





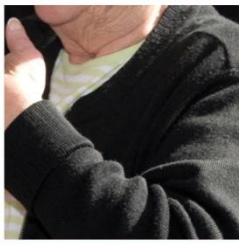

Canterbury
District Health Board

Report for the year ended

30 June 2011









Canterbury
District Health Board
Te Poari Hauora ō Waitaha

OUR MISSION

TĀ MĀTOU MATAKITE

- To promote, enhance and facilitate the health and wellbeing of the people of Canterbury.
- Ki te whakapakari, whakamaanawa me te whakahaere i te hauora mo te orakapai o kā tākata o te rohe o Waitaha.

OUR VALUES

Ā MĀTOU UARA

- Care and respect for others.
  Manaaki me te kotua i etahi atu.
- Integrity in all we do.
  Hapai i a mātou mahi katoa i ruka i te pono.
- Responsibility for outcomes.
  Kaiwhakarite i kā hua.

OUR WAY OF WORKING

KĀ HUARI MAHI

- Be people and community focused.
  Arotahi atu ki kā tākata meka.
- Demonstrate innovation.
  Whakaatu whakaaro hihiko.
- Engage with stakeholders.
  Tu atu ki ka uru.

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DIRECTORY

Board Members
Bruce Matheson – Chair (from 6 December 2010)
Peter Ballantyne – Deputy Chair (from 6 December 2010)
Anna Crighton
Elizabeth Cunningham
Andrew Dickerson
Wendy Gilchrist (from 6 December 2010)
Aaron Keown (from 6 December 2010)
Chris Mene (from 6 December 2010)
David Morrell
Susan Wallace (from 6 December 2010)
Olive Webb (Deputy Chair until 5 December 2010)

Alister James (Chair until 5 December 2010)
Eleanor Carter (until 5 December 2010)
Matea Gillies (until 5 December 2010)
Jo Kane (until 5 December 2010)
Chris Ryan (until 5 December 2010)

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

REPORT FROM THE CHAIR AND CHIEF EXECUTIVE

The 2010/2011 financial year posed many unexpected challenges for the Canterbury Health System.

It's a credit to everyone working to provide treatment, care and services to improve health and maintain independence of people living in Canterbury, that despite the devastation and disruption caused by a magnitude 7.1 earthquake on 4 September2010; a serious jolt on 26 December; the destructive 6.3 quake which hit on 22 February; and two more significant quakes on 13 June, the DHB has continued to improve its performance while keeping a tight rein on the purse strings.

We ended the year breaking even which included a $16m injection from Government to cover specific earthquake related costs. Without the earthquake Canterbury District Health Board (CDHB) would have ended the year in surplus!

This hasn't happened by chance. CDHB started the year with a clear vision on how it was going to deliver more services to meet the increasing demand and improve health outcomes without additional funding.

Changing the way we work, and the way we work with others has been key to our success. The quakes have required us to bring forward plans for the future and implement them now. This has been possible due to the strong relationships that have been developed in Canterbury and the engagement of all parts of the health sector to solve complex and challenging problems. Nothing has been impossible to solve.

A number of services that were planned to be introduced as part of our Vision 2020 have been brought forward and were up and running within weeks following the 22 February earthquake. We have a robust Earthquake Recovery Plan that is providing the framework for what is going to be a long and complex journey. We are now providing more services closer to where people live, with many services being provided in people's own homes.

After the February quake we lost the use of 635 aged residential care beds in the community. Our building stock has sustained ongoing damage as a result of the quakes. Over 7,500 rooms (out of a total of 11,000) were damaged. We have 'made do' and patched up our facilities to ensure they are safe for patients and staff to occupy, however, the cost of further repairs is currently estimated to be in the order of $70 million. While insurance will meet some of this cost, due to changes in the building code, we expect this to be a financial challenge in the coming year.

A new expanded Acute Medical Assessment Unit and stand-alone Outpatient Centre have been approved for development before next winter. Both of these new facilities will free up space in Christchurch Hospital allowing medical wards to relocate back from their temporary location at The Princess Margaret Hospital.

Investing in new models of care, including a range of acute demand management services provided in the community has saved over 18,000 people from being admitted to hospital in the past year.

While we are a big health system we pride ourselves on having a nimble core with an ability to change the way we plan, fund and work with others to provide services that provide value for money and remove wastage from our health system. Importantly this is enabling us to deliver better health outcomes for our people.

Service and organisational barriers are being broken down as we bring providers together under an alliance umbrella. When passionate health providers collectively put patients first, rapid change is possible.

Despite the disruption caused by the quakes CDHB has still met many of the Health Targets and made very good progress in others. We exceeded the shorter stays in ED target, managed to end the year only 504 cases down on our revised Elective Services target and CDHB's Radiotherapy service continued to meet the four week target for patients from Nelson Marlborough, the West Coast as well as those from our own catchment. These achievements are a reflection of the dedication and hard work of many staff, from booking clerks to clinicians and managers.

Our health system is firmly focused on making it better for patients. Prioritising our spending provides opportunities to allocate or reallocate funding to services that are more effective in improving people's health and independence and reducing inequalities. We are constantly seeking ways of working smarter and making the best use of the resources we have.

Significant progress has been made on the initial review of the Business Case for the development of new facilities on the Christchurch Hospital site and for facilities for older people on the Burwood Hospital site. CDHB clinical and corporate staff have worked alongside members of the National Health Board to confirm the clinical need, facility requirements and affordability.

The development of our facilities is essential to enable the on-going development of new models of care and services across our health system in a sustainable, affordable way. We look forward to working with the National Health Board to bring the review process to a conclusion and the facility development to life.

While the past year has been challenging on all fronts, we are in a wonderful position of being able to rebuild our health system from the ground up to make it the envy of other health organisations and structures worldwide.

Bruce Matheson
Chair
28 September 2011

David Meates
Chief Executive
28 September 2011

BOARD MEMBERS

Bruce Matheson – Chair (from 6 December)	Bruce Matheson has spent the past 30 years working for some of Canterbury's leading organisations. He was Managing Director of Spanbild Holdings Ltd (formerly Versatile Buildings Ltd) and was appointed Managing Director after seven years as an independent director. He has been Chief Executive of Meadow Mushrooms Ltd and the Lyttelton Port Company, managed the industrial division of Skellerup Industries and was the Group Financial Director of Donaghys Industries. Bruce currently chairs the Boards of Brannigans Ltd and Fresh Pork New Zealand. He has also held other director roles including Contracting South Canterbury, Canterbury Health Limited, Canterbury Employers Chamber of Commerce and Chair of the Port of Portland, Australia. Bruce is known for his strong team building skills and inclusive management style. He believes that the health sector is very challenging and has the utmost respect for people working in the health sector.
Peter Ballantyne Deputy Chair (from 6 December)	Peter is Deputy Chair and Chair of the Canterbury DHB's Quality, Finance, Audit and 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. Peter is also Deputy Chair of the West Coast District Health Board.
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 and Hospital Advisory Committee.
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 and 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 of the Hospital Advisory Committee.
Andrew Dickerson	Andrew has 26 years experience in the health and disability sectors and is 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.
Wendy Gilchrist (from 6 December)	Wendy is an active strategic member of her community, with a particular interest in family, health and employment issues. A varied career in nursing, medical research, diagnostic service provision and business has provided experience in operational and strategic management, marketing and driving key initiatives. While Chair of the Canterbury Osteoporosis Society for three years Wendy was involved in promoting the establishment of Osteoporosis New Zealand. In response to a community need Wendy was also solely responsible for the establishment of a public school bus service for students from the Sumner area to the schools north of the city, this is now a regular service. She is currently an

	appointed member of the Human Rights Review Tribunal.
Aaron Keown (from 6 December)	Aaron is currently a Christchurch City Council councillor for the Shirley/Papanui Ward and also sits on the Shirley/Papanui Community Board. Aaron is also a director of the Canterbury Development Corporation (CDC). He is keen to see more community involvement in CDHB decisions.
Chris Mene (from 6 December)	Chris Mene is a Project Manager, Facilitator and Trainer with recent health experience in smoking cessation, alcohol harm reduction, youth health and stakeholder engagement. He chairs the Shirley Papanui Community Board (Christchurch City Council) and has more than 20 years experience in community relations and stakeholder engagement. His community service also includes Stopping Violence Services, Wayne Francis Charitable Trust and CPIT Bachelor of Applied Science (with specialty). He brings diverse experiences and knowledge from government, business, community and philanthropic sectors.
David Morrell	David Morrell has had over 9 years service 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 Quality, Finance, Audit and Risk Committee and Chair of the Hospital Advisory Committee and of Brackenridge Estate Ltd, one of CDHB's subsidiary companies.
Susan Wallace (from 6 December)	Susan has whakapapa ties to Te Waipounamu (Kāi Tahu, Kāti Mamoe, Waitaha) and Te Tai Tokerau (Te Roroa, Ngāti Whātua, Ngā Puhi). She is employed by Te Rūnanga o Makaawhio, a Ngāi Tahu Papatipu Rūnanga organisation based on Te Tai o Poutini (West Coast) and has served almost two terms as an appointed member of the West Coast District Health Board. Susan has a public service and administration background, and has been involved in a number of different voluntary, community and Maori organisations. One of two joint-appointed members across two boards, Susan brings a West Coast "face" to this board and a desire to contribute.
Olive Webb	Olive is a Clinical Psychologist and independent Health and Disability Consultant with more than 35 years experience working in the mental health and disability sector, particularly with people with intellectual disabilities. She has served on the Board since 2000, has been Deputy Chair for two terms and is the Chair of the DSAC and CPHAC combined committee. She is committed to rural health issues and delivery, and to creating new solutions for health in post earthquake Canterbury.

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2011.

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 $0.105 million against the budgeted breakeven position (2009/10 result was a net deficit of $8.810 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 30/06/11 $'000	Committee Fees Year ended 30/06/11 $'000
Peter Ballantyne	29	5
Eleanor Carter	13	2
Teresa Chalecki	-	2
Anna Crighton	26	2
Elizabeth Cunningham	26	4
Wendy Dallas-Katoa	-	2
Jonathan Darby	-	-
Richard Davison	-	1
Andrew Dickerson	26	6
Wendy Gilchrist	13	1
Matea Gillies	13	2
Alister James	26	1
Jo Kane	13	2
Aaron Keown	13	-
David Kerr	-	1
Bob Lineham	-	1
Stephen Lowndes	-	2
Bruce Matheson	25	1
Chris Mene	13	1
David Morrell	26	4
Trevor Read	-	2
Chris Ryan	13	2
Margaret Schwass	-	1
William Tate	-	4
Susan Wallace	13	-
Olive Webb	29	4
	317	**53**

Total fees paid for the year were $370,000 (2009/10 - $386,000). The limit of fees authorised for the year ended 30 June 2011 was $395,375 (2009/10 - $395,375).

DIRECTOR FEES

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

	Year Ended 30/06/11 $'000	Year Ended 30/06/10 $'000
David Morrell	10	10
Brian Wood	20	13
	30	**23**

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2011

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

Bruce Matheson	Brannigans Ltd - founding shareholder/director. Brannigans Ltd is a human resource consulting business – a potential conflict of interest may exist in the provision of any consulting services to the Canterbury DHB. Freshpork NZ Ltd – Director. Is engaged in farming, processing and marketing of pork meats in New Zealand – no obvious conflict of interest is anticipated. PA Farms Ltd – Advisory Role. Farms dairy cows in Mid Canterbury, South Canterbury and Southland – no obvious conflict of interest is anticipated. Southern Engineering Solutions Ltd – Advisory Role. Designs and manufactures machinery and equipment for the food processing industry in New Zealand and Australia.
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 the Canterbury DHB from time to time. Spouse, Claire Ballantyne is a Canterbury DHB employee (Ophthalmology Department)
Anna Crighton	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. The Art Registry Co. Limited – Director - Principal Registrar and Director of collections management. Theatre Royal Charitable Foundation – Director - governance of theatrical theatre operations. Christchurch Heritage Trust – Director - governance of Christchurch Heritage. Christchurch Heritage Awards Charitable Trust – Chair. Canterbury Earthquake Heritage Buildings Fund Trust – Chair.

Elizabeth Cunningham	University of Otago, Christchurch – Research Manager, Maori (0.6FTE) - part of the Senior Management Team. The University has various relationships with the Canterbury DHB, including medical training, research, the provision of library services, and leasing of premises. Otautahi Runaka – Member - includes Maori 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 the 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 the Canterbury DHB. Maori Women's Welfare League – Member - the League has contracts through the Ministry of Health for the delivery of health services for Maori. 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. Registered RMA (Resource Management Act) Commissioner - from time to time asked to sit on these panels given her involvement with the Regional Council and in particular understanding the Maori 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.
Wendy Dallas-Katoa	Te Runanga O Ngai Tahu - Programme Leader – Health and Social Wellbeing. Pegasus Health/Partnership Health – 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.

Jonathan Darby	Toastmasters International - a member of two Toastmasters clubs and holds an executive role in one. No conflicts of interest are anticipated regarding my involvement. Parafed Canterbury – Member - this organisation provides sporting and other opportunities to people with disabilities. They also provide services to the same. No conflicts of interest are anticipated.
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 the 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 the Canterbury DHB. NZ Historic Places Trust – Trustee - The Trust promotes the identification, preservation and conservation of the historical & cultural heritage of New Zealand. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance. No conflicts of interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time. NZ Gerontology Association – Member - professional association that promotes the interests of older people and an understanding of ageing. Hope Foundation for Research on Ageing – Member - Promotes research on New Zealand's ageing population and its implications for the future. Osteoporosis (Canterbury) Inc. – Member - provides support, 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. 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.
Wendy Gilchrist	Workrural Ltd/Owner Director – map based aggregation website promoting rural job vacancies in New Zealand. Human Rights Review Tribunal – Appointed Member - Tribunal is a statutory body dealing with cases brought under the Human Rights Act 1993, the Privacy Act 1993 and the Health and Disability Commissioner Act 1994. Animal Diagnostics Ltd – Accounts Manager - Animal Diagnostics is a laboratory dealing in herd testing. Husband is a part owner of the Company. Howard League for Penal Reform - Member

	Husband Dr Nigel Gilchrist is employed as a specialist consultant physician with the CDHB. No potential conflict of interest is expected and should this arise it will be declared at that time.
Matea Gillies	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. Dr Gillies has 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. Dr Gillies is employed by Taupunga Ltd to provide General Practitioner services. Taupunga has a contract with the Pegasus Charitable Trust, Pegasus 24 Hrs Clinic and Dr James Shanks. Manawhenua ki Waitaha – Chairperson - Manawhenua ki Waitaha is a collective of health representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB. Te 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 (Maori /Indigenous Health Institute) - Senior Clinical Lecturer - University of Otago Christchurch School of Medicine
Aaron Keown	Christchurch City Council and Shirley Papanui Community Board – Member - elected member of the Christchurch City Council (CCC) and also a member of the Shirley Papanui Community Board and a member of a number of other Council committees. No conflicts of interest are anticipated from these roles but will be discussed at the appropriate time should they arise.
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 the 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.
Bob Lineham	Civic Assurance (New Zealand Local Government Insurance Corporation Ltd) – Director - this is a specialist insurance company servicing Local Government
	Christchurch City Networks Ltd – Director - involves the installation of broadband infrastructure in Christchurch. This company provides services to the Canterbury DHB.
	New Zealand Local Government Finance Corp Ltd – Director - 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 Mene	Partnership Health Canterbury - Contracted Project Manager - currently engaged as a consultant to manage projects in the primary and community health care space. Two current projects: one involves increasing smoking cessation with community pharmacies in Canterbury, the second involves developing an Alcohol Harm Reduction through improved screening, referral (by primary and community health providers) and interventions.
	Christchurch Polytechnic Institute of Technology - Advisory Board Member to Bachelor of Applied Science - contributes as an industry advisor into the Bachelor of Applied Science (with speciality) degree course. This course includes two specialities which are (1) Physical Activity Health and Wellness and (2) Sports Science. This is a voluntary position.
	Stopping Violence Services (Canterbury) - Board Member - Stopping Violence Services is a social services provider which provides violence prevention services to perpetrators of violence. This is a voluntary position.
	Shirley-Papanui Community Board (Chairperson) - the Christchurch City Council is a Territorial Local Authority and the Shirley-Papanui Community Board is the statutory body elected to serve that metropolitan ward. Elected onto the Community Board and into the role of Community Board Chairperson for the three year period until October 2013. No conflicts of interest are anticipated from this role but will be discussed at the appropriate time should they arise.
	Christchurch City Council - District Licensing Authority (DLA) Panel Member - the Christchurch City Council acts as a DLA which is the decision making body

	for alcohol licensing in Christchurch City. Serves occasionally as a panel member. Christchurch City Council Resource Management Panel Member - the Christchurch City Council is the decision making body for resource consent matters in Christchurch City. Serves occasionally as a panel member. Wayne Francis Charitable Trust - Board Member - the Wayne Francis Charitable Trust is a philanthropic family organisation committed to making a positive and lasting contribution to the community. The Youth focussed Trust funds cancer research which embodies some of the Trust's fundamental objectives – prevention, long-term change, and actions that strive to benefit the lives of many. Canterbury Community Pharmacy Group - Acting General Manager
David Morrell	Brackenridge Estate Limited – Chairman (appointed by Canterbury DHB). Wholly owned subsidiary of the Canterbury DHB - provides intellectual disability services under contracts with the Ministry of Health, Work and Income New Zealand, Accident Compensation Corporate and the Child, Youth and Family Service. British Honorary Consul. Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of the 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 – Chair - (Canterbury DHB Appointee) Trust responsible for Memorial on the Christchurch Hospital site. Historic Places Trust – Subscribing Member. The Trust's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. The Trust identifies records and acts in respect of significant ancestral sites and buildings. The Trust has already been involved with Canterbury DHB buildings.
Trevor Read	Francis Group Consultants – Executive Director. Francis Group is an implementation and support partner for a UK firm, Lightfoot Solutions, Ltd that has contracts with the Canterbury DHB and St John Ambulance to provide a business intelligence tool and related services. Capital Coast DHB - Member of the Costing Unit 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.
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
Susan Wallace	Member – West Coast DHB - appointed board member West Coast DHB Te Rūnanga o Ngāi Tahu - affiliated Member of TRONT. Māori Women's Welfare League - Member - the League is a recipient of Ministry of Health funding for HEHA programmes.
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 - assists 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 IHC's action against the Ministry of Health with the Human Rights Commission. Hororata Community Trust – Trustee.

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, for example, amounts for redundancy (based on length of service), and payment in lieu of notice etc.

The total payments made by Canterbury DHB were $275,145 (2009/10 – 9 employees totalling $517,891) comprising negotiated settlements with all of the former employees.

Number of Employees	TOTAL $
12	275,145
12	**275,145**

REMUNERATION OF EMPLOYEES

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

	30/06/11 (including benefits)				30/06/10 (including benefits)			
	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total	Nursing/ Allied Health	Mgmt/ Admin	Medical	Total
100,000-109,000	27	24	57	**108**	14	22	58	**94**
110,000-119,000	10	12	63	**85**	7	8	60	**75**
120,000-129,000	5	7	65	**77**	4	6	51	**61**
130,000-139,000		7	54	**61**	2	6	53	**61**
140,000-149,000	1	2	27	**30**	1	1	44	**46**
150,000-159,000		3	35	**38**		5	40	**45**
160,000-169,000		2	38	**40**			32	**32**
170,000-179,000		1	25	**26**		2	19	**21**
180,000-189,000		2	24	**26**		1	28	**29**
190,000-199,000		2	28	**30**		1	24	**25**
200,000-209,000			22	**22**		2	18	**20**
210,000-219,000			15	**15**		1	19	**20**
220,000-229,000		2	25	**27**			22	**22**
230,000-239,000		1	25	**26**			22	**22**
240,000-249,000			13	**13**			15	**15**
250,000-259,000			17	**17**			18	**18**
260,000-269,000			17	**17**			14	**14**
270,000-279,000			13	**13**			9	**9**
280,000-289,000			13	**13**			1	**1**
290,000-299,000			7	**7**			4	**4**
300,000-309,000			4	**4**			9	**9**
310,000-319,000			7	**7**			5	**5**
320,000-329,000			5	**5**			8	**8**
330,000-339,000			7	**7**			3	**3**
340,000-349,000		1	1	**2**			3	**3**
350,000-359,000			3	**3**			2	**2**
360,000-369,000			2	**2**			2	**2**
370,000-379,000			2	**2**			2	**2**
380,000-389,000			1	**1**			2	**2**
440,000-449,000				**-**		1		**1**
450,000-459,000			1	**1**				**-**
460,000-469,000				**-**			1	**1**
470,000-479,000				**-**			1	**1**
490,000-499,000		1		**1**				**-**
500,000-509,000			1	**1**				**-**
530,000-539,000				**-**			1	**1**
Total	**43**	**67**	**617**	**727**	**28**	**56**	**590**	**674**

Of the 727 (2009/10 674) positions identified above, 660 (2009/10 618) positions were predominantly clinical and 67 (2009/10 56) positions were management/administrative.

STATUTORY INFORMATION

This Annual Report outlines the Canterbury DHB's financial and non-financial performance for the year ended 30 June 2011 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (e) of the same Act.

Canterbury DHB activity is focused on the provision of services for our resident population that improve health outcomes, reduce inequalities in health status and improve the delivery and effectiveness of the services provided. We take a consistent approach to improving the health and wellbeing of our community and:

- Promote messages related to improving lifestyle choices, physical activity and nutrition and reducing risk behaviours such as smoking, to improve and protect the health of individuals and communities;
- Work 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;
- Work with our hospital and specialist services to provide timely and appropriate quality services to our population and improve productivity, efficiency and effectiveness;
- Take a restorative approach through better access to home and community-based support, rehabilitation services and respite care to support people in need of personal health or disability services to better manage their conditions, improve their wellbeing and quality of life and increase their independence;
- Collaborate across the whole health system to reduce disparities and improve health outcomes for Māori and other high-need populations and to increase their participation in the health and disability sector;
- Actively engage health professionals, providers and consumers of health services in the design of health pathways and service models that benefit the population and support a partnership model that provides a strong and viable voice for the community and consumers in health service planning and delivery; and
- Uphold the ethical and quality standards expected of public sector organisations and of providers of services and has processes in place to maintain and improve quality, including EQuIP4 accreditation and a range of initiatives and performance targets aligned to national health priority areas, the Health Quality and Safety Commission work programme and the Canterbury DHB Quality Strategic Plan.

GOOD EMPLOYER

In line with our obligations and functions, the Canterbury DHB is committed to being a good employer.

Leadership, Accountability and Culture

In Canterbury we recognise that leadership, particularly clinical leadership, is a key component in the delivery of positive patient outcomes. We have a Clinical Board and a Canterbury Clinical Network, which take on the important role of providing oversight of clinical practices and standards.

The Canterbury DHB is building an integrated workforce approach across the Canterbury health system by engaging with primary and community providers on common HR systems, leadership development and workforce planning. Canterbury's capability framework has been selected as the national framework for people-based processes.

All controlled documents – policies, protocols, procedures and guidelines – are required to be prepared in a standardised format, reflecting best practice, are reviewed regularly and are appropriately consulted on.

Staff Mix by Average Age	Average age
Medical	32.7
Nursing	47.0
Allied Health	44.3
Support	51.4
Management & Administration	42.3

Staff Mix by Gender	Number	Percentage
Female	7493	81
Male	1736	19
Total	9230	

Staff Ethnicity	Number
Australian	65
British	577
Chinese	114
Indian	71
Latin American	2
Māori	180
Middle Eastern	11
New Zealander	467
NZ European	3653
Pacific Peoples	54
South African	55
Other African	28
Other Asian	150
Other European	911
Other	4
Not Stated	2888
Total	9230

Recruitment, Selection and Induction

The Canterbury DHB considers strategies to support the attraction and retention of staff to be a priority. We also support the development of regional and national relationships to improve recruitment and establish an employer brand as part of our integrated workforce approach.
We value the contribution a diverse workforce with different skills, experiences and perspectives can make, and this is reflected in our approach to recruitment and the work environment we provide; the Canterbury DHB has an Equal Opportunities Policy.

Safe and Healthy Environment

The Canterbury DHB aims to maintain a safe and healthy environment and participates in the ACC Partnership Programme, maintaining secondary level status in 2010. All Canterbury DHB owned and operated facilities are accredited under EQuIP4 (Evaluation & Quality Improvement Programme), which provides a framework for managing health services to ensure quality and safe care, with a focus on outcomes and evaluations. The Canterbury DHB has been awarded EQuIP4 accreditation, and mandatory Ministry of Health certification, for a 3 year period to September 2012.

We also operate a health monitoring programme including health screening and immunisation. Employees are encouraged to access the Employee Assistance Programme if they are faced with personal problems that may impact their work situation and are encouraged to lead by example in terms of healthier lifestyles, with smoking cessation and HEAL (Healthy Eating, Active Living) activities available for staff.

We do not tolerate any form of harassment or workplace bullying and ensure all staff are aware of harassment policies and procedures to deal with such a situation. This includes discussions with new employees at orientation, information and the training of managers to facilitate early intervention.

Remuneration and Recognition

The Canterbury DHB endeavours to remunerate all staff fairly and consistently, linking this to the principles of performance, employee competency development and organisation affordability.

Employee Engagement and Development

In 2010 the Canterbury DHB undertook a staff survey to measure the engagement of our workforce. Employee engagement illustrates the commitment and energy that employees bring to work and is a key indicator of their involvement and dedication to the organisation. International research suggests that highly engaged people put forth 57% more effort and are 87% less likely to leave an organisation.
The survey was well represented by all demographics and professional groups. The results demonstrated that 68% of Canterbury's overall workforce is engaged, with only 4% reported as disengaged. The areas that people reported to be most happy with were:

- **Empowerment** – they value the work they do and have a high level of confidence;
- **Commitment** – they are committed to their colleagues and prepared to go the extra mile;
- **Nature of the job** – the work people do is mentally stimulating and challenging; and
- **Patient Safety** – they feel confident raising concerns.

The survey identified three areas for initial focus: performance management, career development and incident reporting. Working groups have been established for each, and initiatives to address them are well underway.

Canterbury's focus on engaging and empowering our workforce is evident in turnover rates, which are relatively low: the average time spent working in Canterbury DHB services is 9 years, compared to an average of less than 8 years across all DHBs.

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 2011, 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.

Bruce Matheson
Chair
28 September 2011

Peter Ballantyne
Deputy Chair
28 September 2011

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2011

	Notes	Group			Parent	
		Actual 30/06/11 $'000	Budget 30/06/11 $'000	Actual 30/06/10 $'000	Actual 30/06/11 $'000	Actual 30/06/10 $'000
Income						
Ministry of Health revenue		1,333,681	1,309,178	1,262,542	1,323,125	1,252,552
Patient related revenue	2	40,550	42,581	44,807	39,721	44,006
Other operating income	3	25,254	18,977	20,220	23,123	17,880
Interest income		6,207	3,248	4,239	6,068	4,356
Total income		**1,405,692**	**1,373,984**	**1,331,808**	**1,392,037**	**1,318,794**
Operating expenses						
Employee benefit costs	4	563,628	551,495	542,121	551,157	530,045
Treatment related costs		125,645	119,772	116,647	129,509	120,633
External service providers		570,452	566,435	539,561	570,452	539,561
Depreciation and amortisation		46,866	45,265	42,497	45,578	41,227
Interest expenses on loans		4,668	5,090	4,662	4,668	4,662
Other expenses	5	79,684	68,627	77,683	76,182	74,063
Total operating expenses		**1,390,943**	**1,356,684**	**1,323,171**	**1,377,546**	**1,310,191**
Operating surplus before capital charge		14,749	17,300	8,637	14,491	8,603
Capital charge expense	6	(14,854)	(17,300)	(17,447)	(14,854)	(17,447)
Surplus/(deficit)		**(105)**	**-**	**(8,810)**	**(363)**	**(8,844)**
Other comprehensive income						
Gains on property revaluations	7&14	-	-	16,371	-	16,371
Impairment of property, plant & equipment	7,14&16	(33,845)	-	-	(33,845)	-
Total other comprehensive income		**(33,845)**	**-**	**16,371**	**(33,845)**	**16,371**
Total comprehensive income		**(33,950)**	**-**	**7,561**	**(34,208)**	**7,527**

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2011

	Notes	Group Actual 30/06/11 $'000	Group Budget 30/06/11 $'000	Group Actual 30/06/10 $'000	Parent Actual 30/06/11 $'000	Parent Actual 30/06/10 $'000
Total equity at beginning of the period		229,352	205,062	215,923	227,413	214,018
Total comprehensive income		(33,950)	-	7,561	(34,208)	7,527
Total recognised revenues and expenses		(33,950)	-	7,561	(34,208)	7,527
Other movements:						
Contribution back to Crown		(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Contribution from Crown		5,274	-	7,729	5,274	7,729
Total equity at end of the period	7	**198,815**	**203,201**	**229,352**	**196,618**	**227,413**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2011

	Notes	Group Actual as at 30/06/11 $'000	Group Budget as at 30/06/11 $'000	Group Actual as at 30/06/10 $'000	Parent Actual as at 30/06/11 $'000	Parent Actual as at 30/06/10 $'000
CROWN EQUITY						
General Funds	7	130,304	203,201	126,891	130,442	127,029
Revaluation Reserve	7	145,701	-	181,046	145,701	181,046
Retained earnings/(losses)	7	(77,190)	-	(78,585)	(79,525)	(80,662)
TOTAL EQUITY		**198,815**	**203,201**	**229,352**	**196,618**	**227,413**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and cash equivalents	8	87,803	69,115	69,076	86,870	68,236
Trade and other receivables	9	61,727	41,009	35,763	60,801	34,837
Inventories	10	8,916	9,641	8,644	8,851	8,547
Investments	11	18,132	-	5,275	15,744	3,000
TOTAL CURRENT ASSETS		176,578	119,765	118,758	172,266	114,620
CURRENT LIABILITIES						
Trade and other payables	12	120,294	86,570	92,246	119,935	91,866
Owing to the Ministry of Health		4,355	7,229	4,927	4,355	4,927
Employee benefits	13	141,039	115,000	127,197	139,347	125,628
Borrowings	18	30,000	-	-	30,000	-
TOTAL CURRENT LIABILITIES		295,688	208,799	224,370	293,637	222,421
NET WORKING CAPITAL		(119,110)	(89,034)	(105,612)	(121,371)	(107,801)
NON CURRENT ASSETS						
Investments	11	1,927	12,066	5,171	7,442	10,980
Property, plant and equipment	14	368,284	364,794	411,543	362,822	405,965
Intangible assets	15	698	-	612	692	612
Restricted assets	17	13,686	12,483	12,626	13,547	12,494
TOTAL NON CURRENT ASSETS		384,595	389,343	429,952	384,503	430,051
NON CURRENT LIABILITIES						
Employee benefits	13	7,984	9,625	7,362	7,967	7,343
Restricted funds	17	13,686	12,483	12,626	13,547	12,494
Borrowings	18	45,000	75,000	75,000	45,000	75,000
TOTAL NON CURRENT LIABILITIES		66,670	97,108	94,988	66,514	94,837
NET ASSETS		**198,815**	**203,201**	**229,352**	**196,618**	**227,413**

For and on behalf of the Board

Bruce Matheson
Chair
28 September 2011

Peter Ballantyne
Deputy Chair
28 September 2011

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2011

	Notes	Group Actual 30/06/11 $'000	Group Budget 30/06/11 $'000	Group Actual 30/06/10 $'000	Parent Actual 30/06/11 $'000	Parent Actual 30/06/10 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,308,321	1,326,554	1,274,881	1,297,762	1,265,142
Other receipts		64,172	43,889	62,879	61,214	59,760
Interest received		6,207	3,541	4,239	6,068	4,356
		1,378,700	1,373,984	1,341,999	1,365,044	1,329,258
Cash was applied to:						
Payments to employees		549,164	551,495	533,154	536,814	521,122
Payments to suppliers		750,155	754,834	736,178	750,524	736,545
Interest paid		4,663	5,090	4,673	4,663	4,673
Capital charge		15,428	17,300	13,551	15,428	13,551
GST - net		(1,544)	-	(457)	(1,542)	(448)
		1,317,866	1,328,719	1,287,099	1,305,887	1,275,443
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	60,834	45,265	54,900	59,157	53,815
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant & equipment		53	-	56	44	48
Receipt from sale of investments		-		1,620	-	-
		53	-	1,676	44	48
Cash was applied to:						
Purchase of investments & restricted assets		9,613	-	-	9,206	57
Purchase of property, plant & equipment		35,960	25,000	40,865	34,774	37,308
		45,573	25,000	40,865	43,980	37,365
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		(45,520)	(25,000)	(39,189)	(43,936)	(37,317)
CASH FLOW FROM FINANCING ACTIVITIES						
Cash was provided from:						
Equity injection		5,274	-	7,729	5,274	7,729
		5,274	-	7,729	5,274	7,729
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		3,413	(1,861)	5,868	3,413	5,868
Net increase/(decrease) in cash and cash equivalents		18,727	18,404	21,579	18,634	22,366
Cash and cash equivalents at beginning of year		69,076	50,711	47,497	68,236	45,870
Cash & cash equivalents at end of year	8	**87,803**	**69,115**	**69,076**	**86,870**	**68,236**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

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 2011 and were authorised for issue by the Board on 28 September 2011.

BASIS OF PREPARATION

Statement of compliance

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

Measurement basis

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

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

Functional and presentation currency

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

Changes in accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

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

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

- NZ IAS 24 *Related Party Disclosures (Revised 2009)* replaces *NZ IAS 24 Related Party Disclosures (Issued 2004)* and will be applied for the first time in the DHB and group's 30 June 2012 financial statements. Changes to disclosure requirements include:
  More information is required to be disclosed about transactions between the DHB and entities controlled, jointly controlled, or significantly influenced by the Crown;
  Clarifies that related party transactions include commitments with related parties;
  Information is required to be disclosed about any related parties with Ministers of the Crown.
- 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.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 30 June 2012. Canterbury DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

As the External Reporting Board is to decide on a new accounting standards framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefit entities. This means that the financial reporting requirements for public benefit entities are expected to be effectively frozen in the short-term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

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 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 surplus/deficit when 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 surplus/deficit when 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 surplus/deficit. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the surplus/deficit.

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 surplus/deficit 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 surplus/deficit 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. The 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 surplus/deficit.

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 surplus/deficit 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 surplus/deficit.

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 surplus/deficit, 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.

In light of the Canterbury earthquakes, Canterbury DHB has reviewed the carrying value of land and buildings, resulting in an impairment of land and buildings as further described in note 16. Other than this review, Canterbury DHB has not made any other significant changes to past assumptions concerning useful lives and residual values.

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	
	30/06/11 $'000	30/06/10 $'000	30/06/11 $'000	30/06/10 $'000
ACC Revenue	20,390	21,869	20,390	21,869
Other patient related revenue	20,160	22,938	19,331	22,137
	40,550	**44,807**	**39,721**	**44,006**

3. OTHER OPERATING INCOME

	Group		Parent	
	30/06/11 $'000	30/06/10 $'000	30/06/11 $'000	30/06/10 $'000
Gain/(loss) on sale of property, plant and equipment	(128)	(26)	(129)	(48)
Donations and bequests received	1,822	933	1,821	933
Other	23,560	19,313	21,431	16,995
	25,254	**20,220**	**23,123**	**17,880**

4. EMPLOYEE BENEFIT COSTS

	Group		Parent	
	30/06/11 $'000	30/06/10 $'000	30/06/11 $'000	30/06/10 $'000
Wages and salaries	543,799	528,276	531,487	516,244
Contributions to defined contribution plans	5,365	4,878	5,327	4,878
Increase/(decrease) in employee benefit provisions	14,464	8,967	14,343	8,923
	563,628	**542,121**	**551,157**	**530,045**

5. OTHER EXPENSES

	Group		Parent	
	30/06/11 $'000	30/06/10 $'000	30/06/11 $'000	30/06/10 $'000
Remuneration of auditor:				
Audit fees for financial statement audit	212	204	173	166
Board members' fees	354	364	354	364
Directors' fees	30	23	-	-
Rental costs	4,905	4,947	4,245	4,322
Facilities and infrastructure costs	41,404	37,954	39,617	36,032
Other non-clinical costs	32,779	34,191	31,793	33,179
	79,684	**77,683**	**76,182**	**74,063**

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 2011 was 8%. (June 2010 8%).

7. CAPITAL AND RESERVES

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
General Funds				
Opening Balance	126,891	121,023	127,029	121,161
Equity repayment to Ministry of Health	(1,861)	(1,861)	(1,861)	(1,861)
Equity injection by Ministry of Health	5,274	7,729	5,274	7,729
	130,304	**126,891**	**130,442**	**127,029**
Retained earnings				
Opening balance	(78,585)	(69,775)	(80,662)	(71,818)
Operating surplus/(deficit)	(105)	(8,810)	(363)	(8,844)
Transfer (to)/from revaluation reserve	1,500	-	1,500	-
Closing balance	(77,190)	(78,585)	(79,525)	(80,662)
Represented by:				
Accumulated deficit in parent and subsidiary	(77,268)	(78,663)	(79,603)	(80,740)
Accumulated surplus in associates	78	78	78	78
	(77,190)	**(78,585)**	**(79,525)**	**(80,662)**
Revaluation reserve				
Opening balance	181,046	164,675	181,046	164,675
Impairment charges	(33,845)	-	(33,845)	-
Revaluation of land, building including fitout	-	16,371	-	16,371
Transfer to retained earnings	(1,500)	-	(1,500)	-
Closing balance	145,701	181,046	145,701	181,046
Represented by:				
Revaluation of land	57,108	66,453	57,108	66,453
Revaluation of building including fitout	88,593	113,093	88,593	113,093
Revaluation of reversionary interest in buildings	-	1,500	-	1,500
	145,701	**181,046**	**145,701**	**181,046**
Total Equity	**198,815**	**229,352**	**196,618**	**227,413**

8. CASH AND CASH EQUIVALENTS

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Bank balances and call deposits	34,303	44,076	33,370	43,236
Term deposits less than 3 months	53,500	25,000	53,500	25,000
	87,803	**69,076**	**86,870**	**68,236**

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Trade receivables	11,048	8,843	10,961	8,782
Receivable from the Ministry of Health	39,508	19,266	38,769	18,410
Prepayments	1,914	1,310	1,911	1,310
Other receivables	9,257	6,344	9,160	6,335
	61,727	**35,763**	**60,801**	**34,837**

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Balance at 1 July	2,932	3,928	2,932	3,928
Additional provisions made during the year	1,015	63	1,015	63
Receivables written-off during period	(271)	(1,059)	(271)	(1,059)
Balance at 30 June	**3,676**	**2,932**	**3,676**	**2,932**

The ageing of the impairment provisions are as follows:

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Current	262	354	262	354
1-30 days	145	264	145	264
31-60 days	280	96	280	96
> 61 days	2,989	2,218	2,989	2,218
Balance at 30 June	**3,676**	**2,932**	**3,676**	**2,932**

As at 30 June 2011 and 2010, 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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Current	7,454	4,926	7,418	4,883
1-30 days	2,393	3,459	2,367	3,444
31-60 days	1,155	271	1,145	271
> 61 days	46	187	31	184
Balance at 30 June	**11,048**	**8,843**	**10,961**	**8,782**

10. INVENTORY

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Pharmaceuticals	2,730	2,685	2,730	2,685
Surgical and medical supplies	4,976	4,780	4,976	4,780
Other supplies	2,641	2,581	2,576	2,484
	10,347	10,046	10,282	9,949
Provision for obsolescence	(1,431)	(1,402)	(1,431)	(1,402)
	8,916	**8,644**	**8,851**	**8,547**

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Current investments are represented by:				
Term deposits	14,888	2,275	12,500	-
Bonds	3,244	3,000	3,244	3,000
Total current portion	18,132	5,275	15,744	3,000
Non-current investments are represented by:				
Investment in Subsidiaries	-	-	5,515	5,809
Bonds	1,927	5,171	1,927	5,171
Total non-current portion	1,927	5,171	7,442	10,980
	20,059	**10,446**	**23,186**	**13,980**

Investment in Associates

a) General information

Name of entity	Principal activities	Interest held at 30/06/11	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

	2011 Actual $'000	2010 Actual $'000
Carrying amount at beginning of year	-	-
Carrying amount at end of year	**-**	**-**

c) Summarised financial information of associate entity

	2011 Actual $'000	2010 Actual $'000
Assets	2,229	2,254
Liabilities	1,142	1,498
Revenues	2,877	2,834
Surplus/(deficit)	295	35
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.

e) Subsequent events

SISSAL as an entity will be disestablished with the staff transferred to Canterbury DHB. The functions of SISSAL will be conducted by South Island DHBs under an agency agreement.

Investments in subsidiaries

	Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000
Equity - Canterbury Laundry Service Ltd	5,416	5,394
Advances - Canterbury Laundry Service Ltd	(22)	(38)
Advances - Brackenridge Estate Ltd	121	453
	5,515	**5,809**

At 30 June 2011 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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Term deposits	14,888	2,275	12,500	-
Bonds	5,171	8,171	5,171	8,171

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	
	30/06/11 $'000	30/06/10 $'000
Term deposit with maturities of 6-12 months	14,888	2,275
Weighted average effective interest rates	4.62%	5.00%

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Trade payables	12,481	16,182	12,436	16,102
Other payables	107,813	76,064	107,499	75,764
	120,294	**92,246**	**119,935**	**91,866**

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Non-current liabilities				
Liability for long service leave	3,478	3,331	3,461	3,312
Liability for retirement gratuities	4,506	4,031	4,506	4,031
	7,984	**7,362**	**7,967**	**7,343**
Current liabilities				
Annual leave accruals	56,047	50,008	55,317	49,018
Unpaid days accruals	11,968	10,098	11,924	9,996
ACC accruals	9,497	9,391	9,421	9,349
Conference/sabbatical leave and expenses	20,986	19,243	20,986	19,243
Sick leave	10,429	10,296	10,228	10,140
Other	32,112	28,161	31,471	27,882
	141,039	**127,197**	**139,347**	**125,628**

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

10/11 financial year	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Reversionary interest in buildings $'000	Work in progress $'000	Total $'000
Cost or valuation							
Balance at 1 July 2010	103,682	249,561	174,152	894	3,000	5,468	536,757
Additions	-	15,232	18,395	-	-	3,300	36,927
Disposals/transfers	-	(100)	(4,545)	-	-	-	(4,645)
Revaluation	-	-	-	-	-	-	-
Balance at 30 June 2011	**103,682**	**264,693**	**188,002**	**894**	**3,000**	**8,768**	**569,039**
Depreciation and impairment losses							
Balance at 1 July 2010	-	235	124,085	894	-	-	125,214
Depreciation charge for the year	-	31,388	14,762	-	-	-	46,150
Impairment	9,345	24,500	-	-	-	-	33,845
Disposals/transfer	-	(61)	(4,393)	-	-	-	(4,454)
Balance at 30 June 2011	**9,345**	**56,062**	**134,454**	**894**	**-**	**-**	**200,755**

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.

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
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**
Carrying amount							
At 1 July 2010	**103,682**	**249,326**	**50,067**	**-**	**3,000**	**5,468**	**411,543**
At 30 June 2011	**94,337**	**208,631**	**53,548**	**-**	**3,000**	**8,768**	**368,284**

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

10/11 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 2010	103,682	249,040	164,412	894	3,000	5,468	526,496
Additions	-	15,185	17,254	-	-	3,300	35,739
Disposals/transfers	-	(109)	(3,596)	-	-	-	(3,705)
Revaluation							
Balance at 30 June 2011	**103,682**	**264,116**	**178,070**	**894**	**3,000**	**8,768**	**558,530**
Depreciation and impairment losses							
Balance at 1 July 2010	-	-	119,637	894	-	-	120,531
Depreciation charge for the year	-	31,344	13,519	-	-	-	44,863
Impairment	9,345	24,500	-	-	-	-	33,845
Disposals/transfer	-	(32)	(3,499)	-	-	-	(3,531)
Balance at 30 June 2011	**9,345**	**55,812**	**129,657**	**894**	**-**	**-**	**195,708**

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**
Carrying amount							
At 1 July 2010	**103,682**	**249,040**	**44,775**	**-**	**3,000**	**5,468**	**405,965**
At 30 June 2011	**94,337**	**208,304**	**48,413**	**-**	**3,000**	**8,768**	**362,822**

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. The movements in land and buildings and plant fitout were recognised in the Revaluation Reserve. The Canterbury earthquakes have caused significant damage to some of Canterbury DHB's buildings and assets, and a $33.845M impairment has been recognised in the period to 30 June 2011. See note 16 for further details.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, ownership of the car park building will revert to Canterbury DHB in 2019. This interest was valued as at 30 June 2010 and is included in the Statement of Financial Position under Property, Plant, and Equipment.

15. INTANGIBLE ASSETS

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Software				
Cost				
Opening balance	18,562	21,250	18,555	21,243
Additions	801	748	794	748
Disposals	(65)	(3,436)	(65)	(3,436)
Closing balance	19,298	18,562	19,284	18,555
Amortisation and impairment losses				
Opening balance	17,950	19,288	17,943	19,281
Amortisation charge for the year	716	2,099	715	2,099
Disposals	(66)	(3,437)	(66)	(3,437)
Closing balance	18,600	17,950	18,592	17,943
Carrying amounts	**698**	**612**	**692**	**612**

There are no restrictions over the title of intangible assets and no intangible assets are pledged as security for liabilities. There is no impairment for the financial year ended 30 June 2011. There has been no change since last year.

16. IMPAIRMENT AND THE EFFECTS OF THE CONTINUING CANTERBURY EARTHQUAKES

A 7.1 magnitude earthquake occurred in the Canterbury region on 4 September 2010, with subsequent large aftershocks, including a 6.3 magnitude earthquake on 22 February 2011, and a further 6.3 magnitude earthquake on 13 June 2011. These events caused significant damage to many of the Canterbury DHB's buildings and assets. For example, over 7,500 hospital rooms need some level of repair. Canterbury DHB needed to install a number of temporary infrastructure facilities to ensure continued operations, such as emergency boilers, and water supplies for fire sprinkler systems.

Canterbury DHB has had structural engineers on site since the initial earthquake on 4 September, to assess the amount of damage to Canterbury DHB's buildings and assets. They are completing detailed building by building assessments, and will report on the repairs required to bring the buildings back to the same or better condition than they were in prior to the earthquakes.

While the DHB has received assessments on the general level of damage that report on the level of structural damage to its buildings, it is still working through estimates of the cost of damage, and how repairs will be undertaken. Canterbury DHB will be undertaking these repairs as soon as they are known. Internal DHB staff, working together with external engineers, have calculated a broad estimated range of costs of between $35M and $70M. This includes not only repairs but also other associated costs, such as temporary accommodation and facilities.

These costs exclude extra costs required to upgrade the buildings under the new building codes that have taken effect after the February earthquakes, or other strengthening where required. Quantification of these costs has yet to be determined, but the costs associated with making buildings compliant under the new building codes will be significant. For example, the cost estimates for the Riverside building to be made code compliant are in excess of $200M.

Canterbury DHB considered whether the carrying value of land and buildings exceeded the recoverable amount. As a result, the DHB has recognised a $33.845M asset impairment in Other Comprehensive Income, with a corresponding decrease to the land and buildings Asset Revaluation Reserve and to Property, Plant and Equipment in the Statement of Financial Position. The total carrying amount of Property, Plant, and Equipment for the Group is $368.284M, and would have been $402.129M had we not impaired our assets. For buildings, where the recoverable amount is determined on a depreciated replacement cost basis, Canterbury DHB has based the impairment on the best available estimate of the likely repair costs to restore buildings to their previous condition, excluding any ancillary operating cost increases.

Canterbury DHB incurred a range of other earthquake related costs for the year to 30 June 2011, including the cost of care for patients having to be relocated outside the Canterbury region, as well as other community based costs. The Ministry of Health provided additional funding of $16M to cover a deficit that Canterbury DHB would otherwise have incurred as a direct result. This $16M has been recorded as revenue in our results to 30 June 2011.

Insurance claims recognised as revenue to 30 June 2011 total $0.772M, and primarily relate to initial structural engineering costs incurred. There will be further claims for material damage as a detailed assessment of buildings is completed throughout 2011 by structural engineers, and other costs resulting from the earthquake are identified and incurred. Some damage, such as to roading and car parks, is not covered by insurance, and the costs of repair will be met by Canterbury DHB within its reserves. Additionally, Canterbury DHB's insurance policy provides cover for costs to repair damage to the building code applying at the date of the earthquakes. Costs to repair damage to the new building code are not covered, and will need to be met from Canterbury DHB's reserves. Business interruption claims have not yet been quantified, and these claims will be submitted once they can be reasonably quantified. Our insurers are aware that our claims submitted to date are initial claims only.

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Balance at beginning of year	12,626	12,483	12,494	12,357
Interest received	834	625	827	619
Donations and funds received	2,960	1,687	2,960	1,687
Funds spent	(2,734)	(2,169)	(2,**734**)	(2,169)
Balance at end of year	**13,686**	**12,626**	**13,547**	**12,494**

Residents' trust accounts	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Residents' trust account balance	**984**	**936**	**328**	**309**

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Non-current				
Crown Health Financing Agency loans	45,000	75,000	45,000	75,000
Total non current borrowings	45,000	75,000	45,000	75,000
Current				
Crown Health Financing Agency loans	30,000	-	30,000	-
Total current borrowings	30,000	-	30,000	-
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	
	30/06/11 $'000	30/06/10 $'000	30/06/11 $'000	30/06/10 $'000
Crown Health Financing Agency loans				
Less than one year	30,000	-	30,000	-
Weighted average effective interest rate	*6.53%*	-	*6.53%*	-
Later than one year but not more than five years Later than five years	45,000	75,000	45,000	75,000
Weighted average effective interest rate	*5.99%*	*6.19%*	*5.99%*	*6.19%*

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Net surplus/(deficit)	(105)	(8,810)	(363)	(8,844)
Add back non-cash items:				
Depreciation and amortisation	46,866	42,497	45,578	41,227
(Gains)/losses of reversionary interest	-	(1,500)	-	(1,500)
Donated assets	(1,759)	(674)	(1,759)	(674)
Add back items classified as investing activities:				
(Gains) / losses on asset sale	128	26	129	48
	45,130	31,539	43,585	30,257
Movement in term portion provisions/staff entitlements	622	(2,263)	624	(2,265)
Movements in working capital:				
Decrease/(increase) in receivables & prepayments	(25,964)	12,176	(25,964)	12,427
Decrease/(increase) in stocks	(272)	997	(304)	987
Increase/(decrease) in creditors & other accruals	28,048	1,488	28,069	1,488
Increase/(decrease) in capital charge due to crown	(572)	(267)	(572)	(267)
Increase/(decrease) in staff entitlements	13,842	11,230	13,719	11,188
Net cash inflow/(outflow) from operating activities	**60,834**	**54,900**	**59,157**	**53,815**

20. COMMITMENTS

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Capital commitments				
Property	15,148	22,438	15,148	22,438
Intangible assets	1,332	3,715	1,332	3,715
Other capital commitments	12,400	18,342	12,400	18,290
Total capital commitments at balance date	**28,880**	**44,495**	**28,880**	**44,443**
Non cancellable operating lease commitments				
Accommodation leases	7,643	9,088	4,345	5,501
Other	11	11	-	-
	7,654	**9,099**	**4,345**	**5,501**
Supply commitments	**2,253**	**312**	**-**	**-**
Total non cancellable operating lease and supply commitments	**9,907**	**9,411**	**4,345**	**5,501**
For expenditure within:				
Not later than one year	2,006	2,237	1,078	1,334
Later than one year and not later than five years	5,840	4,756	2,428	3,328
Later than five years	2,061	2,418	839	839
	9,907	**9,411**	**4,345**	**5,501**

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are renegotiated 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 a contingent asset for the financial year ended 30 June 2011 for insurance recoveries in respect of earthquake costs and business interruption that will be brought to account as and when there is certainty of receipt. See note 16 for further details. (2010: nil)

Contingent liabilities
Canterbury DHB has the following contingent liabilities at year end:

- 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.

- 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.

- Canterbury Earthquakes
  In respect of the Canterbury earthquakes there are a number of costs yet to be determined and incurred, both of an operational and capital nature, which will be brought to account as they become quantifiable and a liability crystallises. See note 16 further information.

22. CATEGORIES OF FINANCIAL ASSETS AND LIABILITIES

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Investments in subsidiaries and associates	-	-	5,515	5,809
Loans and receivables				
Cash and cash equivalents	87,803	69,076	86,870	68,236
Debtors and other receivables	61,727	35,763	60,801	34,837
Bonds	5,171	8,171	5,171	8,171
Term deposits (term>3 months)	14,888	2,275	12,500	-
Total loans and receivables	**169,589**	**115,285**	**165,342**	**111,244**
Fair value through profit and loss				
Restricted assets	13,686	12,626	13,547	12,494
Restricted liabilities	13,686	12,626	13,547	12,494
Total fair value through profit and loss	**-**	**-**	**-**	**-**
Other financial liabilities				
Creditors and other payables	124,649	97,173	124,290	96,793
Borrowings - CFA loans	75,000	75,000	75,000	75,000
Total other financial liabilities	**199,649**	**172,173**	**199,290**	**171,793**

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 2011, the Ministry of Health owed Canterbury DHB $38.769million (2010 $18.410 million).

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.

Credit quality of financial assets

The table below provides the credit quality of Canterbury DHB and group's financial assets that are neither past due nor impaired can be assessed by reference to standard and poor's credit rating (if available) or to historical information about counterparty default rates

	Group		Parent	
	As at 30/06/11 $'000	**As at 30/06/10 $'000**	**As at 30/06/11 $'000**	**As at 30/06/10 $'000**
Counterparties with credit rating				
Cash				
AA	87,803	69,076	86,870	68,236
Term deposits				
AA	14,888	2,275	12,500	-
Total cash at bank and term deposits	102,691	71,351	99,370	68,236
Marketable securities-Bonds				
A	1,335	1,335	1,335	1,335
AA	1,909	3,000	1,909	3,000
AA-	1,927	3,836	1,927	3,836
Total marketable securities-Bonds	5,171	8,171	5,171	8,171
Restricted assets				
A	466	716	466	716
A+	600	250	600	250
AA	10,680	8,773	10,541	8,641
AA-	1,138	1,835	1,138	1,835
AAA	-	500	-	500
BBB+	452	350	452	350
Unrated	350	202	350	202
Total restricted assets	13,686	12,626	13,547	12,494

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 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.

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 1 forward exchange contract outstanding at 30 June 2011 (2010: 1)

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 $129.650 million which has not changed from last year.

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
10/11 financial year						
Creditors and other payables	124,649	124,649	124,649	-	-	-
Borrowings- CFA loans	75,000	79,653	31,958	31,776	15,919	-
Restricted liabilities	13,686	13,686	11,375	481	1,550	280
Total	**213,335**	**217,988**	**167,982**	**32,257**	**17,469**	**280**
09/10 financial year						
Creditors and other payables	97,173	97,173	97,173	-	-	-
Borrowings- CFA loans	75,000	79,653	-	31,958	47,695	-
Restricted liabilities	12,626	12,626	9,289	1,405	1,732	200
Total	**184,799**	**189,452**	**106,462**	**33,363**	**49,427**	**200**

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
10/11 financial year						
Creditors and other payables	124,290	124,290	124,290	-	-	-
Borrowings- CFA loans	75,000	79,653	31,958	31,776	15,919	-
Restricted liabilities	13,547	13,547	11,236	481	1,550	280
Total	**212,837**	**217,490**	**167,484**	**32,257**	**17,469**	**280**
09/10 financial year						
Creditors and other payables	96,793	96,793	96,793	-	-	-
Borrowings- CFA loans	75,000	79,653	-	31,958	47,695	-
Restricted liabilities	12,494	12,494	9,157	1,405	1,732	200
Total	**184,287**	**188,940**	**105,950**	**33,363**	**49,427**	**200**

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
10/11 financial year						
Cash and cash equivalents	87,803	87,803	87,803	-	-	-
Debtors and other receivables	61,727	61,727	61,727	-	-	-
Bonds	5,171	5,171	3,244	-	1,927	-
Term deposits (term > 3 months)	14,888	14,888	14,888	-	-	-
Restricted assets	13,686	13,686	11,375	481	1,550	280
Total	**183,275**	**183,275**	**179,037**	**481**	**3,477**	**280**
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**

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
10/11 financial year						
Cash and cash equivalents	86,870	86,870	86,870	-	-	-
Debtors and other receivables	60,801	60,801	60,801	-	-	-
Bonds	5,171	5,171	3,244	-	1,927	-
Term deposits (term > 3 months)	12,500	12,500	12,500	-	-	-
Restricted assets	13,547	13,547	11,236	481	1,550	280
Total	**178,889**	**178,889**	**174,651**	**481**	**3,477**	**280**
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**

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			
	30/06/11 $'000		30/06/10 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(144)	144	(251)	251
Total sensitivity	**(144)**	**144**	**(251)**	**251**

	Parent			
	30/06/11 $'000		30/06/10 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(144)	144	(251)	251
Total sensitivity	(144)	144	**(251)**	**251**

Fair value hierarchy disclosure:

Fair values of financial assets and liabilities with standard terms and conditions and trade in an active market are determined with reference to quoted market price.

The following table discloses the fair value of the financial assets and liabilities the Canterbury DHB and its subsidiaries hold as at balance date.

	Group		Parent	
	As at 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Financial Assets				
Bonds	5,521	5,572	5,521	5,572
ASB unsubordinated Notes	-	3,133	-	3,133
Restricted assets	13,889	12,531	13,750	12,411
Financial Liabilities				
Borrowing-CFA loans	78,617	78,969	78,617	78,969
Restricted liabilities	13,889	12,531	13,750	12,411

The carrying amount of financial assets and liabilities recognised in the financial statement approximates their fair value.

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	
	30/06/11 $'000	30/06/10 $'000	30/06/11 $'000	30/06/10 $'000
Revenue				
Interest on advance and director's fees from/to Canterbury Laundry Service Ltd	-	-	6	233
Interest on advance to Brackenridge Estate Ltd	-	-	4	4
Service fees to Brackenridge Estate Ltd	-	-	60	48
Services to Canterbury Laundry Service Ltd	-	-	425	427
Service fees to Canterbury Laundry Service Ltd	-	-	11	11
Services to South Island Shared Service Agency Ltd	48	83	48	83
Expenses				
Linen services and rentals from Canterbury Laundry Service Ltd	-	-	4,545	4,671
Interest on advance from Brackenridge Estate Ltd	-	-	2	-
Services from South Island Shared Service Agency Ltd	1,084	1,170	1,084	1,170

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 30/06/11 $'000	As at 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Amount receivable owing by associates				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	7	19	7	19
Amount payable owing to associates				
South Island Shared Service Agency Ltd	4	656	4	656
Amount payable owing to subsidiaries				
Canterbury Laundry Service Ltd	-	-	449	458
Amount receivable owing by subsidiaries				
Canterbury Laundry Service Ltd – debtor	-	-	55	133
Brackenridge Estate Ltd – advance	-	-	121	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 30/06/11 $'000	Year ended 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Pegasus Health (Charitable) Ltd	6,804	4,976	3	164
Ryman Healthcare Ltd	8,063	8,607	-	-
Access Home Health	4,286	4,974	-	-
Deloitte	5	2	-	-
McLeans Institute	201	163	-	-
University of Canterbury	214	124	7	6
Social Services Council of the Diocese of Christchurch	4,460	5,363	-	-
Medical Protection Society	99	109	-	-
Partnership Health Primary Health Organisation	75,143	72,944	-	-
Te Runanga O Ngai Tahu	174	213	30	3
University of Otago	8,872	9,137	32	317
Canterbury Asthma Society	134	134	-	-
Christchurch Primary Health Organisation	5,058	4,500	-	-
Maori Women's Welfare League	879	745	-	-
West Coast DHB	871	862	-	13
New Zealand Medical Council	4	-	-	-
Pharmaceutical Management Agency (Pharmac)	329	319	-	-
Brannigans Ltd	3	-	-	-
Royal New Zealand College of GPs	19	-	-	-
Christchurch City Networks Limited (trading as Enable Networks)	5	-	2	-

Below are the aggregate value of revenue transactions and outstanding balances which Canterbury DHB and its subsidiaries have made during the financial year on an arm's length basis with the organisations which fall within the related party definition. Balances outstanding are per the Accounts Receivable ledger, and exclude any provisions made. A provision for impairment of receivables from related parties of $237,253 has been made (2010 $99,293).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/11 $'000	Year ended 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Pegasus Health	81	138	49	32
University of Canterbury	70	51	-	-
Christchurch Polytechnic Institute of Technology	420	400	33	27
Canterbury Medical Research Foundation	29	53	12	13
Partnership Health Primary Health Organisation	40	37	-	-
University of Otago	2,863	2,834	670	210
Christchurch Primary Health Organisation	-	5	-	-
West Coast DHB	15,376	15,014	1,038	321
Neurological Foundation of New Zealand	4	-	-	-
Pharmaceutical Management Agency (Pharmac)	76	-	88	
Nurses Memorial Trust	1	-	-	-

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 (2010 $nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/11 $'000	Year ended 30/06/10 $'000	As at 30/06/11 $'000	As at 30/06/10 $'000
Services purchased by Canterbury DHB:				
Heart Centre at St George's	791	92	-	-
Heart Vision Ltd	2	-	-	-
Services purchased from Canterbury DHB:				
Heart Centre at St George's	9	25	-	3

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.

Compensation of key management personnel:

	Parent	
	Year ended 30/06/11 $'000	**Year ended 30/06/10 $'000**
Salaries & other short term employee benefits	2,914	2,610
Post-employment benefits	36	24
Total key management personnel compensation	**2,950**	**2,634**

The above compensation of key management personnel includes Board and Committee members' fees. For Board and Committee members' fees see page 8.

26. SUBSEQUENT EVENTS

There were no events after 30 June 2011 which could have a material impact on the information in Canterbury DHB's financial statements.

STATEMENT OF SERVICE PERFORMANCE

OVERVIEW

As an effective DHB, we must demonstrate that the actions we take and the services we fund have a positive impact on the health and wellbeing of our population. In order to do so, we choose a set of performance measures against which we set targets to evaluate our performance over each year. The performance measures chosen are a mixture of indicators of access, timeliness and quality, focused on local and national priorities and the things that make a difference to long-term health and wellbeing.

This year, the measures reflect our activity across the lifespan of our population and aggregate the services we deliver into three output classes:

- **Child and Youth Health Services**– services we provide for children 0-18 years of age, including maternity services which are focused on the health and wellbeing of the baby and setting foundations for a healthy future.
- **Adult Health Services** – services we provide for people 19-64 years of age.
- **Older People's Health Services** – services we provide for people 65 years of age and over.

This aggregation of services demonstrates the responsibility we have for our population's health and wellbeing across the whole of their lifetime, while also demonstrating the specific needs of different age groups within our population.

The targets that we set for 2010/11 were based on the growth of our population and the assumption that little increase in funding was available. Our focus has been on the development of innovative service delivery models that enable us to treat more people with the same resources, and performance targets tend to reflect the objective of maintaining performance against increasing population growth. The targets also reflect our commitment to reducing inequalities between population groups and improving health outcomes for those most in need.

Where information is available, we have included past years' performance (as baseline data) and the most recently available national averages to give context in terms of what we are trying to achieve and to enable evaluation of our performance.

Quake Impact

The earthquakes experienced in Canterbury over the past year will have a significant and lasting impact on our population and on our health system. They have also had an immediate and considerable impact on our performance in terms of meeting the targets we set a year ago.

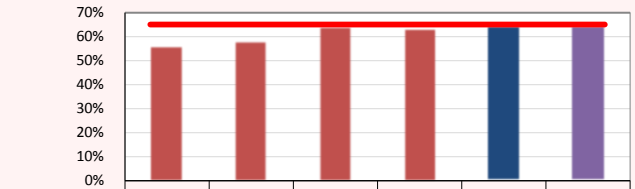
The quakes have displaced many families from their homes and usual health networks, while others who have stayed in their homes face different challenges that have interrupted their usual routines and health-seeking behaviours. Our health system too has been affected, with damage to health service infrastructure across the whole of Canterbury, including aged residential care facilities, pharmacies, laboratories, private medical practices and private hospitals, the premises of community-based health providers and our own DHB facilities.

In light of the impact of the earthquakes, Canterbury's achievements of targets reflects the considerable effort and commitment of health professionals and providers right across our health system. Some targets will take longer to achieve than anticipated because of the significant setbacks caused by the quakes, but we remain committed to achieving the targets we set prior to these events and improving the health and wellbeing of our population.

CHILD AND YOUTH HEALTH SERVICES

Impact Measures (medium-term measures of quality and effectiveness)

The proportion of 'never smokers' among Year 10 students[1]



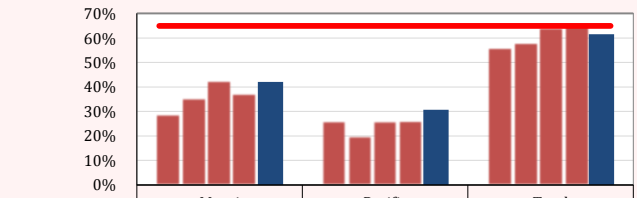
	2006	2007	2008	2009	2010	National Average
Never Smoked	56%	58%	64%	63%	65%	64%
2010/11 (Target)						65%

Target: 65% **Achieved**

The proportion of 'never smokers' among Year 10 students in Canterbury improved in 2010 to **65%**, achieving the target.

This medium-term impact measure is affected by a variety of work to reduce tobacco use. In addition to monitoring youth access to tobacco through controlled purchase operations, the Canterbury DHB makes submissions on tobacco legislation and continues to support smokefree initiatives in public places such as marae, parks and playgrounds throughout Canterbury with support from local councils and the community.

The proportion of children caries-free (no holes/fillings) at age 5[2]



	Maori	Pacific	Total
2006	29.1%	26.4%	56.0%
2007	35.6%	20.3%	57.8%
2008	42.8%	26.6%	64.3%
2009	37.6%	26.8%	65.0%
2010	42.1%	30.7%	61.5%
2010/11 (Target)			65.0%

Target: **Māori 45%** **Not achieved**
Pacific 29% **Achieved**
Total 65% **Not achieved**

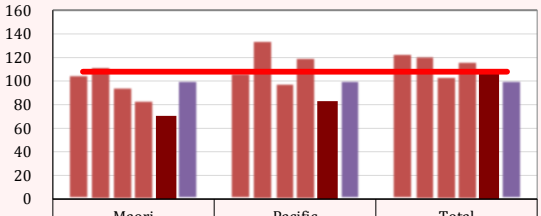
At **61.5%**, the proportion of five year olds with no holes or fillings did not reach the 65% target. However, it is positive to note that rates for both Māori and Pacific children have improved, with the Pacific target being achieved (30.7% achieved vs. 29% target).

We are at the early stages of implementing a targeted intensive preventive care programme for high-risk preschoolers, which we expect will lead to improvements in this medium-term oral health impact measure. Greater enrolment in oral health services and timely examination also contribute to achievement against this measure.

[1] Data is from the national annual Year 10 ASH Survey, which is conducted for calendar, rather than financial, years. www.ash.org.nz

[2] Oral health data is collected against school year data and reported annually in Quarter 3 on calendar years.

The ratio of actual to expected avoidable hospital admissions 0-4 year olds[3]



	Maori	Pacific	Total
2006/07	105.6	106.5	122.8
2007	111.9	134.0	121.3
2008	94.6	97.8	103.5
2009/10	83.5	119.5	116.1
2010/11	70.5	82.8	109.5
National Average	100.0	100.0	100.0
2010/11 (Target)			108.0

Target: Māori <95 **Achieved**

Pacific ≤95 **Achieved**

Total <108 **Substantially achieved**

Avoidable hospitalisations have decreased compared to last year across all ethnicities. Māori (70.5) and Pacific (82.8) rates achieved the target of <95. However, at **109.5**, the total rate exceeds the target of <108. This difference equates to just 21 admissions.

A review of this rate indicates that a number of these children are referrals from primary care with a request for a paediatric assessment. These are not considered unnecessary referrals by our clinical teams.

The rate also reflects changes in admission practice, which have led to a number of patients previously treated as outpatients in assessment areas now being admitted as inpatients.

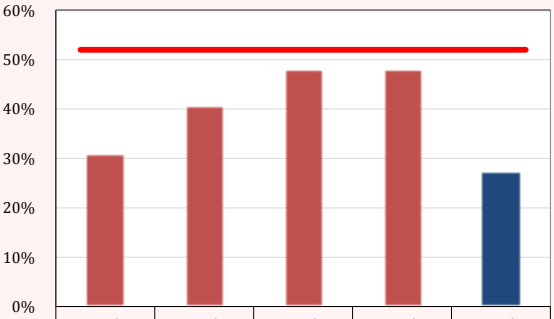
This is a medium-term impact measure that is affected by a variety of programmes and services. Reducing avoidable hospital admissions requires engagement across the whole of the health system and is therefore affected by many of the output measures reported below.

Health Promotion, Protection and Disease Prevention Services

Aim: More children and young people stay well

Associated Output Measures

The percentage of schools engaged in the Health Promoting Schools (HPS) framework[4]



	2006/07	2007/08	2008/09	2009/10	2010/11
% HPS	31%	41%	48%	48%	27%
2010/11 (Target)					52%

Target: 52% **Not achieved**

The percentage of schools engaged in the HPS framework has dropped to **27%** this year as a result of the significant disruption caused by the earthquakes.

Unfortunately, many of the priority schools targeted by HPS are in the areas worst affected by the quakes, with many schools closed due to damage and others less engaged as they cope with other priorities post-quake.

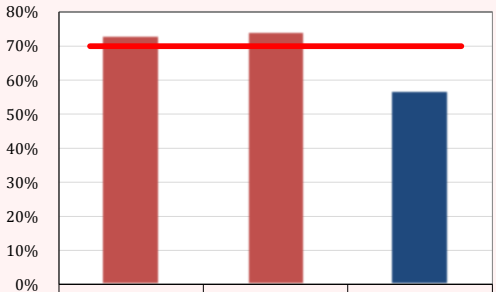
While it is each school's decision whether they wish to re-engage with the HPS programme, our staff are working to bring engagement back up to pre-quake levels.

[3] The "expected" rate is the age-group specific national average, so a ratio less than 100 indicates performance better than the national average. Rates are based on admissions for 26 conditions. Figures prior to 2009/10 have been recalculated following a change in the definition from 37 to 26 conditions. Due to mixed Ministry data availability, 2009/10 figures are for the year to September 2010 and 2010/11 figures the year to March 2011.

[4] The HPS framework is an approach based on activities within the school setting that can impact on health; as such the definition also includes National Heart Foundation Schools (and in previous years Active Schools, Nutrition Fund and Fuelled 4 Schools).

The proportion of 'priority' schools that are engaged in the HPS framework[5]

Target: ≥70% **Not achieved**



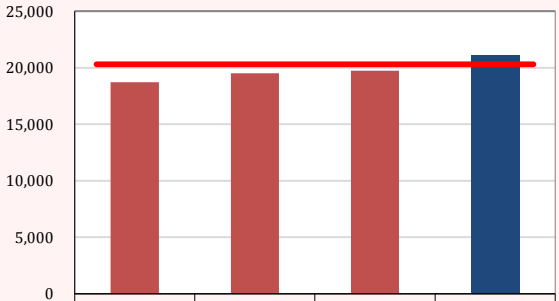
	2008/09	2009/10	2010/11
% Priority Schools in HPS	73%	74%	57%
2010/11 (Target)			70%

57% of 'priority' schools in Canterbury are engaged in the HPS framework. As noted above, this has dropped as a result of the disruption caused by the earthquakes.

A 'priority' school is one that is low decile, rurally isolated and/or has a high percentage of Māori and/or Pacific Island students. There are 88 schools identified as 'priority schools' throughout Canterbury, and we are currently working with 50 of them.

The number of eligible children (< 5) enrolled in school and community oral health services[6]

Target: 20,300 **Achieved**



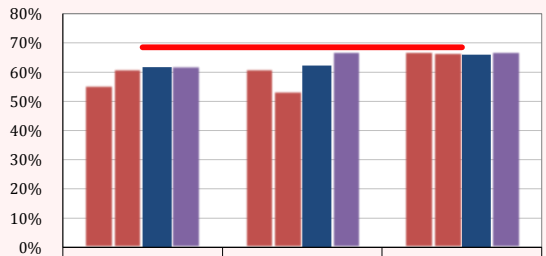
	2007	2008	2009	2010
Under 5 Enrolled	18,707	19,516	19,742	21,131
2010/11 (Target)				20,300

With **21,131** children aged 0 to 4 enrolled in school and community oral health services in 2010, Canterbury has surpassed its target by 831 children.

We continue to progress our upgrade of oral health services, with eleven clinics and twenty mobile units done and only two clinics left to be completed.

The percentage of infants exclusively and fully breastfed at 6 weeks[7]

Target: 68.5% **Not achieved**



	Maori - 6 Weeks	Pacific - 6 Weeks	Total - 6 Weeks
2008	55.4%	61.1%	66.9%
2009	61.2%	53.5%	66.6%
2010	61.8%	62.3%	66.0%
National Average	62.0%	67.0%	67.0%
2010/11 (Target)			68.5%

In 2010, **66%** of Canterbury infants were exclusively and fully breastfed at 6 weeks, falling short of the 68.5% target.

However, it is positive to note that breastfeeding rates for both Māori and Pacific infants have increased in 2010 – showing progress in closing the gap between ethnicities.

A range of breastfeeding support (e.g. peer support and free community lactation consultation) is available in Canterbury. Two additional programmes focusing on Māori and Pacific mothers and young parents have recently been established, and several Māori and Pacific Community Action Projects also support breastfeeding.

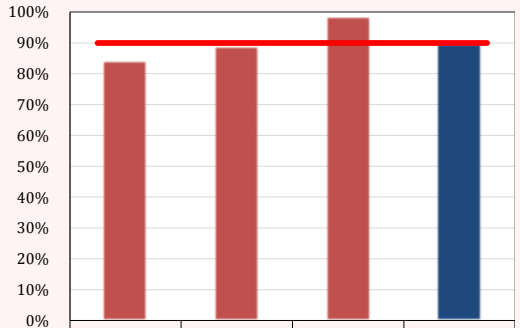
[5] For this measure (unlike the previous one), HPS is defined only as official HPS schools and excludes National Heart Foundation Schools, etc.

[6] Oral health data is collected against school year data and reported annually in Quarter 3 on calendar years.

[7] Breastfeeding rates became a national indicator in 2009/10, and since then the Ministry has provided Plunket data annually in Q4 for calendar years. Figures therefore differ from previously published figures, which were for financial years.

The proportion of compliant tobacco retailers identified from controlled purchase operations

Target: 90% **Achieved**

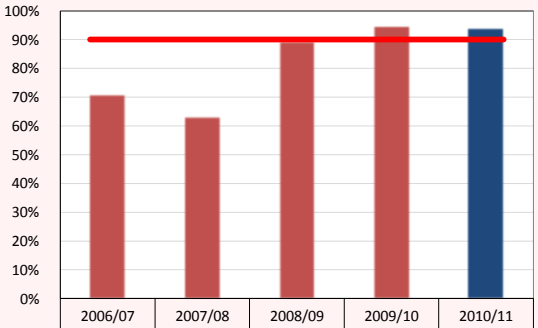


	2007/08	2008/09	2009/10	2010/11
% Compliant Retailers	84%	89%	98%	90%
2010/11 (Target)				90%

90% of tobacco retailers visited during 2010/11 were compliant with legislation, while the other 10% of premise visits resulted in sales without a request for proof of age. This meets the target, but indicates a decrease in compliance compared with last year.

The proportion of compliant alcohol retailers identified from controlled purchase operations[8]

Target: 90% **Achieved**



	2006/07	2007/08	2008/09	2009/10	2010/11
% Compliant Retailers	71%	64%	90%	95%	94%
2010/11 (Target)					90%

Youth access to alcohol is monitored through controlled purchase operations, which found that **94%** of alcohol retailers visited in the 2010/11 were compliant, achieving the target.

The Canterbury DHB raises host responsibility awareness by providing training to the industry and is involved in a range of initiatives to reduce alcohol-related harm.

Screening, Early Detection and Intervention Services

Aim: Children and young people are seen and treated early

Associated Output Measures

The percentage of children and young people (aged 0-19) enrolled with a Primary Health Organisation (PHO)[9]

Target: >95% **Achieved**

	2006/07	2007/08	2008/09	2009/10	2010/11
0-19 % Enrolled	94.9%	96.3%	97.5%	97.6%	95.2%
2010/11 (Target)					95.0%

127,069 children and young people are enrolled with a PHO as of the end of 2010/11, equating to **95.2%** enrolment.

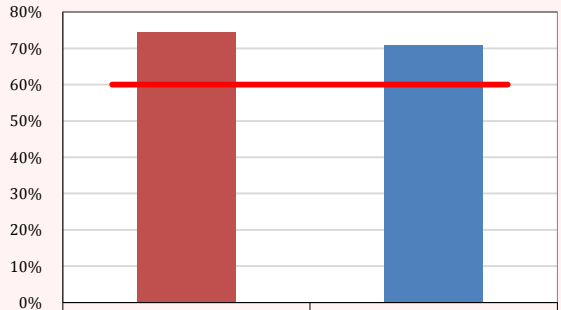
Though lower than in previous years, this meets the 95% target despite the significant impact of the earthquakes on PHO enrolment. Many families have been displaced from their homes and consequently also from their general practices. Establishing and stabilising the enrolled population remains a major focus post-quake, with primary care working to re-engage displaced populations.

[8] Data includes Ashburton from 2009 onwards. The 2008/09 figure differs from the one previously published due to recent availability of backdated Ashburton data for 2009. In 2007/08, targeting of suspected non-compliant premises, rather than random sampling, resulted in lower compliance.

[9] The national target for PHO enrolments is 95%, and the aim is to continue to achieve a standard above this level in Canterbury. The 2008/09 figure differs from the one previously published because it has been recalculated following a subsequent update in population forecasts.

The percentage of children (aged four) receiving B4 Schools Checks[10]

Target: 60% **Achieved**



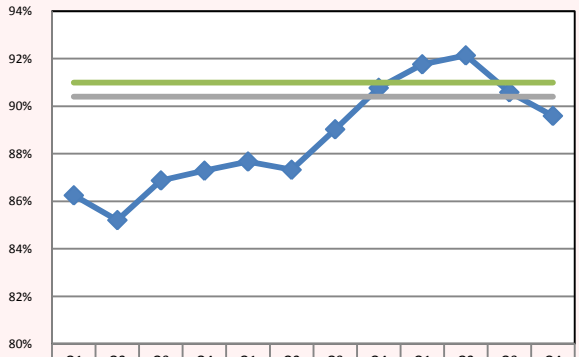
	2009/10	2010/11
B4SC	75%	71%
2010/11 (Target)		60%

In 2010/11, **71%** of all Canterbury four year olds received a B4 School Check (B4SC), which is 11% higher than the target.

This achievement reflects the significant work of B4SC providers to maintain delivery despite the displacement of many children and their families from their homes and general practices post-quake. Mobile nursing teams are being used as an alternate way to connect with hard-to-reach families.

HEALTH TARGET: The percentage of children fully immunised at age two[11]

Target: 91% **Achieved**



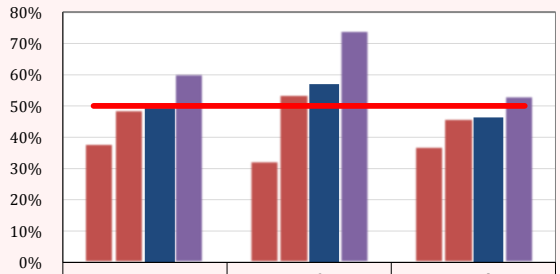
	Q1 08/09	Q2 08/09	Q3 08/09	Q4 08/09	Q1 09/10	Q2 09/10	Q3 09/10	Q4 09/10	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11
2Yr Imms	86%	85%	87%	87%	88%	87%	89%	91%	92%	92%	91%	90%
10/11 (Target)												91%
National Avg												90%

91% of Canterbury two year olds were fully immunised in 2010/11, meeting the target.

This achievement reflects the considerable effort and robust forward planning processes of general practices, outreach immunisation and the Canterbury NIR (National Immunisation Register) Team, despite the challenges presented by the earthquakes, which have displaced many children and their families from their homes and health providers.

The proportion of eligible young women engaged in the HPV (Human Papilloma Virus) vaccination programme[12]

Target: 50% **Not achieved**



	Maori	Pacific	Total
2008/09	37.9%	32.5%	37.1%
2009/10	48.9%	53.8%	46.2%
2010/11	49.3%	57.0%	46.3%
National Average	60.4%	74.0%	53.1%
2010/11 (Target)			50.0%

46.3% of young women (age 12-18) in Canterbury engaged in the HPV vaccination programme in 2010/11. Though short of the total target, it is positive to note that Canterbury has higher rates for Māori (49.3%) and Pacific (57.0%) young women (identified high needs groups) than other ethnicities, with the latter group surpassing the target.

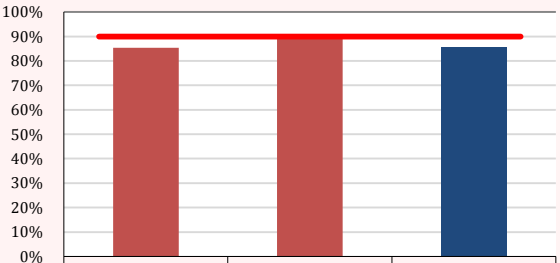
Delivery of the vaccine has improved across all ethnicities, despite the displacement of many young women and their families from their homes and general practices post-quake.

[10] The B4SC Programme began in Canterbury in March 2009. As a result, the previously published figure for the 2008/09 year was not for the full 12 months. Now that a full year's data is available from 2009/10 for comparison, the incomplete 2008/09 data has been left off the graph.

[11] Note that the graph for this measure displays quarter-by-quarter performance, rather than year-by-year.

[12] "Engaged" is defined as having received Dose 1, and "eligible" young women are those aged 12-18. Previously published figures differ, as they included only a subset of the eligible population.

The proportion of children enrolled in dental services, examined according to planned recall[13]



	2008	2009	2010
% recall	85.3%	89.6%	85.4%
2010/11 (Target)			90.0%

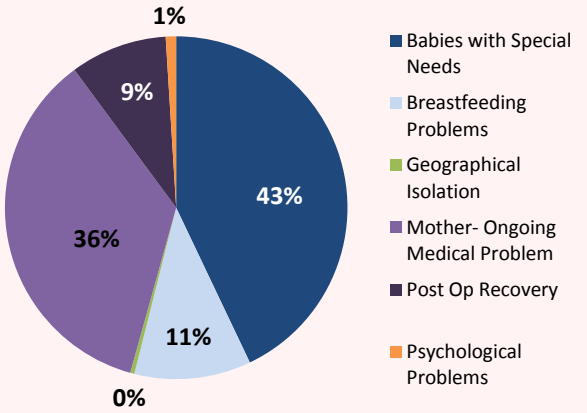
Target: 90% **Not achieved**

85.4% of children enrolled in dental services were examined according to planned recall in 2010, falling 4.6% short of target.

Examination timelines this year have been disrupted by the commissioning of new facilities and quake-related school closures.

We have now almost completed the building programme and are working on strategies to reduce and catch up on missed appointments, including an automated reminder system.

The proportion of women who meet the clinical criteria being offered longer post-natal stays[14]



Target: 100% **Achieved**

The Canterbury DHB offers the opportunity to have a longer post-natal stay to all new mothers who meet the clinical criteria. This can help them to be more confident in caring for their baby on discharge.

During 2010/11, this was 16% of all women who gave birth in Canterbury hospitals. The clinical criteria they met are graphed on the left.

[13] Oral health data is collected against school year data and reported annually in Quarter 3 on calendar years.

[14] All women meeting the clinical criteria are offered a longer post-natal stay as a matter of course. The denominator for this measure is not captured by the patient management system, which instead records the number of women offered a longer stay and the criteria they meet. St George's data is only included for the first half of 2010/11, as data was unavailable for January and February and the unit was closed thereafter due to the quake.

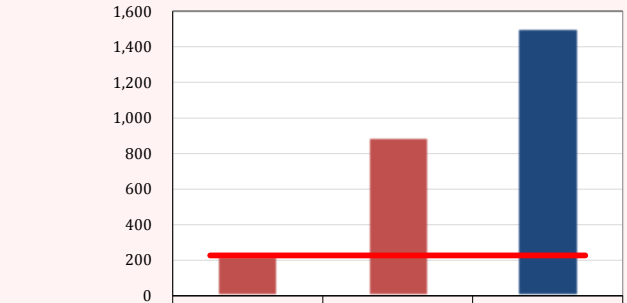
Conditions Management Services

Aim: Fewer children and young people need hospital care

Associated Output Measures

The number of young people (aged 0-19) accessing mental health services in the community or through primary care (outside hospital and specialist services)[15]

Target: ≥226 **Achieved**



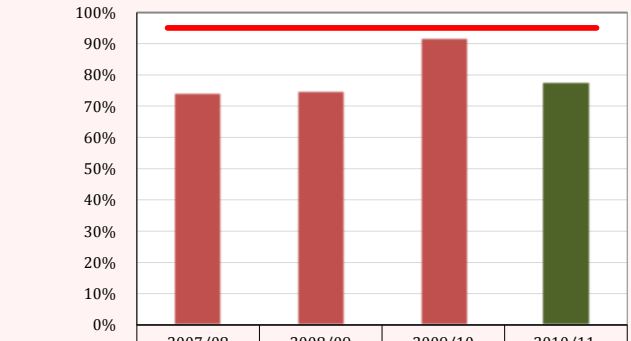
	2008/09	2009/10	2010/11
Prim/Comm Based MH	226	890	1499
2010/11 (Target)			226

During 2010/11, **1,499** young people accessed mental health services exclusively in the community or through primary care –significantly surpassing the target.

The expansion of GP liaison, Brief Intervention Co-ordination (BIC) and other community-based mental health services has resulted in increasing numbers of people accessing mental health services in the community, without needing a referral to hospital.

The proportion of long-term mental health clients (aged 0 - 19) with current relapse prevention plans

Target: 95% **Not achieved**



	2007/08	2008/09	2009/10	2010/11
% with plan	74%	75%	92%	78%
2010/11 (Target)				95%

78% of long-term specialist mental health clients aged 19 and under have current relapse prevention and resiliency plans in place.

At the end of December 2010 (before the February quake), 94% of these clients had current plans in place – just 1% short of target.

The result has been significantly impacted by the February earthquake, which has damaged SMHS buildings, displaced about 200 staff and prevented access to some clinical records.

Mental health activity was reprioritised to meet quake-related need, with specialist services providing increased consult liaison across the health system, which does not include treatment plans.

Specialist Mental Health clinical managers are now conducting audits to lift performance back up and ensure completion and currency of plans.

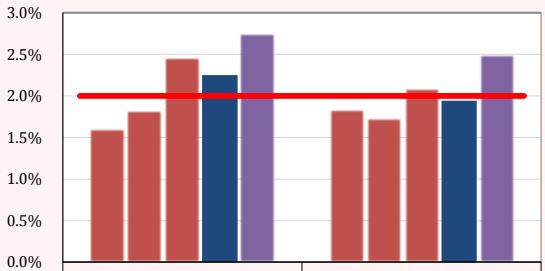
[15] The DHB has recently begun to collect NHI level data from community providers to enable improved monitoring of mental health service delivery across the whole health system. The number of providers who submit this reporting is gradually increasing; therefore, previous years' data is not directly comparable, as it includes fewer providers' data. Data excludes people who also attended Specialist Mental Health Services during the period.

Complex Support Services

Aim: Fewer untimely deaths

Associated Output Measures

Access rates to specialist mental health services (SMHS) for children and young people (aged 0-19)[16]



	Maori	Total
2007/08	1.6%	1.8%
2008/09	1.8%	1.7%
2009/10	2.5%	2.1%
2010/11	2.2%	1.9%
National Average	2.7%	2.5%
2010/11 (Target)		2.0%

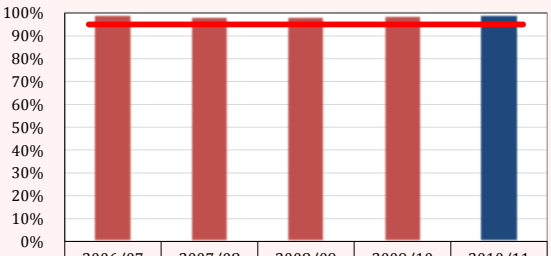
Target: 2% **Substantially achieved**

1.9% of children and young people, and 2.2% of Māori children and young people, accessed Specialist Mental Health Services during the year to March 2011 – just 0.1% short of target for total access, and on target for Māori.

Canterbury's lower specialist access rates reflect several positive changes in Canterbury. Clients accessing specialist services are now being seen more often, and closer working relationships have been developed with community service providers, so that more people remain under GP or NGO care with support from SMHS, rather than accessing secondary services.

The lower rates also reflect the impact of the earthquakes. Due to significant facility damage and the nature of the events, there was a shift in focus of service provision to primary and community care.

HEALTH TARGET: The percentage of young people (aged 0-15) assessed, treated or discharged from ED in under six hours.[17]

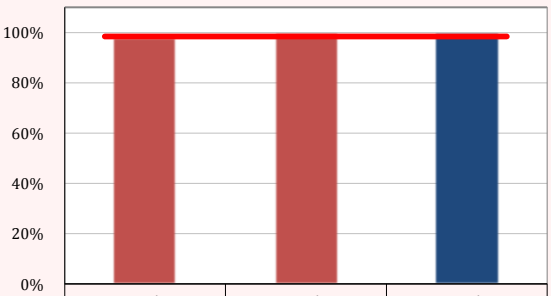


	2006/07	2007/08	2008/09	2009/10	2010/11
0-15 % 6hrs	99.1%	98.4%	98.5%	98.6%	99.3%
2010/11 (Target)					95.0%

Target: >95% **Achieved**

Canterbury has continued its strong achievement in ED performance, with **99.3%** of children and young people assessed, treated or discharged in under six hours during of 2010/11.

The percentage of paediatric patients provided with a First Specialist Assessment (FSA) within 6 months of referral



	2008/09	2009/10	2010/11
ESPI 2 Paed Surg	98.2%	99.8%	99.8%
2010/11 (Target)			98.5%

Target: 98.5% **Achieved**

99.9% of paediatric patients waited less than six months for their first specialist assessment, surpassing the target.

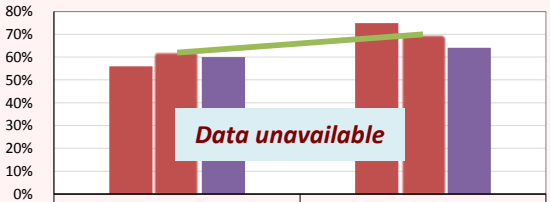
[16] This national indicator measures the percentage of people residing in Canterbury (i.e. excluding those from other DHBs) who are seen by SMHS per year, reported a quarter in arrears (i.e. 2010/11 figures are for the 12 months to March 2011).

[17] This measure is based on the national health target of 95% for a sub-set of the total population: young people aged 0-15. The aim is to maintain performance above the health target in Canterbury.

ADULT HEALTH SERVICES

Impact Measures (medium-term measures of quality and effectiveness)

The proportion of the population (15+) having the recommended servings of fruit (2+ daily) and vegetables (3+ daily)[18]



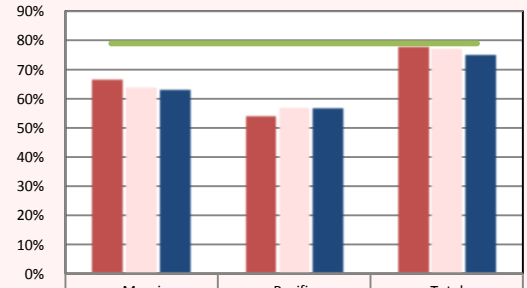
	Fruit	Vegetable
2002/03	55.9%	74.9%
2006/07	61.9%	69.4%
National Average	60.0%	64.1%
2010/11 (Target)	62.0%	70.0%

Target: Fruit 62% **Data unavailable**
Veg 70%

We are unable to report against this measure, as results for the Ministry of Health's 2010/11 NZ Health Survey are not yet available.

However, a wide variety of initiatives promote good nutrition and thus contribute to this medium-term impact measure. These include Health Promoting Schools, Appetite for Life, workplace wellness programmes, edible garden projects, healthy eating promotional campaigns and a range of Healthy Eating Healthy Action Māori and Pacific Community Action Projects.

HEALTH TARGET: The percentage of people with diabetes and satisfactory or better diabetes management (HbA1c<=8%)[19]



	Maori	Pacific	Total
2008/09	67.3%	54.9%	78.3%
2009/10	64.2%	57.3%	77.4%
2010/11	63.6%	57.1%	75.3%
2010/11 (Target)			79.0%

Target: Māori 70% **Not achieved**
Pacific 56% **Achieved**
Total 79% **Not achieved**

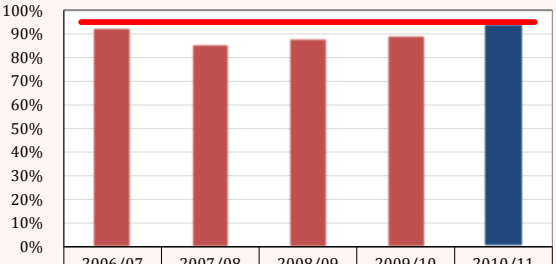
While short of target for the Māori and total population, diabetes management has remained relatively stable at **75.3%** in spite of earthquake disruption to both general practice and people's lives.

Diabetes management is a medium-term impact measure, and various new initiatives have been implemented this year to improve performance. These include: two new GP pathways for those newly diagnosed with Type 2 and those starting insulin; two additional Community Diabetes Nurse Specialists; and the establishment of an Integrated Diabetes Services Development Group (IDSDG), modelled on the successful Integrated Respiratory Service Development Group, to provide governance and direction to ensuring a single, integrated health system for those with diabetes. Increased uptake of diabetes annual reviews this year will also affect achievement against this target.

[18] Fruit and vegetable data is sourced from the Ministry of Health's NZ Health Survey. The survey was undertaken in 2003/04 and 2006/07. Results for the 2010/11 survey are not yet available.

[19] Diabetes data is reported to the DHB by individual PHOs and the Diabetes Centre for the full financial year.

HEALTH TARGET: The percentage of people (aged 16-64) presenting to ED admitted, discharged or transferred within 6 hours[20]



	2006/07	2007/08	2008/09	2009/10	2010/11
16-64 % 6hrs	92.6%	86.0%	88.3%	89.6%	94.1%
2010/11 (Target)					95.0%

Target: 95% **Not achieved**

94.1% of 16-64 year olds presenting at ED in the first six months of 2010/11 were admitted, discharged or transferred within 6 hours. Though 0.9% short of target, this reflects a substantial 4.5% improvement on 2009/10.

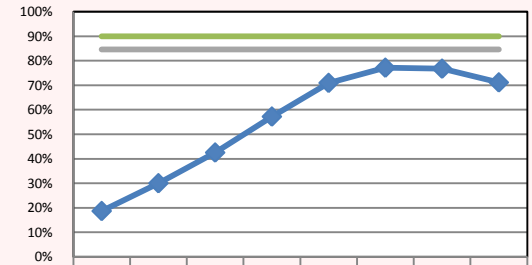
Canterbury takes a 'whole of system' approach to improving performance against this medium-term impact measure. This involves a range of strategies for managing preload (reducing the number of people attending ED, e.g. managing acute events in the community - see page 75), contractility (ensuring effective ED functioning and flow) and afterload (ensuring hospital flow, e.g. timely acute surgery – see page 77 – and supported discharge – see page 84).

Health Promotion, Protection and Disease Prevention Services

Aim: People stay well

Associated Output Measures

HEALTH TARGET: The proportion of hospitalised smokers provided with help and advice to quit[21]



	Q1 09/10	Q2 09/10	Q3 09/10	Q4 09/10	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11
Hosp. Smokers Advice	18.6%	30.0%	42.5%	57.2%	70.9%	77.1%	76.8%	71.1%
10/11 (Target)								90%
National Avg								85%

Target: 90% **Not achieved**

74% of hospitalised smokers were offered help and advice to quit during 2010/11.

Performance was improving steadily prior to the 22 February earthquake (reaching 80% for the month of February). Unfortunately, reconfiguration of wards and departments as a result of the earthquake has split some services across multiple sites. This has disrupted hospital processes, as shown by the recent dip in performance.

The proportion of smokers identified in primary care and provided with help/advice to quit

Data unavailable

Target: 80% **Data unavailable**

The Ministry originally intended for this measure to be collected and reported through the PHO Performance Programme during 2010/11. Unfortunately, no data was made available to DHBs during the year while the Ministry reviewed the data provided by PHOs. The measure is now expected to be a health target in 2011/12.

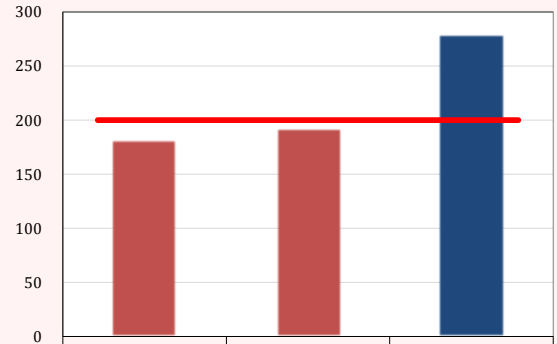
Nonetheless, activity is underway in Canterbury to support smoking cessation in primary care. All three PHOs maintain evidence-based smoking cessation programmes, and significant work has been done to engage PHOs in the smoking cessation national goal.

[20] This measure is based on the national health target of 95% for a sub-set of the total population:- people aged 16-64.

[21] This measure is a national health target, with the hospital programme beginning in 2009. Note that the graph for this measure displays quarter-by-quarter performance, rather than year-by-year.

The number of people enrolled in the Aukati Kai Paipa smoking cessation programme

Target: 200 **Achieved**

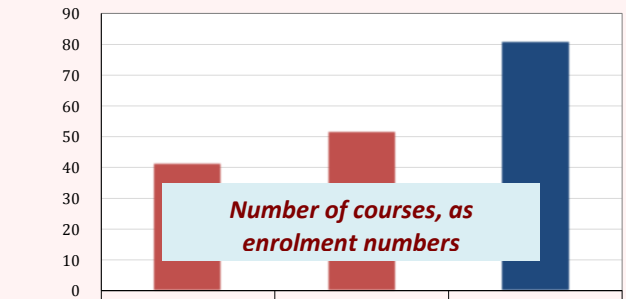


	2008/09	2009/10	2010/11
AKP enrolments	182	192	279
2010/11 (Target)			200

During 2010/11, **279** people have enrolled in Aukati Kai Paipa, surpassing the target and indicating a positive desire to quit smoking despite the stresses of the recent earthquakes.

The number of people enrolled in community-based Appetite for Life (AFL) courses[22]

Target: 540 people **Achieved**



	2008/09	2009/10	2010/11
AFL Courses	42	52	81

The original intent was to measure the number of people enrolled in AFL, but unfortunately data collection has not yet been established to this extent. Instead, the number of courses is collected and graphed on the left.

There were 81 courses in 2010/11, each of which is delivered to a group of 10 to 15 people. This equates to over 800 people – well above the target of 540.

Appetite for Life is a weight management and healthy lifestyle programme run jointly by the DHB and PHOs. It helps participants identify habits that have led to their weight gain and to make small, positive lifestyle changes.

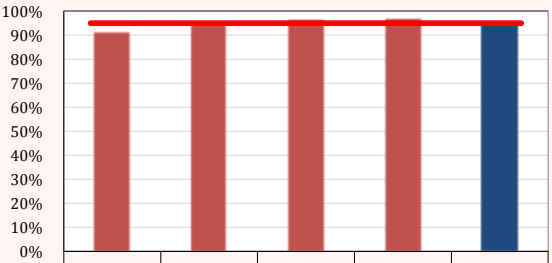
Screening, Early Detection and Intervention Services

Aim: More people are seen and treated early

Associated Output Measures

The percentage of the adult (20-64) population enrolled with a Primary Health Organisation[23]

Target: >95% **Achieved**



	2006/07	2007/08	2008/09	2009/10	2010/11
20-64 % in PHO	91.8%	94.9%	96.7%	97.2%	95.6%
2010/11 (Target)					95.0%

291,545 people aged 20-64 are enrolled with a PHO, equating to **95.6%** PHO enrolment for this age group.

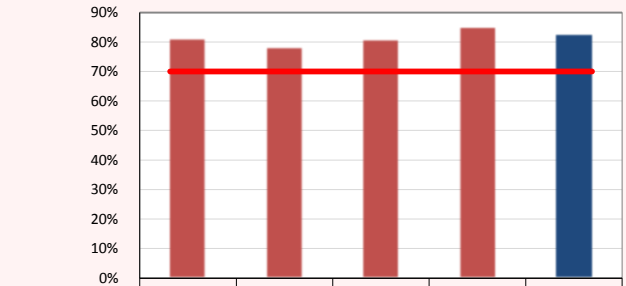
Though lower than in previous years, this meets the 95% target despite the significant impact of the earthquakes on PHO enrolment. Many people have been displaced from their homes and consequently also from their general practices. Establishing and stabilising the enrolled population remains a major focus post-quake, with primary care working to re-engage displaced populations.

[22] The 2008/09 baseline published in the SOI was an estimate based on the number of courses and the average number of participants per course. The actual number of people enrolled in AFL is notable to be captured, so courses are graphed instead.

[23] The national target for PHO enrolments across the country is 95%, and the aim is to continue to achieve above this level in Canterbury. The 2008/09 figure differs from the one previously published, as it has been recalculated following a subsequent update in population forecasts.

The proportion of the eligible population (45-69) receiving breast screen examinations[24]

Target: >70% **Achieved**



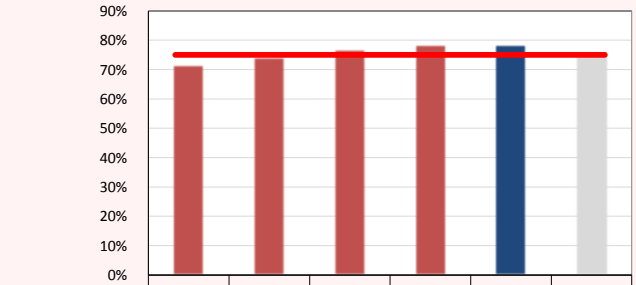
	2006/07	2007/08	2008/09	2009/10	2010/11
% Breast Screening	81.2%	78.4%	81.0%	85.0%	82.7%
2010/11 (Target)					70.0%

Canterbury is surpassing the 70% national target for breast screening, with **82.7%** coverage.

While coverage has decreased somewhat following the earthquakes, Canterbury still remains significantly above the national average of for all ethnicities, with 85.2% of Māori (vs. 58.7% nationally), 72.0% of Pacific (vs. 67.3% nationally) and 82.7% of other (vs. 71.6% nationally) eligible women screened.

The proportion of the eligible population (20-69) receiving cervical cancer screens[25]

Target: >75% **Achieved**



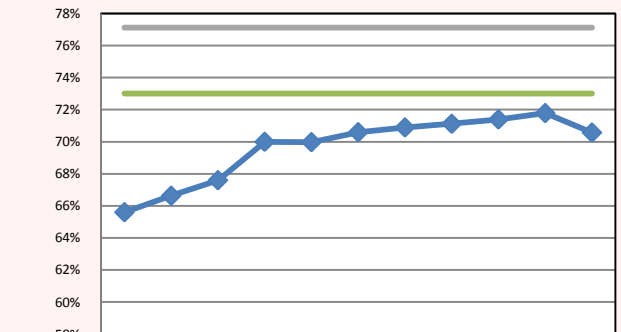
	2006/07	2007/08	2008/09	2009/10	2010	National Average
% Cervical Screening	72.0%	74.4%	77.1%	78.5%	78.5%	76.2%
2010/11 (Target)						75.0%

Canterbury is surpassing the 75% coverage required by the National Cervical Screening Programme, with **78.5%** coverage in 2010.

Canterbury's cervical screening health promotion team (which includes Māori, Pacific and Asian health promoters) educates, recruits and retains women into the programme through avenues such as community events, shopping malls, community groups, sports groups and church groups in both Canterbury and South Canterbury.

HEALTH TARGET: The proportion of eligible population (35-79) having a fasting lipid/glucose test every 5 years[26]

Target: 73% **Not achieved**



	Q1 08/09	Q2 08/09	Q3 08/09	Q4 08/09	Q1 09/10	Q2 09/10	Q3 09/10	Q4 09/10	Q1 10/11	Q2 10/11	Q3 10/11
CVD Test	65.6%	66.6%	67.6%	70.0%	70.0%	70.6%	70.9%	71.1%	71.4%	71.8%	70.6%
10/11 (Target)											73%
National Avg											77%

At **70.6%**, the percentage of the eligible population receiving a fasting lipid/glucose test every 5 years as at the end of March 2011 is 2.4% short of target.

As can be seen in the graph, prior to the February earthquake, Canterbury was making steady progress toward achieving the CVD target. However, the February earthquake displaced many people from their general practices, and shifted primary care focus to more acute issues and reestablishment of damaged infrastructure immediately following the quake, rather than programmes focusing on ongoing management and care.

Stabilising general practice remains a clear focus, and recovery is being closely monitored, with increasing efforts to ensure people with CVD are provided with care in the post-recovery phase.

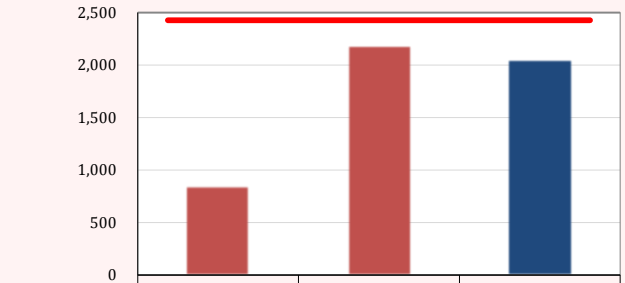
[24] Data from BreastScreen Aotearoa is subject to mixed availability; therefore, 09/10 data is up to April 2010 and 10/11 data is up to May 2011. Standards are based on national targets; Canterbury aims to continue to deliver at a level above these national targets and the national average.

[25] Due to recent delays in data availability, cervical screening data is not yet available for the second half of the 2010/11 year; therefore, figures for the 2010 calendar year are graphed above. Prior figures are graphed for financial years. Standards are based on national targets; Canterbury aims to continue to deliver at a level above these national targets and the national average.

[26] Note that the graph for this measure displays quarter-by-quarter performance, rather than year-by-year.

The number of skin lesions (skin growths, including cancer) removed in primary care, without the need for a hospital appointment[27]

Target: 2,428 **Not achieved**



	2008/09	2009/10	2010/11
Skin Lesions	857	2188	2045
2010/11 (Target)			2428

2,045 people had skin lesion excisions from GPs in the community, without the need for a hospital visit, during 2010/11.

While delivery is down from last year and short of target, this is most likely due to the significant disruption to general practices as a result of the recent earthquakes.

The skin lesion excision training programme for GPs continues to be well utilised, with new GPs trained to perform these procedures.

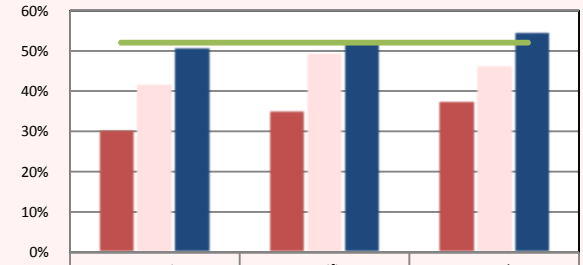
Conditions Management Services

Aim: Fewer people need hospital care

Associated Output Measures

HEALTH TARGET: The proportion of the expected population with diabetes, receiving diabetes annual reviews[28]

Target: **Māori 44%** **Achieved**
Pacific 40% **Achieved**
Total 52% **Achieved**



	Maori	Pacific	Total
2008/09	30.7%	35.5%	37.7%
2009/10	41.8%	49.4%	46.4%
2010/11	51.0%	52.6%	54.7%
Target			52.0%

Despite the considerable disruptions to primary care as a result of the earthquakes, **54.7%** of the population expected to have diabetes received an annual review.

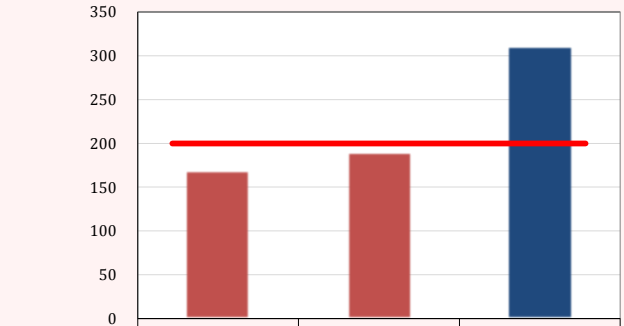
This achievement was the result of the combined efforts of primary care and the Diabetes Centre. The results also show improved equity of access, with the largest increase in diabetes annual reviews amongst the Māori population.

[27] The 2008/09 figure is for seven months, as data was not collected prior to December 2008. Data includes subsidised GP skin lesion removals only.

[28] Diabetes data is reported to the DHB by individual PHOs and the Diabetes Centre for the full financial year.

The number of integrated clinical pathways implemented across primary/secondary care

Target: 200 **Achieved**



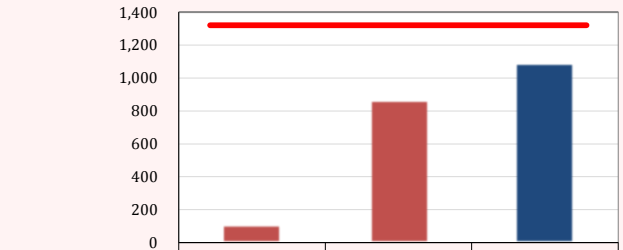
	2008/09	2009/10	2010/11
Health Pathways	168	189	310
2010/11 (Target)			200

At the end of June 2011, there were **310** pathways live on the HealthPathways website. This is a large increase of 121 pathways.

These pathways inform consistent, patient-centred care. The HealthPathways website contains information and resources specifically to help Canterbury general practice navigate the established pathways, including information on referrals, specialist advice, diagnostic tools, GP to GP referral and GP procedure subsidies.

The number of spirometry tests delivered in the community

Target: 1,320 **Not achieved**



	2008/09	2009/10	2010/11
Community Spirometry	109	859	1085
2010/11 (Target)			1320

1,085 spirometry tests were delivered in the community in 2010/11 without the need for a hospital visit.

Although short of target, primary care was subject to considerable disruption as a result of the earthquakes, and this is still a significant increase in access to this diagnostic compared to last year.

Spirometry is a tool for measuring lung function; 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

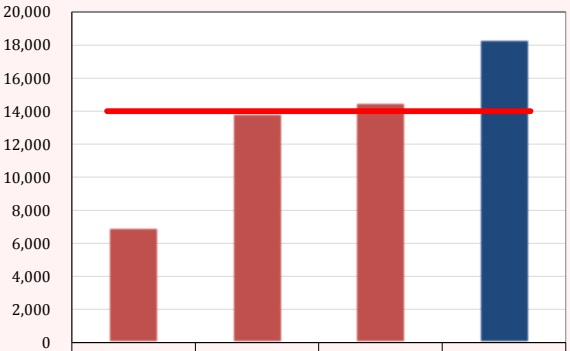
Target: 1,020 **Not achieved**

	2008/09	2009/10	2010/11
Sleep Assessments	65	527	679
2010/11 (Target)			1020

679 sleep assessments were delivered in the community in 2010/11 without the need for a hospital visit. Although short of the target, this is still an improvement in access to this diagnostic compared to last year.

The number of general practices referring for a community based sleep assessment has dropped in the months following the February earthquake, and uptake is expected to improve as general practices and their populations recover from the quake.

The number of urgent care episodes managed in primary care[29]



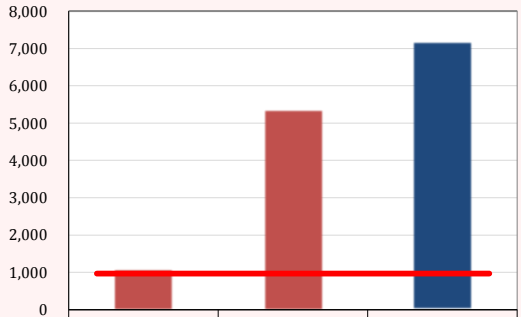
	2007/08	2008/09	2009/10	2010/11
ADMS Referrals	6939	13857	14513	18323
2010/11 (Target)				14000

Target: 14,000 **Achieved**

18,323 urgent care episodes were managed in primary care during 2010/11 – a large increase on both 2009/10 and the target. This equates to approximately 3 wards of inpatient activity had these patients been admitted to hospital, representing a significant increase in our health system's capacity.

Canterbury's Acute Demand Management Services have been expanded following the February earthquake to increase community capacity to manage acutely unwell patients in the community or at home and reduce demand on quake-constrained hospitals.

The number of people (aged 20-64) accessing mental health services in the community or through primary care (outside hospital and specialist services)[30]



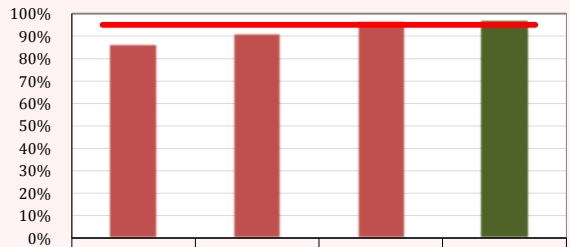
	2008/09	2009/10	2010/11
Prim/Comm Based MH	1116	5353	7189
2010/11 (Target)			968

Target: ≥968 **Achieved**

In 2010/11, **7,189** people aged 20-64 have accessed mental health services in the community or through primary care – significantly surpassing target.

The expansion of GP liaison, Brief Intervention Co-ordination (BIC) and other community-based mental health services has resulted in increasing numbers of people accessing mental health services in the community, without needing a referral to hospital.

The proportion of long-term mental health clients (aged 20-64) with current relapse prevention plans[31]



	2007/08	2008/09	2009/10	2010/11
% with plan	87%	91%	97%	97%
2010/11 (Target)				95%

Target: 95% **Achieved**

Despite significant damage and disruption to the Canterbury DHB's Specialist Mental Health Services as a result of the February earthquake, **97%** of long-term adult clients have current relapse prevention and resiliency plans in place – surpassing the target.

Prior to the earthquake (at the end of December 2010), 99% of long-term adult clients had current plans in place.

[29] Refers to general practice, ED and ambulance referred admission avoidable packages of care which allow people who would otherwise require a hospital admission to be treated in their own homes or community. Previously published 2008/09 figures had a transcription error; the final two digits were accidentally transposed, but have been corrected here.

[30] The DHB has recently begun to collect NHI level data from community providers to enable improved monitoring of mental health service delivery across the whole health system. The number of providers who submit this reporting is gradually increasing; therefore, previous years' data is not directly comparable, as it includes fewer providers' data. As data collection has improved, additional data has been captured; therefore, the 2008/09 figure differs from the one previously published. Data excludes people who also attended Specialist Mental Health Services during the period.

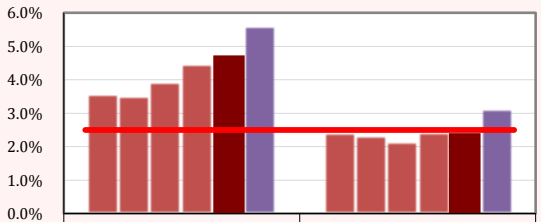
[31] The 2008/09 figure differs from the one previously published because of a change in national reporting practice. Previously, mental health clients receiving only addictions services were excluded, but now they are included, so past years' figures have been recalculated accordingly.

Complex Support Services

Aim: Fewer untimely deaths

Associated Output Measures

Access rates for specialist mental health services (SMHS) for adults (20-64)[32]



	Maori	Total
2006/07	3.5%	2.4%
2007/08	3.5%	2.3%
2008/09	3.9%	2.1%
2009/10	4.5%	2.4%
2010/11	4.7%	2.4%
National Average	5.6%	3.1%
2010/11 (Target)		2.5%

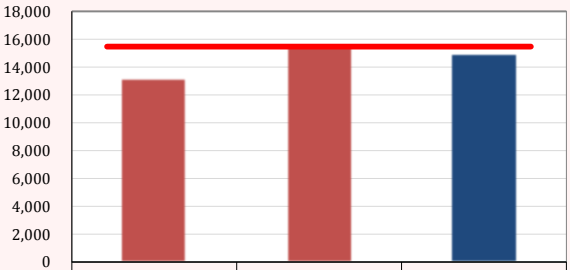
Target: 2.5% **Substantially achieved**

Over the 12 months to March 2011, **2.4%** of adults (aged 20-64) accessed SMHS – just 0.1% short of target for total access.

Having lower specialist access rates actually reflects several positive changes in Canterbury. Clients accessing specialist services are now being seen more often, and closer working relationships have been developed with community service providers, so that more people remain under GP or NGO care with support from SMHS, rather than accessing secondary services.

The lower rates also reflect the impact of the earthquakes. Due to significant facility damage and the nature of the events, there was a shift in focus of service provision to primary and community care.

HEALTH TARGET: The number of elective surgical services discharges provided.[33]



	2008/09	2009/10	2010/11
Electives	13,240	15,636	14,974
2010/11 (Target)			15,478

Target: 15,478 **Substantially achieved**

Canterbury delivered **14,974** elective surgical discharges this year.

Prior to the February earthquake, we were on track to meet this target. However, the quake caused major damage and disruption to Canterbury facilities and services, which has had a significant impact on our ability to deliver elective surgical services.

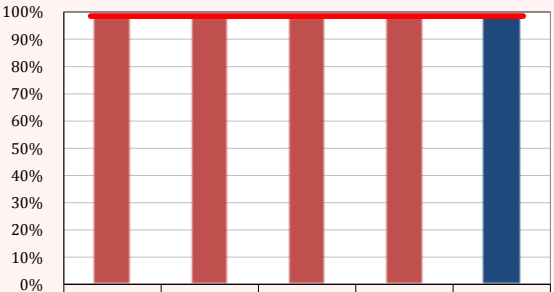
Despite this considerable disruption, Canterbury has still delivered 96.7% of the original target, coming in just 504 discharges short – a significant achievement under the circumstances.

[32] This national indicator measures the percentage of people residing in Canterbury (i.e. excluding those from other DHBs) who are seen by SMHS per year, reported a quarter in arrears (i.e. 2010/11 figures are for the 12 months to March 2011).

[33] Elective surgical discharge volumes are based on the national health target and exclude elective cardiology and dental.

The proportion of people provided with a first specialist assessment within 6 months of referral (ESPI 2)[34]

Target: >98.5% **Achieved**

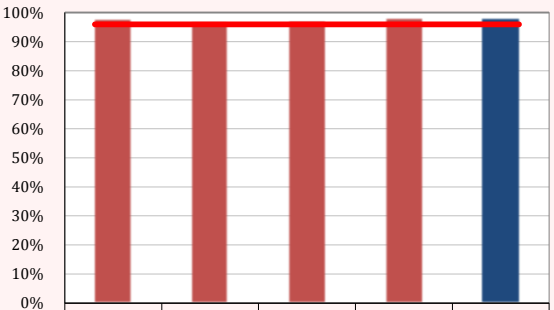


	2006/07	2007/08	2008/09	2009/10	2010/11
ESPI 2	99.4%	99.3%	98.9%	99.1%	99.2%
2010/11 (Target)					98.5%

99.2% of patients waited less than six months for their first specialist assessment in 2010/11 – surpassing the target and national requirements – despite the challenges presented by the earthquakes.

The proportion of people given a commitment, who are treated within 6 months (ESPI 5)[34]

Target: >96% **Achieved**

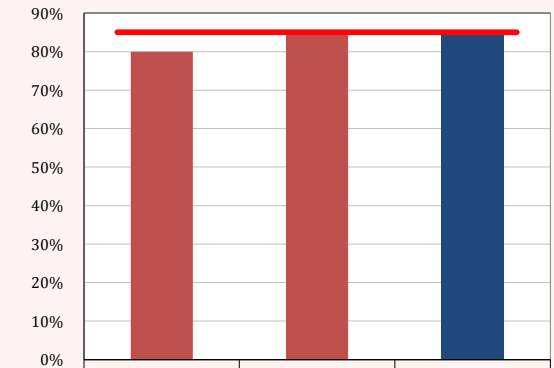


	2006/07	2007/08	2008/09	2009/10	2010/11
ESPI 5	98.1%	97.2%	97.4%	98.4%	98.0%
2010/11 (Target)					96.0%

98.0% of patients waited less than six months for treatment in 2010/11 – surpassing the target and national requirements – despite the challenges presented by the earthquakes.

The proportion of people provided with acute surgery within 24 hours

Target: 85% **Substantially achieved**



	2008/09	2009/10	2010/11
Acute Surgery <24hr	80.0%	84.9%	84.5%
2010/11 (Target)			85.0%

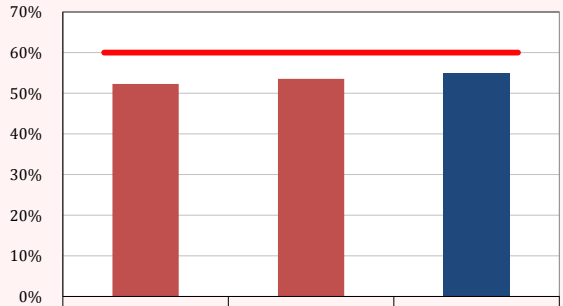
84.5% percent of people requiring acute surgery received it within 24 hours during 2010/11.

Results have been significantly impacted by the ongoing earthquakes, which have increased demand and stretched resources. Additional pressure has been placed on services because of reduced beds as a result of the earthquakes. To alleviate some of this pressure, acute surgical access for services such as Orthopaedics has recently been redesigned to assist timely access to acute theatres, leaving us just 0.5% short of target. This is a strong achievement under the circumstances.

[34] Elective Service Patient Flow Indicators (ESPIs) are measures of system performance at eight critical points, a full explanation of which can be found on the Ministry of Health website www.moh.govt.nz. The ESPI measures are based on national targets, the aim being to deliver at a level above these national targets (current national targets are ≥ 98% for ESPI 2 and ≥95% for ESPI 5).

The percentage of elective and arranged surgery undertaken on a daycase basis[35]

Target: 60% **Not achieved**



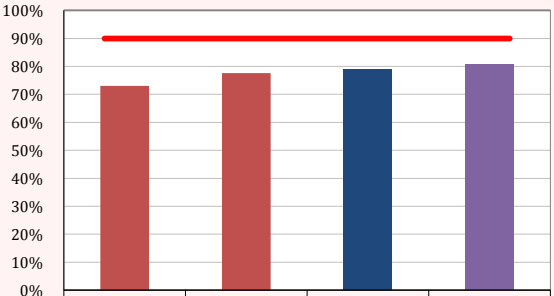
	2008/09	2009/10	2010/11
Day Surgery %	52.3%	53.6%	54.9%
2010/11 (Target)			60.0%

54.9% of elective and arranged surgery in Canterbury was undertaken on a daycase basis during 2010/11.

Though short of target, this is an improvement on previous years and ensures that patients receive surgery with a minimum of disruption to their daily lives and the ability to recover in their own homes where clinically appropriate.

The proportion of people receiving elective or arranged surgery on the day of admission[35]

Target: 90% **Not achieved**



	2008/09	2009/10	2010/11	National Average
DOSA %	73.0%	77.6%	79.0%	80.8%
2010/11 (Target)				90.0%

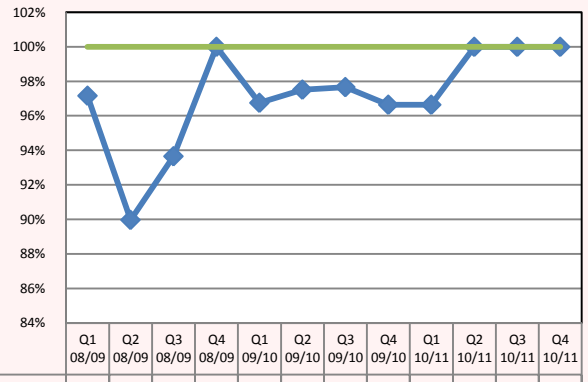
At **79%**, the rate of day of surgery admission (DOSA) is below target, but an improvement on previous years.

Canterbury's overall rate is affected by specialties with lower DOSA rates such as Cardiothoracic and Neurosurgery, which have a large proportion of out of town patients and complicated procedures requiring significant pre-op work.

[35] The Ministry introduced these national indicators for all DHBs in 2010/11. The figures here are Ministry data, and the 2010/11 figure is for the year up to and including 31 March 2011, as this was the most recent data available. The 2008/09 figure for OS6 differs from the one previously published as a result of the ongoing Ministry refinement of this data.

HEALTH TARGET: The proportion of people provided with radiation oncology treatment, within 6 weeks of decision to treat[36]

Target: 100% **Substantially achieved**



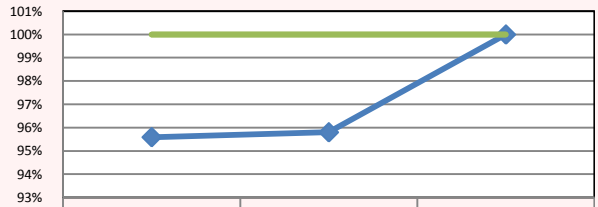
	Q1 08/09	Q2 08/09	Q3 08/09	Q4 08/09	Q1 09/10	Q2 09/10	Q3 09/10	Q4 09/10	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11
6 Weeks	97.2%	90.0%	93.7%	100%	96.8%	97.5%	97.7%	96.6%	96.6%	100%	100%	100%
10/11 (Target)												100%

Despite the significant earthquakes and ongoing aftershocks, which have caused significant disruption to the service and its machinery, Canterbury has reduced waiting times for radiation therapy and come in just 1% off achieving this target.

99% of patients met the health target of 6 weeks from First Specialist Assessment to start of treatment in 2010/11. Though Canterbury's performance is 1% short of target, this result relates to 10 patients in July 2010, and no Canterbury patient has waited more than 6 weeks since.

HEALTH TARGET: The proportion of people provided with radiation oncology treatment, within 4 weeks of decision to treat[36]

Target: 100% **Not achieved**



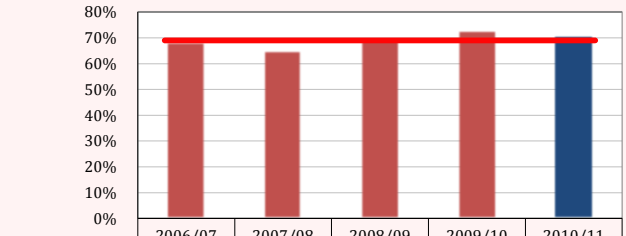
	Q2 10/11	Q3 10/11	Q4 10/11
4 Weeks	95.6%	95.8%	100%
10/11 (Target)			100%
National Avg			100%

From September 2010 to June 2011, **97.3%** of patients received treatment within four weeks. Wait times have continued to reduce, with 100% of patients meeting the four week target in the fourth quarter. This was consistent with the national average for the fourth quarter, which also reached 100%.

Canterbury's long-term focus remains on increasing core capacity and increasing efficiency through lean thinking and process redesign to ensure prompt treatment. A new linear accelerator has recently been installed and is expected to become clinical within a few months.

[36] The measure does not include instances in which a patient chooses to wait for treatment or there are clinical reasons for delay. It includes 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. The national health target changed from 6 weeks to 4 in December 2010, with data capture against the four week target beginning in September 2010. The graph for this measure displays quarter-by-quarter performance, rather than year-by-year. One patient missed the 4 week target by 3 days in quarter 4. However, this was not a capacity issue; it was the direct result of the 13 June aftershocks.

The percentage of people admitted to stroke rehabilitation services after an acute event[37]



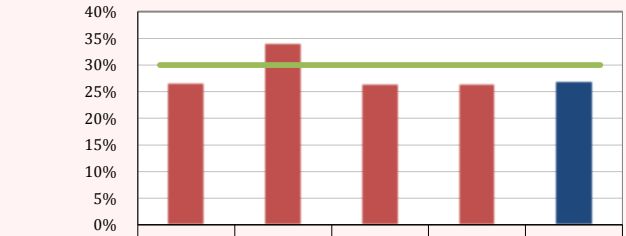
	2006/07	2007/08	2008/09	2009/10	2010/11
% Stroke Service	68%	65%	69%	73%	71%
2010/11 (Target)					69%

Target: ≥69% **Achieved**

71% of people who had a stroke were subsequently admitted to an organised stroke service in the first nine months of 2010/11, which is 2% above target.

Loss of beds at Christchurch Hospital due to the February earthquake has led to the splitting of wards across two hospital sites. While patients continue to be rehabilitated after a stroke, the splitting of wards has interfered with data capture, so it is not possible to report data for the last three months of 2010/11.

The percentage of people admitted to cardiac rehabilitation services after an acute event[38]



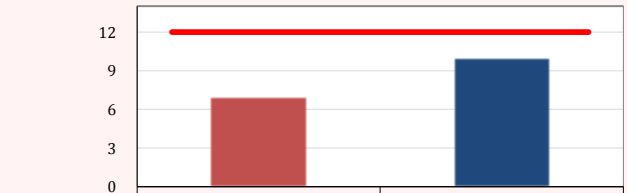
	2006/07	2007/08	2008/09	2009/10	2010/11
% Cardiac Rehab	27%	34%	27%	27%	27%
2010/11 (Target)					30%

Target: ≥30% **Substantially achieved**

The percentage of people enrolled for cardiac rehabilitation has been maintained at **27%**, despite an increase in cardiac events following the earthquakes.

While short of target, this shows significant staff effort in the face of earthquake-related challenges; in the six months including December 2010 (prior to the February earthquake), performance was on target at 31%.

The number of pulmonary rehabilitation programmes provided in the community[39]



	2009/10	2010/11
Pulmonary Rehab	7	10
2010/11 (Target)		12

Target: 12 **Substantially achieved**

While 12 community pulmonary rehabilitation programmes were started during 2010/11, two had to be abandoned as a result of the February earthquake – putting the total number of completed programmes for the year at **10**.

While short of target because of the earthquake, this is nonetheless an clear increase in community based access to this service compared to last year. Exercise classes support these programmes, assisting patients to maintain the benefits.

[37] Princess Margaret Hospital data is included from Q3 09/10 (it was not captured previously). Data for 2010/11 is for the first three quarters only, as data capture was compromised by the splitting of wards across two sites post-quake.

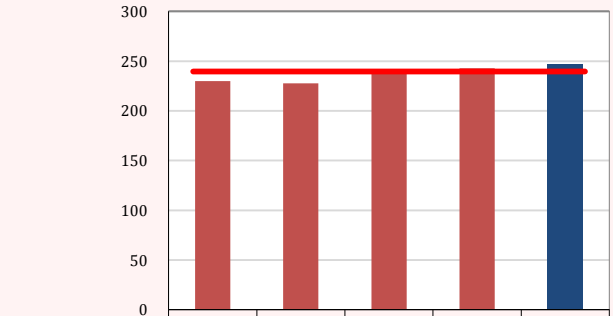
[38] The data includes those enrolled with the Māori Cardiac Outreach programme run at Rehua Marae, with the Christchurch Hospital Cardiac Rehabilitation Programme run primarily in the Canterbury Horticultural Hall and (historically) through the Heart Guide Aotearoa pilot.

[39] To ensure consistency, programmes are counted based on the financial year in which they were completed (e.g. programmes 8 and 9 commenced in 2009/10 but finished in 2010/11; therefore, they are counted as being provided in 2010/11). This measure counts only those programmes delivered in community settings and therefore excludes programmes that are run by Canterbury DHB's Hospital and Specialist Services.

OLDER PEOPLE'S HEALTH SERVICES

Impact Measures (medium-term measures of quality and effectiveness)

The proportion of older people aged 65+ having an unplanned acute admission.



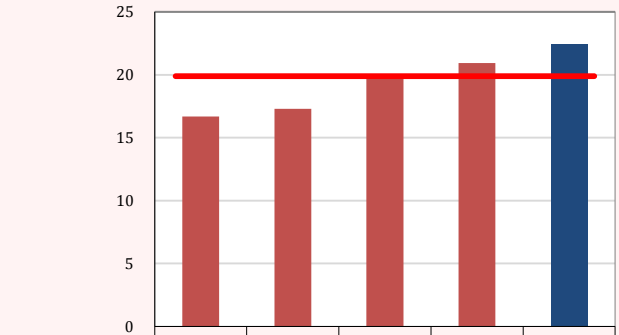
	2006/07	2007/08	2008/09	2009/10	2010/11
DSR Acute Admits 65+	229.8	227.8	239.6	242.8	247.2
2010/11 (Target)					239.6

Target: 239.6 per 100,000 **Not achieved**

Unplanned acute admissions for older people (aged 65+) have risen to a directly standardised rate of **247.2** per 10,000 during 2010/11. This is primarily the result of the earthquakes, with the months associated with the two major earthquakes (September and February) having much higher than usual acute admissions.

This is a medium-term impact measure, as keeping older people well and out of hospital requires engagement across the whole of the health system and will therefore be affected by many of the new programmes being introduced, which are measured in the following pages.

The proportion of older people aged 65+ being admitted to hospital as a result of a fall.



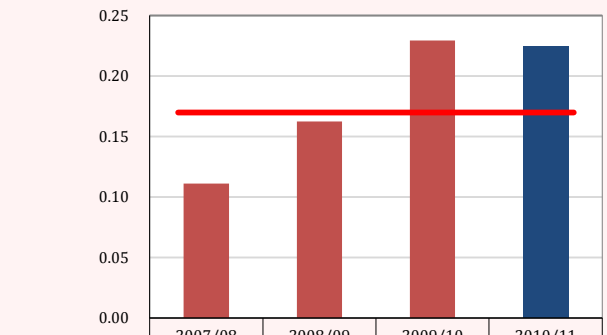
	2006/07	2007/08	2008/09	2009/10	2010/11
DSR Fall Admits 65+	16.7	17.3	19.9	20.9	22.4
2010/11 (Target)					19.9

Target: 19.9 per 100,000 **Not achieved**

Admissions to hospital as a result of a fall amongst older people (aged 65+) continue to rise, with a directly standardised rate of **22.4** per 10,000 in 2010/11.

However, performance against this medium-term impact measure is expected to improve with the new integrated falls prevention service that has been established to help reduce falls in the community and has supported 601 older people during 2010/11. Falls prevention in our hospitals is also a key area of focus.

The rate of SAC 1&2 (serious) incidents in our Hospital and Specialist Services for people 65+.[40]



	2007/08	2008/09	2009/10	2010/11
SAC 1 & 2 Incidents	0.11	0.16	0.23	0.22
2010/11 (Target)				0.17

Target: 0.17 **Achieved**

In 2010/11, the rate of reported serious incidents in Canterbury DHB Hospital and Specialist Services for people over 65 was **0.22** per 1,000 inpatient bed days.

The rate of reported SAC 1 & 2 events increased in 2009/10 and was maintained in 2010/11. This demonstrates the success of our focus during these years on open disclosure and robust systems for capturing and reporting incidents. The increase in reporting shows better transparency and willingness by our staff to learn from the event and prevent it from happening again.

This medium-term impact measure is influenced by a wide range of quality initiatives underway in our hospitals. Informed by improved reporting of incidents, we are now better able to improve systems and outcomes for patients.

[40] The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the consequence or outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. The targets are set to increase the rate of reported incidents, in line with the DHB policy of emphasising the responsibility of staff to report incidents.

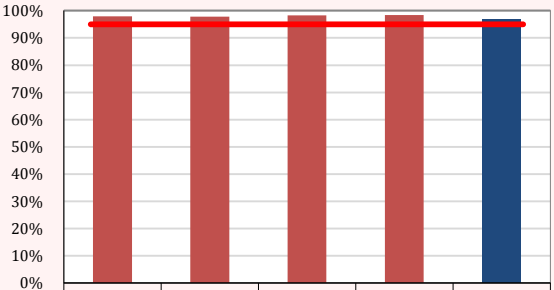
Screening, Early Detection and Intervention Services

Aim: Older people are seen and treated early

Associated Output Measures

The percentage of the population aged over 65 enrolled with Primary Health Organisations[41]

Target: >95% **Achieved**



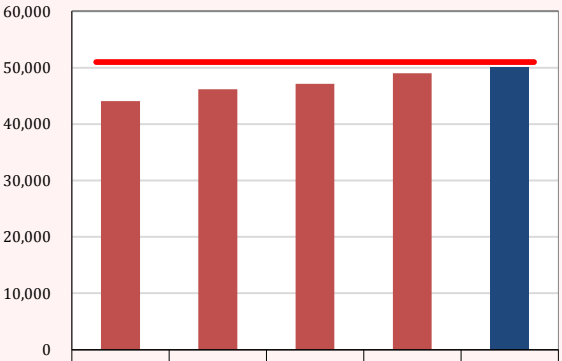
	2006/07	2007/08	2008/09	2009/10	2010/11
65+ % Enrolled	98.0%	97.9%	98.3%	98.4%	96.9%
2010/11 (Target)					95.0%

PHO enrolment among older people aged 65+ remains high at **96.9%** for 2010/11.

Though lower than in previous years, this achieves the 95% target despite the significant impact of the earthquakes on PHO enrolment. Many people have been displaced from their homes and consequently also from their general practices. Establishing and stabilising the enrolled population remains a major focus post-quake, with primary care working to re-engage displaced populations.

The number of flu vaccinations provided to people aged over 65[42]

Target: 51,000 **Substantially achieved**

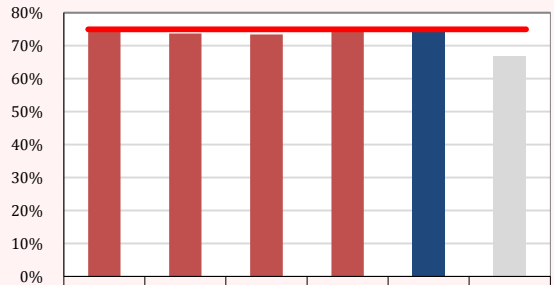


	2006	2007	2008	2009	2010
65+ Flu Vacc	44,083	46,173	47,115	48,987	50,025
2010/11 (Target)					51,000

50,025 people aged over 65 received flu vaccinations in the 2010 year. While short of target, this is 1,038 more vaccinations than were delivered in the 2009 year.

The proportion of the total population aged over 65 having received a flu vaccination[42]

Target: >75% **Substantially achieved**



	2006	2007	2008	2009	2010	National Average
65+ % Flu Vacc	74%	74%	73%	75%	74%	67%
2010/11 (Target)						75%

74% of people aged over 65 received flu vaccinations in 2010 – just short 1% of the 75% target. While the target has not been met, the result is significantly above the national average and 1,038 more vaccinations than the previous year.

The flu vaccination has been heavily promoted in Canterbury in response to our population's increased vulnerability following the earthquakes, so performance is expected to increase in 2011.

[41] The national target for PHO enrolments across the country is 95%, and the aim is to continue to achieve above this level in Canterbury. The 2008/09 figure differs from the one previously published because it has been recalculated following a subsequent update in population forecasts.

[42] The volume target is based on the number of vaccinations required to achieve 75% coverage of an enrolled population of 68,000. Data is for calendar, rather than financial, years due to reporting delays. For the same reason, flu vaccination figures for 2009 differ from those previously published, as data for the second half of 2009 was not yet available when the SOI was published.

Conditions Management Services

Aim: Fewer older people need hospital care

Associated Output Measures

The number of medication reviews provided for older people on multiple medications in primary/community settings

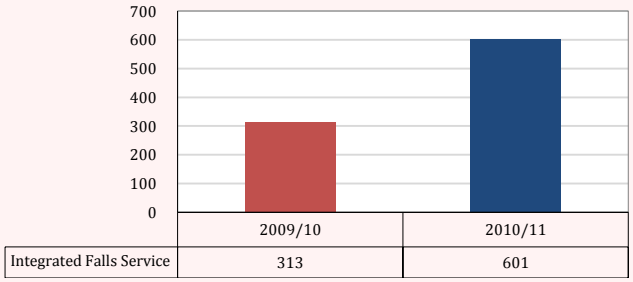
Quake-delayed

Target: 250 **Not achieved**

While delayed by the September and February earthquakes, Canterbury is about to launch the new Medication Management Service (MMS), which is a local development of Medicines Use Reviews modelled on a Waikato DHB service.

This measure refers only to the MMS programme due to be established in the community. Within hospital settings, patients aged over 65 and/or on multiple medications are already targeted for medication reviews.

The number of older people supported through the integrated falls prevention services[43]



Target: N/A

This new service has now been established, with 313 older people supported during the last six months of 2009/10 and **601** during 2010/11.

Now that the new service has been established and initial utilisation collected, the DHB will look to set targets for future years.

The number of post-discharge follow-ups provided in primary care for older people 65+

Quake-delayed

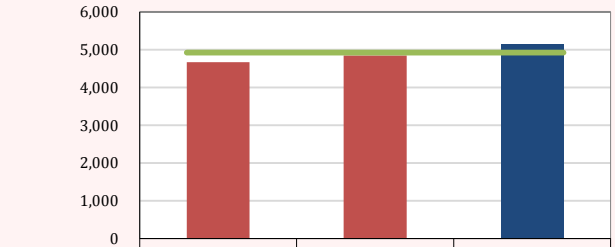
Target: 500 **Not achieved**

This new service was intended to begin in the fourth quarter of 2010/11 to provide older people with a post-discharge follow-up in general practice, rather than in a hospital setting.

However, after the February earthquake the Aged Care Work Stream reprioritised its planned initiatives, and instead accelerated the implementation of the CREST service to meet increased quake-related need for supported discharge (see 'The number of older people accessing supported discharge services after a hospital event' below). As a result, this service has not yet been initiated.

[43] As this is a new service, 2009/10 data covers only the second half of the year, from January to June 2010.

The number of assessments provided for older people with complex needs[44]



	2008/09	2009/10	2010/11
Complex Needs	4673	4853	5143
2010/11 (Target)			4923

Target: additional 250 = 4,923 **Achieved**

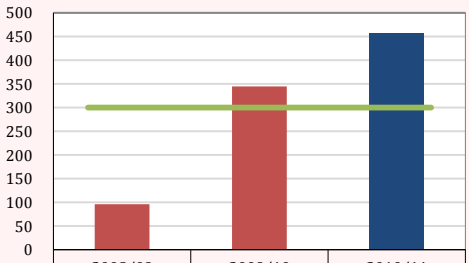
5,143 assessments were provided for older people with complex needs in 2010/11. This is an additional 470 assessments compared with 2008/09 – well above the target increase of 250.

Complex Support Services

Aim: Fewer untimely deaths

Associated Output Measures

The number of older people accessing supported discharge services after a hospital event[45]



	2008/09	2009/10	2010/11
Supported Discharge Service	96	345	457
2010/11 (Target)			300

Target: 300 **Achieved**

457 older people accessed supported discharge services after going to hospital in 2010/11, surpassing target by 157 people.

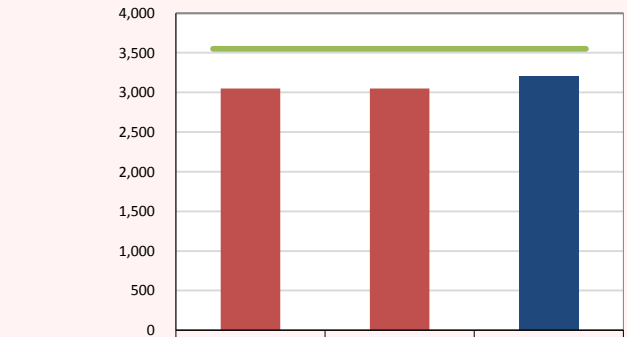
Canterbury provides a variety of supported discharge services, ranging from one-off home visits to our new CREST service, which supports older people for up to six weeks.

CREST (the Community Rehabilitation Enablement and Support Team) is a new community-based supported discharge team that facilitates earlier discharge from hospital to appropriate home-based rehabilitation services for older people. The implementation of CREST was accelerated to meet increased need following the February earthquake and launched in April 2011.

[44] This measure refers to older people with complex needs who would benefit from an enhanced care management approach from general practice, pharmacy and other allied health and social services providers.

[45] Figures include the Meet & Greet (2008/09), Check @ Home (2009/10 onward), Acute Community Liaison (October 2009 onward) and CREST (April 2011 onward) services, for those aged 65+ only.

The number of people supported in their own homes with complex packages of care (L3-5)[46]



	2008/09	2009/10	2010/11
Supported in Own Home	3050	3051	3200
2010/11 (Target)			3550

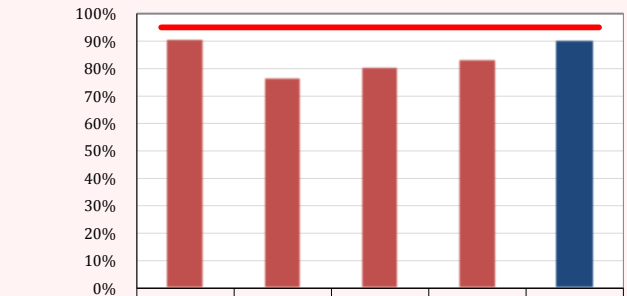
Target: additional 500 = 3,550 **Not achieved**

During 2010/11, **3,200** people have received complex packages of care to support them in their own homes. While short of target, this is an increase of 149 on the previous year.

This lower than anticipated delivery of complex packages of care actually reflects some positive changes as a result of Canterbury's implementation of our restorative model. This approach supports older people to regain their independence and achieve their goals, so that they require less complex packages of care.

Many older people are now also being supported instead through our new CREST service (166 in its first three months) or our expanded acute demand packages of care.

HEALTH TARGET: The proportion of people (65+) assessed, treated or discharged from ED in under six hours[47]



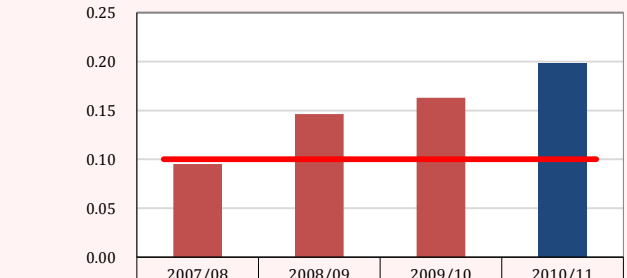
	2006/07	2007/08	2008/09	2009/10	2010/11
65+ % 6hrs	90.8%	76.7%	80.7%	83.6%	90.6%
2010/11 (Target)					95.0%

Target: 95% **Not achieved**

During 2010/11, **90.6%** of older people in Canterbury were assessed, treated or discharged from ED in under six hours. While short of target, this is a substantial 7% improvement on 2009/10.

People over 65 are more likely to have more complex conditions, and as a result tend to take longer to assess and treat. The DHB is focused on further improving performance for this age group.

The rate of SAC 1&2 (serious) patient falls in hospital for older people aged over 65[48]



	2007/08	2008/09	2009/10	2010/11
SAC 1 & 2 Falls	0.10	0.15	0.16	0.20
2010/11 (Target)				0.10

Target: <0.10 **Not achieved**

The rate of reported serious falls for people over 65 in Canterbury DHB hospitals has risen to **0.20** per 1,000 inpatient bed days.

A Clinical Board-led Patient Falls Initiative is currently taking place to reduce the number of patient falls and minimise harm. To date, the initiative has focused on raising awareness of falls prevention and falls risk across hospitals and primary care. This heightened awareness could account for some of the increase in reporting of falls. The increase in the number of events being reported shows willingness by our staff to learn from the event and prevent it from happening again.

[46] Packages of care (L3-5) refer to clients receiving an allocation of respite, carer support, day care or personal care services for greater than 3 hours a week. With improved care management and service delivery, older people with complex needs are able to remain in their own homes for longer.

[47] This measure is based on the national health target of 95% for a sub-set of the total population: people aged 65 and over.

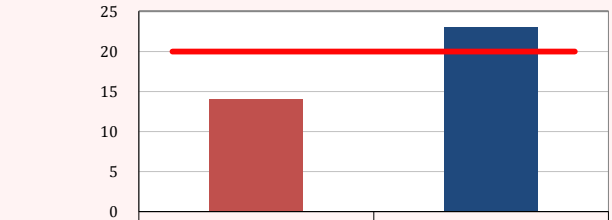
[48] The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the consequence or outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. The 2008/09 figure differs from the one previously published due to a rounding error which has since been detected and corrected.

End of Life Services

Aim: Death with dignity

Associated Output Measures

The number of Aged Residential Care (ARC) facilities trained and providing the Liverpool Care Pathway (LCP) option to residents[49]



	2009/10	2010/11
ARC Facilities	14	23
2010/11 (Target)		20

Target: 20 **Achieved**

23 ARC facilities have been trained to provide the Liverpool Care Pathway (LCP). However, five of these facilities, who had been providing the LCP prior to the earthquake, were damaged by the February earthquake and are now on hold.

The Liverpool Care Pathway is a multi-professional template for care of dying patients and their families/whānau in a variety of settings, focusing on achieving quality of life. It is underpinned by education for health professionals and has close links with specialist palliative care services.

The number of people in ARC services being supported by the Liverpool Care Pathway[49]

Data not available prior to 2010/11

Target: N/A

Approximately **109** clients were supported on the Liverpool Care Pathway during 2010/11. This number is approximate, as some files were lost as a result of the February earthquake, in which five of the sites providing the LCP were seriously damaged.

Now that the new service has been established and initial utilisation collected, the DHB will look to set targets for future years.

[49] The Liverpool Care Pathway is an international programme adopted nationally, and being piloted in Canterbury from September 2009 to August 2011. The DHB intends to monitor and assess this pilot programme and set baselines and targets for numbers of patients as the pilot evolves.

SUMMARY OF REVENUES AND EXPENSES BY OUTPUT CLASS

Group	Actual 30/06/11 $'000	Budget 30/06/11 $'000
Revenue		
0 – 19 years	192,710	191,275
20 – 64 years	580,552	567,511
65+ years	538,689	526,462
In house elimination *	93,741	88,735
Total Revenue	**1,405,692**	**1,373,984**
Expenditure		
0 – 19 years	205,726	191,790
20 – 64 years	578,912	566,021
65+ years	527,418	527,436
In house elimination *	93,741	88,735
Total Expenditure	**1,405,797**	**1,373,984**
Net Surplus / (Deficit)	**(105)**	**0**

* *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

Independent Auditor's 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 2011

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 of the financial statements and statement of service performance of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 22 to 59, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 60 to 87.

Opinion

In our opinion:

- the financial statements of the Health Board and group on pages 22 to 59:
    - comply with generally accepted accounting practice in New Zealand; and
    - fairly reflect the Health Board and group's:
        - financial position as at 30 June 2011; and
        - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board and group on pages 60 to 87:
    - complies with generally accepted accounting practice in New Zealand; and
    - fairly reflects the Health Board and group's service performance for the year ended on 30 June 2011, including:
        - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
        - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 28 September 2011. This 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 our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and statement of service performance are free from material misstatement.

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.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and

- fairly reflect the Health Board and group's service performance achievements.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you based on our audit. Our 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 (the Health Board) and group for the year ended 30 June 2011 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 28 September 2011 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.