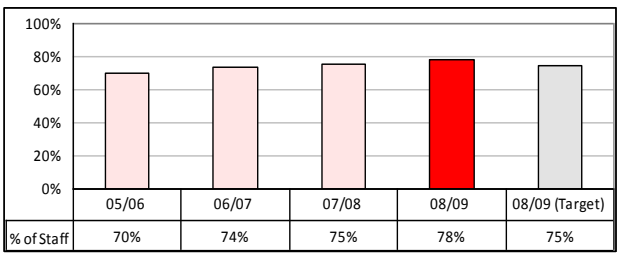
Improve the acceptability of health and disability services to increase Māori utilisation and support a reduction in inequalities in health status and an improvement in health outcomes.

Although progress has been made, Māori, on average, have the poorest health status of any group in NZ and are less likely to access mainstream primary and secondary health and disability services.

With an increasing Māori population in Canterbury Māori participation in service development and in the health workforce needs to be fostered to improve the cultural responsiveness of mainstream primary and secondary services. This includes active participation at governance and advisory levels, a focus on Māori-led service provision and service development and increased participation in the health workforce.

A clear understanding of gaps and inequalities needs to be maintained in order to effectively target service and improve access for those people most in need. This has been recognised in the DHB's Māori Health Plan where effective ethnicity data collection, health status monitoring and identification of areas of inequality are a focus.

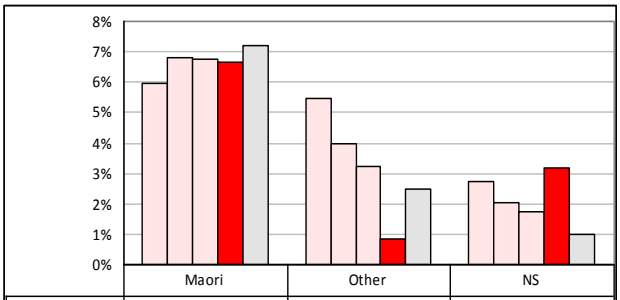
The long-term objective is to improve health outcomes for Māori in Canterbury, reduce inequality in access to services and demonstrate that Māori and their Whānau are supported to achieve their maximum health and wellbeing – Whānau Ora.

IMPROVE UTILISATION OF SERVICES BY IMPROVING RESPONSIVENESS	
The responsiveness and cultural awareness of health services is improved to reduce barriers and increase Māori utilisation.	
Measure - The (i) number of DHB staff identifying as Māori and (ii) Māori staff working in Māori specific roles.  Maori Staff / Maori in Maori Roles 05/06: 176 / 61 06/07: 197 / 64 07/08: 211 / 62 08/09: 208 / 60	*The DHB's target was to monitor staffing numbers, which is done on a regular basis and reported through the DHB's Executive Director of Māori Health to its Board and Statutory Committees as well as to Manawhenua Ki Waitaha.* *The DHB has also introduced a specialist recruitment scheme offering road shows to encourage health as a career and scholarships to support Māori wanting to study to work in primary care settings. There were eight successful applicants for the scholarships in the first year.*
Measure - The number of DHB staff with ethnicity disclosed.  05/06 / 06/07 / 07/08 / 08/09 / 08/09 (Target) % of Staff: 70% / 74% / 75% / 78% / 75%	**Achieved.** *Steady improvement in the recording of staff ethnicity continues to be made and the DHB has exceeded its target.*

IMPROVE THE QUALITY OF SERVICE PLANNING

Planning and targeting of appropriate services to improve Māori Health is improved through the collection of robust ethnicity data.

Measure - The % of inpatients classified by ethnicity group (reducing those recorded as Not Stated or Other).[11]



	Maori	Other	NS
05/06	6.0%	5.5%	2.7%
06/07	6.8%	4.0%	2.1%
07/08	6.8%	3.2%	1.7%
08/09	6.7%	0.8%	3.2%
08/09 (Target)	7.2%	2.5%	1.0%

Partially Achieved.

Overall the inpatient discharge data is consistent with the previous year. The sum of 'other' and 'not stated' has decreased from 4.9% in 2007/08 to 4% in 2008/09; this indicates that the quality of data collection and coding of ethnicity is improving. However further improvements are still required.

Note that a national change in ethnicity codes (backswept through 2008/09) has resulted in the shift from 'Other' to 'Not Stated'. This change moved a number of people who were previously identified under 'Other' to a new category 'Response Unidentifiable' which is grouped under 'Not Stated'.

IMPROVE THE PATHWAYS BETWEEN PRIMARY AND SECONDARY SERVICES

Māori are engaged and participate in health planning and decision-making across the whole of the health system.

Measure - The % of PHOs with DHB approved Māori Health Plans.

	05/06	06/07	07/08	08/09	08/09 (Target)
% PHOs with Maori HP	0%	60%	100%	100%	100%

Achieved.

All Canterbury PHOs have approved Māori Health Plans in place to better enable them to better meet the needs of their enrolled Māori populations.

[11] *This target reflects the DHB's long-term goal to bring ethnicity reporting in line with current Census figures.*

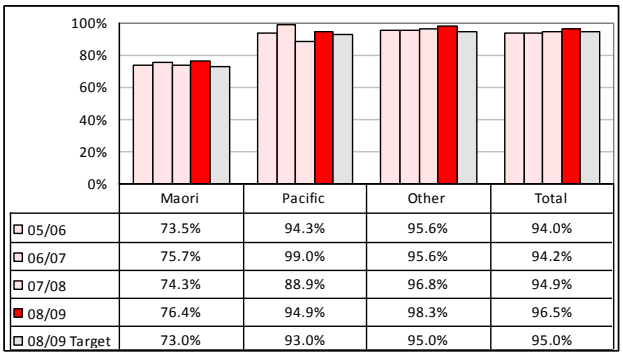
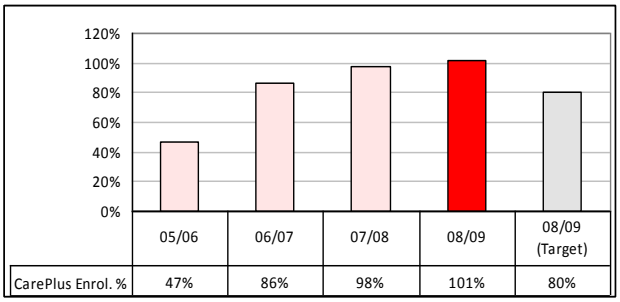
PRIMARY HEALTH

Reduce barriers to primary care to improve the health of our community and avoid unnecessary hospitalisations and build partnerships to improve the management of acute demand.

Primary care is often the first point of contact with health services and reducing barriers to access helps people stay well. Costs are a key barrier to access for some people and hospitalisation rates for people on lower incomes are higher than the Canterbury average. There are also currently more pharmacy prescriptions dispensed per person in Canterbury than the national average for all age groups, except those over 65.

Collaborative programmes across the whole of the health system are key to managing growing acute demand pressures and improving after-hours services to ensure people receive the most appropriate level of care in the most appropriate place. The development of clinically-led integrated pathways of care in priority areas will also support and enhance services to better manage people with long-term conditions.

The long-term objective is to increase the number of people accessing primary health services in Canterbury, particularly people with high needs and those on lower incomes and demonstrate improvements in the range and effectiveness of services provided in primary care settings.

IMPROVE ACCESS TO SERVICES	
People have regular contact with primary care services and are supported to stay well through early diagnosis and intervention.	
Measure – Maintain high PHO enrolment levels with an increase in Māori enrolment as a high needs group-. [12] 	**Achieved.** *PHO enrollment continues to remain high and targets have been achieved across all ethnicity groups.*
Measure – The % of the eligible PHO population enrolled in CarePlus services. 	**Achieved.** *The DHB has achieved its target for CarePlus enrolment levels and achieves 101% by having even more than the 'expected' percentage of the eligible population enrolled.* *CarePlus provides low cost enhanced primary care for people with two or more long-term (chronic) conditions. High enrolment levels are indicative of people with long-term conditions accessing appropriate primary care.*

	Maori	Pacific	Other	Total
05/06	73.5%	94.3%	95.6%	94.0%
06/07	75.7%	99.0%	95.6%	94.2%
07/08	74.3%	88.9%	96.8%	94.9%
08/09	76.4%	94.9%	98.3%	96.5%
08/09 Target	73.0%	93.0%	95.0%	95.0%

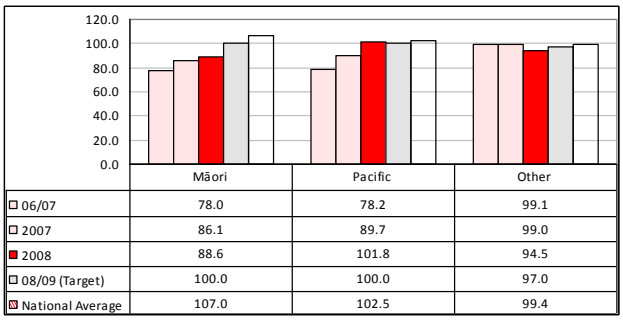
	05/06	06/07	07/08	08/09	08/09 (Target)
CarePlus Enrol. %	47%	86%	98%	101%	80%

[12] *These PHO enrolment results are as at 1 April each year. There was a change in population projections between 2006/07 (based on 2001 census) and 2007/08 onwards (based on 2006 census) for example the Pacific population base moved from 8,940 to 10,315.*

IMPROVE THE QUALITY OF TREATMENT

A reduction in avoidable adverse events or outcomes.

Measure – Ambulatory Sensitive Hospital Admissions for those aged 45-64 years (ISR). [13]



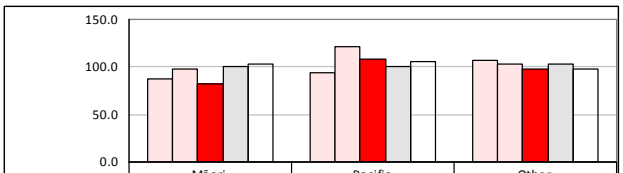
	Māori	Pacific	Other
06/07	78.0	78.2	99.1
2007	86.1	89.7	99.0
2008	88.6	101.8	94.5
08/09 (Target)	100.0	100.0	97.0
National Average	107.0	102.5	99.4

Achieved.

The DHB achieved the target for Māori and Other groupings and there were 6.4 fewer avoidable hospital admissions over the past year for those aged 45-64. While Pacific admissions were slightly above the target the small population numbers means that this amounts to 97.8 actual vs 96.1 expected admissions.

The Canterbury results were better than the national average across all ethnicity groups.

Measure - Ambulatory Sensitive Hospital Admissions for those aged 0-74 years (ISR).



	Māori	Pacific	Other
06/07	88.0	93.5	106.7
2007	97.5	121.3	102.8
2008	82.0	108.4	97.5
08/09 (Target)	100.0	100.0	103.0
National Average	103.4	105.4	97.5

Partially Achieved.

There were 463.1 fewer avoidable hospital admissions over the past year for those aged 0-74. Again Pacific admissions were slightly above the target – 446.8 actual admissions vs 412.4 expected admissions and slightly above than the national average. However this is an improved result against the previous year.

The Canterbury results were better than the national average across the Māori and Other ethnicity groups.

IMPROVE THE PATHWAYS BETWEEN PRIMARY AND SECONDARY SERVICES

The recording of National Health Index (NHI) numbers on prescriptions helps to improve data analysis on prescribing patterns and health needs and support collaborative strategies for optimising the effectiveness of community pharmaceutical and laboratory expenditure.

Measure - The number of valid NHI recorded on prescriptions.

	05/06	06/07	07/08	08/09	08/09 (Target)
% Valid NHI	87%	92%	94%	95%	95%
National Average					96%

Achieved.

The DHB continues to see steady improvement in NHI recording and has met the target.

Over the past year the DHB has completed analysis on NHI recording, identified general practices with lower levels of reporting and is collaborating with PHOs to achieve higher recording rates.

[13] *ASH Admissions are admission to hospital that are seen as potentially preventable by access to appropriate community and primary health care and reflect a mix of 37 conditions. The expected rate is the age-group specific national average admission rate and if actual matches expected the ratio equals 100 – a ratio greater than 100 indicates performance below the national average.*

DISEASE PREVENTION AND MANAGEMENT

Enable healthy choices to support people to improve their overall health and wellbeing.

Recurring health problems or chronic disease can have a significant impact on a person's life and these long-term conditions account for a significant percentage of health expenditure. A number of long-term conditions have common risk factors; inactivity, unhealthy diets, obesity, stress, depression, smoking and alcohol misuse and as such many long-term conditions are preventable.

- Good nutrition, physical activity and maintaining a health body weight are fundamental to the prevention of disease and disability at all ages.
- Vegetable and fruit consumption have been found to be protective against cardiovascular disease and some common cancers, and may also contribute indirectly to maintaining a healthy body weight.
- Smoking is a major cause of lung cancer and chronic obstructive pulmonary disease, heart disease, strokes and a variety of other cancers and kills an estimated 5000 people in New Zealand every year, including deaths due to second-hand smoke exposure. The highest prevalence of smoking is amongst Canterbury young people with approximately one in every four teenagers 15-19 currently smoking.

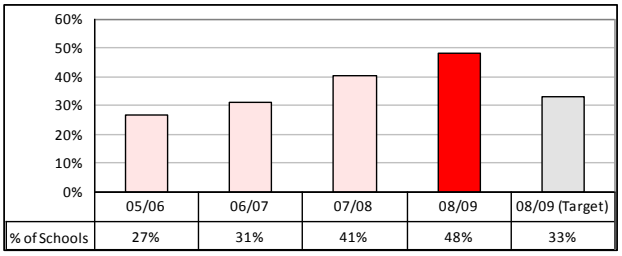
The long-term objective is to reduce the risks associated with long-term (chronic) conditions and the impact of long-term illness and promote wellbeing by enabling our community to make healthy choices through supportive physical, social, economic and policy environments.

IMPROVE ACCESS TO SERVICES

People are supported to reduce risk behaviours and to stay well and healthy.

Associated Measures of Performance

Measure - The % of Canterbury schools working within the Health Promoting Schools Framework. [14]



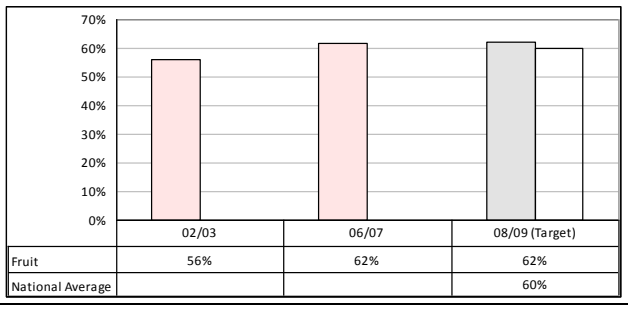
Achieved.

The DHB has funded a total of 124 Nutrition Fund projects in Canterbury schools and early childhood centres over the past year, providing not only policy development for canteen menus and food choices but also practical hands-on projects to raise awareness and improve nutrition such as: working gardens, worm farms and drinking water fountains and training and professional development to sustainability increase capability and capacity in the nutrition workforce.

IMPROVE THE EFFECTIVENESS OF SERVICE PROVISION AND EDUCATION

Exposure to healthy messages reduces risk behaviours and supports people to make healthy choices.

Measure - The % of the population (15+) having two or more servings of fruit a day. [15]



Achieved.

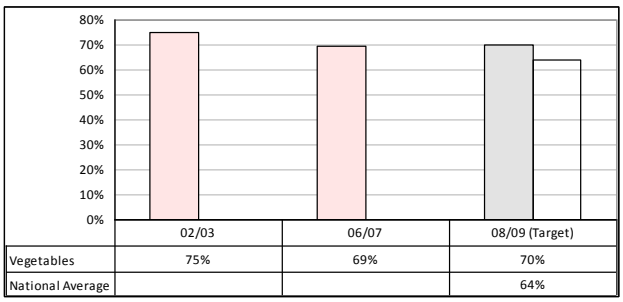
The results of the 2006/07 NZ Health Survey (released in 2008) showed 62% of Canterbury adults ate 2+ servings of fruit a day; a 6% increase on previous 2002/03 survey results and a positive increase in fruit consumption.

[14] *The Health Promoting Schools Framework is used to address health issues with an approach 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 also includes schools promoting Fruit in Schools and Active Schools, Fuelled 4 Schools and Healthy Heart (National Heart Foundation project).*

[15] *This data comes from the NZ Health Survey, completed nationally every three years. The previous Annual Report stated 58% as the 2002/03 result (this was a preliminary figure and was subsequently revised down to 56%). Results from the 2009/10 NZ Health Survey are due in 2010*

IMPROVE THE EFFECTIVENESS OF SERVICE PROVISION (CONTINUED…)

Measure - The % of the population (15+) having three or more serving of vegetables a day. [16]



	02/03	06/07	08/09 (Target)
Vegetables	75%	69%	70%
National Average			64%

Not Achieved.

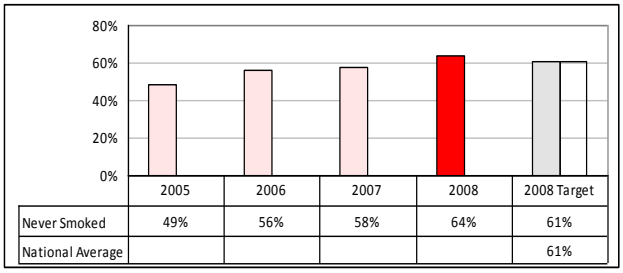
The results of the 2006/07 NZ Health Survey showed 69% of Canterbury adults ate 3+ servings of vegetables; a 6% drop from previous results. While the result is disappointing it is still above the national average.

The DHB has continued to implement its Healthy Eating, Healthy Activity (HEHA) Plan and to fund and support community action projects to enable Māori and Pacific communities to support healthier choices.

IMPROVE COLLABORATION AROUND HEALTHY MESSAGES AND PRACTICE

Promoting clear and consistent messages across sectors is central to achieving a change in risk behaviours for our population.

Measure - The % of 'never smokers' among Year 10 students.



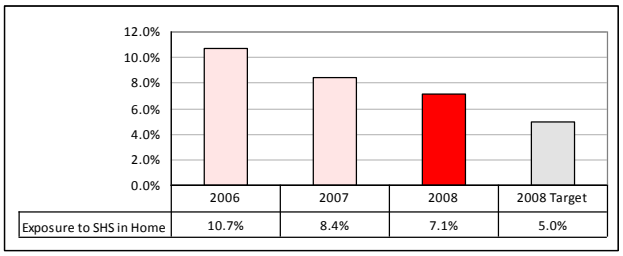
	2005	2006	2007	2008	2008 Target
Never Smoked	49%	56%	58%	64%	61%
National Average					61%

Achieved.

64% of all Canterbury Year 10 students are 'never smokers' a 6% increase over the past year.

The DHB has continued to implement its Tobacco Control Plan and primary and secondary care clinical champions have now been engaged to support smoking cessation across the whole health system. The DHB also continues to support smoke free parks and playgrounds throughout Canterbury with support from local councils and the community.

Measure - The prevalence of exposure for non-smokers to Second Hand Smoke inside the home – NZ population. [17]



	2006	2007	2008	2008 Target
Exposure to SHS in Home	10.7%	8.4%	7.1%	5.0%

Partially Achieved.

Steady progress continues to be made towards the national goal of 5%. The drop for Māori and Pacific was also greater than for the total NZ population; a positive gain.

Locally the DHB is implementing the ABC smoking cessation programme in its hospital services which will ensure all patients have their smoking status recording and those identified smokers will be offered support and advice to quit smoking. The DHB also continues to work with Māori and Pacific communities and support smoke free Maraes and Auahi Kore and Aukati Kai Paipa initiatives to promote smoke free lifestyles.

[16] *This data comes from the NZ Health Survey, completed nationally every three years. The previous Annual Report stated 66% as the 2002/03 result (this was a preliminary figure and was subsequently revised up to 75%). Results from the 2009/10 NZ Health Survey are due in 2010*

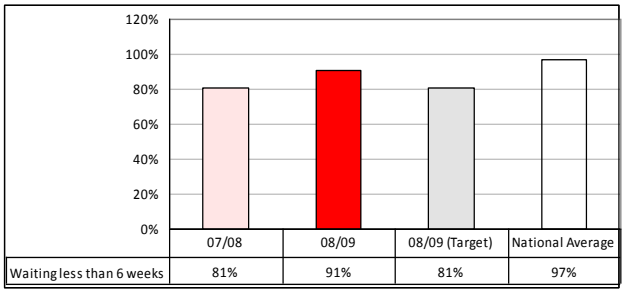
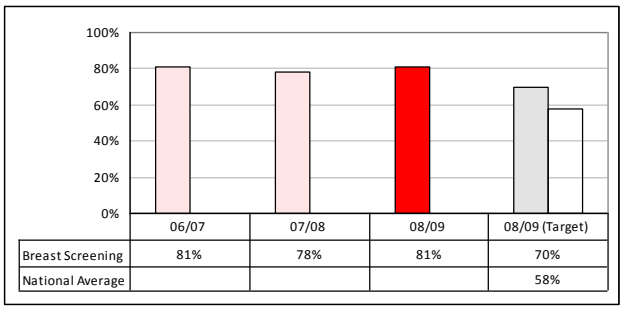
[17] *This data is provided nationally from the Ministry of Health and results are for NZ not individual DHB. A new measurement tool was used by the Ministry in 2008 and previous baselines were recalculated to make them comparable with the 2008 results – differs to 2008/11 SOI.*

CANCER

Reduce the impact of cancer through provision of timely and effective cancer treatment.

Cancer is a leading cause of death and a major cause of hospitalisation in New Zealand. One in three New Zealanders will have some experience of cancer, either personally or through a friend or relative and Māori are 18% more likely to be diagnosed with cancer than other population groups.

The DHB's long-term objective is to improve the health status of Canterbury residents at risk of developing cancer, demonstrate that those people who develop cancer are identified early through improved screening and diagnosis, and to provide appropriate timely treatment to reduce cancer mortality rates.

IMPROVE ACCESS AND QUALITY OF TREATMENT	
People have access to timely cancer treatment, reducing the impact of cancer on patients and their families.	
Measure - The % of patients who wait <six weeks between first specialist assessment and radiation oncology treatment. [18] 	**Achieved.** *Over the past year 91% of all patients started radiation treatment within six weeks of the decision to treat – a 10% improvement on the previous year. 70.5% of people waited less than four weeks.* *While Canterbury results are below the national average, lean thinking process and extended shifts have enabled the DHB to reduce waiting times over the past year. New graduates have been employed over the past year to improve sustainability of services and the DHB will replace the oldest of its three linear accelerator in the coming year, further extending capacity.* [19]
IMPROVE THE PATHWAYS BETWEEN SERVICES	
Reduce deaths from breast and cervical cancers through early diagnosis and intervention.	
Measure - The % of the eligible population screened under the national Cervical Screening Programme. [20]	*This data is provided by a third party and was unavailable to Canterbury DHB at the time these accounts were approved..*
Measure – The % of the eligible population screened under the national BreastScreen Aotearoa Programme. [21] 	**Achieved.** *Breast screening rates continue to be high and above both the target and the national average.*

	06/07	07/08	08/09	08/09 (Target)
Breast Screening	81%	78%	81%	70%
National Average				58%

	07/08	08/09	08/09 (Target)	National Average
Waiting less than 6 weeks	81%	91%	81%	97%

[18] *Before the middle of 2007/08 the DHB did not measure six week waiting times (the previous national target was eight weeks). The 2007/08 performance was based on three months of data. The measure reflects groups A, B and C patients – the remainder, in group D, have planned treatment (either as part of a trial or because of given clinical protocols) and are therefore not included in the performance target.*

[19] *The Linear Accelerators are the machines which treat cancer using high energy x-rays and have a limited life span.*

[20] *Cervical Screening Data is provided through the national screening programme.*

[21] *Breast screening data is provided through the Breastscreen Aotearoa Programme in 2007/08 only a six month report was provided.*

CARDIOVASCULAR DISEASE

Reduce the impact of Cardiovascular Disease (CVD) by support early risk identification and rehabilitation.

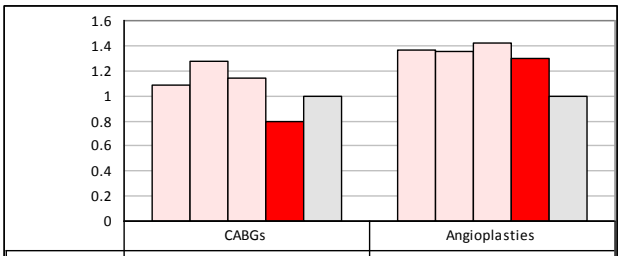
CVD includes coronary heart disease, other disease of the heart, circulation and stroke. It is a leading cause of death in Canterbury. Older people, Māori and Pacific people have higher rates of CVD and with our ageing population rising, rates of CVD are likely to result in increased demand for specialist care.

The long-term objective is to improve the health status of Canterbury residents at risk of developing CDV and reduce mortality rates, particularly for Māori and Pacific groups. The DHB aims to demonstrate that those people who are at risk are identified early and those who suffer an acute CVD event have the skills to reduce the impact of that event on the quality of their life.

MAINTAIN ACCESS TO SERVICES

People have timely access to treatment; reducing the impact of CVD by improving outcomes and providing a better quality of life.

Measure - Standardised discharge rates for key procedures (Coronary Artery Bypass Grafts and Angioplasties)[22].



	CABGs	Angioplasties
05/06	1.08	1.37
06/07	1.28	1.35
07/08	1.14	1.42
08/09	0.80	1.30
08/09 (Target)	1.00	1.00

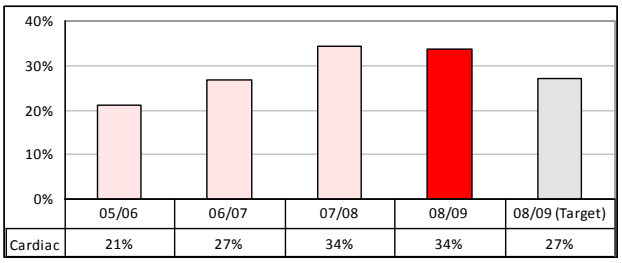
Partially Achieved.

If all DHB were providing services at the same level the standardised discharge rate would be 1. A higher rate than 1 indicates the DHB is providing more than the average NZ rate and less than 1 indicates that the DHB is providing less than the average rate. Intervention analysis does not necessarily indicate what the right rate might be, but compares individual DHBs with the national mean taking population demographics into account.

IMPROVE THE QUALITY OF SERVICES

Reduce the impact of CVD on people's quality of life and reduce risk of readmission through rehabilitation.

Measure - The % of people attending a cardiac rehabilitation programme after admission for an acute event. [23]

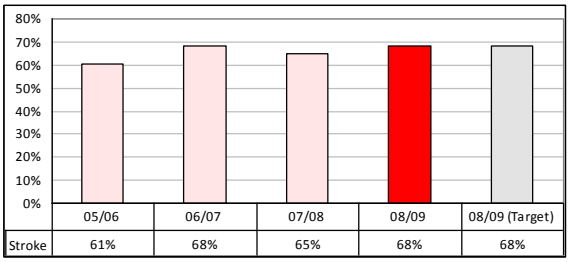


	05/06	06/07	07/08	08/09	08/09 (Target)
Cardiac	21%	27%	34%	34%	27%

Achieved.

The DHB has achieved the target and demonstrates an ongoing commitment to rehabilitation programmes.

Measure - The % of people admitted to an organised stroke service after admission for an acute event. [24]



	05/06	06/07	07/08	08/09	08/09 (Target)
Stroke	61%	68%	65%	68%	68%

Achieved.

The target has been reached and improvement can be seen in the number of people being referred to stroke rehabilitation services.

The DHB is working on including data from its Princess Margaret site and it is anticipated that this will further improved results.

[22] *The intervention rates are to the end of March 2009. This is the most recent data available.*

[23] *The data include the Māori Cardiac Outreach programme run at Rehua Marae, the Christchurch Hospital Cardiac Rehabilitation Programme run primarily in the Canterbury Horticultural Hall and patients enrolled through the Heart Guide Aotearoa pilot.*

[24] *The DHB is working on combining data from all sites – however stroke results do not include data from the Princess Margaret Hospital site.*

DIABETES

Reduce the impact of diabetes by supporting diabetes management.

Diabetes is a significant cause of ill health and premature death in New Zealand. The prevalence of diagnosed diabetes across the population is currently estimated at around 4.6%. However diabetes rates for Māori and Pacific people are around three times higher than other New Zealanders.

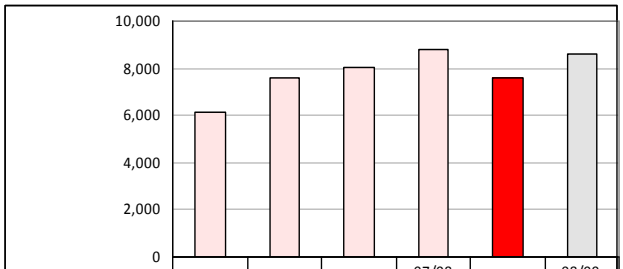
Reducing the incidence and impact of diabetes is a key focus in reducing inequalities in health status and outcomes. Enabling people with diabetes to manage their condition will also reduce the long-term complications of diabetes which impact on the quality of life – such as blindness, amputation and renal failure.

The long-term objective is to improve the health status of Canterbury residents at risk of developing diabetes and demonstrate that those people who develop diabetes are identified and treated early and have the skills to enable good diabetes management in order to reduce the impact of diabetes on their quality of life.

IMPROVE ACCESS TO DIABETES SERVICES

Reduce the impact of diabetes on patients and their families through early diagnosis and intervention.

Measure - The number of annual diabetes checks delivered. [25]



	2005	2006	2007	07/08 (MoH Est.)	08/09	08/09 (Target)
Diabetes Annual Checks	6,142	7,625	8,032	8,808	7,585	8,620

Not Achieved.

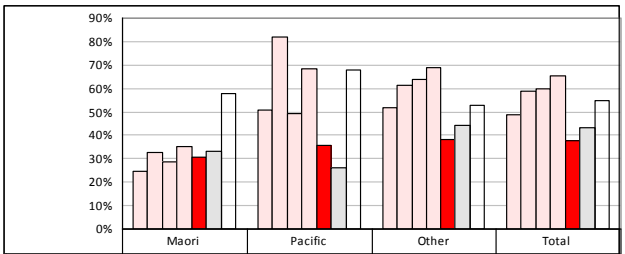
7,585 free annual diabetes checks were delivered over the past year. This is below the target set by the DHB and is less than the number of annual checks provided in 2007/08.

Some general practices have expressed concerns over the 'annual check' format and indicated their reluctance to support diabetes management in this form. This is affecting Canterbury's diabetes results and the DHB has committed to working collaboratively with primary and secondary care to establish clinically-led patient pathways for diabetes in the coming year in order to improve diabetes results and outcomes.

IMPROVE THE QUALITY OF DIABETES SERVICES

Target services to the population of need to make improvements in diabetes management.

Measure - The % of the population estimated to have diabetes, receiving free annual diabetes checks. [26]



	Maori	Pacific	Other	Total
2005	25%	51%	52%	49%
2006	33%	82%	61%	59%
2007	29%	49%	64%	60%
07/08 (MoH Est.)	35%	68%	69%	65%
08/09	31%	36%	38%	38%
2008/09 (Target)	33%	26%	44%	43%
National Average	58%	68%	53%	55%

Not Achieved.

38% of the Canterbury population expected to have diabetes received a free annual check. Although a change in the base population projection has significantly and negatively influenced the results; the number of checks delivered is still disappointing.

Canterbury is below the national average in terms of the number of annual diabetes checks being delivered for our population and a clear focus is needed to understand the reason for this performance and to increase these rates.

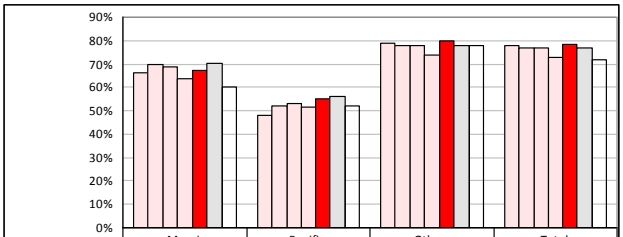
A consumer survey was undertaken over the past year, in collaboration with the Local Diabetes Team, and this will assist in understanding perceived barriers to attending the free annual checks and improving the process around annual checks.

[25] *Diabetes data is provided directly to the DHB on a financial quarter basis through the five Canterbury PHOs. Prior to 2008 data was provided via the Local Diabetes Team on a calendar year and this was changed in line with national expectations in 2008/09. The 2007/08 financial year baseline is an estimate of the financial year result provided by the Ministry of Health.*

[26] *This data is based on the 'expected' or 'estimated' to have diabetes. This denominator is set by the Ministry of Health and revised on an annual basis the denominator increased from 13,470 in 2007 to 20,134 in 2008. Note the national averages are at end of Q3.*

IMPROVE THE QUALITY OF DIABETES SERVICES (CONTINUED…)

Measure - The % of people on the diabetes register who received an annual check and had good diabetes management (HBA1c<8.0%).



	Maori	Pacific	Other	Total
2005	66%	48%	79%	78%
2006	70%	52%	78%	77%
2007	69%	53%	78%	77%
07/08 (MoH Est.)	64%	52%	74%	73%
08/09	67%	55%	80%	78%
2008/09 (Target)	70%	56%	78%	77%
National Average	60%	52%	78%	72%

Achieved.

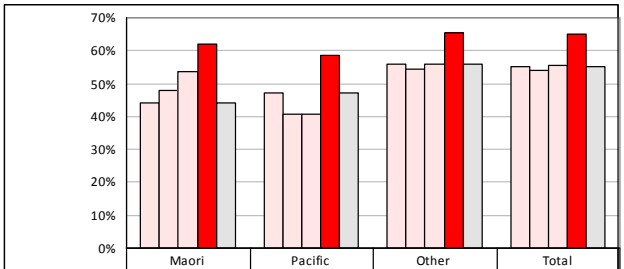
78% of the Canterbury population receiving a free diabetes check had good diabetes control; 6% above the national average and a 5% improvement on the previous year's results.

While the DHB has not met the targets for Māori and Pacific groups improvements have been made against the previous year's results.

IMPROVE THE PATHWAYS BETWEEN PRIMARY AND SECONDARY SERVICES

Reduce adverse events through increased uptake of appropriate screening and through integrated pathways that support early diagnosis and intervention.

Measure - The % of people having diabetes checks also having an eye screen in the past two years.



	Maori	Pacific	Other	Total
2006	44%	47%	56%	55%
2007	48%	41%	55%	54%
07/08 (MoH Est.)	54%	41%	56%	55%
08/09	62%	59%	65%	65%
2008/09 (Target)	44%	47%	56%	55%

Achieved.

65% of those being seen for annual checks are also having their eyes regularly screened. This is a positive result and a 10% improvement has been made over the past year. The DHB has exceeded the targets for all ethnicity groups.

RESPIRATORY DISEASE

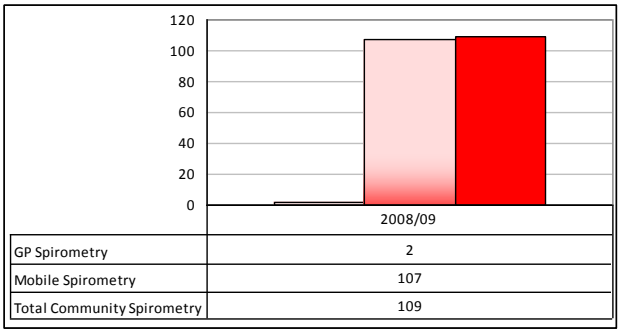
Reduce the impact of respiratory disease by supporting respiratory disease management.

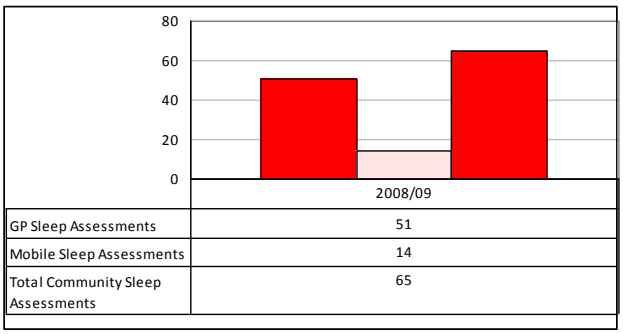
Respiratory disease is recognised as one of the developing chronic disease burdens associated with an ageing population. Up to 100,000 people may be affected by respiratory issues within the Canterbury population including Chronic Obstructive Pulmonary Disease (COPD), asthma and sleep disorders.

Very closely linked to the prevalence of smoking; improvements in early diagnosis and the management of respiratory illness provide a major opportunity to reduce inequalities and improve Māori health. However, rising levels of obesity and an ageing population are increasing the incidence of COPD and Obstructive Sleep Apnoea (OSA) and place increased demand pressure on specialist services in Canterbury.

Improving self management of risk behaviours and respiratory conditions and the development of integrated pathways between primary and secondary services will assist in managing growing demand.

The long-term objective is to improve the health status of Canterbury residents at risk of respiratory disease and demonstrate that those people who have developed chronic respiratory disease have access to timely treatment and services to enhance recovery and improve their quality of life.

<table>
<tr><th colspan="2">IMPROVE ACCESS TO RESPIRATORY SERVICES</th></tr>
<tr><td colspan="2">People have access to timely treatment; reducing the impact of respiratory conditions on the quality of people's lives.</td></tr>
<tr><td>Measure - An increase in access to spirometry services.[27]
 

<table>
<tr><td></td><td>2008/09</td></tr>
<tr><td>GP Spirometry</td><td>2</td></tr>
<tr><td>Mobile Spirometry</td><td>107</td></tr>
<tr><td>Total Community Spirometry</td><td>109</td></tr>
</table></td><td>109 spirometry tests were delivered in the community over the past six months.
Spirometry tests have not previously been available in the community and through the Canterbury Initiative the DHB has established an integrated respiratory service and pathways for respiratory disease with a community based respiratory physician and a mobile respiratory service. Six general practices have been so far been 'approved' to delivery spirometry and it is anticipated that the number of spirometry tests delivered in the community will steadily increase over the coming year.</td></tr>
<tr><td>Measure - An increase in access to sleep studies.
 

<table>
<tr><td></td><td>2008/09</td></tr>
<tr><td>GP Sleep Assessments</td><td>51</td></tr>
<tr><td>Mobile Sleep Assessments</td><td>14</td></tr>
<tr><td>Total Community Sleep Assessments</td><td>65</td></tr>
</table></td><td>65 sleep assessments were delivered in the community.
These sleep assessments have not previously been available in the community and are now being delivered through the newly established Canterbury Initiative. 19 general practices have been 'approved' to provide sleep assessments and it is anticipated that the number will steadily increase over the coming year.</td></tr>
<tr><th colspan="2">IMPROVE THE QUALITY RESPIRATORY SERVICES AND PATHWAYS BETWEEN PRIMARY AND SECONDARY SERVICES</th></tr>
<tr><td colspan="2">A reduction in avoidable adverse events or outcomes.</td></tr>
<tr><td>Measure - A reduction in readmissions for COPD.</td><td rowspan="2">All four of the respiratory indicators in this section were new performance measures for Canterbury DHB. The aim was to establish clear definitions and begin to collect this information and establish baselines and targets for the chosen indicators.
Subsequently the DHB has adopted the first two indicators and has chosen to monitor change over time against the number of acute hospital admissions for COPD. This is reflected in the DHB Statement of Intent for 2009/10.</td></tr>
<tr><td>Measure - An increase in post acute admission follow-ups in primary care.</td></tr>
</table>

[27] *The data for the spirometry and sleep indicators is provided by the Canterbury Initiative and relates to the last six months of the 2008/09 year.*

PROVIDING HOSPITAL AND SPECIALIST SERVICES

Provide hospital and specialist service efficiently and effectively.

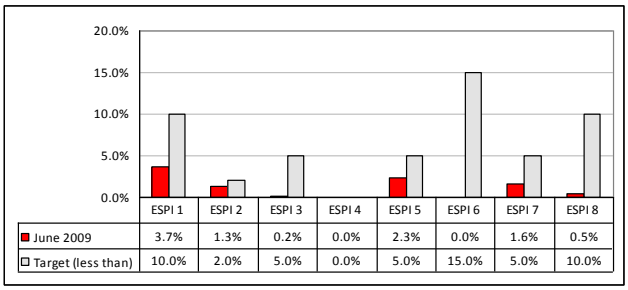
The DHB is the major provider of health services in Canterbury. To remain clinically and financially sustainable the DHB must provide quality services, retain an effective workforce, continue to improve operating efficiency and effectiveness, and meet all contract requirements within budget.

The long-term objective is to improve the health status of Canterbury residents through the provision of services in a timely manner, within available resources, for those with the greatest level of need.

IMPROVE ACCESS TO SERVICES

Achievement of compliance with all eight of the Ministry of Health's Elective Services Patient Flow Indicators (ESPIs) demonstrating the right people have access to the right services at the right time.

Measure - Maintain compliance with the eight national ESPIs.[28]



	ESPI 1	ESPI 2	ESPI 3	ESPI 4	ESPI 5	ESPI 6	ESPI 7	ESPI 8
June 2009	3.7%	1.3%	0.2%	0.0%	2.3%	0.0%	1.6%	0.5%
Target (less than)	10.0%	2.0%	5.0%	0.0%	5.0%	15.0%	5.0%	10.0%

Achieved.

Canterbury DHB was ESPI compliant for every month of the 2008/09 year.

The DHB also delivered 14,809 elective discharges, 1,888 more than the previous year.[29] A significant increase of 14.6% above the base and additional discharges planned.

Elective Service Patient Flow Indicators (ESPIs)	**Ministry of Health performance indicators used to monitor how patients are managed while awaiting an elective (non-urgent) service. They do not measure the volume of elective services delivered, or whether a DHB is delivering the same level of service for its population as another DHB.**
ESPI1	**DHB services that appropriately acknowledge and process all patient referrals within 10 working days** Following a request for a specialist opinion, the patient and their primary care practitioner are to be advised within 10 days whether or not a first specialist assessment (FSA) is indicated and can be provided (within six months).
ESPI2	**Patients waiting longer than six months for their first specialist assessment (FSA)** All patients accepted for an FSA should be seen within six months of the date of referral.
ESPI3	**Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)** If resources and patient mix remain the same, a service will be able to treat in the future the same volume of patients it has in the past. Thus, based on this historic treatment pattern, a service can predict to a reasonable degree of accuracy, the volume of patients to whom a commitment to treatment within six months can be given. Commitment should be given to patients with the highest clinical priority. This indicator measures the number of patients above the aTT who have not been given a commitment to treatment. The goal is to have no patients above the aTT without a commitment to treatment.
ESPI4	**Clarity of treatment status** Following specialist assessment, all patients should know if and/or when they will receive treatment. Thus patients within the booking system should be assigned a status appropriate to their priority. Where no such status is allocated, patients default to a residual waiting list. The goal is to ensure no patients are on residual waiting lists.
ESPI5	**Patients given a commitment to treatment but not treated within six months** All patients given a commitment to treatment should receive it within six months. The goal is to ensure no patients with this status remain untreated after six months.
ESPI6	**Patients in active review who have not received a clinical assessment within the last six months** Active review is a care pathway for patients for whom elective surgery is considered to be the best option for their care, but where: ▪ this service is not available within the current public funding or provider capacity; and ▪ there is a realistic probability that the patient's condition may meet the threshold for treatment in the foreseeable future. These are the patients who would next receive treatment if provider capacity increases.

[28] *The Ministry of Health has set ESPI compliance targets which all DHBs must achieve in order to receive additional electives funding and these are the targets reflected here. The DHB has internal 'buffers' seeking a higher level of achievement to drive continuous improvement and support its commitment to improved transparency and fairness – these are set out in the DHB's 2008/09 Annual Plan.*

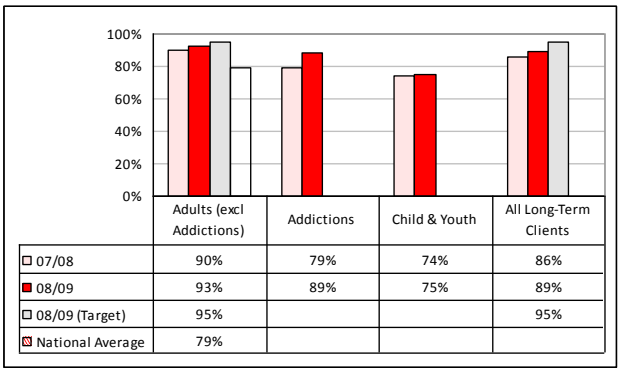
[29] *Elective Surgery Discharges for 2008/09 include Dental and Cardiology.*

	While in the category of active review, patients should receive a clinical assessment every six months. If at any time a patient's condition deteriorates to the point where their priority score exceeds the aTT, they should be given a commitment to treatment If a patient's condition remains unchanged by the time of the third assessment, they should be returned to the care of their GP. The goal is to ensure no patients in active review fail to receive their review every six months.
ESPI7	**Patients who have not been managed according to their assigned status and who should have received treatment** All patients should be assigned a status appropriate to their priority and managed according to that status. This indicator measures those patients, irrespective of their assigned status, who have a priority score above the aTT and: who have not received treatment within six months and: with regard to those placed in active review, have not received a clinical assessment within the last six months. It is therefore made up of a portion of the patients counted in indicators three and five. The goal is that no patients appear in this indicator.
ESPI8	**The proportion of patients treated who were prioritised using nationally recognised processes or tools** A number of tools are available to assist clinicians to assign a priority to patients. Those that meet specified criteria are registered within the national information system as "nationally recognised tools". This measure indicates the percentage of patients prioritised using nationally recognised processes or tools. The goal is to have all patients prioritised using nationally recognised processes or tools.

IMPROVE THE QUALITY OF SERVICES

A reduction in avoidable adverse events and improvements in quality, patient safety and patient satisfaction.

Measure - The % of long-term mental health clients with up-to-date relapse (crisis) prevention plans. [30]



	Adults (excl Addictions)	Addictions	Child & Youth	All Long-Term Clients
07/08	90%	79%	74%	86%
08/09	93%	89%	75%	89%
08/09 (Target)	95%			95%
National Average	79%			

Partially Achieved.

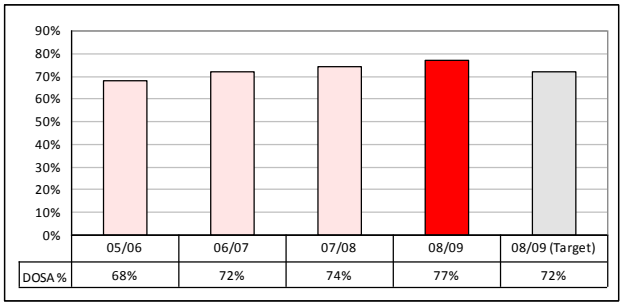
93% of all long-term adult clients (20+ and excluding those with addictions) now have current relapse prevention plans in place. 89% of all long-term clients (all ages and including those people with addictions) have current plans in place.

While the DHB has not fully achieved its 95% target, 327 more clients have current relapse prevention plans in place than in the previous year, a significant 24.4% improvement. The national target is 90%.

[30] *The DHB did not collect this data prior to 2007/08.*

IMPROVE THE QUALITY OF SERVICES (CONTINUED…)

Measure - The % of Day of Surgery Admissions for elective surgery. [31]



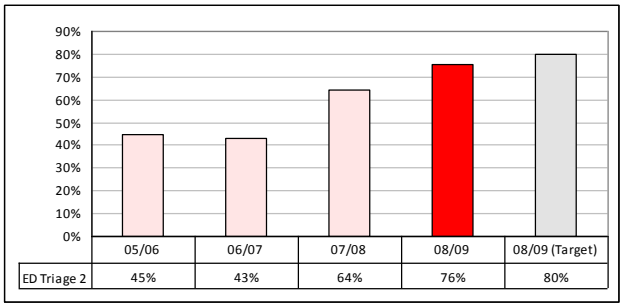
	05/06	06/07	07/08	08/09	08/09 (Target)
DOSA %	68%	72%	74%	77%	72%

Achieved.

The DHB continues to make steady progress in increasing the percentage of Day of Surgery Admissions.

This success will not only free-up beds previously being used unnecessarily but is also less disruptive for patients who can spend the night before surgery in their own homes.

Measure - The % of triage 2 patients seen in the ED within target times. [32]

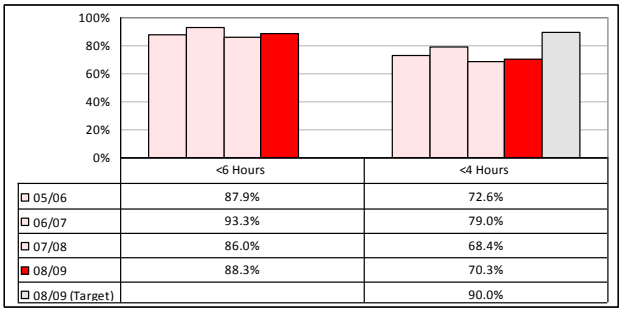


	05/06	06/07	07/08	08/09	08/09 (Target)
ED Triage 2	45%	43%	64%	76%	80%

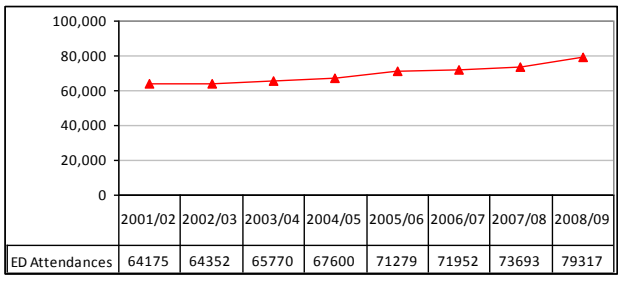
Partially Achieved.

The DHB continues to make steady progress in increasing the percentage of triage 2 patients seen within target times.

Measure - The % of people presenting to ED being admitted, discharged or referred within 4hrs of arrival.



	<6 Hours	<4 Hours
05/06	87.9%	72.6%
06/07	93.3%	79.0%
07/08	86.0%	68.4%
08/09	88.3%	70.3%
08/09 (Target)		90.0%



	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
ED Attendances	64175	64352	65770	67600	71279	71952	73693	79317

Partially Achieved.

The DHB has not achieved the target for four hour wait times but waiting times have been steadily improving over the past year. The national target is for a reduction in six hour wait times and the DHB's improvements are equally demonstrating positive reductions in six hour wait times.

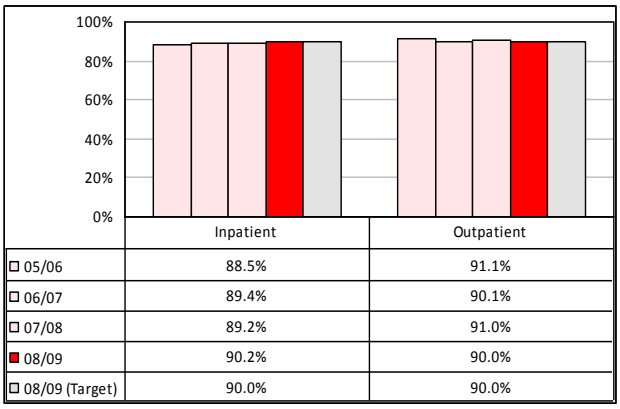
70.3% of people waited less than four hours and 88.3% of people waited less than six.

This improvement is particularly relevant when considering the increase in attendances at the ED from 73,693 in 2007/08 to 79,317 in 2008/09. Despite the steady increase in presentations the DHB is still making improvements in waiting times.

[31] *This data covers Medical & Surgical, Women's & Children's, Rural and Burwood Hospital and Specialist Service divisions and excludes day cases.*
[32] *This data refers to patients who begin assessment and treatment by a health professional within Australasian College of Emergency Medicine Guidelines; which recommends triage 2 patients be seen within 10 minutes.*

IMPROVE THE QUALITY OF SERVICES (CONTINUED…)

Measure – The % of patient overall satisfaction.

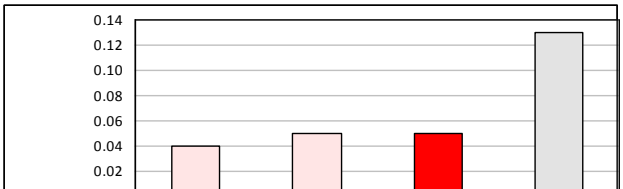


	Inpatient	Outpatient
05/06	88.5%	91.1%
06/07	89.4%	90.1%
07/08	89.2%	91.0%
08/09	90.2%	90.0%
08/09 (Target)	90.0%	90.0%

Achieved.

The DHB has achieved the patient satisfaction targets for both inpatient and outpatient services and has maintained consistently high rates over the past several years.

Measure - The rate of staphylococcus aureus bloodstream infections. [33]

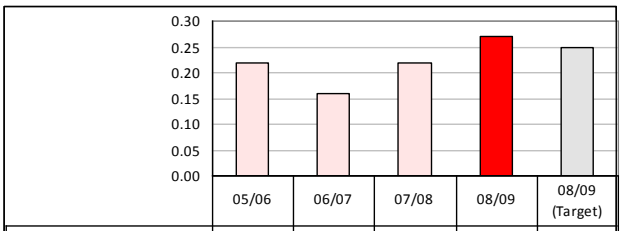


	06/07	07/08	08/09	08/09 (Target)
Staph Aureus Rate	0.04	0.05	0.05	0.13

Achieved.

The DHB's rate of staphylococcus aureus bloodstream infections continues to be low and well below target.

Measure – The rate of pressure ulcers. [34]

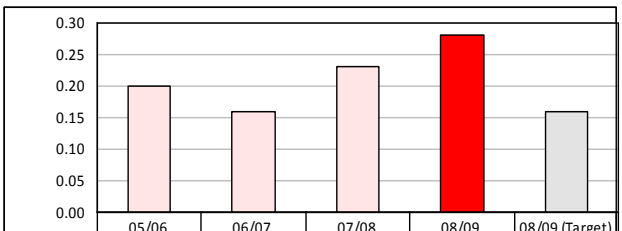


	05/06	06/07	07/08	08/09	08/09 (Target)
Pressure Ulcers Reported (incl MH)	0.22	0.16	0.22	0.27	0.25

Not Achieved.

While the DHB has not achieved the target for this indicator the increased rates are attributed to the active education programmes which have been undertaken by Hospital and Specialist Service Divisions which are subsequently increasing reporting of pressure ulcers. Additional and accurate reporting is considered an important step in improving patient safety.

Measure – The rate of patient falls causing moderate or serious injury. [35]



	05/06	06/07	07/08	08/09	08/09 (Target)
Patient Falls	0.20	0.16	0.23	0.28	0.16

Not Achieved.

The DHB has not met its target for this measure and has implemented a divisional patient falls prevention programme in its Older Person's Health Service Division.

If a patient is considered on admission as a falls risk, a falls assessment and strategy is completed. Moderate and Serious falls reporting has now been separated out and actively monitored and special causes are investigated and result in risk and falls prevention initiatives and system changes where appropriate. It is anticipated that patient fall levels will reduce over the coming year.

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[33] *Data reported is per 1,000 inpatient bed days and excludes Mental Health Services.*

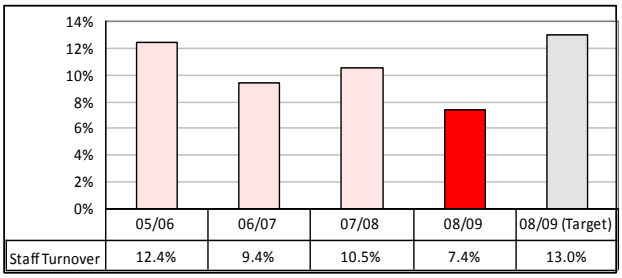
[34] *Data reported is per 1,000 inpatient bed days referring to the number of inpatient bed-days in the quarter calculated on the midnight census rate. The baseline data differs from the 2008/09 Statement of Intent in that the DHB has been able in the past year to incorporate all its divisions in Pressure Ulcer reporting when previously Mental Health and Older Person's Health divisions have been excluded. The baselines have been subsequently adjusted to reflect results including all divisions.*

[35] *Data reported is per 1,000 inpatient bed day equivalents referring to the total inpatient days plus half the total day patient attendances.*

BE A GOOD EMPLOYER

Establish a healthy working environment and foster positive partnerships between staff and management to fully implement the attributes of a good employer.

Measure - Staff turnover rates.

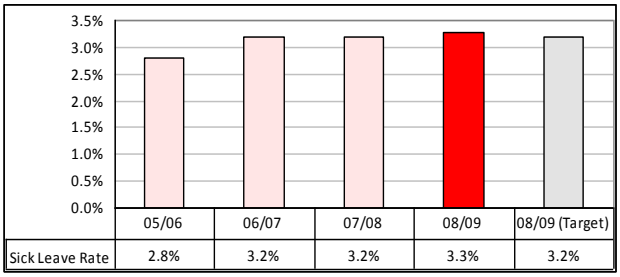


	05/06	06/07	07/08	08/09	08/09 (Target)
Staff Turnover	12.4%	9.4%	10.5%	7.4%	13.0%

Achieved.

The DHB's turnover rate continues to remain low and is well below target.

Measure – Staff sick leave rate.



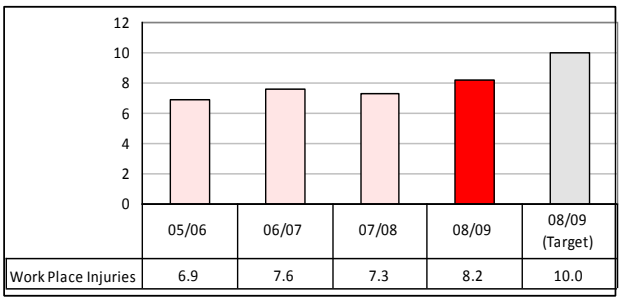
	05/06	06/07	07/08	08/09	08/09 (Target)
Sick Leave Rate	2.8%	3.2%	3.2%	3.3%	3.2%

Not Achieved.

The DHB's sick leave rate has risen slightly on the previous year and is 0.1% higher than the target rate.

Rates of influenza vaccinations amongst staff continue to increase with 55% of all Canterbury DHB vaccinated this year.

Measure - Workplace injuries (per million hours).



	05/06	06/07	07/08	08/09	08/09 (Target)
Work Place Injuries	6.9	7.6	7.3	8.2	10.0

Achieved.

The DHB continues to maintain positive low workplace injury rates.

SUMMARY OF REVENUES AND EXPENSES BY OUTPUT CLASS

	Funding $'000	Governance & Funding Admin $'000	Provider $'000	In House Elimination $'000	Total DHB $'000
ACTUAL 08/09					
Revenue					
MoH revenue	1,156,695	329	678,450	(633,575)	1,201,899
Patient Related Revenue	-	-	43,285	-	43,285
Other	-	-	33,667	-	33,667
Total Revenue	**1,156,695**	**329**	**755,402**	**(633,575)**	**1,278,851**
Expenditure					
Personnel	-	3,426	509,203	-	512,629
Depreciation	-	60	45,040	-	45,100
Interest	-	-	4,698	-	4,698
Capital Charge	-	-	17,791	-	17,791
Other	1,159,359	(3,121)	188,331	(633,575)	710,994
Total Expenditure	**1,159,359**	**365**	**765,063**	**(633,575)**	**1,291,212**
Net Surplus/(Deficit)	**(2,664)**	**(36)**	**(9,661)**	**-**	**(12,361)**
BUDGET 08/09					
Revenue					
MoH revenue	1,125,958	4,150	667,516	(628,882)	1,168,742
Patient Related Revenue	-	-	38,303	-	38,303
Other	-	-	35,886	-	35,886
Total Revenue	**1,125,958**	**4,150**	**741,705**	**(628,882)**	**1,242,931**
Expenditure					
Personnel	-	2,859	502,087	-	504,946
Depreciation	-	-	47,214	-	47,214
Interest	-	-	5,632	-	5,632
Capital Charge	-	-	21,697	-	21,697
Other	1,125,958	1,291	165,075	(628,882)	663,442
Total Expenditure	**1,125,958**	**4,150**	**741,705**	**(628,882)**	**1,242,931**
Net Surplus/(Deficit)	-	-	-	-	-
VARIANCE TO 08/09 BUDGET					
Revenue					
MoH revenue	30,737	(3,821)	10,934	(4,693)	33,157
Patient Related Revenue	-	-	4,982	-	4,982
Other	-	-	(2,219)	-	(2,219)
Total Revenue	**30,737**	**(3,821)**	**13,697**	**(4,693)**	**35,920**
Expenditure					
Personnel	-	567	7,116	-	7,683
Depreciation	-	60	(2,174)	-	(2,114)
Interest	-	-	(934)	-	(934)
Capital Charge	-	-	(3,906)	-	(3,906)
Other	33,401	(4,412)	23,256	(4,693)	47,552
Total Expenditure	**33,401**	**(3,785)**	**23,358**	**(4,693)**	**48,281**
Net Surplus/(Deficit)	**(2,664)**	**(36)**	**(9,661)**	**-**	**(12,361)**

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

AUDIT REPORT

TO THE READERS OF
CANTERBURY DISTRICT HEALTH BOARD AND GROUP'S
FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2009

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, Andy Burns, using the staff and resources of Audit New Zealand, to carry out the audit. The audit covers the financial statements and statement of service performance of the Health Board and group for the year ended 30 June 2009.

Unqualified Opinion

In our opinion:

- The financial statements of the Health Board and group on pages 29 to 58:
    - comply with generally accepted accounting practice in New Zealand; and
    - fairly reflect:
        - the Health Board and group's financial position as at 30 June 2009; 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 59 to 82:
    - 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 2 October 2009, 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 2009 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.

Other than the audit, 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 and group for the year ended 30 June 2009 included on the Canterbury District Health Board's website. The Canterbury District Health Board's Board is responsible for the maintenance and integrity of the Canterbury District Health Board's website. We have not been engaged to report on the integrity of the Canterbury District 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 2 October 2009 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.