Canterbury District Health Board

Report for the year ended 30 June 2010

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

During the 2009/2010 financial year people across the Canterbury Health System worked hard to ensure that we not only rose to meet our financial challenges but changed the way we worked to provide better, more sustainable services for Canterbury people.

We have focussed on reducing duplication, variation and wastage. In addition, the transformation that is occurring within the Canterbury Health System is making our health system better – more cohesive, more sustainable, more patient focussed and based on trusted relationships. This transformation is a collaborative journey involving front line staff from hospitals, primary care and the community, all agreeing on a whole of system approach to change called Vision 2020.

Canterbury District Health Board is also working hard to support other DHBs and regions. This includes Canterbury DHB providing Chief Executive services to the West Coast DHB.

In 2009/10 we made great strides towards living within our means, making $10.6 million of procurement savings that have been re-invested back into front line services. We know, however, that the coming 12 months are going to remain a very challenging time with increased demands on the system.

Prioritising our spending provides an opportunity to allocate or reallocate funding to services that are more effective in improving people's health and independence and reducing inequalities. The process is important regardless of whether the decision relates to additional expenditure or continuing existing expenditure. It's about working smarter and making the best of the resources we have.

While we remain fortunate in New Zealand that we are still experiencing funding growth, this is at a rate that is lower than the actual cost of delivering services and we need to continue to transform what we are doing. Fortunately Canterbury DHB has a reputation for looking at what is best for its population and taking a path that will deliver that. It is one of our strengths.

Despite the financial challenges, in the last year Canterbury people have received, and the Canterbury Health System has delivered, far more health services from the $1.3 billion dollars allocated to our District Health Board.

- 1,254,296 people visited their General Practice, 24,334 more than last year
- 15,636 people had elective surgery, 2,396 more than last year
- 12,464 people accessed mental health services, 1,690 more than last year
- 107,980 people were discharged from hospital, 6,927 more than last year
- 31,094 women had a breast cancer screening, 2,235 more than last year
- 48,987 people received a free influenza vaccination,
- 6,241 people had a cardiovascular disease risk assessment, 1,378 more than last year
- 6,093 (89%) two year olds completed their age appropriate vaccinations,
- 9,852 people had a free diabetes check, 2,267 more than last year
- 74,865 children had a dental check, 952 more than last year
- 87,091 people attended Christchurch Emergency Department, 7,774 more than last year
- 6,532 babies were born, 69 more than last year
- 1,640,917 total surgery minutes were provided, 54,205 more than last year
- 5,480 hospitalised smokers were offered the opportunity to quit
- 4,827 B4 school checks were completed, 3,665 more than last year
- 948 people had hip/knee replacements, 26 more than last year
- 1,122 people had radiation treatment in under six weeks,
- 20,481 adolescents accessed free oral health care, 482 more than last year
- 31,389 operations were performed, 3,813 more than last year
- 5,965 rest home beds were made available for people 65 years and over, 536 more than last year

- 107,980 inpatients in our hospitals, 6,927 more than last year

The stories behind these statistics paint a picture of success in many areas.

An extension to Christchurch Women's Hospital has created space for 28 extra beds at Christchurch Hospital.

Through new agreed pathways, General Practice teams are able to deliver more procedures such as pipelle biopsy and skin lesion removal in their practice and have been given direct access to fully funded diagnostics in the community which has reduced the need for hospital referral. Getting the right people referred to hospital has reduced waiting times and created a higher rate of conversion to surgery. As an example child patients with cough and asthma conditions have had their waiting times to see a specialist reduced from up to six months, to less than two months.

Our 'Making Time For Caring' initiative has been implemented in 17 wards across three divisions at Christchurch Hospital. Through it, direct nursing patient care has increased substantially. We also had stock savings on average of $4,000 per ward, improved patient and staff satisfaction and a drop in short term sick leave of 5.5%.

A supply chain initiative led to $10.6 million in procurement savings, 3,000 hours of clinical care time released for patients in women's and children's wards and the development of a closer relationship with West Coast and Auckland DHBs and Health Alliance.

All these achievements have been made against an extremely challenging financial climate which will continue for some years. Working strongly in Canterbury's favour is however a health system that is willing and able to think differently and identify opportunities to improve the quantity and quality of services while living within its financial means.

Alister James
Chair
29 September 2010

David Meates
Chief Executive
29 September 2010

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 37 years experience. She has served on the Board for over nine years and is committed to rural health issues and delivery.
Andrew Dickerson	Andrew has 25 years experience in the health and disability sectors and was a former Chief Executive of Age Concern Canterbury. He would like to see improved access to elective surgery and better integration of hospital and GP services. Andrew believes the results of rest home audits should be made public and is committed to improving accountability and transparency in the health service.
Anna Crighton	Anna Crighton served 12 years as a Christchurch City Councillor. Anna is committed to the CDHB continually improving its health care and services especially Aged Care Services, elective surgery and for the CDHB to work closely with GPs. As an advocate for stronger communities she believes the CDHB must be fully accountable and transparent to its patients and Canterbury residents. She is a member of the Community and Public Health and Disability Support Committee.
Chris Ryan	An Ashburton GP for 20 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 need to be involved in decision making, and money should be spent on effective projects
David Morrell	David Morrell has had over eight years on the District Health Board, was a hospital chaplain, and had 22 years as Christchurch City Missioner where he established new services for people with alcohol, drug and mental health issues. He is committed to quality services accessible for all. He is a member of the CDHB Quality, Finance, Audit and Risk Committee and Chair of its Hospital Advisory Committee and its Brackenridge Estate.
Eleanor Carter	Eleanor is an advocate for patient needs. Previously a Health Cuts Hurt spokesperson, Eleanor believes that health services should be funded according to community need in a transparent and effective manner.
Elizabeth Cunningham	Elizabeth Cunningham, who is of Ngai Tahu and Ngati Mutunga descent, is a research manager (Maori) at the University of Otago, Christchurch School of Medicine She has worked at all levels of the health sector, including as a health professional; a service manager; and as an advisor to Ministers of Health on Maori health issues. She is also a longstanding member of the Maori Women's Welfare League. Elizabeth is a member of the Quality, Finance, Audit and Risk committee as well as a member on the CDHB Hospital Advisory committee.
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 32 years. He is of Ngai Tahu descent and Chairperson of the Ngai Tahu Runanga Health collective - Manawhenua ki Waitaha. He believes primary and secondary health services need to work together more efficiently

Peter Ballantyne	Peter is Chair of 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 2010.

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 $8.81 million against the budgeted deficit of $9 million. (2008/09 result was a net deficit of $12.361 million).

BOARD FEES

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

	Board Fees Year ended 30/06/10 $'000	Committee Fees Year ended 30/06/10 $'000
Alister James	52	2
Olive Webb	32	3
Jo Kane	26	4
David Morrell	26	5
Anna Crighton	26	2
Andrew Dickerson	26	7
Chris Ryan	26	4
Eleanor Carter	26	3
Peter Ballantyne	26	6
Matea Gillies	26	5
Elizabeth Cunningham	26	5
David Kerr		3
Trevor Read		3
William Tate		5
Margaret Schwass		1
Wendy Dallas-Katoa		2
Teresa Chalecki		2
Richard Davison		1
Bob Lineham		2
Stephen Lowndes		3
	318	**68**

Total fees paid for the year were $386,000 (2008/09 - $390,000). The limit of fees authorised for the year ended 30 June 2010 was $395,375 (2008/09 - $395,375).

DIRECTOR FEES

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

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

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2010

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

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) – Trustee - sometime recipient of funding grants from Community and Public Health for courses run by the organisation. 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 an 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	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. IHC/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. Contracted to provide clinical opinion regarding IHCs action against the Ministry of Health with the Human Rights Commission.

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 and 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, information 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 theatrical theatre operations.
	Lottery Canterbury / Kaikoura Community Distribution Committee- Member - distribution of profits from NZ Lotteries for funding of Community projects.
	Christchurch Heritage Awards Charitable Trust – Member.
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.
	Mid Canterbury Medical Services Ltd – Director (this Company acts as Trustee for his Practice Trust)
	Spouse, Mairead 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 is a Crown Entity which purchases pharmaceuticals for New Zealand (including on behalf of DHBs within New Zealand) for the New Zealand Pharmaceutical

	schedule.
	NZ Medical Association Services Ltd – Director. Publishes NZ Medical Journal and related publications. Purchases services and supplies for members of NZMA.
	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 – Deputy Chair - (Canterbury DHB appointee) Trust responsible for Memorial Chapel 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) – Director - 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.

	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	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. 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. 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. I have a small contract with Pegasus Health as an advisor on Maori health that may pose a possible conflict of interest. Taupunga Ltd – Director. Taupunga Ltd provides General Medical Services. I am employed by Taupunga Ltd to provide General Practitioner services. Taupunga has a contract with the Pegasus 24 Hrs Clinic and Dr James Shanks. Manawhenua ki Waitaha – Chairperson - Manawhenua ki Waitaha is a collective of health representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a Memorandum of Understanding between Manawhenua ki Waitaha and 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. Better Sooner More Convenient (BMSC) – Transitional Leadership Board Member
Peter Ballantyne	West Coast District Health Board – Appointed Member Bishop Julius Hall of Residence - Trust Board Member.

	University of Canterbury - Audit and Risk Committee Member. The University of Canterbury provides certain services to the Canterbury DHB.
	Deloitte – Consultant - Deloitte carries out certain consulting assignments for Canterbury DHB from time to time.
	Spouse, Claire Ballantyne is a Canterbury DHB employee (Ophthalmology Department)
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.
	Rural Canterbury PHO – Board Member. Primary Health Organisation funded by the Canterbury DHB.
Stephen Lowndes	Member of the Canterbury Aoraki Conservation Board and the Akaroa Civic Trust Board. I do not consider 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.
	In addition Francis Consultants have a consultancy contract with the Shared Services Establishment Board to undertake an opportunity assessment for national arrangements and enhancements in procurement and supply chain.
	Acting Team Leader for the Costing Unit at Capital and Coast DHB. To the best of my knowledge, none of these activities presents a general conflict of interest with my role on the Canterbury District Health Board, Hospital Advisory Committee, but should a conflict arise this will be discussed at the time.
Theresa Chalecki	New Zealand Association of Gerontology – Canterbury Branch-Committee member. This is an Incorporated Society providing information and education on ageing and age related issues to health professionals and people working with older people. As a member of this committee I participate in planning education and meetings and administrative issues for the branch. This Association does not have any funding contracts.
	Canterbury Asthma Society – Manager. Not for profit organisation providing education and health promotion regarding Asthma and Chronic Obstructive Pulmonary Disease (COPD). The Canterbury DHB currently provides funding for provision of some of these services.

	New Zealand Nurses Organisation (NZNO) – Paying member for professional affiliation. NZNO is a professional body and union. I am not an employee or party to any of the contracts they negotiate so there is no conflict of interest from a financial perspective. The only potential conflict would be a decision which would have a major impact on fellow nurses of that professional body.
Wendy Dallas-Katoa	Te Runanga O Ngai Tahu - Programme Leader – Health and Social Wellbeing
	Pegasus Health/Partnership Health (PHO) – Maori Health Advisory Group Member
	Manawhenua Ki Waitaha – Ōnuku Rūnanga Representative. Manawhenua Ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the Canterbury DHB area. There is a memorandum of understanding between Manawhenua and the Canterbury DHB.
	Partnership Health PHO "Te Kei o te Waka"– Board Member – iwi/manawhenua representative. Partnership Health Canterbury is a Primary Health Organisation (PHO). The PHO has entered into an agreement with the Canterbury DHB under which the PHO agreed to provide a range of health care services and the management tasks associated with the delivery and funding of these services. The PHO has the power to subcontract the delivery of any or all such services and associated management tasks.
	Healthy Christchurch – Steering Committee. Ngāi Tahu representative to this Committee
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.

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 $517,891 (2008/09 – 8 employees totalling $92,319) comprising negotiated settlements with all of the former employees.

Number of Employees	TOTAL $
9	517,891
9	**517,891**

REMUNERATION OF EMPLOYEES

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

	30/06/10 (including benefits)				30/06/09 (including benefits)			
	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total
100,000-109,000	14	22	58	**94**	22	23	60	**105**
110,000-119,000	7	8	60	**75**	7	9	63	**79**
120,000-129,000	4	6	51	**61**	4	7	64	**75**
130,000-139,000	2	6	53	**61**	2	5	59	**66**
140,000-149,000	1	1	44	**46**	1	4	41	**46**
150,000-159,000		5	40	**45**		2	37	**39**
160,000-169,000			32	**32**		1	23	**24**
170,000-179,000		2	19	**21**		1	31	**32**
180,000-189,000		1	28	**29**			19	**19**
190,000-199,000		1	24	**25**		2	27	**29**
200,000-209,000		2	18	**20**		1	19	**20**
210,000-219,000		1	19	**20**		1	27	**28**
220,000-229,000			22	**22**		2	17	**19**
230,000-239,000			22	**22**			23	**23**
240,000-249,000			15	**15**			19	**19**
250,000-259,000			18	**18**			15	**15**
260,000-269,000			14	**14**			11	**11**
270,000-279,000			9	**9**			13	**13**
280,000-289,000			1	**1**			5	**5**
290,000-299,000			4	**4**		1	8	**9**
300,000-309,000			9	**9**			4	**4**
310,000-319,000			5	**5**			6	**6**
320,000-329,000			8	**8**			3	**3**
330,000-339,000			3	**3**		1	2	**3**
340,000-349,000			3	**3**				**-**
350,000-359,000			2	**2**			4	**4**
360,000-369,000			2	**2**			3	**3**
370,000-379,000			2	**2**			1	**1**
380,000-389,000			2	**2**			1	**1**
410,000-419,000				**-**			1	**1**
440,000-449,000		1		**1**				**-**
460,000-469,000			1	**1**				**-**
470,000-479,000			1	**1**			1	**1**
530,000-539,000			1	**1**				
Total	**28**	**56**	**590**	**674**	**36**	**60**	**607**	**703**

Of the 674 (2008/09 703) positions identified above, 618 (2008/09 643) positions were predominantly clinical and 56 (2008/09 60) positions were management/administrative.

OTHER ENTITLEMENTS (employees earning over $100,000)

	Allied Health	Mgmt / Admin	Nursing	RMO	SMO
Annual leave pa	5 wks	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) (a) 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 2010, for the above additional disclosure requirements. Further detail on performance is provided in the Statement of Service Performance on page 65.

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 improving lifestyle choices, physical activity and nutrition and reducing 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. We have a patient-centred model of care for health 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 (e.g. older people) or a particular disease or condition (e.g. diabetes or mental illness). 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.

	Over the past year a number of key improvements have been made in improving the health and wellbeing of the Canterbury population: ▪ 89% of all Canterbury two-year-olds have been fully immunised, a 3% increase on 2008/09. ▪ 65% of all age five children have no holes or fillings in their teeth. ▪ 97% of the population is enrolled with primary care, with a 2% improvement in Māori enrolment rates. ▪ 71% of people are now seen in under four hours in Canterbury Emergency Departments, and 90% of people are waiting less than six hours – this is despite more than 7,700 additional people presenting to Canterbury EDs. ▪ 97% of patients wait less than six weeks for radiation oncology (cancer) treatment. ▪ 15,636 elective surgery discharges were delivered, 2,396 more than in 2008/09.[1] ▪ 96% of all long-term mental health clients have relapse prevention or crisis plans in place, 7% more than the previous year. ▪ The ABC Strategy for Smoking Cessation was rolled out in all CDHB hospitals. 67% of hospitalised smokers were offered advice and support to quit in the month of June 2010. ▪ We have embarked on a major transformation of our mental health and addiction services to provide an integrated, responsive and flexible system of care that provides faster access to services for people with mental illness and alcohol and other drug addiction problems. ▪ We have piloted a range of improvements in care for older people that recognise the need to be flexible and meet individual needs. Restorative home support has been a key area of focus.
(b) To promote the integration of health services, especially primary and secondary health services:	The Canterbury Initiative is a joint initiative between general practice, Canterbury PHOs and Canterbury DHB. The Canterbury Initiative brings together health professionals from across the health system 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 remove traditional boundaries by ensuring services are delivered in the most appropriate and convenient settings. The new pathways help 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. 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.

[1] *Elective surgical discharges exclude elective cardiology and dental procedures.The DHB's result for the 2009/10 year is the figure as accessed at 2 August 2010 and may change slightly with further coding.*

	During the 2009/10 year, 4,038 GP Subsidised Procedures were delivered in the community rather than in hospital settings, including: ▪ 2,188 Excisions of skin lesions; ▪ 415 Sleep assessments; ▪ 271 Spirometry tests; ▪ 162 Pipelle biopsies; ▪ 869 Steroid injections; and ▪ 133 Mirena insertions. In addition to these improvements, an Electronic Referral Management System is currently being piloted through the Canterbury Initiative. This will provide a single point of electronic referral, allowing consistent triage both within and across different referral pathways Building on the success of the Canterbury Initiative, the Canterbury Clinical Network (an alliance of Canterbury health professionals from across the health sector, which includes the DHB) has this year embarked on the implementation of its *Better, Sooner, More Convenient* Business Case. The Canterbury Clinical Network's Expression of Interest was one of nine across the country to be approved to the business case stage. Continuing the Canterbury Initiative's emphasis on clinical leadership and primary/secondary collaboration, the *Better, Sooner, More Convenient* implementation plan describes a range of transformation initiatives focused on improving front-line health care services through work streams around areas like aged care, urgent care, rural health and management of long-term conditions.
(c) To promote effective care or support for those in need of personal health services or disability support services:	The 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 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. Effective primary health care services are also important in keeping people well and reducing unnecessary hospital admissions. This includes 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 wellbeing of the Canterbury population: ▪ 98% of people over 65 are now enrolled with general practice in Canterbury; ▪ 21% of those people are accessing CarePlus or High User Health Card services, ensuring low cost access to enhance primary care for older people, particularly those with two or more long-term (chronic) conditions; and

	▪ 75% of people over 65 received an influenza vaccination in 2009, 9% higher than the national average. 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 are being 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 are being targeted to support 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[2] tool and service users will have their needs reviewed annually or more frequently as required. 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 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:	The 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 implemented an Action Plan for Disability that outlines the steps it is taking to implement the NZ Disability Strategy, including disability-sensitive approaches to staff education, property development, employment, contracting and monitoring. 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:	The Canterbury DHB has a Māori Health Plan. The key objectives include reducing health inequalities, supporting Māori participation in health and Māori health workforce development. Progress in implementing projects that support the DHB's Māori Health Plan include the following. ▪ 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. ▪ A formal Memorandum of Understanding is in place with Manawhenua Ki Waitaha[3] to improve Māori input into the planning and development of health and disability services in Canterbury.

[2] *InterRAI – the International Resident Assessment Instrument is a comprehensive geriatric assessment tool.*
[3] *Manawhenua ki Waitaha is a representative group which is comprised of seven Ngāi Tahu Rūnanga.*

	▪ We have recently completed a Māori Health Profile to identify the real gaps and inequalities in health outcomes at a local level, which will enable us to more effectively improve access and utilisation. ▪ 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. ▪ Smokefree lifestyles have been promoted to improve Māori health status through Auahi Kore initiatives and the Aukati Kai Paipa programme. There is also an emphasis on smokefree marae, with eight marae in Canterbury now smokefree. Over the coming year, we will look to review our Māori Health Plan with Manawhenua Ki Waitaha and align our direction with the national Whānau Ora direction. Whānau Ora and Māori Health will also be key areas of focus for the *Better, Sooner, More Convenient* Business Case implementation. In addition, Canterbury will take the lead in the South Island for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori studying towards health careers and working in health fields.
(f) To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:	The Canterbury DHB works with general practice 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. Tobacco smoking is inextricably linked to a number of health inequalities and remains the foremost opportunity to target improvement in the health of the population with high needs and to improve Māori health. Over the past year, a number of key improvements have been made in reducing outcome disparities amongst various population groups in Canterbury: ▪ 87% of all Māori and 89% of all Pacific two-year-olds were immunised in Canterbury, compared to 89% for other ethnicities; ▪ 49% of Māori and 53% of Pacific young women received the HPV immunisation, exceeding the 46% rate for other ethnicities; ▪ The rate of avoidable hospital admissions for Māori and Pacific people over the past year is below (better than) the national average and the rate for other ethnicities; and ▪ 100% of the estimated Pacific population is enrolled with primary care.
(g) To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:	The 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 councils 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. In 2007 we established a formal Consumer Council, which supports a partnership model that provides 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 in improving the delivery of health and disability services.
(h) To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:	Through its Health Services Planning work, the Canterbury 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. This included Vision 2020 workshops and 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 with 'Our Health System Showcase 09'. A key objective of the Showcase was to share the understanding and challenges the system faces and to encourage cross-sectoral engagement to solve these issues.
(i) To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations:	Canterbury DHB has a Clinical Board to provide advice to the CEO on quality and clinical issues and promote quality improvement within the DHB. The Clinical Board is a multidisciplinary 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 Board also sponsors both the DHB's Quality Strategic Plan and the DHB's Quality and Innovation Awards and supports key policies to promote quality and patient safety, such as our goal of zero harm from patient falls. 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.
(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 retention rates have improved from 88.6% to 89.7% for clinical staff and from 88.1% to 91.0% for non-clinical staff.

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) (a)-(e)	
Function:	**What has been done to meet function**
(a) To ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement.	Crown Funding Agreement requirements were observed and deliverables met during the year and the DHB has met the requirements of all funding agreements that it has entered into. Refer above with regard to the services and responsibilities observed.
(b) To actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:	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 joint/collaborative ways, participating in national projects, national benchmarking exercises and national pricing projects. 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, primarily through the Canterbury Initiative but also across a number of areas throughout the health system. The DHB also has key clinical networks in place which ensure that strategic and operational decisions are fully informed through appropriate clinical involvement and support at all levels of the decision making process. More recently, the implementation of the Canterbury Clinical Network's *Better, Sooner, More Convenient* Business Case involves considerable collaboration throughout the health sector. The Canterbury Clinical Network is an evolving alliance of Canterbury health professionals from across the health sector, including GPs, secondary care specialists, practice nurses, community nurses, physiotherapists, community pharmacists, Māori and Pacific health providers, PHOs, IPAs and the DHB. 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 Southern Cancer Network and the South Island Regional Mental Health

	Network. We have also formalised our long-standing clinical partnership arrangements with the West Coast DHB, along with joint CEO arrangements, clinical appointments, service development and service planning and shared back-office services. This closer collaboration will provide greater certainty in terms of both the planning and delivery of health services for the populations of both DHBs, as well as supporting the development of a more appropriate workforce in both locations. Over the coming year, we will also make some key decisions around how we organise services across the whole of the South Island in order to ensure our wider population has access to sustainable services in the future.
(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 through the Canterbury Initiative 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 also provides health promotion information through its Community Health Information Centre, open to the public five days a week.
(d) To establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:	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 and delivery of health and disability services.[4] 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.[5]

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

(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, and a number of projects have been developed to support Māori service provision in Canterbury. These include: ▪ The development of a South Island regional Māori workforce recruitment project to enhance the Māori health workforce in our region; ▪ Road shows to encourage health as a career; and ▪ Scholarships to support Māori wanting to study to work in primary care settings. Over the coming year, Canterbury will take the lead in the South Island for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori studying towards health careers and working in health fields.

For and on behalf of the Board

Alister James
Chair
29 September 2010

Olive Webb
Deputy Chair
29 September 2010

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 2010, 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
29 September 2010

Olive Webb
Deputy Chair
29 September 2010

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2010

	Notes	Group			Parent	
		Actual 30/06/10 $'000	Budget 30/06/10 $'000	Actual 30/06/09 $'000	Actual 30/06/10 $'000	Actual 30/06/09 $'000
Income						
Ministry of Health revenue		1,262,542	1,259,702	1,201,899	1,252,552	1,191,204
Patient related revenue	2	44,807	39,517	43,285	44,006	43,213
Other operating income	3	20,220	15,180	28,123	17,880	25,928
Interest income		4,239	4,716	5,544	4,356	5,599
Total income		**1,331,808**	**1,319,115**	**1,278,851**	**1,318,794**	**1,265,944**
Operating expenses						
Employee benefit costs	4	542,121	529,390	512,629	530,045	501,743
Treatment related costs		116,647	115,660	112,786	120,633	115,774
External service providers		539,561	538,953	525,784	539,561	525,784
Depreciation and amortisation		42,497	46,303	45,100	41,227	43,786
Interest expenses on loans		4,662	5,786	4,698	4,662	4,692
Other expenses	5	77,683	72,023	72,424	74,063	69,005
Total operating expenses		**1,323,171**	**1,308,115**	**1,273,421**	**1,310,191**	**1,260,784**
Operating surplus before capital charge		8,637	11,000	5,430	8,603	5,160
Capital charge expense	6	(17,447)	(20,000)	(17,791)	(17,447)	(17,791)
Surplus/(deficit)		**(8,810)**	**(9,000)**	**(12,361)**	**(8,844)**	**(12,631)**
Other comprehensive income						
Gains on property revaluations	7	16,371	-	-	16,371	-
Total other comprehensive income		**16,371**	**-**	**-**	**16,371**	**-**
Total comprehensive income		**7,561**	**(9,000)**	**(12,361)**	**7,527**	**(12,631)**

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2010

	Notes	Group Actual 30/06/10 $'000	Group Budget 30/06/10 $'000	Group Actual 30/06/09 $'000	Parent Actual 30/06/10 $'000	Parent Actual 30/06/09 $'000
Total equity at beginning of the period		215,923	234,654	249,515	214,018	247,880
Total comprehensive income		7,561	(9,000)	(12,361)	7,527	(12,631)
Amounts recognised directly in equity:						
Impairment of property, plant and equipment	14	-	-	(19,802)	-	(19,802)
Total recognised revenues and expenses		7,561	(9,000)	(32,163)	7,527	(32,433)
Other movements:						
Contribution back to Crown		(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Contribution from Crown		7,729	-	432	7,729	432
Total equity at end of the period	7	**229,352**	**223,793**	**215,923**	**227,413**	**214,018**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2010

	Notes	Group Actual as at 30/06/10 $'000	Group Budget as at 30/06/10 $'000	Group Actual as at 30/06/09 $'000	Parent Actual as at 30/06/10 $'000	Parent Actual as at 30/06/09 $'000
CROWN EQUITY						
General Funds	7	126,891	122,452	121,023	127,029	121,161
Revaluation Reserve	7	181,046	184,477	164,675	181,046	164,675
Retained earnings/(losses)	7	(78,585)	(83,136)	(69,775)	(80,662)	(71,818)
TOTAL EQUITY		**229,352**	**223,793**	**215,923**	**227,413**	**214,018**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and cash equivalents	8	69,076	25,429	47,497	68,236	45,870
Trade and other receivables	9	35,763	29,800	47,939	34,837	47,264
Inventories	10	8,644	8,000	9,641	8,547	9,534
Investments	11	5,275	-	3,895	3,000	3,624
TOTAL CURRENT ASSETS		118,758	63,229	108,972	114,620	106,292
CURRENT LIABILITIES						
Trade and other payables	12	92,246	72,400	90,758	91,866	90,378
Owing to the Ministry of Health		4,927	5,000	5,194	4,927	5,194
Employee benefits	13	127,197	105,000	115,967	125,628	114,440
TOTAL CURRENT LIABILITIES		224,370	182,400	211,919	222,421	210,012
NET WORKING CAPITAL		(105,612)	(119,171)	(102,947)	(107,801)	(103,720)
NON CURRENT ASSETS						
Investments	11	5,171	9,170	8,171	10,980	10,299
Property, plant and equipment	14	411,543	415,794	387,902	405,965	384,625
Intangible assets	15	612	-	1,962	612	1,962
Surplus property	16	-	-	5,460	-	5,460
Restricted assets	17	12,626	11,522	12,483	12,494	12,357
TOTAL NON CURRENT ASSETS		429,952	436,486	415,978	430,051	414,703
NON CURRENT LIABILITIES						
Employee benefits	13	7,362	7,000	9,625	7,343	9,608
Restricted funds	17	12,626	11,522	12,483	12,494	12,357
Borrowings	18	75,000	75,000	75,000	75,000	75,000
TOTAL NON CURRENT LIABILITIES		94,988	93,522	97,108	94,837	96,965
NET ASSETS		**229,352**	**223,793**	**215,923**	**227,413**	**214,018**

For and on behalf of the Board

Alister James
Chair
29 September 2010

Olive Webb
Deputy Chair
29 September 2010

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2010

	Notes	Group Actual 30/06/10 $'000	Group Budget 30/06/10 $'000	Group Actual 30/06/09 $'000	Parent Actual 30/06/10 $'000	Parent Actual 30/06/09 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,274,881	1,259,702	1,190,244	1,265,142	1,179,665
Other Receipts		62,879	54,697	61,099	59,760	58,841
Interest Received		4,239	4,716	5,544	4,356	5,599
		1,341,999	1,319,115	1,256,887	1,329,258	1,244,105
Cash was applied to:						
Payments to Employees		533,154	532,974	505,553	521,122	494,917
Payments to Suppliers		736,178	730,636	707,104	736,545	706,781
Interest Paid		4,673	5,786	4,422	4,673	4,407
Capital Charge		13,551	20,000	19,826	13,551	19,826
GST - net		(457)	-	772	(448)	773
		1,287,099	1,289,396	1,237,677	1,275,443	1,226,704
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	54,900	29,719	19,210	53,815	17,401
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant & equipment		56	-	13,108	48	13,097
Receipt from sale of investments		1,620	-	-	-	-
		1,676	-	13,108	48	13,097
Cash was applied to:						
Purchase of Investments & Restricted Assets		-	-	2,896	57	1,545
Purchase of property, plant & equipment		40,865	40,000	22,835	37,308	21,894
		40,865	40,000	25,731	37,365	23,439
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		(39,189)	(40,000)	(12,623)	(37,317)	(10,342)
CASH FLOW FROM FINANCING ACTIVITIES						
Cash was provided from:						
Equity injection		7,729	-	432	7,729	432
		7,729	-	432	7,729	432
Cash was applied to:						
Equity repaid to Crown		1,861	1,861	1,861	1,861	1,861
		1,861	1,861	1,861	1,861	1,861
NET CASH INFLOW/ (OUTFLOW) FROM FINANCING ACTIVITIES		5,868	(1,861)	(1,429)	5,868	(1,429)
Net increase/(decrease) in cash and cash equivalents		21,579	(12,142)	5,158	22,366	5,630
Cash and cash equivalents at beginning of year		47,497	37,571	42,339	45,870	40,240
Cash & cash equivalents at end of year	8	**69,076**	**25,429**	**47,497**	**68,236**	**45,870**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2010

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 2010 and were authorised for issue by the Board on 29 September 2010.

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.

Canterbury DHB has adopted the following revisions to accounting standards during the financial year which have only had a presentation or disclosure effect:

- 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". Canterbury DHB has adopted this standard for the year ending 30 June 2010 and has selected the option of presenting items of income and expense and components of other comprehensive income in a single statement of comprehensive income with subtotals.

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 IFRS 9 *Financial Instruments* will eventually replace *NZ IAS 39 Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is effective for reporting period beginning on or after 1 January 2013. Canterbury DHB has not yet assessed the impact of the new standard and expects it will not be early adopted.
- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)*. Canterbury DHB has elected to defer the adoption of NZ IAS *Borrowing Costs (revised 2007)* in accordance with its transitional provisions that are applicable to public benefit entities. Consequently, all borrowing costs are recognised as an expense in the period in which they are incurred.

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 comprehensive income.

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 comprehensive income. 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 other comprehensive income. 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 comprehensive income 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 is recognised in the surplus or deficit. It 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 surplus or deficit 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 comprehensive income 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 surplus or deficit 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 other comprehensive income.

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 comprehensive income. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the statement of comprehensive income.

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 surplus or deficit.

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 surplus or deficit.

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 other comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in other comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in other comprehensive income.

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 other comprehensive income, a reversal of the impairment loss is also recognised in other comprehensive income.

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 comprehensive income 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 comprehensive income 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 comprehensive income.

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 surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of comprehensive income 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 comprehensive income.

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 comprehensive income, 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 aligning useful lives with the revaluation performed as at 30 June 2010.

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	
	30/06/10 $'000	30/06/09 $'000	30/06/10 $'000	30/06/09 $'000
ACC Revenue	21,869	22,641	21,869	22,641
Other patient related revenue	22,938	20,644	22,137	20,572
	44,807	**43,285**	**44,006**	**43,213**

3. OTHER OPERATING INCOME

	Group		Parent	
	30/06/10 $'000	30/06/09 $'000	30/06/10 $'000	30/06/09 $'000
Gain/(loss) on sale of property, plant and equipment	(26)	10,309	(48)	10,300
Donations and bequests received	933	603	933	602
Other	19,313	17,211	16,995	15,026
	20,220	**28,123**	**17,880**	**25,928**

4. EMPLOYEE BENEFIT COSTS

	Group		Parent	
	30/06/10 $'000	30/06/09 $'000	30/06/10 $'000	30/06/09 $'000
Wages and salaries	528,276	500,506	516,244	489,870
Contributions to defined contribution plans	4,878	5,047	4,878	5,047
Increase/(decrease) in employee benefit provisions	8,967	7,076	8,923	6,826
	542,121	**512,629**	**530,045**	**501,743**

5. OTHER EXPENSES

	Group		Parent	
	30/06/10 $'000	30/06/09 $'000	30/06/10 $'000	30/06/09 $'000
Remuneration of auditor:				
Audit fees for financial statement audit	204	197	166	160
Board members' fees	318	318	318	318
Directors' fees	23	23	-	-
Rental costs	4,947	4,589	4,322	4,044
Facilities and infrastructure costs	37,954	36,062	36,032	34,975
Other non-clinical costs	34,237	31,235	33,225	29,508
	77,683	**72,424**	**74,063**	**69,005**

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 2010 was 8%. (June 2009 8%).

7. CAPITAL AND RESERVES

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
General Funds				
Opening Balance	121,023	122,452	121,161	122,590
Equity repayment to Ministry of Health	(1,861)	(1,861)	(1,861)	(1,861)
Equity injection by Ministry of Health	7,729	432	7,729	432
	126,891	**121,023**	**127,029**	**121,161**
Retained earnings				
Opening balance	(69,775)	(57,414)	(71,818)	(59,187)
Operating surplus/(deficit)	(8,810)	(12,361)	(8,844)	(12,631)
Closing balance	(78,585)	(69,775)	(80,662)	(71,818)
Represented by:				
Accumulated deficit in parent and subsidiary	(78,663)	(69,853)	(80,740)	(71,896)
Accumulated surplus in associates	78	78	78	78
	(78,585)	**(69,775)**	**(80,662)**	**(71,818)**
Revaluation reserve				
Opening balance	164,675	184,477	164,675	184,477
Impairment charges	-	(19,802)	-	(19,802)
Revaluation of land, building including fitout	16,371	-	16,371	-
Closing balance	181,046	164,675	181,046	164,675
Represented by:				
Revaluation of land	66,453	68,603	66,453	68,603
Revaluation of building including fitout	113,093	94,572	113,093	94,572
Revaluation of reversionary interest in buildings	1,500	1,500	1,500	1,500
	181,046	**164,675**	**181,046**	**164,675**
Total Equity	**229,352**	**215,923**	**227,413**	**214,018**

8. CASH AND CASH EQUIVALENTS

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Bank balances and call deposits	44,076	43,959	43,236	42,670
Term deposits less than 3 months	25,000	3,538	25,000	3,200
	69,076	**47,497**	**68,236**	**45,870**

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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Trade receivables	8,843	11,719	8,782	11,564
Receivable from the Ministry of Health	19,266	27,422	18,410	26,942
Prepayments	1,310	1,147	1,310	1,147
Other receivables	6,344	7,651	6,335	7,611
	35,763	**47,939**	**34,837**	**47,264**

Trade and other receivables are non-interest bearing and receipt is normally on 30-day terms. Therefore, the carrying value of receivables approximates their fair value.

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

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Balance at 1 July	3,928	2,162	3,928	2,162
Additional provisions made during the year	63	2,129	63	2,129
Receivables written-off during period	(1,059)	(363)	(1,059)	(363)
Balance at 30 June	**2,932**	**3,928**	**2,932**	**3,928**

The ageing of the impairment provisions are as follows:

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Current	354	883	354	883
1-30 days	264	785	264	785
31-60 days	96	196	96	196
> 61 days	2,218	2,064	2,218	2,064
Balance at 30 June	**2,932**	**3,928**	**2,932**	**3,928**

As at 30 June 2010 and 2009, 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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Current	4,926	6,822	4,883	6,697
1-30 days	3,459	1,643	3,444	1,598
31-60 days	271	2,155	271	2,155
> 61 days	187	1,099	184	1,114
Balance at 30 June	**8,843**	**11,719**	**8,782**	**11,564**

10. INVENTORY

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Pharmaceuticals	2,685	2,755	2,685	2,755
Surgical and Medical Supplies	4,780	5,347	4,780	5,347
Other Supplies	2,581	2,149	2,484	2,042
	10,046	10,251	9,949	10,144
Provision for Obsolescence	(1,402)	(610)	(1,402)	(610)
	8,644	**9,641**	**8,547**	**9,534**

No inventories are pledged as security for liabilities, however some inventories are subject to retention of title clauses. There has been no change since last year.

11. INVESTMENTS

Canterbury DHB has the following investments:

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Current investments are represented by:				
Investment in Subsidiaries	-	-	-	300
Term deposits	2,275	2,896	-	2,325
Bonds	3,000	999	3,000	999
Total current portion	5,275	3,895	3,000	3,624
Non-current investments are represented by:				
Investment in Subsidiaries	-	-	5,809	2,128
Bonds	5,171	8,171	5,171	8,171
Total non-current portion	5,171	8,171	10,980	10,299
	10,446	**12,066**	**13,980**	**13,923**

Investment in Associates

a) General information

Name of entity	Principal activities	Interest held at 30/06/10	Balance date
South Island Shared Service Agency Limited	Provision of support services relating to South Island DHBs funding arm contracting	47%	30 June

South Island Shared Service Agency Limited is an unlisted company.

b) Investment in associate entities

	2010 Actual $'000	2009 Actual $'000
Carrying amount at beginning of year	-	-
Carrying amount at end of year	**-**	**-**

c) Summarised financial information of associate entity

	2010 Actual $'000	2009 Actual $'000
Assets	2,254	2,059
Liabilities	1,498	1,319
Revenues	2,834	3,351
Surplus/(deficit)	35	352
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 30/06/10 $'000	As at 30/06/09 $'000
Equity - Canterbury Laundry Service Ltd	5,394	394
Advances - Canterbury Laundry Service Ltd	(38)	2,404
Advances - Brackenridge Estate Ltd	453	(370)
	5,809	**2,428**

At 30 June 2010 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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Term deposits	2,275	2,896	-	2,325
Bonds	8,171	9,170	8,171	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:

	Group	
	30/06/10 $'000	30/06/09 $'000
Term deposit with maturities of 6-12 months	2,275	571
Weighted average effective interest rates	5.00%	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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Trade payables	16,182	15,167	16,102	14,900
Other payables	76,064	75,591	75,764	75,478
	92,246	**90,758**	**91,866**	**90,378**

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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Non-current liabilities				
Liability for long service leave	3,331	4,849	3,312	4,832
Liability for retirement gratuities	4,031	4,776	4,031	4,776
	7,362	**9,625**	**7,343**	**9,608**
Current liabilities				
Annual leave accruals	50,008	45,334	49,018	44,540
Unpaid days accruals	10,098	7,166	9,996	7,102
ACC accruals	9,391	7,899	9,349	7,852
Conference/sabbatical leave and expenses	19,243	16,197	19,243	16,197
Sick leave	10,296	8,842	10,140	8,706
Other	28,161	30,529	27,882	30,043
	127,197	**115,967**	**125,628**	**114,440**

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

09/10 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation							
Balance at 1 July 2009	100,083	337,841	166,466	894	1,500	11,725	618,509
Additions	289	26,034	20,751	-	-	(6,257)	40,817
Disposals/transfers	5,460	-	(13,065)	-	-	-	(7,605)
Revaluation	(2,150)	(114,314)	-	-	1,500	-	(114,964)
Balance at 30 June 2010	**103,682**	**249,561**	**174,152**	**894**	**3,000**	**5,468**	**536,757**
Depreciation and impairment losses							
Balance at 1 July 2009	-	106,982	122,731	894	-	-	230,607
Depreciation charge for the year	-	26,088	14,310	-	-	-	40,398
Revaluation	-	(132,835)	-	-	-	-	(132,835)
Disposals/transfer	-	-	(12,956)	-	-	-	(12,956)
Balance at 30 June 2010	**-**	**235**	**124,085**	**894**	**-**	**-**	**125,214**

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.

08/09 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'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**
Carrying amount							
At 1 July 2009	**100,083**	**230,859**	**43,735**	**-**	**1,500**	**11,725**	**387,902**
At 30 June 2010	**103,682**	**249,326**	**50,067**	**-**	**3,000**	**5,468**	**411,543**

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

09/10 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation							
Balance at 1 July 2009	100,083	337,319	159,005	894	1,500	11,679	610,480
Additions	289	26,035	17,105	-	-	(6,211)	37,218
Disposals/transfers	5,460	-	(11,698)	-	-	-	(6,238)
Revaluation	(2,150)	(114,314)	-	-	1,500	-	(114,964)
Balance at 30 June 2010	**103,682**	**249,040**	**164,412**	**894**	**3,000**	**5,468**	**526,496**
Depreciation and impairment losses							
Balance at 1 July 2009	-	106,807	118,154	894	-	-	225,855
Depreciation charge for the year	-	26,028	13,100	-	-	-	39,128
Revaluation	-	(132,835)	-	-	-	-	(132,835)
Disposals/transfer	-	-	(11,617)	-	-	-	(11,617)
Balance at 30 June 2010	**-**	**-**	**119,637**	**894**	**-**	**-**	**120,531**

08/09 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'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**
Carrying amount							
At 1 July 2009	**100,083**	**230,512**	**40,851**	**-**	**1,500**	**11,679**	**384,625**
At 30 June 2010	**103,682**	**249,040**	**44,775**	**-**	**3,000**	**5,468**	**405,965**

Revaluation

Canterbury DHB revalued its land, buildings and plant fitouts as at 30 June 2010. 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 decrease in the value of land ($2,150,000), and the net increase in the value of buildings and fitout ($18,521,000). The movements in land and buildings and plant fitouts have 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 2010 was $352,722,000.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, the car park building will belong to Canterbury DHB in 2019. This interest was valued as at 30 June 2010 to $3,000,000 (2009, $1,500,000), and is included in the Statement of Financial Position under Property, Plant, and Equipment. Of this amount, $1,500,000 is included in the Revaluation Reserve.

15. INTANGIBLE ASSETS

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Software				
Cost				
Opening balance	21,250	18,478	21,243	18,478
Additions	748	2,819	748	2,812
Disposals	(3,436)	(47)	(3,436)	(47)
Closing balance	18,562	21,250	18,555	21,243
Amortisation and impairment losses				
Opening balance	19,288	17,195	19,281	17,195
Amortisation charge for the year	2,099	2,067	2,099	2,067
Disposals	(3,437)	26	(3,437)	19
Closing balance	17,950	19,288	17,943	19,281
Carrying amounts	**612**	**1,962**	**612**	**1,962**

There are no restrictions over the title of intangible assets. No intangible assets are pledged as security for liabilities. There is no impairment for the financial year ended 30 June 2010. There has been no change since last year.

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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Balance at beginning of year	12,483	11,522	12,357	11,402
Interest received	625	846	619	840
Donations and funds received	1,687	2,326	1,687	2,326
Funds spent	(2,169)	(2,211)	(2,169)	(2,211)
Balance at end of year	**12,626**	**12,483**	**12,494**	**12,357**

Residents' trust accounts	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Residents' trust account balance	**936**	**893**	**309**	**310**

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 Comprehensive Income, Financial Position or Cash Flow of Canterbury DHB.

18. BORROWINGS

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'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	
	30/06/10 $'000	30/06/09 $'000	30/06/10 $'000	30/06/09 $'000
Crown Health Financing Agency loans				
Later than one year but not more than five years	75,000	60,000	75,000	60,000
Weighted average effective interest rate	*6.19%*	*6.22%*	*6.19%*	*6.22%*
Later than five years	-	15,000	-	15,000
Weighted average effective interest rate	-	*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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Net surplus/(deficit)	(8,810)	(12,361)	(8,844)	(12,631)
Add back non-cash items:				
Depreciation and amortisation	42,497	45,100	41,227	43,786
(Gains)/losses of reversionary interest	(1,500)	-	(1,500)	-
Donated assets	(674)	-	(674)	-
Add back items classified as investing activities:				
(Gains) / losses on asset sale	26	(10,309)	48	(10,300)
	31,539	22,430	30,257	20,855
Movement in term portion provisions/staff entitlements	(2,263)	1,041	(2,265)	1,049
Movements in working capital:				
Decrease/(increase) in receivables & prepayments	12,176	(11,930)	12,427	(11,823)
Decrease/(increase) in stocks	997	(678)	987	(640)
Increase/(decrease) in creditors & other accruals	1,488	4,347	1,488	4,218
Increase/(decrease) in capital charge due to crown	(267)	(2,035)	(267)	(2,035)
Increase/(decrease) in staff entitlements	11,230	6,035	11,188	5,777
Net cash inflow/(outflow) from operating activities	**54,900**	**19,210**	**53,815**	**17,401**

20. COMMITMENTS

	Group		Parent	
	As at 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Capital commitments				
Property	22,438	15,845	22,438	15,845
Intangible assets	3,715	2,562	3,715	2,562
Other capital commitments	18,342	16,408	18,290	16,370
Total capital commitments at balance date	**44,495**	**34,815**	**44,443**	**34,777**
Non cancellable operating lease commitments				
Accommodation leases	9,088	7,463	5,501	3,614
Other	11	11	-	-
	9,099	**7,474**	**5,501**	**3,614**
Supply commitments	**312**	**991**	**-**	**-**
Total non cancellable operating lease and supply commitments	**9,411**	**8,465**	**5,501**	**3,614**
For expenditure within:				
Not later than one year	2,237	2,241	1,334	1,053
Later than one year and not later than five years	4,756	2,961	3,328	1,211
Later than five years	2,418	3,263	839	1,350
	9,411	**8,465**	**5,501**	**3,614**

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. CONTINGENCIES

Contingent assets
Canterbury DHB has no contingent assets for the financial year ended 30 June 2010. (2009: nil)

Contingent liabilities
Canterbury DHB has the following contingent liabilities 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 ruling in an employment court case relating to sleepovers 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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Investments in subsidiaries and associates	-	-	5,809	2,428
Loans and receivables				
Cash and cash equivalents	69,076	47,497	68,236	45,870
Debtors and other receivables	35,763	47,939	34,837	47,264
Bonds	8,171	9,170	8,171	9,170
Term deposits (term>3 months)	2,275	2,896	-	2,325
Total loans and receivables	**115,285**	**107,502**	**111,244**	**104,629**
Fair value through profit and loss				
Restricted assets	12,626	12,483	12,494	12,357
Restricted liabilities	12,626	12,483	12,494	12,357
Total fair value through profit and loss	**-**	**-**	**-**	**-**
Other financial liabilities				
Creditors and other payables	97,173	95,952	96,793	95,572
Borrowings - CFA loans	75,000	75,000	75,000	75,000
Total other financial liabilities	**172,173**	**170,952**	**171,793**	**170,572**

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 2010, the Ministry of Health owed Canterbury DHB $18.41 million ($26.9 million at 30 June 2009).

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 debt securities price risk on its investments. This price risk arises due to market movements in listed debt securities. 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 2010 was nil (2009: 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 was one forward exchange contract outstanding at 30 June 2010 (2009: 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.

Canterbury DHB has a maximum amount that can be drawn down against its loan facility of $129.65 million.

Contractual maturity analysis of financial liabilities

The tables below analyse Canterbury DHB and group's financial liabilities into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date, based on undiscounted cash flows.

Contractual maturity analysis of financial liabilities for the Group

	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	2-5 years $'000	More than 5 years $'000
09/10 financial year						
Creditors and other payables	97,173	97,173	97,173	-	-	-
Borrowings- CFA loans	75,000	75,000	-	30,000	45,000	-
Restricted liabilities	12,626	12,626	9,289	1,405	1,732	200
Total	**184,799**	**184,799**	**106,462**	**31,405**	**46,732**	**200**
08/09 financial year						
Creditors and other payables	95,952	95,952	95,952	-	-	-
Borrowings- CFA loans	75,000	75,000	-	-	60,000	15,000
Restricted liabilities	12,483	12,483	7,696	1,450	2,687	650
Total	**183,435**	**183,435**	**103,648**	**1,450**	**62,687**	**15,650**

Contractual maturity analysis of financial liabilities for the Parent

	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	2-5 years $'000	More than 5 years $'000
09/10 financial year						
Creditors and other payables	96,793	96,793	96,793	-	-	-
Borrowings- CFA loans	75,000	75,000	-	30,000	45,000	-
Restricted liabilities	12,494	12,494	9,157	1,405	1,732	200
Total	**184,287**	**184,287**	**105,950**	**31,405**	**46,732**	**200**
08/09 financial year						
Creditors and other payables	95,572	95,572	95,572	-	-	-
Borrowings- CFA loans	75,000	75,000	-	-	60,000	15,000
Restricted liabilities	12,357	12,357	7,570	1,450	2,687	650
Total	**182,929**	**182,929**	**103,142**	**1,450**	**62,687**	**15,650**

Contractual maturity analysis of financial assets

The tables below analyse Canterbury DHB and group's financial assets into relevant maturity groupings based on the remaining period at the balance sheet date to the contractual maturity date, based on undiscounted cash flows.

Contractual maturity analysis of financial assets for the Group

	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	2-5 years $'000	More than 5 years $'000
09/10 financial year						
Cash and cash equivalents	69,076	69,076	69,076	-	-	-
Debtors and other receivables	35,763	35,763	35,763	-	-	-
Bonds	8,171	8,171	3,000	5,171	-	-
Term deposits (term > 3 months)	2,275	2,275	2,275	-	-	-
Restricted assets	12,626	12,626	9,289	1,405	1,732	200
Total	**127,911**	**127,911**	**119,403**	**6,576**	**1,732**	**200**
08/09 financial year						
Cash and cash equivalents	47,497	47,497	47,497	-	-	-
Debtors and other receivables	47,939	47,939	47,939	-	-	-
Bonds	9,170	9,170	999	3,000	5,171	-
Term deposits (term > 3 months)	2,896	2,896	2,896	-	-	-
Restricted assets	12,483	12,483	7,696	1,450	2,687	650
Total	**119,985**	**119,985**	**107,027**	**4,450**	**7,858**	**650**

Contractual maturity analysis of financial assets for the Parent

	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	2-5 years $'000	More than 5 years $'000
09/10 financial year						
Cash and cash equivalents	68,236	68,236	68,236	-	-	-
Debtors and other receivables	34,837	34,837	34,837	-	-	-
Bonds	8,171	8,171	3,000	5,171	-	-
Term deposits (term > 3 months)	-	-	-	-	-	-
Restricted assets	12,494	12,494	9,157	1,405	1,732	200
Total	**123,738**	**123,738**	**115,230**	**6,576**	**1,732**	**200**
08/09 financial year						
Cash and cash equivalents	45,870	45,870	45,870	-	-	-
Debtors and other receivables	47,264	47,264	47,264	-	-	-
Bonds	9,170	9,170	999	3,000	5,171	-
Term deposits (term > 3 months)	2,325	2,325	2,325	-	-	-
Restricted assets	12,357	12,357	7,570	1,450	2,687	650
Total	**116,986**	**116,986**	**104,028**	**4,450**	**7,858**	**650**

Sensitivity Analysis
The table below illustrates the potential effect on the surplus or deficit for reasonably possible market movements, with all other variables held constant, based on Canterbury DHB and group's financial instrument exposures at balance date. Canterbury DHB accounts for its financial assets and financial liabilities by using the historical cost basis. Therefore, interest rate changes do not have any surplus or deficit impact.

	Group			
	30/06/10 $'000		30/06/09 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(251)	251	(793)	793
Total sensitivity	**(251)**	**251**	**(793)**	**793**

	Parent			
	30/06/10 $'000		30/06/09 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(251)	251	(793)	793
Total sensitivity	**(251)**	**251**	**(793)**	**793**

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	
	30/06/10 $'000	30/06/09 $'000	30/06/10 $'000	30/06/09 $'000
Revenue				
Interest on advance and director's fees from/to Canterbury Laundry Service Ltd	-	-	233	190
Interest on advance to Brackenridge Estate Ltd	-	-	4	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	83	80	83	80
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	4,671	4,420
Interest on advance from Brackenridge Estate Ltd	-	-	-	6
Services from South Island Shared Service Agency Ltd	1,170	1,351	1,170	1,351

Interest charged on advances to / from Canterbury Laundry Service Ltd and Brackenridge Estate Ltd is at normal borrowing rates. Other balances are at normal trading terms.

Canterbury DHB pays for items such as power, rate 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 30/06/10 $'000	As at 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Amount receivable owing by associates				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	19	196	19	196
Amount payable owing to associates				
South Island Shared Service Agency Ltd	656	567	656	567
Amount payable owing to subsidiaries				
Brackenridge Estate Ltd – advance	-	-	-	370
Canterbury Laundry Service Ltd	-	-	458	456
Amount receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – debtor	-	-	133	51
Canterbury Laundry Service Ltd – advance	-	-	-	2,450
Brackenridge Estate Ltd – advance	-	-	453	-

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 30/06/10 $'000	Year ended 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Pegasus Health (Charitable) Ltd	4,976	1,403	164	18
Ryman Healthcare Ltd	8,607	8,348	-	-
Access Home Health	4,974	4,538	-	-
Deloitte	2	32	-	-
McLeans Institute	163	173	-	-
University of Canterbury	124	117	6	2
Age Concern Canterbury	-	2	-	1
Social Services Council of the Diocese of Christchurch	5,363	4,859	-	-
Nurse Maude	26,258	24,162	-	3
Medical Protection Society	109	105	-	1
Partnership Health Primary Health Organisation	72,944	69,714	-	478
Hurunui-Kaikoura Primary Health Organisation	3,930	3,623	-	-
Amuri Health Centre Ltd	-	2	-	2
Te Runanga O Ngai Tahu	213	4	3	-
University of Otago	9,137	8,419	317	336
Environment Canterbury	-	19	1	-
Canterbury Asthma Society	134	-	-	-
Christchurch Primary Health Organisation	4,500	4,336	-	7
Maori Women's Welfare League	745	892	-	-
Rural Canterbury Primary Health Organisation	13,761	14,120	-	1
West Coast DHB	862	-	13	-

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 $99,293 has been made (2009 $92,050).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/10 $'000	Year ended 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Pegasus Health	138	19	32	6
University of Canterbury	51	324	-	33
Christchurch Polytechnic Institute of Technology (CPIT)	400	392	27	27
Nurse Maude	21	60	30	51
Canterbury Medical Research Foundation	53	83	13	35
Partnership Health Primary Health Organisation	37	129	-	(22)
Hurunui Kaikoura Primary Health Organisation	-	1	-	-
24 Hour Surgery Ltd	3	3	-	-
Environment Canterbury	3	3	-	-
Southlink Health	-	9	-	-
University of Otago	2,834	3,513	210	543
Christchurch Primary Health Organisation	5	-	-	-
Rural Canterbury Primary Health Organisation	148	198	21	178
West Coast DHB	15,014	-	321	-

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 (2009 $nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/10 $'000	Year ended 30/06/09 $'000	As at 30/06/10 $'000	As at 30/06/09 $'000
Services purchased by Canterbury DHB:				
Heart Centre at St George's	92	1,328	-	-
Te Kura Kaupapa Māori o Te Whanau Tahi	-	7	-	-
Christchurch Polytechnic Institute of Technology	9	23	5	-
Heart Vision Ltd	-	2	-	-
Services purchased from Canterbury DHB:				
Heart Centre at St George's	25	31	3	2
Christchurch Polytechnic Institute of Technology	400	392	29	27

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 was the Chair of the Christchurch Polytechnic Institute of Technology Council until February 2010. He was also the Chair, Board of Trustees, Te Kura Kaupapa Māori o Te Whanau Tahi until May 2010 and is currently a co-opted board member.

Compensation of key management personnel:

	Group		Parent	
	Year ended 30/06/10 $'000	Year ended 30/06/09 $'000	Year ended 30/06/10 $'000	Year ended 30/06/09 $'000
Salaries & other short term employee benefits	2,092	1,851	2,092	1,851
Post-employment benefits	21	255	21	255
Total key management personnel compensation	**2,113**	**2,106**	**2,113**	**2,106**

The above compensation of key management personnel does not include Board and Committee members' fees. For Board and Committee members' fees see page 7.

26. SUBSEQUENT EVENTS

A 7.1 magnitude earthquake hit the Canterbury region on 4 September 2010. Some property was damaged and losses are expected as a result of the earthquake. The extent of the loss can only be determined with certainty at a later time. There were no other events after 30 June 2010 which could have a material impact on the information in Canterbury DHB's financial statements (30 June 2009 – no events).

STATEMENT OF SERVICE PERFORMANCE

Overview

This Statement of Service Performance has been grouped into four output classes. These groupings enable us to provide an overview of the services that the DHB is responsible or accountable for. The four output classes we have chosen are:

- Public Health Services (disease prevention);
- Personal Health Services – with subsets of primary and community services (early intervention and the management of long-term conditions) and hospital level and specialist services (complex care and support);
- Mental Health Services (focused across the whole continuum or patient journey); and
- Older Persons' Health Services (also focused across the whole patient journey).

This Statement of Service Performance describes the DHB's non-financial performance under each output class 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 operational performance, ensuring the DHB is delivering sustainable and quality services effectively and efficiently.

The performance measures include national measures, which are consistent across all 21 DHBs, along with local measures and associated targets. The measures presented are intended to provide a picture of access to services, timeliness of service provision and the quality of care being provided, in order to enable evaluation of performance over time. In determining the set of performance measures, we have focused on our identified health gain priorities, the transformation we are seeking to achieve and the expectations of the Minister of Health. The national 'Health Targets' are the measures that reflect the Minister of Health's expectations for 2009/10, and these are mixed through the Statement of Service Performance.

While the DHB is a provider of hospital and specialist services, we are also the funder of services for our community and work in partnership with other health and disability service providers, external agencies and organisations to collectively improve the health of our community. As the funder, we are often reliant on a third party to deliver the outputs needed to achieve the desired outcomes or objective, and our role is in influencing and enabling change through partnership, leadership and supportive contracting. A number of the associated performance measures in the 2009/10 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.

Output Class 1

Public Health Services

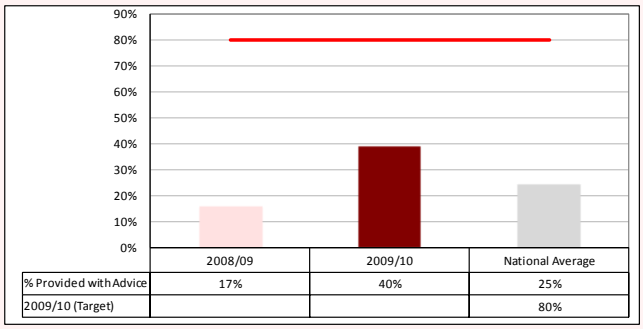
To provide environments, both physical and social, that support health enhancing behaviour

Strategic Goal 1.1: Reduced tobacco harm

To ensure that all smokers are identified and given advice and support to quit smoking

Associated Measures of Performance

The percentage of hospitalised smokers provided with advice and help to quit. [6]

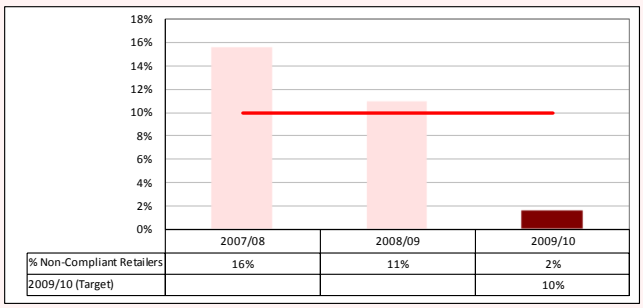


Target: 80% **Not Achieved**

This was a new project this year. While the DHB has not achieved the target the ABC[7] Strategy for Smoking Cessation has been implemented in all Canterbury DHB hospital sites, with steady monthly improvement in both the identification of smokers and the provision of cessation advice and support. We achieved 67% for the month of June 2010.

Support for smokers includes Nicotine Replacement Therapy (NRT), Quitpacks and referrals to Quitline, Aukati Kaipaipa and Pacific smoking cessation services.

The percentage of non-compliant tobacco retailers identified from controlled purchase operations.



Target: <10% non-compliant **Achieved**

In addition to monitoring youth access to tobacco through controlled purchase operations, the Canterbury DHB makes submissions on tobacco legislation and continues to support smoke free initiatives in public places such as marae, parks and playgrounds throughout Canterbury with support from local councils and the community.

[6] *The 2008/09 baseline figure is based on 6months' data, from 1 January 2009 to 20 June 2009. The national health target was set at 80%. The DHB supported this target and the implementation of the new ABC programme, establishing the systems to measure baselines and performance over the 2009/10 year.*

[7] *The ABC Strategy for Smoking Cessation involves staff Asking whether the patient smokes (A), offering Brief advice to quit (B) and referring the patient to Cessation support (C).*

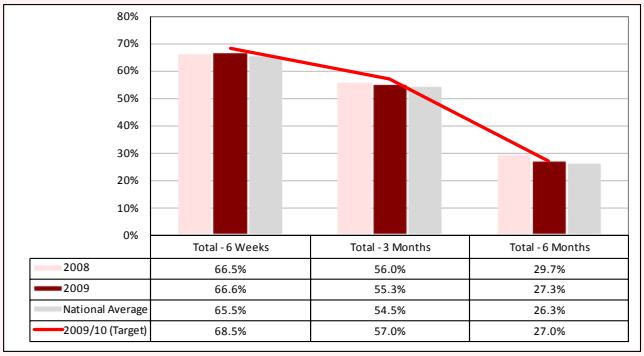
Strategic Goal 1.2: Improved nutrition

To improve the health of children and young people through improved nutrition

Associated Measures of Performance

The percentage of infants exclusively and fully breastfed at 6 weeks, 3 months and 6 months.[8]

Target: 6wks 68.5% 3mths 57% 6mths 27% **Not Achieved**

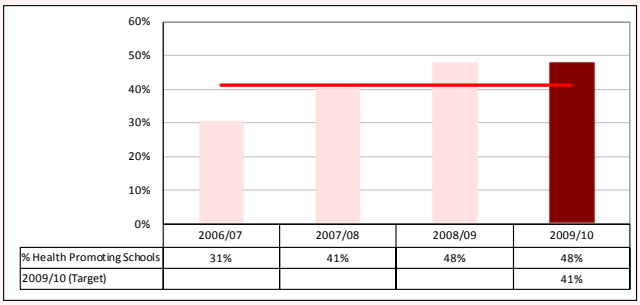


	Total - 6 Weeks	Total - 3 Months	Total - 6 Months
2008	66.5%	56.0%	29.7%
2009	66.6%	55.3%	27.3%
National Average	65.5%	54.5%	26.3%
2009/10 (Target)	68.5%	57.0%	27.0%

Although breastfeeding rates fell slightly short of target for infants at 6 weeks and 3 months, the 6 month target was achieved. There has been considerable progress this year in the implementation of the Healthy Eating Healthy Action Breastfeeding Action Plan, including training Mum4Mum Peer Support Administrators and volunteer Breastfeeding Peer Support Counsellors – including Māori, Pacific and rural trainees – who provide breastfeeding advice and support to other mothers in the community.

The percentage of schools supporting the Health Promoting Schools Framework.[9]

Target: >41% **Achieved**



	2006/07	2007/08	2008/09	2009/10
% Health Promoting Schools	31%	41%	48%	48%
2009/10 (Target)				41%

The Canterbury DHB's Health Promoting Schools team continues to support schools and after school programmes in a range of health promotion activities, including the formation of student health teams, policy formation and review, the provision of physical activity and nutrition resources and professional development opportunities for teaching staff.

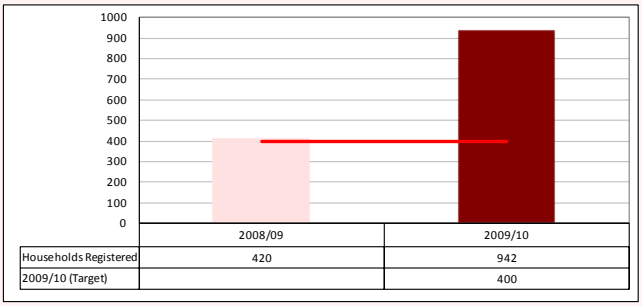
Strategic Goal 1.3: Collaboration to reduce risk factors

To engage multiple sectors in action to reduce risk factors for those most at risk of poor health and to share resources and capability across the region

Associated Measures of Performance

The number of eligible households registered in the home insulation retrofitting programme.

Target: 400 homes **Achieved**



	2008/09	2009/10
Households Registered	420	942
2009/10 (Target)		400

The Warm Families Programme has exceeded expectations by enabling 942 Canterbury households to receive home insulation upgrades at low or no cost. Recipients reported improvements for a range of health conditions, and the mean number of household days off work or school was reduced considerably.

[8] *Breastfeeding data is for calendar years, rather than financial years, and from Plunket only. Targets have been set emphasising the DHB's focus on increasing rates at 6 weeks and 3 months while seeking to maintain rates at 6 months where the DHB is already achieving higher than average rates.*

[9] *HPS is viewed as a framework to be 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.*

Output Class 2a

Personal Health Services – Primary and Community Services

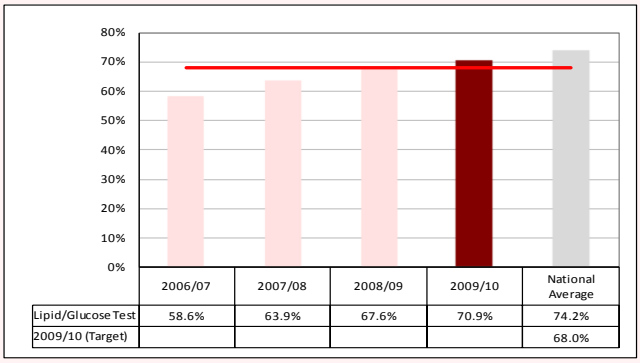
To improve health outcomes for our population and release secondary care resource through early intervention and support for the management of chronic conditions in primary or community settings

Strategic Goal 2.1: Prevention and early intervention

To identify early any health concerns that may adversely affect future health and wellbeing and to reduce unnecessary hospital admissions

Associated Measures of Performance

The percentage of eligible adult population having had a fasting-lipid/glucose test in the last five years.

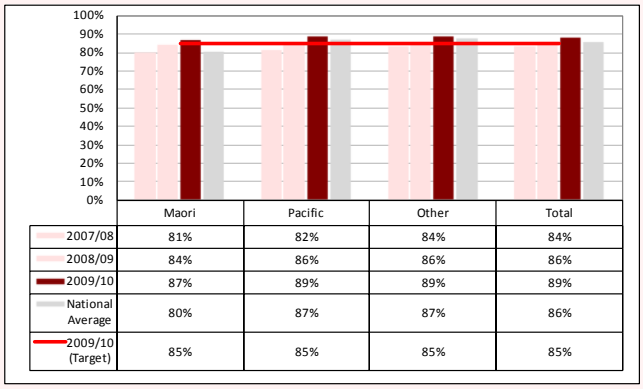


	2006/07	2007/08	2008/09	2009/10	National Average
Lipid/Glucose Test	58.6%	63.9%	67.6%	70.9%	74.2%
2009/10 (Target)					68.0%

Target: 68% **Achieved**

Canterbury PHOs participating in the Cardio Vascular Disease (CVD) component of the PHO performance programme have continued to improve CVD risk assessment rates, particularly for their high needs populations.

The percentage of two year olds fully immunised.



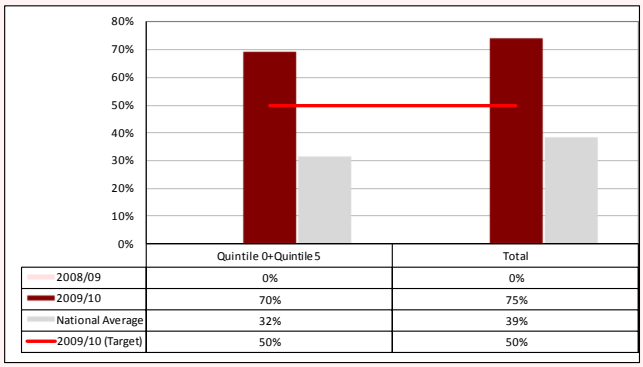
	Maori	Pacific	Other	Total
2007/08	81%	82%	84%	84%
2008/09	84%	86%	86%	86%
2009/10	87%	89%	89%	89%
National Average	80%	87%	87%	86%
2009/10 (Target)	85%	85%	85%	85%

Target: Māori 85% **Pacific 85%** **All 85%** **Achieved**

Immunisation coverage of two year olds in Canterbury has exceeded the health target, reflecting considerable effort from general practices, outreach immunisation and the Canterbury NIR (National Immunisation Register) Team. In the fourth quarter of the year, immunisation rates reached 91%.

A Hub of Immunisation Services in Canterbury is planned to provide integrated immunisation support services and target hard-to-reach populations from September 2010 in order to further improve immunisation coverage.

The percentage of four year olds receiving B4 School Checks.



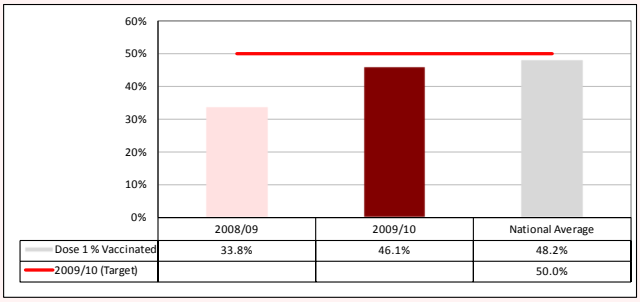
	Quintile 0+Quintile 5	Total
2008/09	0%	0%
2009/10	70%	75%
National Average	32%	39%
2009/10 (Target)	50%	50%

Target: 50% **Achieved**

Our new B4 School Check Programme is now well established in Canterbury. This is the final core WellChild/Tamariki Ora check, which children receive at age four. Developing a model to deliver this programme was logistically challenging, but we are now one of the highest performing DHBs in the country. We have surpassed the targets and aim to further increase the percentage of children who receive their B4 School Check next year.

The percentage of eligible girls completing HPV immunisation.[10]

Target: 50% **Not Achieved**



Canterbury took a different approach from other DHBs by delivering the HPV (Human Papilloma Virus) immunisation through general practice rather than a school-based programme. Although we did not quite achieve our target, end of year data shows that we have delivered as well as other DHBs of similar size, and we have high rates for Māori (48.8%) and Pacific (52.7%) ethnic groups. The HPV vaccine is now part of business as usual for general practice, with girls notified as they turn 12.

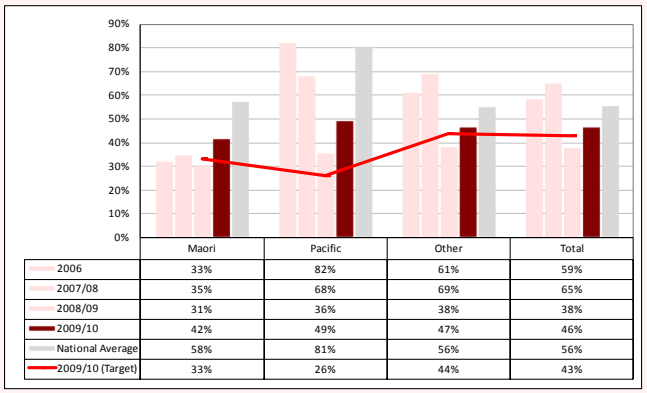
Strategic Goal 2.2: Management of long term conditions

To ensure people with long term conditions and those at risk of developing chronic conditions have the resources, information, support and care to enable them to self manage their condition and stay well

Associated Measures of Performance

The percentage of people with diabetes attending free annual reviews.[11]

Target: Māori >33% Pacific >26% All >43% **Achieved**

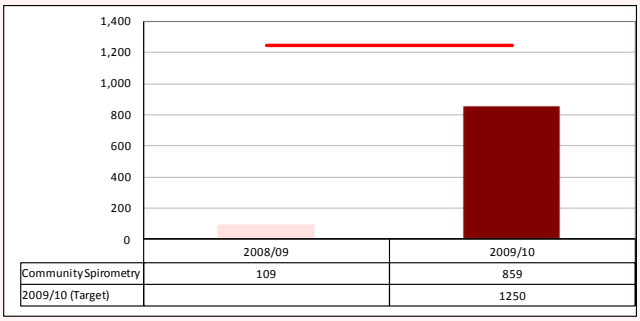


	Maori	Pacific	Other	Total
2006	33%	82%	61%	59%
2007/08	35%	68%	69%	65%
2008/09	31%	36%	38%	38%
2009/10	42%	49%	47%	46%
National Average	58%	81%	56%	56%
2009/10 (Target)	33%	26%	44%	43%

Canterbury has achieved the target for diabetes annual reviews across all ethnicities and improved considerably on last year. Diabetes management guidelines and referral pathways have been established to provide general practice with recall schedules for diabetes annual reviews and describe education offered to general practice teams about the detection and management of diabetes.

The number of community-based spirometry tests delivered.[12]

Target: 1,250 **Not Achieved**



859 spirometry tests were delivered in the community this year without the need for a hospital visit. Although short of the target, this is still a significant improvement in access to this diagnostic, amounting to 750 more spirometry tests delivered in the community than last year.

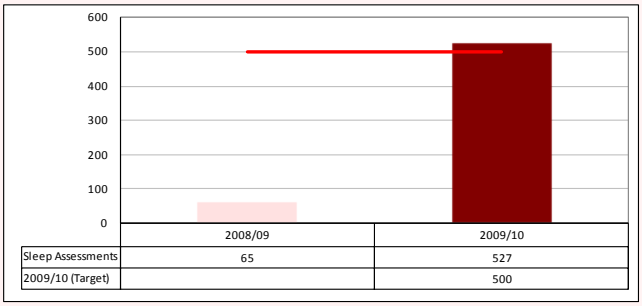
[10] *The eligible population is now defined as young women born 1990-1997, and all data graphed here is for this age range. Past reports have included data only for those born 1992, 1993 and 1997.The figure for the 'national average' is actually the average for the large DHBs: Auckland, Canterbury, Capital and Coast, Counties Manukau, Waikato and Waitemata.*

[11] *Previous years' diabetes data has been collected on calendar years and has been changed to financial years. The 2007/08 figure is an estimated baseline of the financial year performance provided by the Ministry of Health. Diabetes data is provided to the DHB by the individual PHOs and the Diabetes Centre.*

[12] *Spirometry is a tool for measuring lung function; following the volume and flow of inhaled and exhaled air assists in assessing a range of respiratory conditions.*

The number of level 4 sleep assessments delivered in the community.

Target: 500 **Achieved**



527 sleep assessments were delivered in the community this year without the need for a hospital visit, meeting the target for increasing access to this diagnostic.

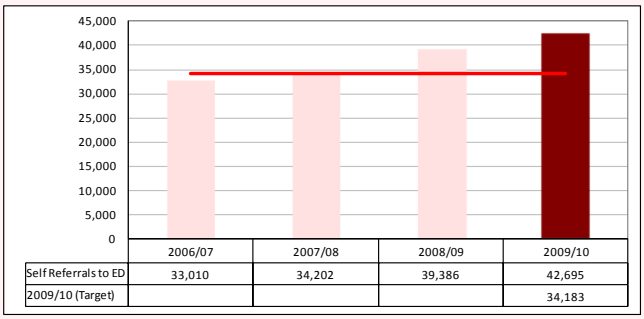
Strategic Goal 2.3: Acute demand management

To reduce acute demand and Emergency Department (ED) growth, especially in self and ambulance referrals and to support the DHB to reduce waiting times in ED by improving patient flow and supporting discharge

Associated Measures of Performance

The number of self referrals to ED.[13]

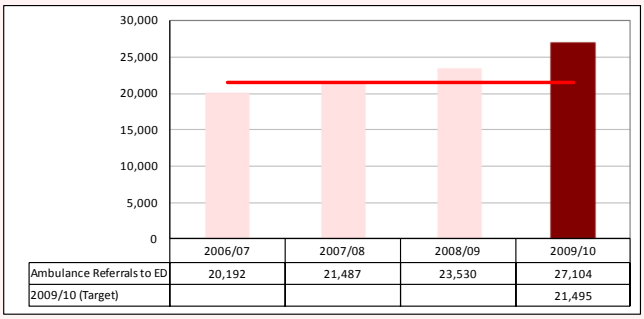
Target: ≤34,183 **Not Achieved**



The number of self referrals to ED has continued to grow. However, an After Hours Nurse-led Telephone Triage Service is currently being rolled out across Canterbury. Under this new service, patients ringing their general practice after hours speak with a nurse who provides health advice and directs them either to the appropriate urgent care services or to general practice. Once fully established, the service has the potential to reduce the volume of people self-referring to ED for care that could be safely provided in primary settings.

The number of ambulance referrals to ED. [14]

Target: ≤21,495 **Not Achieved**



The number of ambulance referrals to ED has continued to grow. In an effort to address this, the Canterbury DHB has launched the Ambulance Referral Pathway Pilot. This enables ambulance crews to access acute community care options, providing alternatives to hospital transfer for patients who can be safely managed in the community. Use of the pathway is expected to grow with continued support and education, as ambulance crews become more comfortable with this significant change to current practice.

[13] *The 2007/08 baseline figure reported in the forecast SSP in the 2009/12 SOI was 34,183; however, this figure has since been updated as a result of the data being refreshed. 2009/10 data includes self referrals to both Christchurch and Ashburton Hospitals' EDs. Previous years include only Christchurch ED data, as Ashburton data was not recorded at that time.*

[14] *The 2007/08 baseline figure reported in the forecast SSP in the 2009/12 was 21,495; however, this figure has since been updated as a result of the data being refreshed. 2009/10 data includes ambulance referrals to both Christchurch and Ashburton Hospitals' EDs. Previous years include only Christchurch ED data, as Ashburton data was not recorded at that time.*

Output Class 2b

Personal Health Services – Hospital Level and Specialist Services

To meet increasing demand, improve the patient journey and deliver maximum health benefits

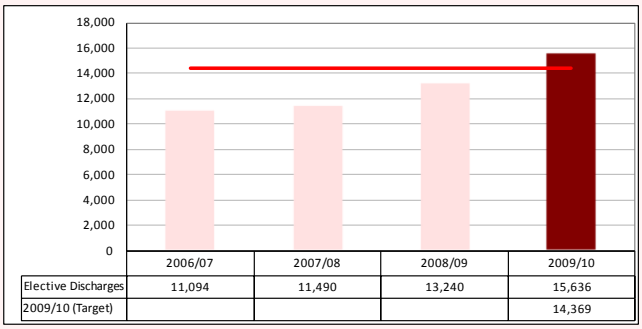
Strategic Goal 2.4: Increased hospital capacity

To increase our capacity and capability to provide services in line with the growth in our population and within clinically appropriate timeframes

Associated Measures of Performance

The volume of elective services discharges for Canterbury DHB residents.[15]

Target: 14,369 **Achieved**

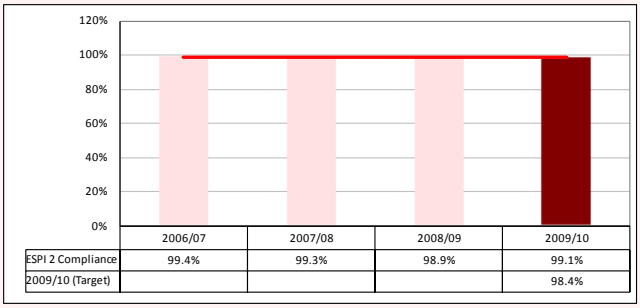


	2006/07	2007/08	2008/09	2009/10
Elective Discharges	11,094	11,490	13,240	15,636
2009/10 (Target)				14,369

The Canterbury DHB has delivered a record number of electives this year, surpassing our target by over a thousand discharges and last year's delivery by more than two thousand discharges.

The percentage of patients waiting less than six months for their first specialist assessment (ESPI 2).

Target: >98.4% **Achieved**

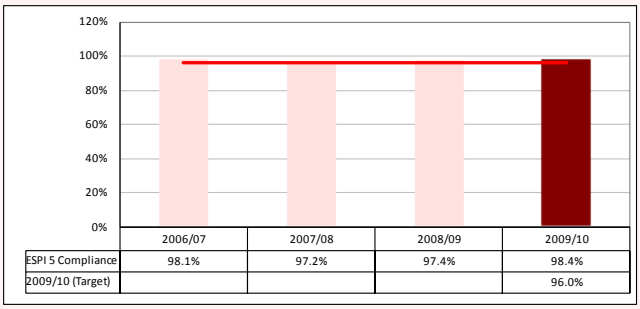


	2006/07	2007/08	2008/09	2009/10
ESPI 2 Compliance	99.4%	99.3%	98.9%	99.1%
2009/10 (Target)				98.4%

99.1% of patients waited less than six months for their first specialist assessment – surpassing the requirements for compliance with ESPI 2.[16]

The percentage of patients given a commitment of treatment and treated within six months (ESPI 5).

Target: >96% **Achieved**



	2006/07	2007/08	2008/09	2009/10
ESPI 5 Compliance	98.1%	97.2%	97.4%	98.4%
2009/10 (Target)				96.0%

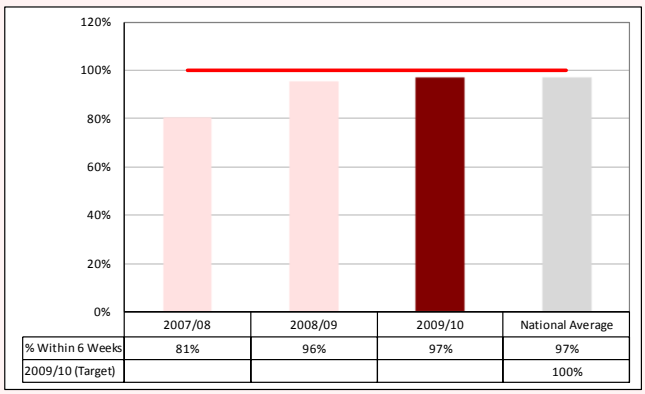
98.4% of patients waited less than six months for treatment – surpassing the requirements for ESPI 5 compliance.

[15] *Elective surgical discharges exclude elective cardiology and dental procedures. The DHB set a target of 14,000 discharges, which was subsequently increased during the year to 14,369 to meet the expectations of the Minister of Health. The DHB's result for the 2009/10 year is the figure as accessed at 2 August 2010 and may change slightly with further coding; previous years' figures were accessed at 14 September 2009.*

[16] *Elective Service Patient Flow Indicators (ESPIs) are measures of system performance at eight critical points. For 2009/10, the national threshold for compliance with ESPI 2 was 2% (i.e. DHBs must achieve 98% or better) and for ESPI 5 was 5% (i.e. DHBs must achieve 95% or better). A full explanation can be found on the Ministry of Health website www.moh.govt.nz.*

The percentage of people receiving radiation treatment within 6 weeks of the decision to treat. [17]

Target: 100% **Not Achieved**



	2007/08	2008/09	2009/10	National Average
% Within 6 Weeks	81%	96%	97%	97%
2009/10 (Target)				100%

Although performance has improved this year by 1% (corresponding to 73 more people receiving treatment than in 2008/09), the Canterbury DHB has not met the radiation therapy health target. In order to meet this target longer-term, the DHB has put significant effort into building DHB capacity and replacing the DHB's older linear accelerators (linacs). The first new replacement linac went operational in May 2010, and a second replacement linac is to be in use by the end of 2010. The new linacs are expected to increase radiation therapy capacity, reliability and accuracy. A new project in Radiation Oncology is supporting the department to achieve shorter treatment turnaround times, using lean thinking and production planning.

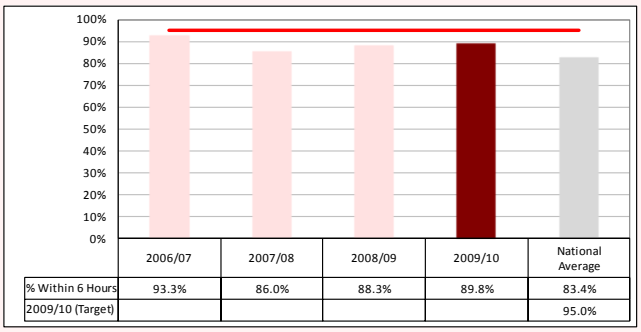
Strategic Goal 2.5: Shorter stays in ED

To deliver Emergency Department (ED) services to patients in a timely manner that respects the patient's needs and values their time

Associated Measures of Performance

The percentage of people presenting to ED who are discharged or transferred to an inpatient bed within 6 hours. [18]

Target: 95% **Not Achieved**

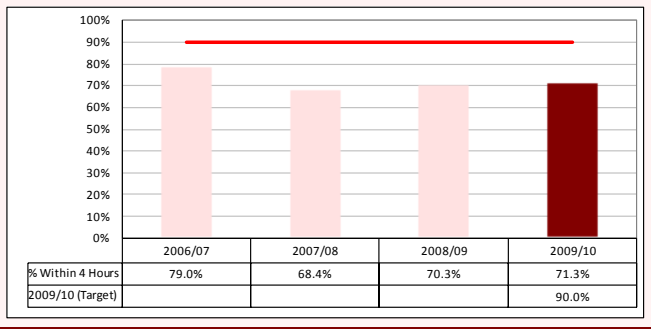


	2006/07	2007/08	2008/09	2009/10	National Average
% Within 6 Hours	93.3%	86.0%	88.3%	89.8%	83.4%
2009/10 (Target)					95.0%

Performance against the ED health target has improved despite increasing ED attendances throughout Canterbury (up 9.8% compared with 2008/09). Ashburton Hospital has continued its strong ED performance, remaining well above the 95% target, but Christchurch Hospital has struggled to meet the target with the increase in attendances.

The percentage of people presenting to ED who are discharged or transferred to an inpatient bed within 4 hours. [12]

Target: 90% **Not Achieved**



	2006/07	2007/08	2008/09	2009/10
% Within 4 Hours	79.0%	68.4%	70.3%	71.3%
2009/10 (Target)				90.0%

Performance against the 4 hour target has improved on last year. Within Christchurch Hospital ED, work to manage patient flow has included a stronger team approach and a 'breech screen' which enables staff to target areas that require further improvement. There has also been extensive activity to reduce hospital gridlock and improve the transfer of ED patients on to their next phase of care.

[17] *The wait time is defined as the time between the decision to commence radiation treatment and the start of treatment. The measure does not include instances in which a patient chooses to wait for treatment or there are clinical reasons for delay. The measure reflects groups A, B and C. Group D patients have planned treatment (either as part of a trial or because of given protocols) and are therefore not included in targets. Previously data had been collected against an eight week target. The 2008/09 result was previously reported in error as 91% in the 2009 Annual Report; the actual result of 96% is displayed above.*

[18] *2009/10 data includes both Christchurch and Ashburton Hospitals' EDs. Previous years include only Christchurch ED data, as Ashburton data was not recorded at that time.*

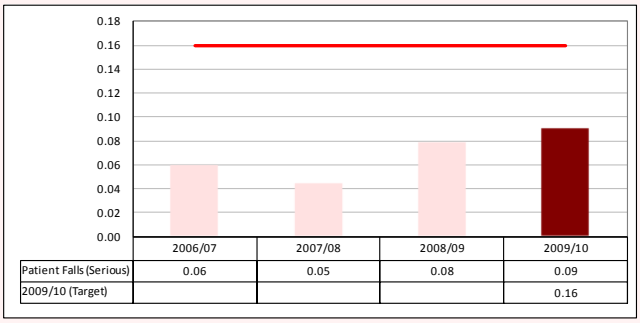
Strategic Goal 2.6: Improving the Patient Journey

To reduce waste and variation in service delivery and improve the quality of patient care through a standardised approach

Associated Measures of Performance

The rate of patient falls (causing serious injury) per 1000 inpatient day equivalents.[19]

Target: <0.16 **Achieved**

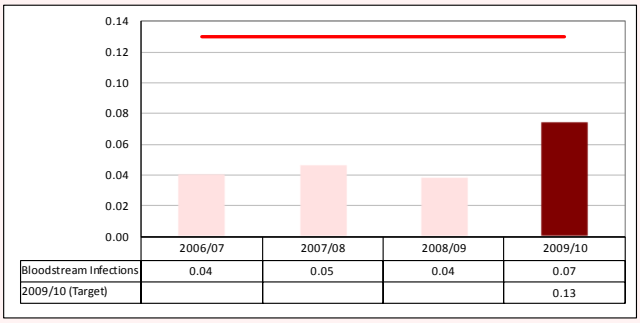


	2006/07	2007/08	2008/09	2009/10
Patient Falls (Serious)	0.06	0.05	0.08	0.09
2009/10 (Target)				0.16

The rate of patient falls within Canterbury DHB hospitals remains low, at only 0.09 serious falls per 1000 inpatient day equivalents.

The rate of staphylococcus aureus bloodstream infections per 1000 inpatient bed days.[20]

Target: <0.13 **Achieved**



	2006/07	2007/08	2008/09	2009/10
Bloodstream Infections	0.04	0.05	0.04	0.07
2009/10 (Target)				0.13

Although slightly higher than last year, the rate of staphylococcus aureus bloodstream infections in Canterbury DHB hospitals is well below target.

[19] *Total falls includes only those falls associated with serious injury to provide a direct measure of injury caused. The rate is per 1000 inpatient day equivalents - reflecting the total inpatient bed-days in the period plus half the total day patients.*

[20] *Staphylococcus Aureus Bloodstream Infections data includes all sites, including HSS Mental Health Services, and the rate is per 1000 inpatient bed days. The 2008/09 figure reported in the 2009 Annual Report was 0.05; however, this figure was for the eleven months up to and including May 2009, as June 2009 data was not available at that time. The figure has since been updated to 0.04 for the entire 2008/09 year.*

Output Class 3

Mental Health Services

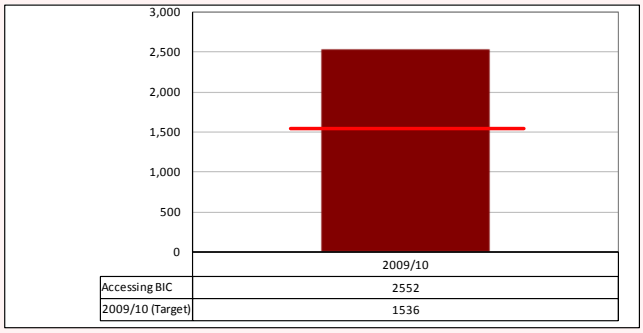
To provide more flexible options and develop a 'whole of sector approach' to better support people affected by mental illness

Strategic Goal 3.1: Improved services and access

To improve access pathways for people with mental illness to reduce unplanned hospital-level admissions and to ensure the ability to meet future needs within available resources.

Associated Measures of Performance

The number of people accessing Brief Intervention Counselling services in primary care.[21]

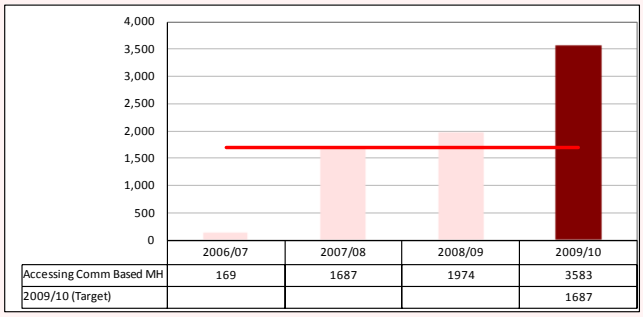


	2009/10
Accessing BIC	2552
2009/10 (Target)	1536

Target: 1,536 **Achieved**

This is a new programme, and access to Brief Intervention Counselling in primary care has greatly exceeded the target.

The number of people accessing community-based mental health and rehabilitation services.[22]



	2006/07	2007/08	2008/09	2009/10
Accessing Comm Based MH	169	1687	1974	3583
2009/10 (Target)				1687

Target: >1,687 **Achieved**

Community access to mental health and rehabilitation services has increased significantly this year, ensuring that more people receive support closer to home.

[21] *This information comes from PHO contract monitoring reports.*

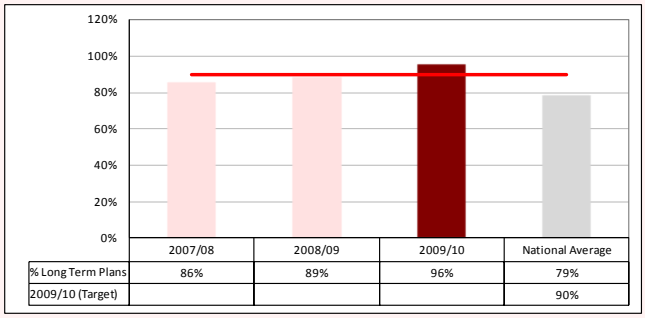
[22] *This data is provided by NGOs who are not providing information through the Mental Health Information National Collection (MHINC) system but through additional reporting streams against DHB contract monitoring.*

Strategic Goal 3.2: Self management and relapse prevention

To improve self management and identification of early relapse warning signs to reduce acute admissions

Associated Measures of Performance

The percentage of long-term clients with current relapse or recovery plans in place.



	2007/08	2008/09	2009/10	National Average
% Long Term Plans	86%	89%	96%	79%
2009/10 (Target)				90%

Target: 90% **Achieved**

The Canterbury DHB's Specialist Mental Health Services surpassed the target for the number of long-term mental health clients who have recovery plans. Canterbury rates are well above the national average.

Output Class 4

Older Persons' Health Services

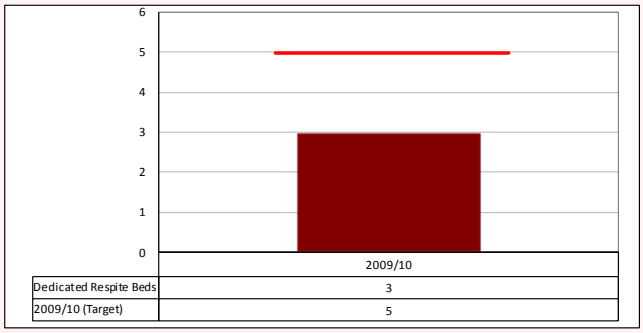
To support older people to stay healthy and fit in their own homes and to provide high quality aged residential care, home-based support and district nursing services to those who need them.

Strategic Goal 4.1: Respite care

To enable older people to remain safe and well in their own homes and reduce acute admissions

Associated Measures of Performance

The number of dedicated respite beds available. [23]



Target: 5 **Not Achieved**

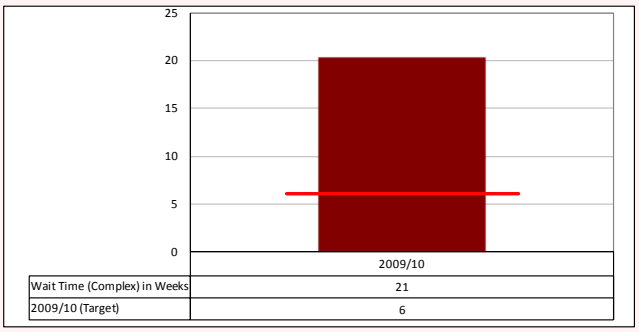
Three providers have been selected for Canterbury to provide three new planned respite beds. The beds will enhance consumers' and providers' ability to book their respite arrangements ahead of time. These beds are in addition to the existing capacity in Canterbury. An RFP for further respite beds is currently being planned.

Strategic Goal 4.2: Improved assessment and services

To improve assessment processes and provide flexible, responsive services to support older people to stay in their own homes and maximise independence

Associated Measures of Performance

The maximum wait time for complex assessment. [24]



Target: 6 weeks **Not Achieved**

At 20.6 weeks (144 days), the maximum wait time for complex assessment exceeded our target of six weeks (42 days). The Older Persons' Health Specialist Service has identified causes of long waiting times and is closely monitoring wait times to ensure the target will be met in future. The average wait time for complex assessment is 2.7 weeks (18.7 days).

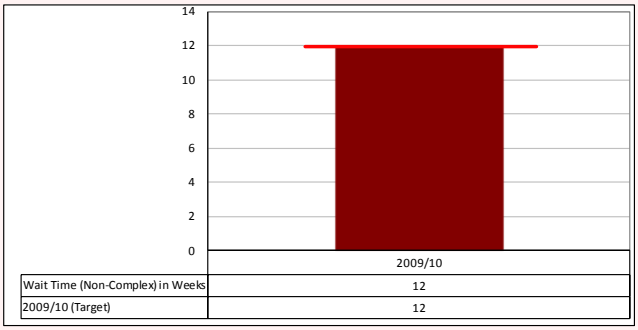
[23] *There is no baseline for this measure, as previously beds were a flexible (rather than dedicated) resource.*
[24] *There is no baseline, as this is a new measure. Complex and non-complex assessment services were separated with a new non-complex assessment service beginning in August 2009.*

Strategic Goal 4.3: Restorative home support

To provide more timely and targeted responses to enable older people to return home with the necessary treatment and supports to restore functioning and maintain independence

Associated Measures of Performance

The maximum wait time for non-complex assessment.[25]



Target: 12 weeks **Achieved**

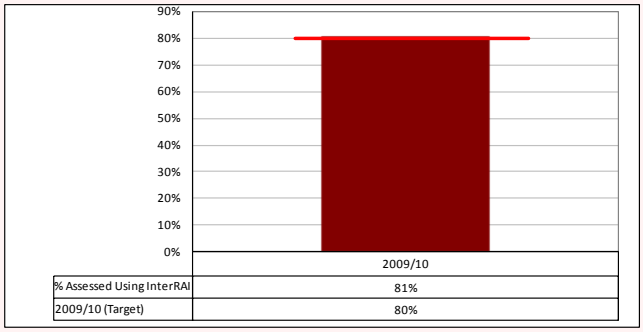
The Canterbury DHB has met this target, ensuring that all non-complex clients receive their assessments in 12 weeks or less. The average wait time for non-complex assessment is 2.4 weeks (17 days).

Strategic Goal 4.4: Quality aged residential care

To ensure aged residential care residents receive consistently high quality health services

Associated Measures of Performance

The percentage of people accessing residential services having been assessed using the InterRAI assessment tool.[26]



Target: 80% **Achieved**

81% of people accessing residential services were assessed using the InterRAI assessment tool – surpassing the target and ensuring consistency in assessment.

[25] *There is no base line as this is a new measure. The non-complex assessment service (Canterbury Care Coordination Centre) began in August 2009.*

[26] *InterRAI, the International Resident Assessment Instrument, is a comprehensive geriatric assessment tool. Quarter 4 data can only be calculated up until late April 2010, so data is for approximately 9 months. The new hardware was brought live in Canterbury in April (cutover 23rd). At this time, the feed from the database to the DSS/data warehouse was ceased. This is because the data warehouse is to be hosted by Taranaki DHB nationally, although at this stage it has not been implemented. The installation is awaiting vendor resource, and is scheduled to commence in August.*

SUMMARY OF REVENUES AND EXPENSES BY OUTPUT CLASS

Group	Actual 30/06/10 $'000	Budget 30/06/10 $'000
Revenue		
0 – 19 years	182,923	183,550
20 – 64 years	548,352	544,592
65+ years	506,411	505,200
In house elimination *	94,122	85,773
Total Revenue	**1,331,808**	**1,319,115**
Expenditure		
0 – 19 years	187,899	185,388
20 – 64 years	542,376	547,126
65+ years	516,221	509,829
In house elimination *	94,122	85,772
Total Expenditure	**1,340,618**	**1,328,115**
Net Surplus / (Deficit)	**(8,810)**	**(9,000)**

* *In house elimination includes items that are not part of core Vote Health funding, such as ACC contracts, and subsidiary company operations.*

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 2010

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, A P Burns, using the staff and resources of Audit New Zealand, to carry out the audit on her behalf. The audit covers the financial statements and statement of service performance included in the annual report of the Health Board and group for the year ended 30 June 2010.

Unqualified opinion

In our opinion:

- The financial statements of the Health Board and group on pages 28 to 64:
    - comply with generally accepted accounting practice in New Zealand; and
    - fairly reflect:
        - the Health Board and group's financial position as at 30 June 2010; 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 65 to 78:
    - 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 29 September 2010, 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 2010 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 New Zealand Institute of Chartered Accountants.

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

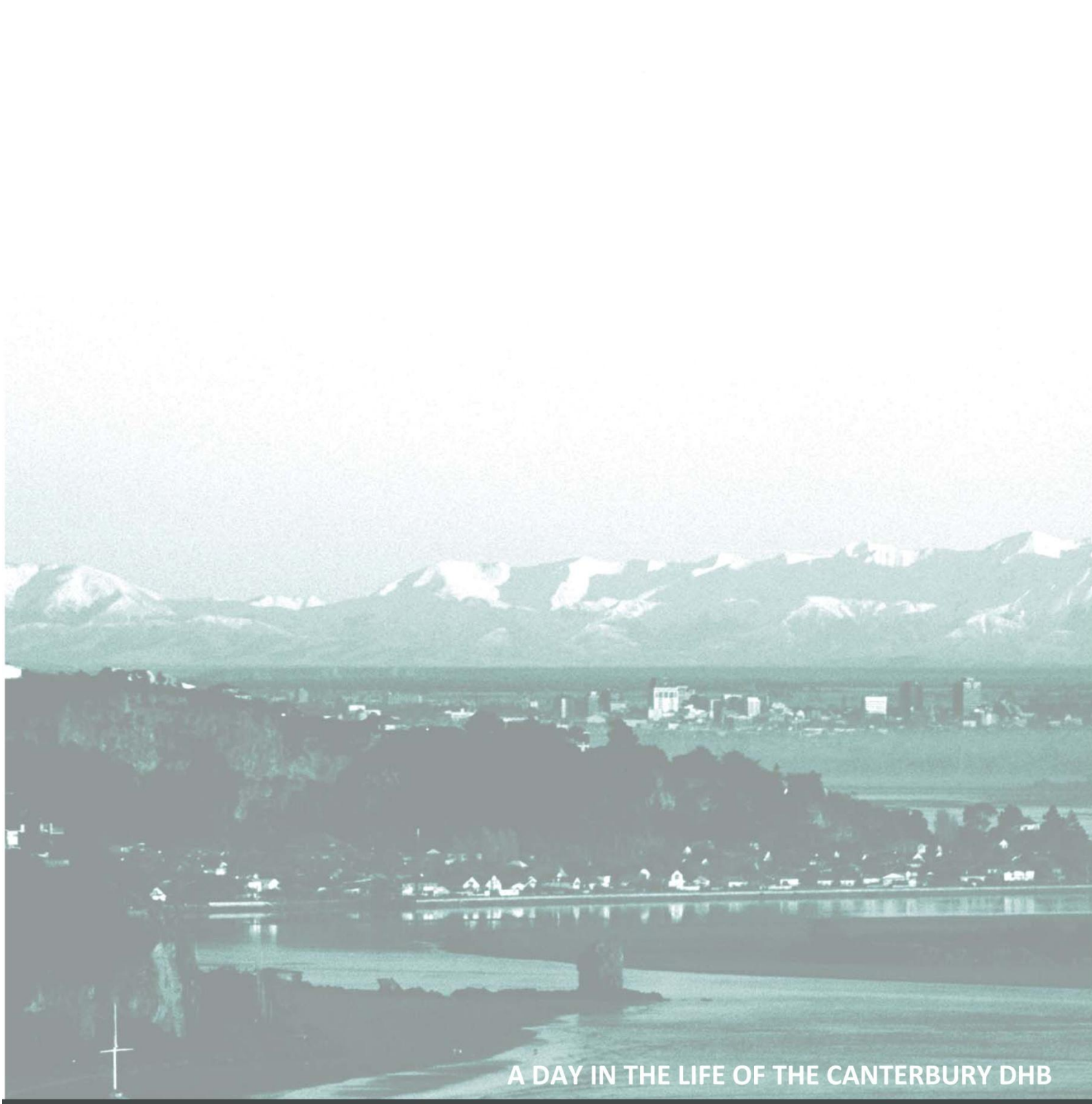
A P Burns
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand

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 2010 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 29 September 2010 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.



A DAY IN THE LIFE OF THE CANTERBURY DHB

On an average Canterbury day: *3,370 people are seen in general practice; 217 people present at the Christchurch ED; 36 people have elective surgery; $356,611 is spent on pharmaceuticals; $66,521 worth of laboratory tests are completed; 134 people 65+ have a free flu vaccination; 203 children have a dental check; 46 young women have HPV vaccinations; 98 women have a cervical smear; 21 people have a free diabetes check; 55 adolescents access free dental services; 347 people have an Outpatient appointment and 959 people have a follow-up appointment; 5 cases of infectious diseases are notified; 651 Meals on Wheels are delivered; $78,980 is spent on Home Based Support Services; and 18 babies are born.*