Canterbury
District Health Board
Te Poari Hauora ō Waitaha

For the year ended
30 June 2013

Annual Report

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
Peter Ballantyne – Deputy Chair
Anna Crighton
Elizabeth Cunningham
Andrew Dickerson
Wendy Gilchrist
Aaron Keown
Chris Mene
David Morrell
Susan Wallace
Olive Webb

Chief Executive
David Meates

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2nd Floor, H Block
The Princess Margaret Hospital
Cashmere Road
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Auditor
Audit New Zealand on behalf of the Auditor-General

Banker
Westpac Banking Corporation

REPORT FROM THE CHAIR AND CHIEF EXECUTIVE

The 2012/13 financial year was characterised by some outstanding achievements against a backdrop of ongoing disruption. Quake repairs, services relocating, planning and designing new facilities have impacted and involved most staff in some way. It was another year of continuous change and challenges for the Canterbury Health System.

We celebrated the Government's announcement it had allocated around $600 million for health facility redevelopments in Christchurch. At the Burwood Health Campus we are building a new specialist facility for older people and those requiring rehabilitation. Work is underway and is due for completion in 2015. At the same time design work is underway for a state-of-the-art acute services wing at Christchurch Hospital, and that's expected to be complete in 2018. Thousands of staff and people who use our services are involved in these projects.

Canterbury DHB continues to work with rural communities to develop fit-for-purpose facilities close to where people live to house the services they use most often. Tenders for the construction of a new Integrated Family Health Centre in Kaikoura are underway; plans for a health hub in Rangiora are advanced. The Rangiora facility is expected to open in the second quarter of 2015.

New facilities are also being developed on the Ashburton Hospital site to replace quake-damaged theatres and ward areas will also be strengthened. In Akaroa, discussions with the community are ongoing to arrive at a facility solution that meets the need to be accessible and sustainable.

Integrated Family Health Centres will enable primary and community providers to provide a range of services in a way that saves peoples' time. Each IFHC will be designed to fit the needs of its community as we work to ensure the services people use most often are at the heart of the community.

Construction has become part of our health services with many other works happening across our hospital sites, including on-going repairs and construction at Hillmorton and quake repairs at The Princess Margaret Hospital.

Highlights of the year include the opening of a new Acute Medical Assessment Unit and two new wards at Christchurch Hospital, as well as the reopening of child and family mental health services at Whakatata House on Cashel Street – one of the city's few grand old buildings which was damaged by the quakes, but has been since been strengthened and restored to its former glory.

To date the cost of quake repairs is estimated to be in excess of $500 million. Repairs are not expected to be complete until 2021.

Staff, patients and visitors to our facilities have been faced with ongoing disruptions as we've had to move and decant departments to allow earthquake repair works and other construction projects to continue. More than half of all general medical services have had to be moved or experienced significant disruptions as we reconfigure services.

Canterbury DHB is playing a major role in the development of the Health Precinct. The Health Precinct is one of the cornerstone projects of Christchurch City's redevelopment. This is separate to our own redevelopment projects – the Health Precinct will bring together private and public providers and companies, including IT, infrastructure, tertiary institutes and businesses who are part of Canterbury's innovation network.

There is evidence to suggest the wellbeing of Canterbury people has been dealt a double blow – the first being the stress of the quakes themselves, and the second blow relates to the prolonged and enduring stress and physical and financial hardship many are faced with as they battle insurers and officialdom to sort out property issues.

The harmful effects of prolonged stress and uncertainty can have a profound impact on both physical and mental health. We are now seeing some of these effects, particularly among our children and young people. We continue to work closely with a range of stakeholders including other government agencies to support our communities.

Canterbury DHB has played a major role in developing a social well-being campaign to help support our communities through the tough times. The AllRight? Campaign is designed to help Cantabrians think about their mental health and wellbeing and what they can do to improve it and how they can access help.

Despite multiple challenges, the Canterbury Health System has continued to achieve outstanding results and deliver world class services. This is a credit to the professionalism and people-focus of those working in our health system.

Our health system goal of providing more services closer to where people live and work, often in a person's own home, is paying dividends. Canterbury's Acute Demand Management Services accepted almost 25,374 referrals to allow people to receive urgent care in the community – avoiding a trip to Christchurch Hospital's Emergency Department.

Our vision is a Canterbury Health System that delivers a seamless flow of care, rather than a series of individual events. A system that allows the right care, in the right place, at the right time, provided by the right person.

We continue to develop services in primary care and the community that support people to stay well and take increased responsibility for their own health. In doing so we are freeing up hospital-based services to provide the necessary acute and elective care, support people who require complex hospital care and provide specialist advice to primary care providers.

HealthPathways is an online resource to aid clinicians when making decisions on the best treatment options for their patient. More than 660 pathways have been created ranging from treating genetic conditions and infectious diseases to surgical complications. It has been introduced throughout the South Island and is also being trialled in Hutt Valley DHB. Canterbury's Health Pathway system has also been picked up in Australia with a number of health authorities adopting the system.

Ongoing work with other South Island District Health Boards to improve the way services are provided across the South Island is proving successful and making substantial savings. The South Island Strategic Procurement Group and the South Island Support Service Level Alliance have been responsible for saving an estimated $50 million across the South Island over the past three years.

Canterbury DHB has staff involved in all workstreams which cover child health; health of older people; information services; mental health; quality and safety; the southern cancer network; a regional training hub and support services.

Canterbury staff have lead roles in many South Island Alliance projects which have led to improved services for people throughout the South Island. This includes a range of information services projects including e-referrals (which have been firmly embedded in Canterbury over the past year), e-Prescribing and a new Patient Administration System are all underway in the South Island to link information systems and better integrate health care.

There are a number of collaborative workforce planning initiatives, including a specialised mental health planning arm. The South Island public health partnership has set regional priorities: alcohol harm reduction, tobacco control and maximising health co-benefits from making our health system more sustainable.

Canterbury DHB has a developed innovation brand, via Innovations, and continues to work with the New Zealand Health Innovation Hub to identify ideas that will lead to improved patient outcomes and have commercial potential.

Investing in new technology and patient information systems is helping us to save patients' time. An Electronic Referral Management System has seen Canterbury's General Practitioners and Community providers make almost 113,000 requests for services, ensuring prompt care, faster diagnosis, and less time waiting.

The Canterbury Health System has reached pre-quake levels in some of the Government's health targets and achieved or even surpassed others. In the past financial year CDHB achieved over 100% of its elective surgery result. It is remarkable that Canterbury DHB has continued to perform so well in the Health Targets against the backdrop of constant disruption. This is a strong reflection of the absolute commitment from everyone working in our health system to meet the needs of our community.

It's been a challenging and remarkable year in so many ways – and we are constantly impressed by the dedication and innovation coming from those who work in the Canterbury Health System.

In 2012 we published our first set of Quality Accounts, to provide a snapshot of how we are doing. It's a people-friendly publication that focuses on a range of services and provides real life stories that demonstrate we are having a positive impact on peoples' health and well-being.

During the year The Kings Fund, a leading UK health authority, reviewed the Canterbury Health System and provided an in-depth assessment of how we were doing. They found our health system to be a global leader in developing a truly integrated health system where people are at the heart of everything we do.

The King's Fund report concluded:

- Has the Canterbury Health System been transformed? No
- Is it transforming? Yes
- Is what it is doing transformational? Certainly

The Kings Fund have ranked Canterbury among the top health care systems world-wide. This external validation is a credit to everyone in our health system.

We continue to work together towards making it better for over 500,000 people who count on us to fund and provide quality health services.

Bruce Matheson
Chair
31 October 2013

David Meates
Chief Executive
31 October 2013

BOARD MEMBERS

Bruce Matheson Chair	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 Board of Fresh Pork New Zealand. He has also held other director roles including Brannigans Ltd, 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	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 and is a member of the University of Canterbury Council.
Anna Crighton	Anna Crighton served 12 years as a Christchurch City Councillor. Anna is committed to the Canterbury DHB continually improving its health care and services especially aged care services, elective surgery and for Canterbury DHB to work closely with GPs. As an advocate for stronger communities she believes the Canterbury DHB 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, Quality, Finance Audit & Risk Committee and Hospital Advisory Committee.
Elizabeth Cunningham	Elizabeth Cunningham, who is of Ngai Tahu and Ngati Mutunga descent, is a former research manager (Māori) at the University of Otago, Christchurch School of Medicine. She has worked at all levels of the health sector, including as a health professional and a service manager, and as an advisor to Ministers of Health on Māori health issues. She is also a longstanding member of the Māori Women's Welfare League. Elizabeth is a member of the Quality, Finance Audit and Risk Committee, Community and Public Health and Disability Support Committee and Hospital Advisory Committee.
Andrew Dickerson	Andrew has 29 years experience in the health and disability sectors and is a former Chief Executive of Age Concern Canterbury. He has a strong commitment to the public health service and his interests include older person's health, cancer services, rural health, improving access to elective surgery and the promotion of healthy lifestyles and disease prevention. Andrew supports health research and is the Chairman of the Canterbury Healthcare of the Elderly Education Trust. Andrew is committed to improving accountability and transparency in our public health services.

Wendy Gilchrist	Wendy is an active 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 and the CERA Community Forum. Post the Christchurch earthquakes Wendy established the Victoria Streetscape Project in response to stakeholder concern to avoid ad hoc redevelopment in the area.
Aaron Keown	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 Canterbury DHB decisions.
Chris Mene	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 11 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, Chair of the Hospital Advisory Committee and was previously Chair of Brackenridge Estate Ltd, one of Canterbury DHB's two subsidiary companies.
Susan Wallace	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 Māori 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 36 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 Community and Public Health and Disability Support Committee. She is committed to rural health issues and delivery, and to creating new solutions for health in post earthquake Canterbury.

WHAT ARE WE TRYING TO ACHIEVE?

The Canterbury DHB is the largest funder and provider of health and disability services in Canterbury. The decisions we make in terms of which services to fund and at what level have a significant impact on the health of our population. In achieving our mission to '*improve, promote and protect the health and wellbeing of the Canterbury community*', it is important that we understand the level of need within our population and the drivers of demand so that we can shift resources to where they are most needed to improve the health of our population and ensure the sustainability of Canterbury's health system.

This section provides an overview of the key elements of our outcomes framework, which has been agreed across all five South Island DHBs as a means of demonstrating whether we are making a positive change in the health of our collective population. The framework identifies three strategic goals or outcomes:

- PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH: The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing.

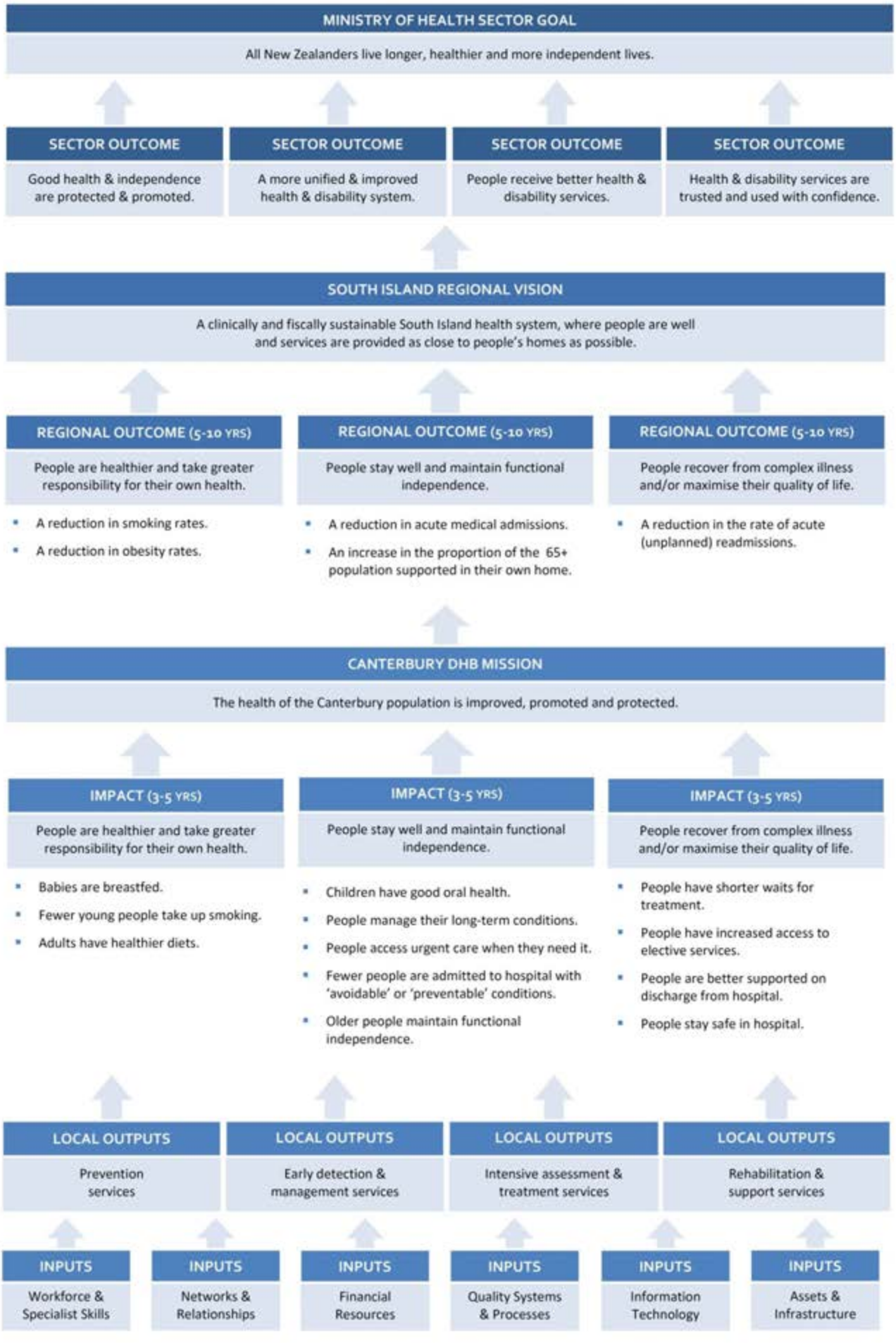
- PEOPLE STAY WELL AND MAINTAIN FUNCTIONAL INDEPENDENCE: The development of primary and community-based services that provide early diagnosis and treatment and support to better manage enduring health conditions, reduce the complications of disease and injury and maintain functional independence in their own homes and communities.

- PEOPLE RECOVER FROM COMPLEX ILLNESS AND/OR MAXIMISE THEIR QUALITY OF LIFE: The development of systems and models of care that free up secondary and specialist resources to provide timely and appropriate complex care and advice to reduce the progression of illness, better support people's functional capacity and improve people's quality of life.

These long-term outcomes will be achieved not just through the work of the DHB alone, but through the combined effects of the whole of the Canterbury health system, central and local government and our regional DHB partners.

The intervention logic diagram on the following page visually demonstrates how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired regional outcomes and the overarching sector goals of Government.

Intervention logic provides both a framework for the way we approach our work and a means of monitoring and demonstrating our success. Strategies and outcome logic are continuously refined across all the main areas of activity to ensure that the DHB has a good understanding of what action is being taken and how effective these interventions have been.


MINISTRY OF HEALTH SECTOR GOAL
All New Zealanders live longer, healthier and more independent lives.
SECTOR OUTCOME
Good health & independence are protected & promoted.
SECTOR OUTCOME
A more unified & improved health & disability system.
SECTOR OUTCOME
People receive better health & disability services.
SECTOR OUTCOME
Health & disability services are trusted and used with confidence.
SOUTH ISLAND REGIONAL VISION
A clinically and fiscally sustainable South Island health system, where people are well and services are provided as close to people's homes as possible.
REGIONAL OUTCOME (5-10 YRS)
People are healthier and take greater responsibility for their own health.
A reduction in smoking rates.
A reduction in obesity rates.
REGIONAL OUTCOME (5-10 YRS)
People stay well and maintain functional independence.
A reduction in acute medical admissions.
An increase in the proportion of the 65+ population supported in their own home.
REGIONAL OUTCOME (5-10 YRS)
People recover from complex illness and/or maximise their quality of life.
A reduction in the rate of acute (unplanned) readmissions.
CANTERBURY DHB MISSION
The health of the Canterbury population is improved, promoted and protected.
IMPACT (3-5 YRS)
People are healthier and take greater responsibility for their own health.
Babies are breastfed.
Fewer young people take up smoking.
Adults have healthier diets.
IMPACT (3-5 YRS)
People stay well and maintain functional independence.
Children have good oral health.
People manage their long-term conditions.
People access urgent care when they need it.
Fewer people are admitted to hospital with 'avoidable' or 'preventable' conditions.
Older people maintain functional independence.
IMPACT (3-5 YRS)
People recover from complex illness and/or maximise their quality of life.
People have shorter waits for treatment.
People have increased access to elective services.
People are better supported on discharge from hospital.
People stay safe in hospital.
LOCAL OUTPUTS
Prevention services
LOCAL OUTPUTS
Early detection & management services
LOCAL OUTPUTS
Intensive assessment & treatment services
LOCAL OUTPUTS
Rehabilitation & support services
INPUTS
Workforce & Specialist Skills
INPUTS
Networks & Relationships
INPUTS
Financial Resources
INPUTS
Quality Systems & Processes
INPUTS
Information Technology
INPUTS
Assets & Infrastructure

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

We have identified measures related to each of the three strategic outcomes outlined on page 9. Given the long-term nature of these 'outcome' measures (5-10 years in the life of the health system), our aim is to make a measurable change over time rather than achieve a fixed target.

We also have a set of medium-term (3-5 years) 'impact' measures, where individual DHB performance can have a measureable impact to the longer-term outcomes we are seeking. These reflect areas of activity where the DHB can influence change and help to demonstrate the difference we are making in the health of the Canterbury population. Because change will be evident over a shorter period of time, these impact measures are our 'main measures' of performance; we have set local targets against them in order to evaluate the impact of service delivery over a three-year period.

This section provides an update on our progress against these measures. Results are broken down by ethnicity wherever possible to assess our impact on Māori and Pacific health and reducing inequalities.

Overall, these indicators would suggest the health status of the Canterbury population has improved over the past year. In particular, smoking rates are reducing, acute medical admissions have stayed low, fewer older people are being admitted to hospital as a result of a fall, and mental health services are better integrated. These results are heartening considering the exceptional circumstances under which the health system has been operating and the environment in which our population has been living.

PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH.

LONG-TERM OUTCOME MEASURES

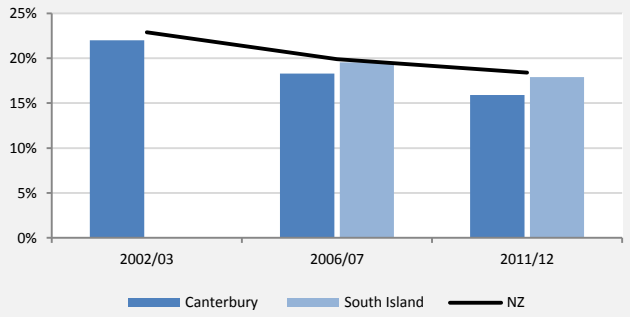
A reduction in smoking rates.

Canterbury's smoking rates continue to decline, with the 2011/12 New Zealand Health Survey finding that just 16% of our population smoke – down from 18% in 2006/07 and 22% in 2002/03. Smoking rates in Canterbury are below the national and South Island rates (both 18%).

Canterbury's success in continuing to reduce smoking prevalence can be attributed to two factors. The first is fewer young people taking up smoking – see the impact measure below for more information. The second is encouraging current smokers to quit, which we do through our ABC quit initiatives in hospitals, general practices and pharmacies, as well as ensuring access to Aukati Kaipaipa and a variety of other smoking cessation programmes.

Data sourced from the New Zealand Health Survey.[1]

The percentage of the population (aged 15+) who smoke



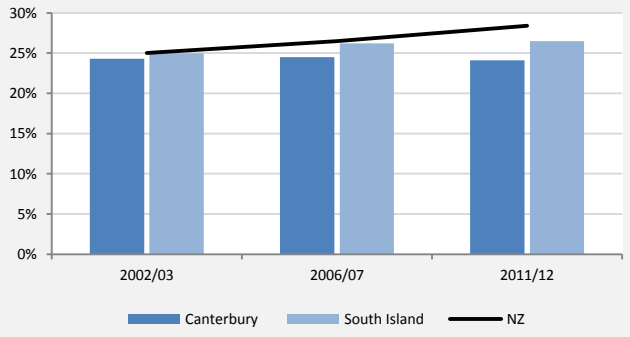
A reduction in obesity rates.

Canterbury's obesity rate has remained relatively stable over the past decade, with the 2011/12 New Zealand Health Survey finding that 24% of our population are obese – similar to 25% in 2006/07 and 24% in 2002/03. This contrasts with the South Island (27%) and national rates (28%), which are higher than Canterbury's and appear to be increasing.

Canterbury's lower rates of obesity are likely to reflect the success of local initiatives that encourage healthier diets and more physical activity, such as Health Promoting Schools, Appetite for Life and Green Prescriptions. Indeed, the impact measures below show that more Cantabrians eat the recommended number of servings of fruit and vegetables than other New Zealanders.

Data sourced from the New Zealand Health Survey.[1]

The percentage of the population (aged 15+) who are obese



[1] *The NZ Health survey was conducted by the Ministry of Health in 2003/04, 2006/07 and 2011/12.*

MEDIUM-TERM IMPACT MEASURES

More babies are fully and exclusively breastfed.

Canterbury's overall breastfeeding rates have remained relatively stable over the past five years, with 66% of all six-week-olds fully or exclusively breastfed in 2012/13.

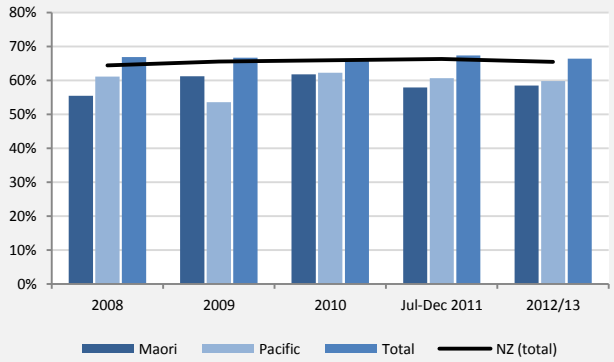
Māori and Pacific breastfeeding rates remain lower than those of the total population, at 58% and 60% respectively. However, some of this may be because the data measured is from Plunket only. Canterbury has several smaller non-Plunket Tamariki Ora providers who specifically target Māori and Pacific mothers. However, data from these providers is not able to be included in the results (see footnote).

Improving breastfeeding rates, particularly for Māori and Pacific babies, is a key focus for the Canterbury Breastfeeding Steering Group. A range of services are available across the Canterbury region to encourage and support mothers to breastfeed, such as peer support (including Māori and Pacific peer support) and community-based lactation consultation.

Data sourced from Plunket via the Ministry of Health.[2]

The percentage of Canterbury babies fully/exclusively breastfed at 6 weeks

	Actual 12/13	Target 2012
Māori	58%	67%
Pacific	60%	67%
Total	66%	67%



Fewer young people take up tobacco smoking.

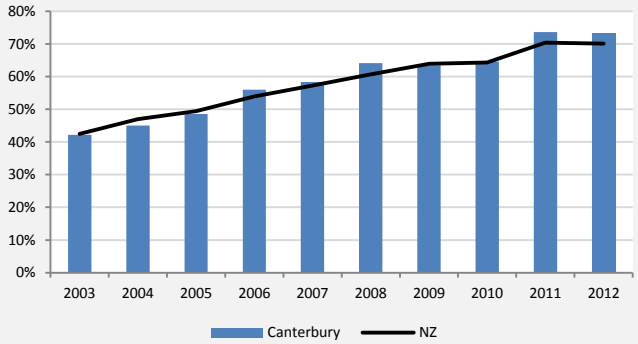
Canterbury young people continue to be less likely to take up smoking than youth in other parts of New Zealand. The 2012 ASH survey results show that 73% of Year 10 (age 14) students in Canterbury have never smoked – compared with 70% for New Zealand as a whole. While Canterbury's 2012 result is slightly down from 74% in 2011, it is still much higher than the results seen in 2010 (65%) and earlier years, and the long-term trend is an increasing percentage of young people who have never smoked.

This reflects the impact of supportive legislation and social environments combined with local initiatives such as Health Promoting Schools, smokefree public places (e.g. parks, marae, etc.) and training and advice provided to tobacco retailers to limit youth access to tobacco.

Data sourced from national Year 10 ASH Survey.[3]

The percentage of 'never smokers' among Year 10 Canterbury students.

Actual 2012	Target 2012
73%	74%



More adults have healthier diets.

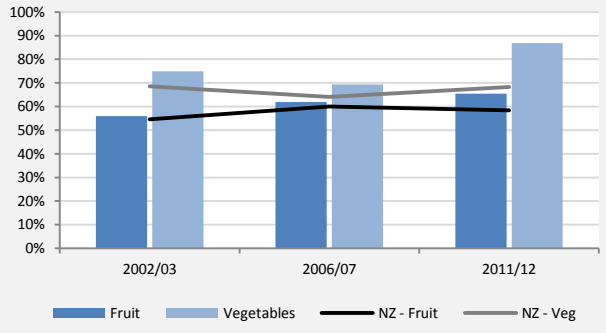
The 2011/12 results of the New Zealand Health Survey indicate that more Cantabrians than ever before are eating two or more servings of fruit (65%) and three or more servings of vegetables (87%) daily. These results are well above the national results for fruit (58%) and vegetable (68%) consumption – indicating that Cantabrians eat more fruit and vegetables than other New Zealanders.

These results reflect the impact of local initiatives that encourage healthier diets and lifestyles, such as Health Promoting Schools, Appetite for Life and Senior Chef.

Data sourced from the New Zealand Health Survey. [1]

The percentage of the population (age 15+) having the recommended servings of fruit and vegetables.

	Actual 11/12	Target 12/13
Fruit 2+	65%	>62%
Veg 3+	87%	>70%



[2] *The Ministry of Health sources this data from Plunket for calendar years. There have been issues with data availability; therefore, the 2011 breastfeeding data presented is only for the final 6 months of 2011 (i.e. July to December), and the latest result is for the 2012/13 financial year, rather than the usual calendar year. Non-Plunket Tamariki Ora providers' data cannot be included in the results, as the necessary raw data from Plunket is not available (i.e. only percentages, rather than numerator and denominator data, have been provided).*

[3] *The ASH survey is run by Action on Smoking and Health. It provides a point prevalence data set and is reported on calendar years. www.ash.org.nz.*

PEOPLE STAY WELL AND MAINTAIN FUNCTIONAL INDEPENDENCE.

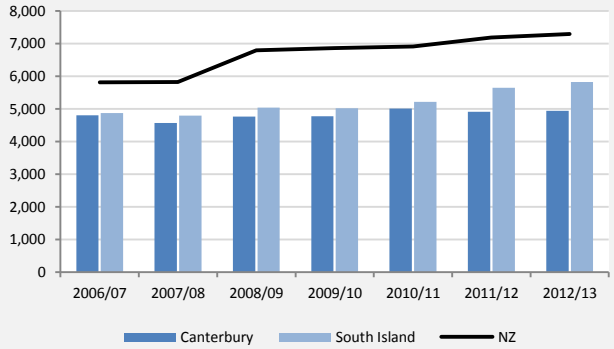
LONG-TERM OUTCOME MEASURES

A reduction in the proportion of the population being admitted to hospital for an acute medical illness.

At 4,939 per 100,000 people, Canterbury's standardised acute medical admission rate is the lowest of any large DHB in the country, and just 68% of the national rate (7,296 per 100,000). This reflects the success of our health-system-wide focus on keeping people well in their own homes and communities.

Data sourced from National Minimum Data Set.

The rate of acute medical admissions to hospital (age-standardised, per 100,000)

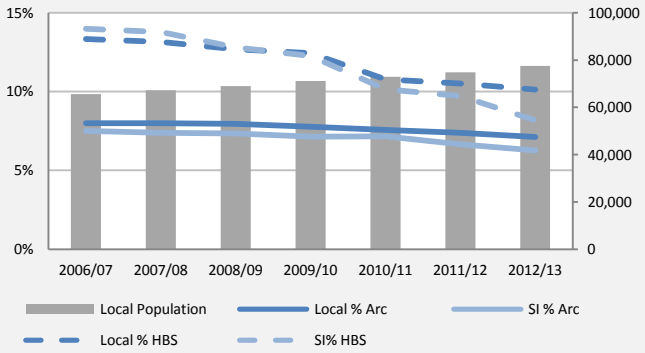


An increase in the proportion of the population 65+ supported to live well in their own homes.

Over the last several years, the percentage of the population in aged residential care has decreased from 8% down to 7%. This brings us closer to the South Island rate and is consistent with our strategic direction of supporting people to 'age in place'. The percentage of those receiving home-based support has remained between 10% and 11 % over the past three years - higher than the South Island rate. However, these are early results, and it will take time to see whether the changes we are making towards a more restorative model will be reflected in these measures in the long term.

Data sourced from Client Claims Payments provided by SIAPO.

The percentage of the older population (65+) in ARC and those receiving home-based support services



MEDIUM-TERM IMPACT MEASURES

More children have good oral health.

The overall percentage of caries-free five-year-olds has remained relatively stable, at 64% in 2012.

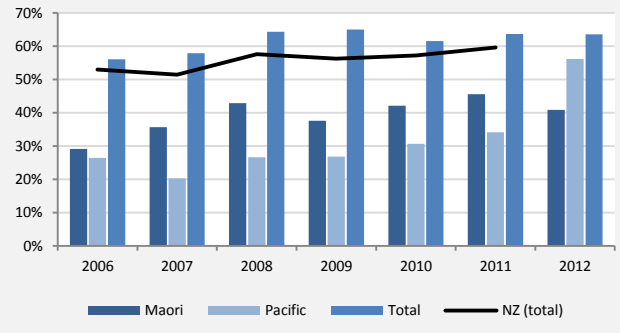
The percentage of Māori five-year-olds (41%) who are caries-free has dropped slightly, while caries-free rates for Pacific five-year-olds (56%) have increased dramatically. Results for these populations are subject to a greater degree of variation due to the smaller numbers of children involved; however, the general trend still appears to be towards improvement and a reduction in inequalities.

A new model of care for high-risk children was introduced in 2012, which provides more intensive preventive care in high-risk children aged 12-24 months. It is likely that the proportion of caries-free five-year-olds will stay at or about the current level until the first of these children targeted by the new model of care reach five years old (around 2015), at which point we expect to see improvements.

Data sourced from Ministry of Health.[4]

The percentage of Canterbury children caries-free (no holes or fillings) at age 5.

	Actual 2012	Target 2012
Māori	41%	67%
Pacific	56%	67%
Total	64%	67%



[4] *Oral health data is reported annually for the school year (i.e. calendar year) and is based on the national DHB performance indicator PP11.*

More people better manage their long-term conditions.

The national diabetes 'Get Checked' programme was replaced with local programmes across the country from 1 July 2012. In Canterbury, this has taken the form of a new 'Diabetes Care Improvement Package' (DCIP). The DCIP specifies the minimum standard of care any person with diabetes can expect from their general practice team. This covers a wide range of care, including monitoring (e.g. blood tests, blood pressure, weight), routine screening (e.g. retinal screens, podiatry), a personalised care plan and referral to appropriate supporting services (e.g. insulin education, nutrition classes, Green Prescriptions).

As the programme has only begun this year, there are no past years' data to provide comparison. However, early results appear promising: of those having an HbA1c blood glucose test during the nine months up to 30 June 2013, three out of four (76%) had a satisfactory or better result. Results were lower for Māori (64%) and Pacific (57%) people, indicating that we still have work to do in reducing inequalities.

We expect to see results improve in future years as the DCIP becomes ingrained in general practice, and as general practices share their successes and innovations for improving diabetes management.

Data sourced from laboratories and MoH VDR.

The percentage of the Canterbury population identified with diabetes with HbA1c≤64mmol/mol (indicating 'satisfactory' or better diabetes management).

	Actual 12/13	Target 12/13
Māori	64%	n/a
Pacific	57%	n/a
Total	76%	n/a

This measure uses a different methodology than in previous years. The measure is now based on the Ministry of Health's Virtual Diabetes Register and is the percentage of those on the register who have had an HbA1c test in the nine months October 2012-June 2013[5], whose HbA1c was 64 mmol/mol or less.

Explicit targets were not set for this measure, as baseline data was not available at the time of target-setting.

People access care appropriate to their needs.

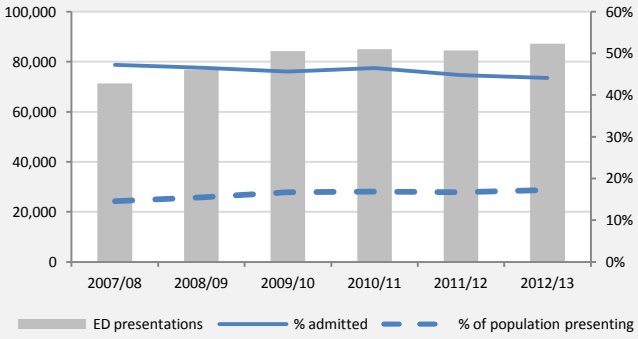
The percentage of the population presenting at ED has remained steady at 17% over the past four years, indicating that growth in ED presentations is in line with population growth.

This reflects the impact of local initiatives such as Acute Demand Management Services and Community Rehabilitation Enablement and Support Team (CREST) in successfully helping people to stay well in their own homes and communities – an impressive achievement in the context of the additional quake-related challenges of the past few years.

Data sourced from individual DHBs.[6]

The percentage of the Canterbury population presenting at ED

Actual 12/13	Target 12/13
17%	≤18%



Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

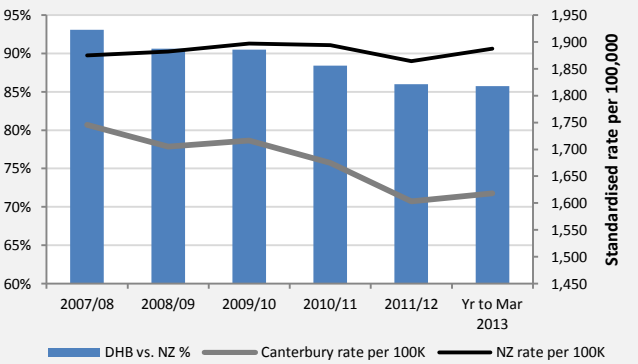
In the year to 31 March 2013, Canterbury's avoidable hospital admission rate was 1,618 per 100,000 – just 86% of the national rate (which was 1,888 per 100,000).

This result shows Canterbury's continued strong performance in preventing avoidable hospitalisations. A wide range of local initiatives contribute to preventing unnecessary admissions to hospital, including our community-based Acute Demand Management Services, HealthPathways, CREST and long-term condition management programmes.

Data sourced from the Ministry of Health. [7]

The percentage of avoidable admissions for the Canterbury population compared to the NZ population (aged 0-74).

Actual Mar 13	Target 12/13
86%	≤95%



[5] *Community laboratory data is not available for the first three months of 2012/13, hence the measure is for nine months only.*
[6] *'Presenting' and 'admitted' are defined as per the MoH national ED health target.*
[7] *This measure is based on the national DHB performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 for Canterbury divided by the standardised rate per 100,000 for NZ. A lower percentage is therefore better, as it indicates a lower rate of avoidable hospitalisation than the national rate. Canterbury aims to remain under the national rate. The 2012/13 result is for the year up to and including March 2013, as this was the most recent result available from MoH at the time of publishing.*

Older people maintain functional independence.

At 8.2%, the percentage of the Canterbury population aged 75+ admitted to hospital as a result of a fall in 2012/13 is lower than the previous year (8.4%) and remains below the national rate (8.5%), although it is still higher than the target we set to reduce the falls admission rate to 7.9%.

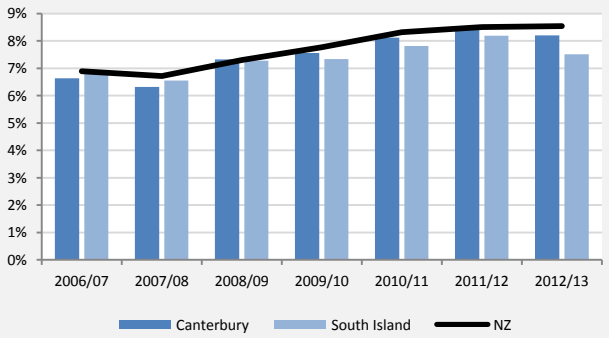
The Canterbury health system has a falls prevention campaign with an aspirational goal of 'zero harm' from falls. This system-wide approach uses quality control systems, clinical leadership and evidence-based intervention strategies to reduce the risk and severity of falls in Canterbury.

A number of inter-related programmes have been put in place to reduce falls-related harm. All of them take an evidence-based, best practice approach and are championed by the Canterbury DHB Clinical Board and the Canterbury Clinical Network. We expect to see their impact on this measure in future years, with continuing decreases in rates of hospital admissions for falls.

Data Sourced from National Minimum Data Set.

The percentage of the Canterbury population (75+) admitted to hospital as a result of a fall.

Actual 12/13	Target 12/13
8.2%	7.9%



PEOPLE RECOVER FROM COMPLEX ILLNESS AND/OR MAXIMISE THEIR QUALITY OF LIFE.

LONG-TERM OUTCOME MEASURES

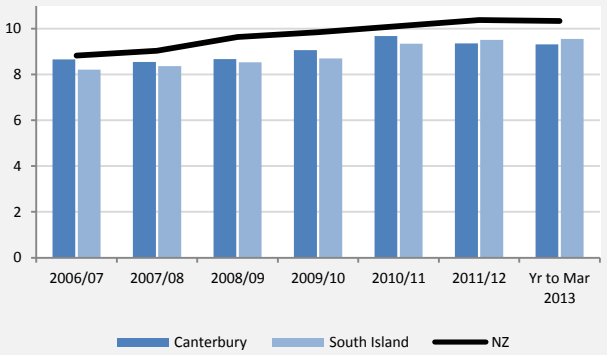
A reduction in the rate of acute (unplanned) readmissions to hospital.

Canterbury's acute readmission rate for the year to 31 March 2013 was 9.3% – the third-lowest un-standardised acute readmission rate in the country and the lowest of any large DHB. This suggests that people in Canterbury are getting the right care at the right time to recover safely and avoid needing to return to hospital. This has been achieved while maintaining a relatively short average length of stay.

This result reflects both the impact of quality treatment in our hospitals and also good post-discharge support in the community through services like CREST.

Data sourced from Ministry of Health

The rate of acute (unplanned) readmissions to hospital within 28 days of discharge[8]



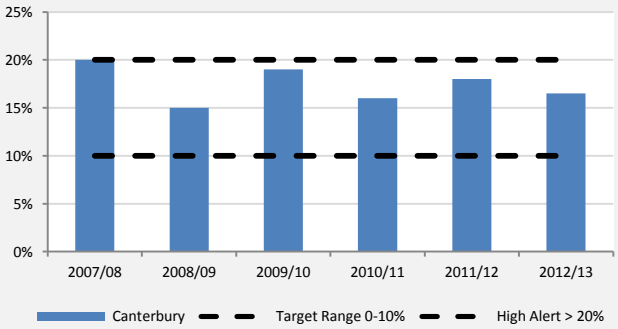
A reduction in the rate of acute (unplanned) readmissions to hospital – mental health.

Mental health acute readmission rates have stabilised below the high alert level, but continue to be somewhat variable year-to-year. However, at 17%, the 2012/13 results are an improvement on the previous year.

Moving into 2013/14, improving the responsiveness of Canterbury's mental health services will be a key focus, supported by relapse prevention planning and improved access to and integration between mental health care of all levels: general practice brief intervention counselling, NGOs and our own Specialist Mental Health Services.

Data sourced from national Mental Health and Addictions KPI Framework.

The rate of acute (unplanned) readmissions to mental health services within 28 days[9]



MEDIUM-TERM IMPACT MEASURES

More people receive timely emergency care.

Over the 2012/13 year, 95% of people presenting at ED were admitted or discharged within six hours – meeting the national health target.

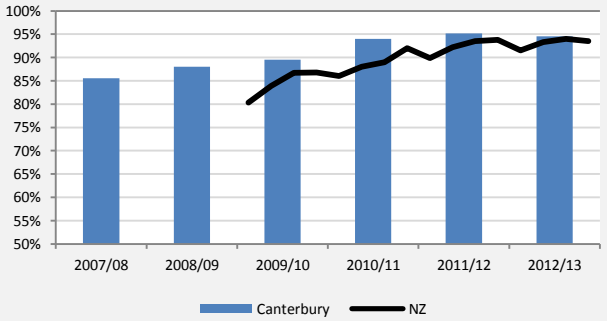
Canterbury's strong ED performance results from taking a 'whole of system' approach, with a wide range of integrated strategies for preload (reducing ED attendances), contractility (effective ED functioning and flow) and afterload (hospital flow and supported discharge).

This approach ensures hospital services are well supported by community-based services such as afterhours nurse-led telephone triage, the Acute Demand Management Service (which delivers acute demand packages of care in the community, instead of hospital) and CREST (which supports older people in the community after discharge from hospital or helps them to avoid hospital admission altogether).

Data sourced from individual DHBs.[10]

The percentage of people presenting at Canterbury EDs who are admitted, discharged or transferred within 6 hours.

Actual 12/13	Target 12/13
95%	95%



[8] *This measure is the national DHB performance measure OS8. The 2012/13 result is for the year up to and including March 2013, as this was the most recent result available from MoH at the time of publishing.*
[9] *This measure is based on the national Mental Health and Addictions KPI Framework measure, introduced in 2007/08.*
[10] *This measure is the national health target 'Shorter stays in Emergency Departments', introduced in 2009/10.*

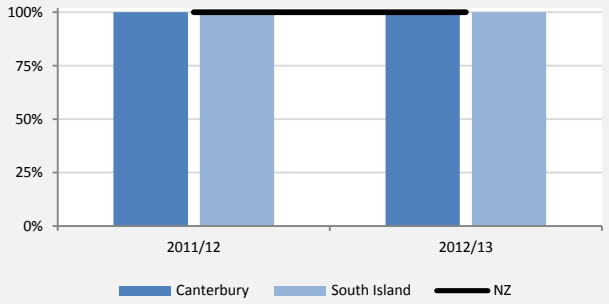
More people receive timely cancer services.

Canterbury has continued to work hard to deliver against the national cancer treatment health target throughout 2012/13. All but five of the 1,927 patients ready for radiation therapy treatment received treatment within four weeks of the decision to treat.

Data sourced from individual DHBs.[11]

The percentage of patients ready for treatment who receive radiation therapy within four weeks of decision to treat.

Actual 12/13	Target 12/13
99.7%	100%



More people receive timely access to elective services.

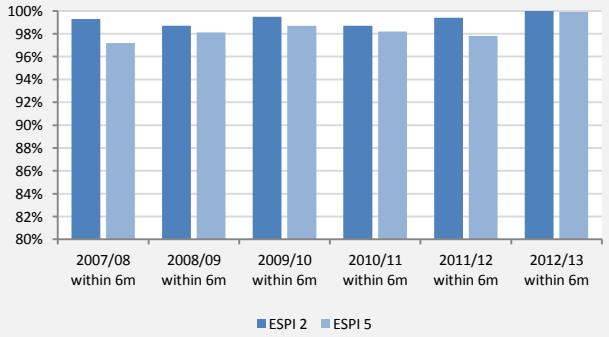
Despite the challenges of having less hospital capacity post-quake, Canterbury has improved the timeliness of service provision for specialist assessment and treatment. As of June 2013, 100% of Cantabrians needing a First Specialist Assessment (FSA) received one within six months of referral, and 99.9% of those given a commitment to treat began their treatment within six months – the remaining 0.1% relates to three patients waiting to be seen a specialist surgeon who was away.

Reaching 100% within six months has been a major achievement, requiring the concerted efforts of people working throughout the DHB's hospital and specialist services, as well as referrers in the community. Over the coming year, we will look to further improve to five months.

Data sourced from Ministry of Health.[12]

The percentage of people waiting ≤6 months from:

	Actual Jun 13	Target 12/13
- referral to FSA (ESPI 2).	100%	100%
- commitment to treat until treatment (ESPI 5).	99.9%	100%



Fewer people experience adverse events that cause harm.

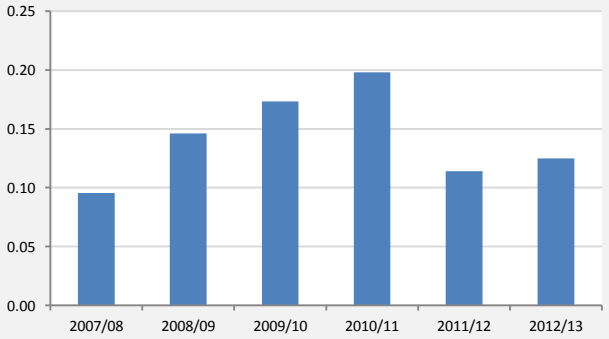
Canterbury's strong focus on falls prevention appears to be paying off, with the rate of SAC 1 & 2 hospital falls (those considered most serious with the highest consequence and likelihood) remaining low since the introduction of our 'zero harm' safety campaign in our hospital services.

This campaign is part of Canterbury's 'whole of system' approach to falls prevention and focuses on effective systems and consistent processes for minimising falls including: staff training, assessing patient fall risk, improving environmental safety, establishing falls champions and improving data collection to improve falls management.

Data sourced from Individual DHBs.[13]

The rate of SAC 1 and 2 level falls in Canterbury hospitals for older people (65+)

Actual 12/13	Target 12/13
0.12	0.12



[11] *This measure is the national health target 'Shorter waits for cancer treatment', introduced in September 2010. Due to late identification of an administrative error, it was found that five patients treated in Canterbury waited longer than four weeks for radiotherapy; four patients waited four weeks and one day, and one patient waited four weeks and three days. This result differs from previously published health target results*

[12] *The Elective Services Patient Flow Indicators (ESPIs) are measures of system performance, for which DHBs receive summary reports from the Ministry of Health on a monthly basis.*

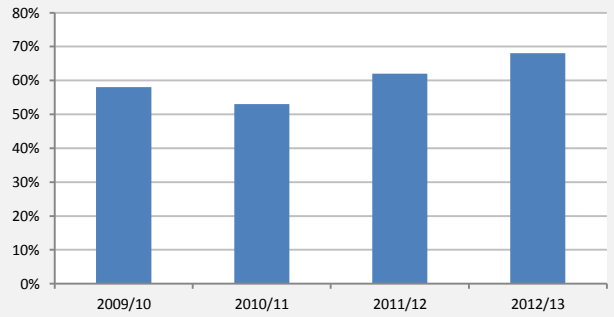
[13] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days*

More people receive timely post-discharge care.

It is encouraging to see an upward trend in the percentage of people leaving Specialist Mental Health Services who have contact with a community-based mental health service within seven days of discharge. This ensures continuity of care and support for the individual, and it shows the improvements being made by mental healthcare providers across the system in working together and providing a connected, seamless service for clients.

Data sourced from national Mental Health and Addictions KPI Framework.

The percentage of people having a post-discharge contact within seven days of discharge from Specialist Mental Health Services	Actual 12/13	Target 12/13
	68%	n/a[14]



[14] *No target was set for this measure because at the time of target-setting, data was not yet established.*

STATEMENT OF SERVICE PERFORMANCE 2012/13

MEASURING OUR NON-FINANCIAL PERFORMANCE

As part of evaluating our performance, we provide an annual forecast of the services we plan to fund and provide (and to what standard) and report actual delivery against that forecast at the end of each year. The following section presents Canterbury's actual performance against the forecast 'outputs' presented in our Statement of Intent 2012-15.

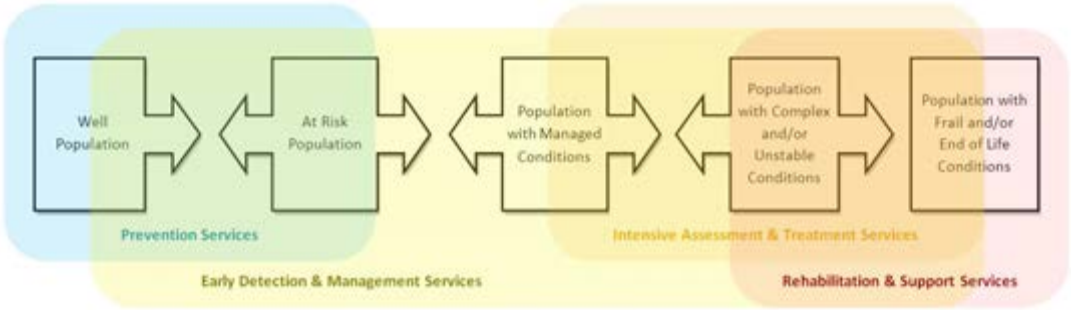
In presenting our performance, it would be overwhelming to measure every output delivered. We therefore choose to measure those activities with the greatest potential to contribute to improving the health and wellbeing of our population, those which are markers of broader system changes and those where we expect to see a marked change in activity levels or settings.

In doing so, we also cannot simply measure 'volumes'. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'. We therefore present a mix of measures focused on four elements of service performance: Volume (V), Quality (Q), Timeliness (T) and Coverage (C). Together, these short-term outputs have an impact that contributes to the longer-term health outcomes we seek to achieve for our population.

As well as comparing our 2012/13 results against the targets we set in our Statement of Intent, we have included (wherever possible) a prior year's result and trend chart to assess performance over time and a national result to give wider context in terms of what we are trying to achieve.

The outputs that we measure are grouped into four 'output classes' that are a logical fit with the continuum of care: Prevention Services, Early Detection and Management Services, Intensive Assessment and Treatment Services, and Rehabilitation and Support Services. This helps to provide a picture of overall performance by grouping services with similar aims or goals.

FIGURE 1: OUTPUT GROUPING SET AGAINST THE CONTINUUM OF CARE FOR OUR POPULATION



Notes on the Data

This Statement of Service Performance incorporates a large number of measures to better reflect the scope and volume of services delivered or contracted by the Canterbury DHB. This creates some additional considerations:

- Access to a significant proportion of public health services (such as laboratory tests, emergency care, maternity services and palliative care) is unrestricted or 'demand-driven'. For such services, we cannot set targets. However, volumes of actual use of these services are included to give the reader a more rounded picture of what is happening across our health system. There are not targets for these services, but simply a forecast or estimate of expected demand, indicated by the abbreviation '**Est.**'
- Some service data is provided or held by third parties, outside the DHB, and can be affected by a lag in invoicing for the services provided. Rather than footnote every instance, a symbol is used to indicate where this is the case: **Δ** marks data that can be affected by a lag in invoicing and therefore may differ from previously published figures. Such data in this document was run on or before 4 September.

- Some data is collected on calendar, rather than financial, years and is indicated with the following symbol: †. In these cases, the '11/12' result is for the 2011 calendar year, and the '12/13' result is for 2012.
- Any other irregularities have been footnoted.

2012/13 PERFORMANCE OVERVIEW

Our performance results for 2012/13 show the Canterbury health system's ongoing recovery following the earthquakes. It is particularly positive to see the increases in uptake of the new programmes we have put in place since the earthquake to support our most vulnerable populations, such as CREST and the community-based falls prevention service. While we haven't met every target, we have improved performance in many areas, and our higher-level outcome and impact measures show that we are having a positive impact on the health and wellbeing of our population.

PEOPLE ARE SUPPORTED TO STAY WELL. We have made a strong start on eight-month-old immunisation coverage, achieving 92% - well above the new national health target of 85%. 97% of all two year old children were 'reached' by immunisation services, indicating the systematic approach and complete commitment of primary care, immunisation coordinators and outreach providers in tracking down almost every child in Canterbury.

MORE SERVICES ARE PROVIDED IN THE COMMUNITY. 25,374 packages of care were provided for acutely unwell people in community settings rather than our hospitals. 8,860 people were supported in their own homes by home support services, and 7,911 by district nursing services. The success of this approach is evident Canterbury's standardised acute medical admission rate; at 4,939 per 100,000, Canterbury's standardised acute medical admission rate is the lowest of any large DHB in the country, and just 68% of the national rate (7,296 per 100,000). Our un-standardised acute readmission rate (9.3%) is the third-lowest in the country, suggesting that people are getting the right care at the right time to recover safely and avoid needing to return to hospital.

VULNERABLE PEOPLE ARE SUPPORTED. 6,962 people accessed brief intervention counselling in primary care settings, and more long-term specialist mental health clients now have current relapse prevention plans in place. Our Community Rehabilitation Service Team (CREST) provided additional support to 1,850 older people on discharge from hospital or direct GP referral and our new community-based falls prevention service received 1,613 referrals – twice as many as expected.

PEOPLE ARE WAITING LESS. In spite of the reduced capacity across our hospital services, 100% of people referred for a first specialist assessment and 99.9% of people given a commitment for treatment received their assessment or treatment within 6 months.

OUR SYSTEM IS BETTER CONNECTED. 667 integrated pathways have been developed across primary/secondary care to improve patients' care and streamline referral processes. 45,555 radiology tests were provided on direct community referral, without the need for a hospital appointment. Many of these are types of tests that have not traditionally been accessible to GPs.

OUR HOSPITAL SERVICES ARE STILL DELIVERING. 17,066 elective surgical discharges were delivered – 956 above target – and 41,052 surgical first specialist assessments were undertaken. Rates of people not attending hospital appointments have dropped.

The results we have collectively achieved reflect the hard work of teams right across our health system to 'make it better' for our population. As we move forward into 2013/14, we will continue to take a collective approach towards achieving our strategic direction: supporting people to stay well, building primary and community capacity to support people closer to home, and releasing hospital and specialist capacity to focus on the delivery of complex care.

PREVENTION SERVICES

Preventative health services promote and protect the health of our population by improving physical and social environments and supporting people to make healthier choices. These services include education programmes to raise awareness of risk behaviours, legislation and policy to protect people from environmental risks, and health protection services such as immunisation and lifestyle programmes that support people to modify their lifestyles and maintain good health.

Success is defined by positive changes in behaviours and high coverage levels, which signal engagement in programmes and the effectiveness of positive health messaging and the quality of the support and advice being provided.

As our population continues to struggle with the day-to-day challenges of earthquake recovery, encouraging people to make lifestyle changes has been difficult. Not unexpectedly, targets for a number of measures around participation in health lifestyle interventions have not been met. However, it is pleasing to note that there are some exceptions to this: 345 smokers participated in the Aukati Kaipaipa smoking cessation programme in 2012/13 (up from 207 last year), and 1,936 people were supported to increase their physical activity through Green Prescriptions (well above our target of 1,500).

We have also made some key achievements for safeguarding the health of our most vulnerable populations. We increased B4 School Check coverage to ensure children get the best start to school and later life, and began a new Gateway Assessment programme for children and young people referred by Child Youth and Family. We are particularly pleased to have made a strong start on eight-month-old immunisation coverage, achieving 92% - well above the new national health target of 85%.

OUTPUT MEASURES

HEALTH PROMOTION AND EDUCATION SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Number of volunteer mothers trained to provide in Mum 4 Mum breastfeeding peer support	V [15]	44	35	50	-	
Percentage of mothers having established breastfeeding on discharge from hospital	Q [16]	81%	81%	≥85%	-	
Percentage of hospitalised smokers who receive smoking cessation advice and support - Full year results	C [17]	83%	90%	95%	-	
- Quarter 4 results		90%	93%	95%	96%	-
Percentage of identified smokers attending general practice who receive smoking cessation advice and support	C [18]	25%	35%	90%	57%	
Number of smokers participating in the Aukati Kaipaipa smoking cessation programme	V	207	345	≥200	-	
Percentage of tobacco retailers compliant with legislation	Q [19]	97%	83%	≥90%	-	
Percentage of 'priority' schools supported by the Health Promoting Schools framework	C [20]	78%	74%	≥70%	-	

[15] *Mum4Mum training supports social change by allowing the DHB to deliver key messages through informal contact facilitated by appropriately trained volunteer mothers.*

[16] *The proportion of women breastfeeding is seen as a measure of service quality by demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period. The 2011/12 result differs from the one previously published, as we have detected an error that was mistakenly excluding some births, and this has now been corrected.*

[17] *The ABC Strategy for Smoking Cessation was implemented in all Canterbury DHB hospitals from 2009 and involves Asking a patient's smoking status, offering Brief quit advice and referring the patient to Cessation support.*

[18] *The ABC initiative is new to primary care, with data collection beginning in 2010/11 via the national PHO Performance Programme.*

[19] *Youth access to tobacco is monitored through controlled purchase operations (CPOs) to test whether retailers require proof of age. Compliance results reflect the quality of the information, training and advice services provided to retailers. During 2012/13, we targeted retailers about whom we had received complaints, those in low socioeconomic areas and those near high schools. While this resulted in a lower rate of compliance, it also means we are targeting the 'right' retailers. Non-compliant retailers are always included in a follow-up CPO, and we have found that they rarely sell to a minor for a second time – a good sign that retailers respond to infringement notices and return to compliance following a CPO.*

[20] *The Health Promoting Schools framework addresses health issues through activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated and/or have a high proportion of Māori and/or Pacific children. The number of participating schools has actually increased in 2012/13 (from 69 up to 70); however, the percentage has decreased, as additional schools have been classified as 'priority' schools this year (from 81 up to 94) as a result of being seriously affected by the earthquakes and/or the proposed education reforms.*

Number of community 'Appetite for Life' courses provided	V [21]	68	52	90	-	
Number of Green Prescriptions provided to people needing additional physical activity support	V [22]	1,941	1,936	≥1,500	-	
POPULATION-BASED SCREENING SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Percentage of children (age 4) provided with B4 School Checks	C [23]	76%	86%	80%	80%	
Percentage of children referred by Child Youth and Family (CYF) who receive a Gateway Assessment	C [24]	new	78%	100%	-	new
Percentage of women aged **25-69** having a cervical cancer screen every three years	C [25]	75%	75%	75%	77%	
Percentage of eligible women (45-69) having a breast screen examination every two years	C [25]	82%	82%	≥70%	72%	
IMMUNISATION SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Percentage of children fully immunised at age eight months - Full year results	C	new	92%	85%	-	new
- Quarter 4 results		new	92%	85%	90%	-
Percentage of two-year-olds 'reached' by immunisation services	Q [26]	97%	97%	≥95%	95%	
Percentage of eligible young women (12-18) engaged in the HPV vaccination programme	C [27]	46%	47%	≥46%	57%	
Percentage of young people (<18) receiving a free influenza ('flu') vaccination	C [28] †	21%	19%	40%	-	
Percentage of older people (65+) receiving a free influenza ('flu') vaccination	C [28] †	71%	71%	75%	65%	
Number of older people (65+) receiving a free influenza ('flu') vaccination	V [29] †	49,052	49,361	≥53,000	-	

[21] *'Appetite for Life' (AFL) is a healthy lifestyle programme that helps participants make positive changes to the habits that have led to their weight gain. The lower number of courses in 2012/13 reflects changes in delivery model: (a) fewer courses with larger numbers of participants; (b) targeting key communities; and (c) modifying AFL to be for men as well as women. While course numbers decreased, participant numbers were similar to previous years and AFL is reaching a wider demographic.*

[22] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.*

[23] *The B4 School Check (B4SC) is the final core WellChild/Tamariki Ora check, which children receive at age four. It is free and includes vision, hearing, oral health, height and weight. It allows health concerns to be identified and addressed early in a child's development, giving him/her the best start for school and later life. Canterbury's B4SC programme began in March 2009. Results differ from those previously published due to the detection of an error; previous results omitted the vision and hearing components of the B4SC (which are provided separately from the rest of the check). Complete results, including the vision and hearing components, have been sourced from 2010/11 onward and are provided above.*

[24] *In 2012/13, we have successfully implemented the Gateway programme, in collaboration with Education and Child Youth and Family. The new programme currently has a wait list, but a number of initiatives are underway to address this now that the service is established.*

[25] *National screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce associated mortality. Standards are based on national targets, and data is subject to availability from the national programmes. The National Cervical Screening Programme has changed its targets and reporting to the 25-69 age group, and data for the 20-69 age group is no longer available. Therefore, data for the 25-69 age group is presented for cervical screening for all years, rather than 20-69 as appeared in our Statement of Intent.*

[26] *A child is 'reached' if (s)he is fully immunised, is on a catch-up schedule, or the family has declined immunisations or opted off the National Immunisations Register. This reflects the quality of immunisation services in 'reaching' parents of eligible children and providing advice to enable them to make informed choices for their children.*

[27] *The measure is young women aged 12-18 provided with Dose 1. The 'NZ result' is based on the six 'major' DHBs. The target was set to acknowledge the work needed to reconnect people with general practice and re-establish coverage post-quake.*

[28] *While flu vaccination uptake experienced a lull in 2012, we are seeing very strong uptake so far in the 2013 flu vaccination season amongst both under-18-year-olds and over-65-year-olds (33% and 75% respectively as of 22 July 2013).*

[29] *The volume target is the number of vaccinations to achieve 75% coverage assuming an enrolled population of 70,752 (Jan 2012). Volume is important, as with population growth in this age group, a greater volume must be delivered each year to maintain the same percentage coverage.*

EARLY DETECTION AND MANAGEMENT SERVICES

Early detection and management services support people to better manage their long-term conditions and avoid complications, acute illness and crises. By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes.

With our hospital capacity reduced by the earthquakes, providing flexible and responsive services in the community is all the more important, as it allows early intervention and treatment to occur without the need for a hospital appointment. This helps more people stay well and reduces the rate of avoidable hospital admissions and unnecessary specialist referrals.

Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services. Increases in access to diagnostics and agreed referral pathways and reductions in avoidable hospital admissions also reflect improvement.

It is positive to see that measures around engagement with health providers appear to be picking up after the quake disruption seen in prior years, suggesting that our population is now re-engaging with their usual health providers. Preschool enrolment in oral health services has lifted considerably (to 71%), and more children are being seen on time for their dental checks (90%). More people are receiving care in the community that would traditionally have required a hospital visit, including 2,358 skin lesion removals, 1,503 spirometry tests and 45,555 radiology tests.

A key post-quake focus has been supporting our vulnerable populations. We have increased access to mental health services, and 6,962 people have accessed brief intervention counselling in general practice over the past year. Community pharmacists working under the new Medication Management Service have provided 1,694 medication reviews to help people with multiple medications to manage them better – while short of our ambitious target of 2,000, this is more than double last year's delivery of 632.

OUTPUT MEASURES

PRIMARY HEALTH CARE (GP) SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Percentage of newborns (aged <2 weeks) enrolled with a GP or WellChild provider	C	new	92%	90%	-	new
Percentage of the Canterbury population enrolled with a PHO	C	96%	96%	≥95%	96%	
Number of integrated patient pathways established across primary/secondary care	V [30]	519	667	>470	-	
Number of people accessing Brief Intervention Counselling (BIC)	V [31] Δ	5,750	6,962	≥4,000	-	
Avoidable hospitalisation rate for Canterbury children (age 0-4) as a percentage of the national rate	Q [32]	108%	112%	≤95%	100%	

[30] *These clinically designed pathways inform new patient-centred models of care. The HealthPathways website helps general practice navigate the pathways, with information on referrals, specialist advice, diagnostic tools, GP procedure subsidies and patient handouts. The measure includes clinical, referral and resource pathways.*

[31] *The Brief Intervention Coordination Service (which began in 2009) provides people with mild to moderate mental health concerns up to 5 sessions of free 'early' psychological intervention from their general practice teams, with the possibility of onward referral to a related community agency if appropriate. The aim is to provide early intervention and help people to reduce the likelihood of developing enduring conditions.*

[32] *Some hospital admissions are seen as preventable through early intervention; they provide an indication of the access and effectiveness of primary care and the interface between primary and secondary services. The measure is defined as the standardised rate per 100,000 for Canterbury divided by the standardised rate per 100,000 for NZ. A lower percentage is better, indicating a lower rate of avoidable hospitalisation than the national rate (100%). While Canterbury's percentage vs. the NZ rate has worsened, our rate per 100,000 has actually improved from 5,021 to 4,921 – showing that Canterbury's rate is getting better, although not as quickly as the NZ rate. Data is subject to availability from MoH; 2012/13 results are for the year to 31 March 2013, while prior results are for true financial years.*

Oral Health Services	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Percentage of children (<5) enrolled in oral health services	C †	54%	71%	66%	-	
Percentage of enrolled children (0-12) examined according to planned recall	T †	87%	90%	90%	-	
Percentage of adolescents (13-17) accessing DHB-funded oral health services	C [33] †	65%	65%	75%	72%	
Long-term Conditions Programmes	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**	**Trend 09/10-12/13**
Percentage of people with diabetes who are supported to manage their condition	C [34]	new	72%	52%	-	new
Percentage of eligible population receiving CVD risk assessments every five years	C [35]	20%	33%	75%	67%	
Number of skin lesions (skin growths, including cancer) removed in primary care	V Δ	2,320	2,358	≥2,000	-	
Number of spirometry tests delivered in community (rather than hospital) settings	V [36] Δ	1,179	1,503	≥1,000	-	
Pharmacy Services	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**	**Trend 09/10-12/13**
Number of pharmaceutical items dispensed in the community	V Δ	8.4M	6.7M	Est. <9M	-	
Number of medication reviews provided to people on multiple medications	V [37]	632	1,694	2,000	-	
Referred Services	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**	**Trend 09/10-12/13**
Number of community-based laboratory tests completed	V Δ	2.6M	2.0M	Est. <2.6M	-	
Number of GP-referred Community-Referred Radiology tests completed	V [38] Δ	39,763	45,555	Est. >30,000	-	
Percentage of Community-Referred Radiology tests that are accepted	Q [38] Δ	92%	93%	90%	-	
Percentage of people receiving their elective coronary angiogram within 3 months	T [39]	new	95%	85%	88%	new
Percentage of people receiving their Computed Tomography (CT) scans within 6 weeks	T [39]	new	89%	75%	79%	new
Percentage of people receiving their Magnetic Resonance Imaging (MRI) scans within 6 weeks	T [39]	new	83%	75%	62%	new

[33] The NZ result is for 2011 (rather than 2012), as this was the most recent result available from MoH.

[34] This measure differs from the former diabetes annual review health target, which has been discontinued nationally. The measure is now based on the Ministry of Health's Virtual Diabetes Register (VDR) and is the percentage of those on the VDR who have had an HbA1c test in the nine months October 2012-June 2013 (community laboratory data is not available for the first three months of 2012/13). An HbA1c test requires referral by a health professional; therefore, this measure acts as a proxy measure of the percentage of people who have been supported to manage their diabetes.

[35] This refers to CVD risk assessments undertaken in primary care in line with the 'more heart and diabetes checks' health target and reported through the national PHO Performance Programme (PPP). Canterbury's largest PHO has been participating in the CVD components of the PPP for just 3 years (hence the 'trend' goes from 2010/11 onwards), compared with over 5 years amongst other PHOs. This has resulted in lower baseline figures, but an alternative means of identifying people whose risk has been assessed has been established and is being promoted to help lift coverage.

[36] Spirometry is a tool for measuring lung function, assisting in the assessment of a range of respiratory conditions. Community respiratory volumes are delivered by GPs or by mobile community respiratory providers, meaning people do not need to wait for a hospital appointment.

[37] Canterbury's Medication Management Service began in late 2011.

[38] Data has been captured since the introduction of the Community-Referred Radiology (CRR) service in 2010/11. The acceptance rate of CRR tests reflects the appropriateness of referrals and hence the quality of referral education/information and clinical referring practices.

[39] These measures are the national DV2 diagnostics performance measures. The measure counts both those who have had their diagnostic and those who are still waiting, and results cover only the month of June 2013, as this is what is available from MoH.

INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Intensive assessment and treatment services are more complex services provided by specialist healthcare professionals. These services are typically provided in settings which enable the co-location of clinical expertise and specialist equipment – usually (but not always) hospitals. A proportion of these services are driven by demand that we must meet, such as emergency (acute) and maternity services. However, others are planned (elective) services where access is determined by capacity, clinical need and treatment thresholds.

With the loss of beds in our hospitals, it is even more important to reduce avoidable demand in order to provide specialist services in a timely manner. By reducing the utilisation of our limited resources for avoidable acute or less complex demand, we are able to free up specialist services to undertake more complex and elective interventions. Success is therefore defined by a reduction in acute demand and increased access to less complex care in community settings rather than in hospitals.

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action. Success is therefore also defined by increased access to services and timely treatment.

We are committed to funding and providing high-quality health services for our community. As a provider of services, we closely monitor patient safety within our hospitals. Improved patient safety is reflected by improved patient health outcomes and a reduction in adverse events and delays in treatment, which as well as causing harm, drive unnecessary costs and redirect resources from other services.

Performance has improved in most service areas under this output class. Most significant is the delivery of 25,374 acute demand packages of care in the community rather than in hospital and reductions in the lengths of stay in our hospitals. By reducing acute demand and providing support to discharge people early, we have been able to deliver an increased number of elective surgeries, specialist assessments and outpatient appointments.

More of our specialist assessments are virtual, reducing the need for a hospital visit, and we have increased day of surgery admission rates, meaning people are not spending unnecessary nights in hospital.

OUTPUT MEASURES

SPECIALIST MENTAL HEALTH SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Percentage of young people (0-19) accessing specialist mental health services	C [40] Δ	2.8%	2.6%	≥3%	2.8%	
Percentage of adults (20-64) accessing specialist mental health services	C [40] Δ	3.6%	3.4%	≥2.5%	3.4%	
Percentage of people referred for non-urgent mental health and addictions services who are seen within 3 weeks	T [41]	69%	72%	≥70%	76%	
Percentage of people referred for non-urgent mental health and addictions services who are seen within 8 weeks	T [41]	85%	87%	≥75%	91%	
Percentage of young long-term mental health clients (0-19) with current relapse prevention plans	Q [42]	90%	95%	≥95%	84%	
Percentage of adult long-term mental health clients (20-64) with current relapse prevention plans	Q [42]	99%	99%	≥95%	92%	

[40] *The national expectation is that around 3% of the total population will need to access specialist mental health services. This measure includes specialised services provided by the DHB and by NGOs who submit NHI-level reporting. 2011/12 results differ from those previously published as the result of the correction of a calculation error. 2012/13 results (both CDHB and NZ) are for the year to 31 March 2013 due to delays in reporting. The NZ result is based on the PP6 national DHB performance measure, using PRIMHD data.*

[41] *This is the national DHB performance measure PP8. Results are subject to MoH availability, and are for the years ending 31 March.*

[42] *Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what actions to take. The NZ result is for 2012.*

ACUTE/URGENT SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Percentage of enrolled children under six with access to free primary care after hours	C	new	100%	75%	-	new
Percentage of general practices providing access to telephone triage outside business hours	C [43]	83%	91%	95%	-	
Number of acute demand packages of care provided in community (rather than hospital) settings	V [44]	19,645	25,374	18,000	-	
Number of presentations at hospital emergency departments	V [45]	84,444	87,241	Est. <92,000	-	
Percentage of people receiving chemotherapy treatment within 4 weeks of decision to treat	T [46]	100%	100%	100%	100%	
QUALITY AND PATIENT SAFETY MEASURES *These quality and patient safety measures apply across all CDHB hospital services, not just elective or acute services.*	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Reported rate of medication, IV and blood incidents per 1,000 inpatient bed days	Q [47]	1.9	2.2	2.3	-	
Rates of *Staph Aureus* hospital-acquired bloodstream infections (HABSI) per 1,000 inpatient bed days	Q [48]	0.04	0.07	≤0.04	-	

[43] *Afterhours nurse-led telephone triage was extended Canterbury-wide from February 2010. General practices are encouraged to sign up for the service, but it is not mandatory.*

[44] *Acute demand packages of care allow people who would otherwise require a hospital admission to be treated in their own homes or community through Canterbury's Acute Demand Management Service (ADMS).*

[45] *This measure uses the national ED health target definition, which excludes people who did not stay for treatment.*

[46] *Data capture for this measure began when it was introduced as a health target for 2010/11.*

[47] *The target was set to increase the rate of reported incidents, in line with the DHB policy of open disclosure and staff responsibility to report all adverse events. Achievement reflects transparency and willingness by our staff to learn from events and prevent them from happening again.*

[48] *Staphylococcus aureus is often found in the nose or on the skin of healthy people, causing them no harm. However, Staph aureus can cause infection, and hospitalised patients are at greater risk because they are unwell and have lowered resistance to infection. It is transmitted via contact with people already carrying the bacteria, or through improperly washed hands, surfaces or equipment; therefore, rates of Staph aureus in hospital can reflect the effectiveness of infection control procedures. This year we trialled the Centres for Disease and Control (CDC) HABSI definition, which excludes non-inpatients. However, we have decided that our former definition, which includes non-inpatients receiving care from our hospital staff, is a more complete reflection of HABSI, and we will resume its use next year. Hence, results for this year will differ from both the previous and next year. Results using the CDC definition are only available for 2011/12 and 2012/13.*

ELECTIVE/ARRANGED SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Number of surgical First Specialist Assessments (FSA) provided	V	39,045	41,052	Est. >38,000	-	
Percentage of surgical FSAs that are non-contact (virtual) FSAs	Q [49]	6.9%	7.3%	4.5%	-	
Number of elective surgical discharges provided	V [50]	16,494	17,066	16,110	-	
Percentage of elective/arranged surgery provided as day cases	Q [51]	56%	55%	58%	58%	
Percentage of elective/arranged surgery delivered on the day of admission	Q [51]	82%	88%	82%	86%	
Average elective and arranged inpatient length of stay (days)	Q [52]	3.7	3.6	≤4.0	3.9	
Number of outpatient attendances	V	611,205	618,162	Est. >600,000	-	
Outpatient 'Did Not Attend' rates	Q	4.9%	4.6%	≤5%	-	
MATERNITY SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Number of maternity deliveries in Canterbury	V [53]	5,736	5,778	Est. >6,000	-	
'Baby Friendly' hospital accreditation	Q [54]	yes	yes	yes	-	N/A
Percentage of total deliveries made in primary birthing units	Q [53]	11%	9%	13%	-	
ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Number of admissions for older people (65+) accessing inpatient AT&R services	V	3,261	3,101	Est. >3,000	-	
Percentage of admissions into AT&R (PMH) made by direct community referral	Q	16%	19%	≥20%	-	
Percentage of AT&R inpatients discharged to their own homes (not into aged residential care)	Q [55] Δ	72%	73%	≥70%	-	

[49] *Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity across the system, reducing wait times for patients and taking duplication and waste out of the system.*

[50] *These elective surgery volumes are based on the national health target definition and exclude elective cardiology and dental.*

[51] *When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own homes and frees up hospital beds where capacity in tight post-quake. These measures are based on the national indicators OS6 and OS7. 2012/13 results are for the year to 31 March 2013, as this was the most recent data available from MoH at the time of publishing; prior results are for true financial years.*

[52] *Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision. National indicator OS3 data is provided by the Ministry one quarter in arrears, so results are for the year to 31 March 2012 and 2013.*

[53] *Maternity delivery figures exclude home births. The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women birth in secondary or tertiary facilities when it is not needed in order to make better use of resources and to ensure limited secondary services are more appropriately available for those women who need complex or specialist intervention.*

[54] *The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. IT was established in 1992 to encourage maternity hospitals to deliver a high standard of care and implement best practice in relation to infant feeding for pregnant women, mothers and babies. An assessment and accreditation process recognises those that have achieved the required standard.*

[55] *While living in aged residential care (ARC) is appropriate for a small proportion of our population, when people receive adequate support for their needs, remaining in their own homes provides a higher quality of life as a result of staying active and positively connected to their communities. Therefore, a discharge from AT&R to home (rather than ARC) reflects the quality of AT&R and community support services in terms of assisting that person to regain their functional independence so that, with appropriate community supports, the person is able to safely 'age in place'.*

REHABILITATION AND SUPPORT SERVICES

Rehabilitation and support services assist people to regain functional independence after an illness or disability. Even when returning to full health is not possible, timely access to responsive support services helps people to manage their needs and remain safe and well in their own homes. In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of the wider health system, reducing acute demand for services and the need for more complex intervention. By providing ongoing care for patients and improving recovery after an acute illness or hospital admission, these services also help to reduce hospital readmission rates.

Services that support people in their own homes typically provide a much higher quality of life, as a result of people staying active and positively connected to their communities. Success is therefore defined by increased access to community-based services, less dependence on hospital and residential care and a reduction in illness or deterioration that leads to acute admission or readmission.

Overall, more people have accessed community-based services this year. The Community Rehabilitation Enablement and Support Team (CREST) supported 1,850 people after hospital discharge or on referral from their GP to reduce the likelihood of hospital admission or readmission. Early indications of a lower hospital readmission rate for people supported by CREST suggest the effectiveness of the service, although it will take time to see whether these changes are sustained in the long term. The new community-based falls prevention service is proving popular, with 1,613 referrals received this year – twice the number expected.

This increase in community-based care appears to be having the desired effect; a drop in the number of people entering lower-level Aged Residential Care (ARC) suggests more people are being supporting to stay safe and well in their own homes without needing to go into a rest home. A lower rate of acute hospital admissions from Aged Residential Care (ARC) is also evident, indicating that there is quality residential care for those who need it.

It is pleasing to note the increased use of evidence-based and evidence-informed programmes and tools such as the Liverpool Care Pathway and InterRAI (International Residential Assessment Instrument). This provides greater assurance that quality services are being provided, allowing the DHB to focus on increasing access.

OUTPUT MEASURES

NEEDS ASSESSMENT AND SERVICE COORDINATION	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Number of older people (65+) provided with a clinical assessment of need	V [56] Δ	8,204	6,589	Est. >8,000	-	
Percentage of people 65+ receiving long-term home-based support who have had a comprehensive clinical assessment	Q [57] Δ	85%	88%	85%	-	
Percentage of people entering ARC who have had a clinical assessment of need using InterRAI	Q [58] Δ	new	91%	90%	-	new
PALLIATIVE CARE SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**	**Trend 09/10-12/13**
Number of people supported by hospice or home-based palliative services	V [59] Δ	3,076	3,295	Est. >2,000	-	
Number of ARC facilities trained to provide the Liverpool Care Pathway (LCP)	C [60]	27	42	40 sites	-	

[56] *Due to a change in service model, some clinical assessments of need are now provided directly by the community support services providers and we are unable to capture these volumes. Therefore, the numbers for 12/13 are incomplete; this does not reflect a decrease in service.*
[57] *Comprehensive clinical assessment ensures that service decisions are based on a robust, internationally verified assessment tool (InterRAI) so that the level of support provided matches a person's level of need and people receive equitable access to support.*
[58] *InterRAI is an evidence-based geriatric assessment tool. Using InterRAI ensures assessments are high quality and consistent so that people receive equitable access to support and care. InterRAI also supports improved integration by providing health professionals with a common language of assessment and an electronic means of transferring information. We have excluded clients for whom InterRAI assessment is not applicable (e.g. clients already in ARC, palliative clients, clients under the Mental Health Act).*
[59] *The 2011/12 result differs from the one reported in last year's Annual Report as the result of an error being corrected.*
[60] *The LCP is an international programme adopted nationally and reflects best-practice care. It began in Canterbury in September 2009.*

Rehabilitation Services	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result	Trend 09/10-12/13
Percentage of people referred to stroke rehabilitation services after an acute event	C	75%	74%	≥70%	-	
Percentage of people referred to cardiac rehabilitation services after an acute event	C	25%	25%	≥30%	-	
Number of people accessing community-based pulmonary rehabilitation courses	V [61]	83	100	≥108	-	
Number of older people accessing community-based falls prevention programmes	V [62]	737	1,613	800	-	
Home-Based Support Services	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**	**Trend 09/10-12/13**
Number of people supported by home-based support services	V Δ	8,124	8,860	Est. >8,400	-	
Number of people supported by district nursing services	V Δ	5,833	7,911	Est. >6,000	-	
Older people supported by CREST services on hospital discharge or direct GP referral	V [63]	1,154	1,850	1,100	-	
Rate of acute readmissions to hospital services: for CREST patients for non-CREST (65+) patients **Difference**	Q [64]	 17% 20% -3%	 17% 20% -3%	 -10%	-	
Respite and Day Services	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**	**Trend 09/10-12/13**
Number of people supported by day services	V Δ	664	654	Est.>550	-	
Number of people accessing mental health planned and crisis respite	V Δ	754	829	Est. >800	-	
Occupancy rate of mental health planned and crisis respite	C [65] Δ	71%	85%	≥85%	-	
Residential Care Services	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**	**Trend 09/10-12/13**
Number of (subsidised) ARC rest home bed-days provided	V [66] Δ	613,514	572,747	Est. <676,000	-	
Number of (subsidised) ARC hospital bed-days provided	V [66] Δ	464,188	452,514	Est. <507,000	-	
Number of (subsidised) ARC dementia bed-days provided	V Δ	212,439	221,474	Est. >212,000	-	
Number of (subsidised) ARC psycho-geriatric bed-days provided	V Δ	65,369	69,430	Est. >62,000	-	
Percentage of ARC residents receiving vitamin D supplements	C	63%	73%	75%	-	
Rate of acute admissions into hospital from ARC facilities	Q [67] Δ	3.2%	3.1%	≤4.0%	-	

[61] *The current measure excludes DHB-run courses. Next year this measure will be extended to include all people attending pulmonary rehabilitation, whether DHB-run courses in Ashburton and Christchurch or community-based courses throughout Canterbury. In 2012/13, this totalled 206 courses.*
[62] *This measure refers to Canterbury's Integrated Falls Prevention Service, launched in February 2012. The service seeks to support older people to maintain their independence and live safely in their own homes and communities, reducing harm as a result of falls. The 2011/12 result differs from the one previously published, as an error in manual counting has been found and corrected.*
[63] *The Community Rehabilitation Enablement and Support Team (CREST) began in April 2011 and coordinates wrap-around home-based rehabilitation services in order to facilitate early discharge from hospital or avoid hospital admission altogether.*
[64] *The effectiveness of CREST is measured by comparing readmission rates for CREST clients with rates for the 65+ population not receiving CREST care.*
[65] *Occupancy rates provide an indication of a service's capacity. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directed to other areas.*
[66] *Historical utilisation reflects the situation prior to the earthquakes and loss of ARC capacity; it is likely that utilisation will drop against an increase in home-based support, district nursing and CREST services as people are supported in their own homes.*
[67] *The denominator for this measure is the total number of acute admissions into hospital.*

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2013.

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 surplus of $286.877M against the budgeted deficit of $40.006M (2011/12 result was a net deficit of $0.043M).

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 30/06/13 $'000	Committee Fees Year ended 30/06/13 $'000
Peter Ballantyne	32.5	6.8
Anna Crighton	26.0	4.3
Elizabeth Cunningham	26.0	5.0
Wendy Dallas-Katoa	-	.8
Jonathan Darby	-	1.3
Andrew Dickerson	26.0	5.8
Wendy Gilchrist	26.0	5.3
Aaron Keown	26.0	4.0
Bob Lineham	-	2.3
Bruce Matheson	52.0	4.8
Chris Mene	26.0	4.0
David Morrell	26.0	5.0
Trevor Read	-	1.3
Mary Richardson	-	1.8
William Tate	-	4.0
Susan Wallace	26.0	1.5
Olive Webb	26.0	4.6
	318.5	**62.6**

Total fees paid for the year were $381,100 (2011/12 - $382,000). The limit of fees authorised for the year ended 30 June 2013 was $422,875 (2011/12 - $422,875).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	Board		QFARC		HAC		CPH&DSAC	
	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended
Bruce Matheson	13	10	12	10	6	5	5	3
Peter Ballantyne	13	13	12	12	6	6	5	5
Olive Webb	13	13	12	8	6	3	5	5
David Morrell	13	12	12	11	6	5	5	5
Anna Crighton	13	12	12	9	6	3	5	5
Elizabeth Cunningham	13	12	12	10	6	6	5	4
Andrew Dickerson	13	13	12	12	6	6	5	5
Susan Wallace	13	13	12	4	6	1	5	1
Chris Mene	13	10	12	5	6	6	5	5
Aaron Keown	13	8	12	9	6	4	5	3
Wendy Gilchrist	13	10	12	11	6	5	5	5
Wendy Dallas-Katoa	-	-	-	-	-	-	5	3
Jonathan Darby	-	-	-	-	-	-	5	5
Mary Richardson	-	-	-	-	-	-	5	4
Bob Lineham	-	-	12	9	-	-	-	-
William Tate	-	-	12	11	6	5	-	-
Ana Rolleston	-	-	-	-	6	6	-	-
Trevor Read	-	-	-	-	6	4	-	-

DIRECTOR FEES

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

	Year Ended 30/06/13 $'000	Year Ended 30/06/12 $'000
David Morrell	-	10
Brian Wood	20	20
Jane Cartwright	5	-
	25	**30**

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2013

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

Bruce Matheson	Freshpork NZ Ltd – Director. Engaged in farming, processing and marketing of pork meats in New Zealand – no 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. The McLean Institute – Board of Governors The Chair of the Canterbury DHB is an ex-officio member of the Board of Governors pursuant to an Act of Parliament. The McLean Institute operates Holly Lea, a rest home which provides residential aged care services under contract with the Canterbury DHB. Snap Internet Ltd –Chairman – Board of Directors This company is an internet provider which provides services to the Canterbury DHB.
Peter Ballantyne	West Coast District Health Board - Appointed Member – Deputy Chair. Bishop Julius Hall of Residence, Trust Board Member. University of Canterbury, Council 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. Christchurch Heritage Trust – Trustee Governance of Christchurch Heritage. Historic Places Aotearoa Inc – President.
Elizabeth Cunningham	Te Runanga o Ngai Tahu (TRONT) – Director Governance body for Ngai Tahu. Canterbury District Police Advisory Group – Co Chair South Island Oncology Research Group – Chair 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. Māori Women's Welfare League – President Rapaki Branch The League has contracts through the Ministry of Health for the delivery of health services for Māori.

	Kawa Whakaruruhau Roopu Bachelor of Nursing/Midwifery Christchurch Polytechnic – Chair A committee of Christchurch Polytechnic, Department of Health Services, providing input and oversight in relation to course programmes.
	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 Māori issues around Section 8 of the RMA Act. If conflicts arise they will be advised.
	CERA Recovery Strategy Advisory Committee – Member (Ngai Tahu Representative)
Wendy Dallas-Katoa	Te Kahui o Papaki ka Tai – Deputy Chair, Mana Whenua Representative Māori Advisory Group to Pegasus Health/PHO
	Manawhenua Ki Waitaha – Trust Member, Representative of Onuku Runanga 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.
	NSP Kaitiaki Advisory Group – MoH Appointed Member
	Whakaruruhau Komiti National Breastfeeding Māori Advisory Group
	Te Reo Kotahi - Pan - NGO sector delegate to CERA
	National Health Promotion Forum – Chair, Māori Advisory Group
	Community Services Service Level Alliance
	Pegasus Health Community Board
Jonathan Darby	Toastmasters International - a member of two Toastmasters clubs and holds an executive role in one. No conflicts of interest are anticipated regarding this 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.
	Lotteries Individuals with Disabilities Distribution Committee – Member This is a Committee of the Lotteries Commission responsible for allocating grants for mobility and communication equipment to help people with disabilities achieve independence and gain access to the community. No conflicts of interest are anticipated but will be addressed as appropriate should they arise.
	Advisory Committee on Assisted Reproductive Technology (ACART) - Member
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 – Member The Trust promotes the identification, preservation and conservation of the historical & cultural heritage of New Zealand. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance. No conflicts of interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time. NZ Gerontology Association – Member Professional association that promotes the interests of older people and an understanding of ageing. Hope Foundation for Research on Ageing – Member Promotes research on New Zealand's ageing population and its implications for the future. Osteoporosis (Canterbury) Inc. – Member Provides support, 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	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. The company may collaborate with Canterbury Health Laboratories. CERA Community Forum – Member Community forum formed under the Canterbury Earthquake Recovery Act to provide the Minister with information and advice on earthquake recovery matters. Child Help Line – Board Member Husband Dr Nigel Gilchrist is employed as a specialist consultant physician with the Canterbury DHB. No potential conflict of interest is expected and should this arise it will be declared at that time. Dr Nigel Gilchrist is also the founding Director of the Canterbury Geriatric Medical Research Trust (est 1986), a charitable trust that leases space from Canterbury DHB and also provides some charitable works for the Canterbury DHB at no cost to the Canterbury DHB.

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. Canterbury Development Corporation – Director. No conflicts of interest are anticipated from these roles but will be discussed at the appropriate time should they arise. Canterbury Regional Transport Committee - Christchurch City Council Representative Canterbury Regional Innovation System (CRIS) – Director Grouse Entertainment – Director and Shareholder
Bob Lineham	Civic Assurance (New Zealand Local Government Insurance Corporation Ltd) – Director (resigned July 2013) This is a specialist insurance company servicing Local Government 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 (CCHL) – Chief Executive This is an infrastructure investment company. Also acts as a director in a number of non-operating CCHL shelf companies. Civic Property Pool – Trustee Red Bus Limited - Director
Chris Mene	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 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 Clinical Network – Project Manager, Child & Youth Workstream Contracted to Pegasus Health.
David Morrell	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. Honorary Canon- Christchurch Cathedral The Cathedral congregation runs a food programme in association with Canterbury DHB staff. Great Christchurch Buildings Trust – Trustee The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing. Spouse is a member of the Hospital Ladies Visitors Association – no potential conflict of interest is expected and should this arise it will be declared at that time.
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.
Mary Richardson	Christchurch Methodist Mission – Executive Director Migrant Centre – Board Member.

Ana Rolleston	Manawhenua ki Waitaha – Trustee Representative of Wairewa Rūnanga. 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 ki Waitaha and the Canterbury DHB. Christchurch PHO – Board Member The Christchurch PHO is mostly funded by either the Ministry of Health and/or the CDHB. The Christchurch PHO supports General Practitioners delivering primary health care in Christchurch. Māori Women's Welfare League – Member The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori. South Island Alliance Programme Office, Southern Cancer Network – Inequalities Project Manager (Staff Member) The Southern Cancer Network is one of four Regional Cancer Networks in New Zealand established to support the implementation of cancer control strategies and action plans in New Zealand and is funded by the Ministry of Health. The Southern Cancer Network works closely with the Nelson/Marlborough DHB, West Coast DHB, Canterbury DHB, South Canterbury DHB and Southern DHB. The CDHB provides hosting functions for the South Island Alliance Programme Office. Philanthropy New Zealand – Board Member A membership organisation that provides training and support for philanthropic organisations. The membership organisations fund a variety of community projects. West Coast Local Cancer Network/Team – Member The West Coast Local Cancer Network/Team provides a forum for key stakeholders to discuss, debate and plan local cancer initiatives through a partnership approach. CDHB provides some cancer services to the West Coast.
William Tate	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. Rata Te Awhina Trust – Chair West Coast Māori provider affiliated with He Oranga Pounamu and recipient of Ministry of Health funding. Te Waipounamu Māori Women's Welfare League - Area Representative to National Executive of Māori Women's Welfare League.

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. 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. 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 $451,854 to 8 employees (2011/12 – 4 employees totalling $182,299) comprising negotiated settlements with all of the former employees.

REMUNERATION OF EMPLOYEES

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

	30/06/13 (including benefits) Total	30/06/12 (including benefits) Total
100,000-109,000	135	136
110,000-119,000	101	82
120,000-129,000	80	64
130,000-139,000	75	70
140,000-149,000	50	54
150,000-159,000	54	41
160,000-169,000	30	37
170,000-179,000	30	37
180,000-189,000	23	24
190,000-199,000	24	22
200,000-209,000	22	36
210,000-219,000	33	23
220,000-229,000	27	22
230,000-239,000	23	27
240,000-249,000	10	25
250,000-259,000	30	14
260,000-269,000	21	13
270,000-279,000	16	19
280,000-289,000	13	18
290,000-299,000	12	19
300,000-309,000	17	4
310,000-319,000	14	11
320,000-329,000	10	6
330,000-339,000	3	6
340,000-349,000	7	6
350,000-359,000	3	5
360,000-369,000	7	4
370,000-379,000	7	3
380,000-389,000	1	2
390,000-399,000	3	-
400,000-409,000	2	1
410,000-419,000	1	3
420,000-429,000	2	-
430,000-439,000	1	-
440,000-449,000	1	1
450,000-459,000	-	-
460,000-469,000	1	-
490,000-499,000	-	-
500,000-509,000	-	-
530,000-539,000	1	1
540,000-549,000	-	1
560,000-569,000	1	
Total	**891**	**837**

Of the 891 (2011/12 837) positions identified above, 776 (2011/12 750) positions were predominantly clinical and 115 (2011/12 87) positions were management/administrative.

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STATUTORY INFORMATION

This Annual Report outlines the Canterbury DHB's financial and non-financial performance for the year ended 30 June 2013 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

Consistent with our vision for the Canterbury Health system and our organisational values, the Canterbury DHB is committed to being a great place to work and develop.

Leadership, Accountability and Culture

It is often said that an organisation's strength is derived from its leaders and leadership behaviour, systems and processes, and storytelling – in other words its culture. This coupled with aligned strategies, structures, staffing, and skills; as well as integrated physical infrastructure, relationships and networks provides the best chance of achieving of our vision, as well as having the ability to meet the challenges of delivering quality health services to a vulnerable and dislocated population. To meet this considerable challenge we need an engaged, motivated, and highly skilled workforce that is committed to doing its best for their patients and for the wider health system.

Staff Mix by Average Age	Average age
Medical	42.6
Nursing	46.8
Allied Health	42.2
Support	50.1
Management & Administration	45.8

Staff Mix by Gender	Number	Percentage
Female	7,801	81
Male	1,845	19
Total	9,646	

Our leadership practices are concerned with ensuring that those who know best are the ones who are involved in developing and determining outcomes. This approach together with effective governance arrangements within CDHB and across our health system work in a way so as to deliver positive patient outcomes.

Our expectations are that our leaders will tell a clear, consistent and compelling story about our direction of travel; will motivate and energise their teams to meet agreed organisational goals; and will be responsible and accountable for outcomes.

Staff Ethnicity	Number
Australian	85
British	618
Chinese	105
Indian	99
Latin American	6
Māori	197
Middle Eastern	20
New Zealander	438
NZ European	4,528
Pacific Peoples	67
South African	53
Other African	45
Other Asian	255
Other European	887
Other	1
Not Stated	2,242
Total	9,646

Integrated Talent Management

We utilise an integrated approach to attracting, selecting and engaging people across the Canterbury Health System for today, tomorrow and the future. This approach has a range of elements including recruitment, candidate care, talent management and succession planning, and strategic sourcing. The purpose of this approach is to support an integrated Canterbury Health System by providing proactive, targeted and agile initiatives at every level; maximising opportunities that result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey throughout the Canterbury Health system. As part of these approaches we fully embrace best practices of equity and diversity. We are also active participants in the development of consistent regional approaches to recruitment and associated support systems; as well as influencing the shape of national direction in this critical area.

Workplace Safety, Health and Wellness

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by a professional Health and Safety team that includes experts in workplace safety, occupational health and rehabilitation, as well as employee Wellness. In addition to working with our employees this dedicated team also provides advice and support to management and staff. There is a health monitoring programme which includes screening and immunisation and employees are encouraged to access the Employee Assistance Programme if they are faced with personal problems

that may impact their work situation. Wellness programmes and activities to encourage and support employees in terms of healthier lifestyles are available throughout the organisation. An employee participation programme with safety training encourages all employees to be responsible for building and maintaining a healthy and safe environment at work. Canterbury DHB continues to participate in the ACC Partnership Programme and is focussed on developing and implementing injury prevention programmes that address high risk areas and in the rehabilitation of employees back to work following an injury or illness. We do not tolerate any form of harassment or workplace bullying and ensure all staff is 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

Our policy is to ensure a fair, equitable, and transparent approach to remuneration management as well as a consistent approach to conditions of employment for both our IEA and MECA contracted workforces. Our IEA practice is to remunerate at an agreed market line which includes consideration of appropriate market data, as well as alignment to the principles of performance, employee competency development and organisation affordability. We also monitor feedback from employee engagement, exit, and attachment surveys to ensure our practices are relevant.

Employee Engagement

In June 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 80% of Canterbury's overall workforce is either engaged or highly engaged, with only 2% 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 would be comfortable being a patient here and feel confident raising any concerns.

Staff also highlighted our staff wellness programme and formal communication as areas of strength.

Canterbury's focus on engaging and empowering our workforce is evident in our improvement since 2010. Engagement has improved by 2.5% across the board and in all factors measured. Turnover rates also remain relatively low: the average time spent working in Canterbury DHB services is 9.6 years, compared to an average of 8.2 years across all DHBs.

Employee Development

We continue to develop 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. This work is underpinned by a capability framework that has identified the management and leadership knowledge, skills, and behavioural attributes that will be required by all employees as we transform our system. To enable this work we have formed a tertiary alliance with the University of Otago, the University of Canterbury, and the TANZ network (10 SI and lower NI polytechnic institutes) to make available a common curriculum of development to all employees. These programmes are additional to the extensive skills development initiatives that come through the various professional groups for both clinical and non clinical employees. The rollout of an online performance appraisal process that ensures that all employees are focussed on the right things and expected behaviours at an individual level is continuing with completion expected in 2014/15. This process also identifies and provides input to the development needs of individuals.

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 2013, 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.

For and on behalf of the Board

Bruce Matheson
Chair
31 October 2013

Peter Ballantyne
Deputy Chair
31 October 2013

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2013

	Notes	Group			Parent	
		Actual 30/06/13 $'000	Budget 30/06/13 $'000	Actual 30/06/12 $'000	Actual 30/06/13 $'000	Actual 30/06/12 $'000
Income						
Ministry of Health revenue		1,417,954	1,379,624	1,369,837	1,399,457	1,358,473
Patient related revenue	2	44,487	33,140	44,786	44,487	44,786
Other income	3	320,016	32,091	50,366	315,776	47,651
Interest income		9,417	6,023	7,337	9,253	7,179
Total income		**1,791,874**	**1,450,878**	**1,472,326**	**1,768,973**	**1,458,089**
Operating expenses						
Employee benefit costs	4	599,959	610,010	583,999	585,355	571,519
Treatment related costs		128,613	128,767	138,428	127,844	142,460
External service providers		581,255	601,001	581,046	581,255	581,046
Depreciation and amortisation		48,191	49,625	46,454	46,573	45,087
Interest expenses on loans		5,765	4,708	4,529	5,765	4,529
Other expenses	5	128,195	79,273	102,858	122,955	98,948
Total operating expenses		**1,491,978**	**1,473,384**	**1,457,314**	**1,469,747**	**1,443,589**
Operating surplus before capital charge		299,896	(22,506)	15,012	299,226	14,500
Capital charge expense	6	(13,019)	(17,500)	(15,055)	(13,019)	(15,055)
Surplus/(deficit)		**286,877**	**(40,006)**	**(43)**	**286,207**	**(555)**
Other comprehensive income						
Impairment of property, plant & equipment	7 & 14 & 16	(25,108)	-	(14,297)	(25,108)	(14,297)
Revaluation of property, plant & equipment	14	93,245	-	-	93,245	-
Total other comprehensive income		**68,137**	**(40,006)**	**(14,297)**	**68,137**	**(14,297)**
Total comprehensive income		**355,014**	**(40,006)**	**(14,340)**	**354,344**	**(14,852)**

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2013

	Notes	Group			Parent	
		Actual 30/06/13 $'000	Budget 30/06/13 $'000	Actual 30/06/12 $'000	Actual 30/06/13 $'000	Actual 30/06/12 $'000
Total equity at beginning of the period		185,325	212,401	198,815	182,616	196,618
Total comprehensive income		355,014	(40,006)	(14,340)	354,344	(14,852)
Total recognised revenues and expenses		540,339	172,395	(14,340)	536,960	(14,852)
Other movements:						
Contribution back to Crown		(3,722)	(1,861)	-	(3,722)	-
Contribution from Crown		-	30,000	850	-	850
Total equity at end of the period	7	**536,617**	**200,534**	**185,325**	**533,238**	**182,616**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2013

	Notes	Group Actual as at 30/06/13 $'000	Group Budget as at 30/06/13 $'000	Group Actual as at 30/06/12 $'000	Parent Actual as at 30/06/13 $'000	Parent Actual as at 30/06/12 $'000
CROWN EQUITY						
General Funds	7	127,432	172,062	131,154	127,570	131,292
Revaluation Reserve	7	199,541	145,701	131,404	199,541	131,404
Retained earnings/(losses)	7	209,644	(117,229)	(77,233)	206,127	(80,080)
TOTAL EQUITY		**536,617**	**200,534**	**185,325**	**533,238**	**182,616**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and cash equivalents	8	87,039	61,446	51,819	86,036	50,408
Trade and other receivables	9	374,000	45,872	57,959	372,372	56,539
Inventories	10	7,983	9,641	8,493	7,888	8,397
Investments	11	2,491	-	74,329	-	71,500
TOTAL CURRENT ASSETS		471,513	116,959	192,600	466,296	186,844
CURRENT LIABILITIES						
Trade and other payables	12	121,351	95,300	121,059	121,026	120,725
Owing to the Ministry of Health		-	4,500	2,514	-	2,333
Employee benefits	13	163,505	153,321	152,422	161,059	150,145
Borrowings	18	-	-	30,000	-	30,000
TOTAL CURRENT LIABILITIES		284,856	253,121	305,995	282,085	303,203
NET WORKING CAPITAL		186,657	(136,162)	(113,395)	184,211	(116,359)
NON CURRENT ASSETS						
Investments	11	54,843	54,650	54,650	60,237	60,171
Property, plant and equipment	14	427,483	429,431	349,700	421,128	344,412
Intangible assets	15	5,038	5,265	939	5,036	938
Restricted assets	17	14,766	13,686	15,012	14,766	15,012
TOTAL NON CURRENT ASSETS		502,130	503,032	420,301	501,167	420,533
NON CURRENT LIABILITIES						
Employee benefits	13	7,754	8,000	6,919	7,724	6,896
Restricted funds	17	14,766	13,686	15,012	14,766	15,012
Borrowings	18	129,650	144,650	99,650	129,650	99,650
TOTAL NON CURRENT LIABILITIES		152,170	166,336	121,581	152,140	121,558
NET ASSETS		**536,617**	**200,534**	**185,325**	**533,238**	**182,616**

For and on behalf of the Board

Bruce Matheson

Bruce Matheson
Chair
31 October 2013

Peter Ballantyne
Deputy Chair
31 October 2013

This statement is to be read in conjunction with the Notes following the Statement of Cash Flows and the Audit Report

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2013

	Notes	Group Actual 30/06/13 $'000	Group Budget 30/06/13 $'000	Group Actual 30/06/12 $'000	Parent Actual 30/06/13 $'000	Parent Actual 30/06/12 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,391,426	1,379,624	1,383,792	1,372,997	1,372,835
Other receipts		71,066	65,231	84,856	67,258	82,242
Interest received		9,417	6,023	7,337	9,253	7,179
		1,471,909	1,450,878	1,475,985	1,449,508	1,462,256
Cash was applied to:						
Payments to employees		588,041	610,010	573,681	573,626	561,792
Payments to suppliers		835,910	809,041	819,299	829,983	819,539
Interest paid		5,685	4,708	4,363	5,685	4,363
Capital charge		13,019	17,275	18,926	13,019	18,926
GST - net		1,363	-	(2,983)	1,341	(2,976)
		1,444,018	1,441,034	1,413,286	1,423,654	1,401,644
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	27,891	9,844	62,699	25,854	60,612
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant & equipment		-	-	30	-	20
Receipts from restricted assets & investments		73,341	-	3,552	73,613	3,552
		73,341	-	3,582	73,613	3,572
Cash was applied to:						
Purchase of investments & restricted assets		1,774	-	112,472	2,179	112,037
Purchase of property, plant & equipment		60,516	134,104	45,293	57,938	44,109
		62,290	134,104	157,765	60,117	156,146
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		11,051	(134,104)	(154,183)	13,496	(152,574)
CASH FLOW FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		-	15,000	54,650	-	54,650
Equity injection		-	30,000	850	-	850
		-	45,000	55,500	-	55,500
Cash was applied to:						
Equity repaid to Crown		3,722	1,861	-	3,722	-
		3,722	1,861	-	3,722	-
NET CASH INFLOW/ (OUTFLOW) FROM FINANCING ACTIVITIES		(3,722)	43,139	55,500	(3,722)	55,500
Net (decrease)/increase in cash and cash equivalents		35,220	(81,121)	(35,984)	35,628	(36,462)
Cash and cash equivalents at beginning of year		51,819	142,567	87,803	50,408	86,870
CASH & CASH EQUIVALENTS AT END OF YEAR	8	**87,039**	**61,446**	**51,819**	**86,036**	**50,408**

This statement is to be read in conjunction with the Notes following the Statement of Cash Flows and the Audit Report

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2013

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 has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

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 Linen Services Ltd (formerly Canterbury Laundry Service Ltd) (100% owned) and Brackenridge Estate Ltd (100% owned).

The financial statements of Canterbury DHB are for the year ended 30 June 2013 and were authorised for issue by the Board on 31 October 2013.

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 dollars. 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 but not yet effective that have not been early adopted and which are relevant to Canterbury DHB include:

- NZ IFRS 9 *Financial Instruments* will eventually replace *NZ IAS 39 Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost

or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Canterbury DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means Canterbury DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Canterbury DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. 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 surplus /deficit.

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 GAAP, 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.

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 & Fit-out	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, resulting in 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 Canterbury 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 the 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 a 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 Defined Benefit Plan Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, 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 Canterbury 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, Canterbury 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. Canterbury 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 a re-measurement 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.

Critical accounting estimates and assumptions

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, advance in medical technology, 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	
	30/06/13 $'000	30/06/12 $'000	30/06/13 $'000	30/06/12 $'000
ACC Revenue	22,822	23,599	22,822	23,599
Other patient related revenue	21,665	21,187	21,665	21,187
	44,487	**44,786**	**44,487**	**44,786**

3. OTHER INCOME

	Group		Parent	
	30/06/13 $'000	30/06/12 $'000	30/06/13 $'000	30/06/12 $'000
Gain/(loss) on sale of property, plant and equipment	43	(226)	14	(240)
Donations and bequests received	1,299	1,158	1,299	1,158
Insurance revenue	294,672	24,708	294,672	24,708
Other	24,002	24,726	19,791	22,025
	320,016	**50,366**	**315,776**	**47,651**

4. EMPLOYEE BENEFIT COSTS

	Group		Parent	
	30/06/13 $'000	30/06/12 $'000	30/06/13 $'000	30/06/12 $'000
Wages and salaries	583,537	568,627	569,157	556,775
Contributions to defined contribution plans	4,503	5,054	4,456	5,016
Increase/(decrease) in employee benefit provisions	11,919	10,318	11,742	9,728
	599,959	**583,999**	**585,355**	**571,519**

5. OTHER EXPENSES

	Group		Parent	
	30/06/13 $'000	30/06/12 $'000	30/06/13 $'000	30/06/12 $'000
Remuneration of auditor:				
Financial statement audit fees	239	240	196	194
Board members' fees	319	318	319	318
Directors' fees	25	30	-	-
Rental costs	6,364	5,300	5,583	4,626
Facilities and infrastructure costs (note 16)	61,244	56,519	59,014	54,543
Other non-clinical costs	60,004	40,451	57,843	39,267
	128,195	**102,858**	**122,955**	**98,948**

6. CAPITAL CHARGE

Canterbury DHB pays capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the period ended June 2013 was 8%. (June 2012 8%).

7. CAPITAL AND RESERVES

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
General Funds				
Opening Balance	131,154	130,304	131,292	130,442
Equity repayment to Ministry of Health	(3,722)	-	(3,722)	-
Equity injection by Ministry of Health	-	850	-	850
	127,432	**131,154**	**127,570**	**131,292**
Retained earnings				
Opening balance	(77,233)	(77,190)	(80,080)	(79,525)
Operating surplus/(deficit)	286,877	(43)	286,207	(555)
Transfer (to)/from revaluation reserve	-	-	-	-
Closing balance	209,644	(77,233)	206,127	(80,080)
Represented by:				
Accumulated surplus in parent and subsidiary	209,566	(77,311)	206,049	(80,158)
Accumulated surplus in associates	78	78	78	78
	209,644	**(77,233)**	**206,127**	**(80,080)**
Revaluation reserve				
Opening balance	131,404	145,701	131,404	145,701
Impairment charges	(25,108)	(14,297)	(25,108)	(14,297)
Revaluation of land, building including fit-out	93,245	-	93,245	-
Transfer to retained earnings	-	-	-	-
Closing balance	199,541	131,404	199,541	131,404
Represented by:				
Revaluation of land	86,109	57,108	86,109	57,108
Revaluation of building including fit-out	113,432	74,296	113,432	74,296
	199,541	**131,404**	**199,541**	**131,404**
Total Equity	**536,617**	**185,325**	**533,238**	**182,616**

8. CASH AND CASH EQUIVALENTS

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Bank balances and call deposits (refer note 26)	87,039	17,819	86,036	16,408
Term deposits less than 3 months	-	34,000	-	34,000
	87,039	**51,819**	**86,036**	**50,408**

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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Trade receivables	18,635	9,343	18,371	9,240
Receivable from the Ministry of Health	52,081	25,553	50,867	24,407
Prepayments	2,776	1,950	2,773	1,947
Other receivables	300,508	21,113	300,361	20,945
	374,000	**57,959**	**372,372**	**56,539**

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.

Other receivables includes $294.5M (June 2012 $15.8M) insurance receivable.

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

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Balance at 1 July	3,605	3,676	3,602	3,676
Additional provisions made during the year	1,339	595	1,342	592
Receivables written-off during period	(1,632)	(666)	(1,632)	(666)
Balance at 30 June	**3,312**	**3,605**	**3,312**	**3,602**

The ageing of the impairment provisions are as follows:

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Current	121	937	121	934
1-30 days	612	198	612	198
31-60 days	225	187	225	187
> 61 days	2,354	2,283	2,354	2,283
Balance at 30 June	**3,312**	**3,605**	**3,312**	**3,602**

As at 30 June 2013 and 2012, 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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Current	15,488	8,582	15,293	8,532
1-30 days	2,491	711	2,455	693
31-60 days	(472)	169	(502)	154
> 61 days	1,128	(119)	1,125	(139)
Balance at 30 June	**18,635**	**9,343**	**18,371**	**9,240**

10. INVENTORY

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Pharmaceuticals	4,445	2,554	4,445	2,554
Surgical and medical supplies	4,806	4,542	4,806	4,542
Other supplies	509	2,919	414	2,823
	9,670	10,015	9,665	9,919
Provision for obsolescence	(1,777)	(1,522)	(1,777)	(1,522)
	7,983	**8,493**	**7,888**	**8,397**

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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Current investments are represented by:				
Term deposits	2,491	74,329	-	71,500
Total current portion	2,491	74,329	-	71,500
Non-current investments are represented by:				
Term Deposits	54,843	54,650	54,843	54,650
Investment in Subsidiaries	-	-	5,394	5,521
Total non-current portion	54,843	54,650	60,237	60,171
	57,334	**128,979**	**60,237**	**131,671**

Investment in Associates

a) General information

Name of entity	Principal activities	Interest held at 30/06/13	Balance date
South Island Shared Service Agency Limited	Non Trading Company	47%	30 June

South Island Shared Service Agency Limited is an unlisted company. It is no longer operating and will be held as a shelf company. The functions of the South Island Shared Service Agency Limited are being conducted by the South Island Alliance Programme Office under the umbrella of Canterbury DHB under an agency agreement with South Island DHBs.

b) Investment in associate entities

	2013 Actual $'000	2012 Actual $'000
Carrying amount at beginning of year	-	-
Carrying amount at end of year	**-**	**-**

c) Summarised financial information of associate entity

	2013 Actual $'000	2012 Actual $'000
Assets	-	944
Liabilities	-	20
Revenues	-	1,035
Surplus/(deficit)	-	(163)
Group's interest	-	47%

d) Share of associates' contingent liabilities and commitments

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

Investments in subsidiaries

	Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000
Equity - Canterbury Linen Services Ltd	5,201	5,436
Advances - Canterbury Linen Services Ltd	(40)	(42)
Advances - Brackenridge Estate Ltd	233	127
	5,394	**5,521**

At 30 June 2013 subsidiary companies comprise:

	Percentage Interest	Balance Date
Canterbury Linen Services Ltd	100%	30 June
Brackenridge Estate Ltd	100%	30 June

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

Joint Ventures
NZ Health Innovation Hub - the four largest District Health Boards (Counties Manukau, Auckland, Waitemata and Canterbury) established a national Health Innovation Hub. The Hub engages with the DHBs, clinicians and Industry to collaboratively realise and commercialise products and services that can make a material impact on healthcare in NZ and internationally.

The Hub has been structured as a limited partnership, with the four foundation DHBs each having a 25% shareholding in the limited partnership and the general partner, NZ Health Innovation Hub Management Limited, which was incorporated on 26 June 2012.

Other investments

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Term deposits	57,334	128,979	54,650	126,150

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	
	30/06/13 $'000	30/06/12 $'000
Term deposits with maturities of 1-12 months	3,129	74,329
Weighted average effective interest rates	4.31%	4.50%
Term deposits with maturities later than 1 year but no more than 5 years	54,650	54,650
Weighted average effective interest rates	5.22%	5.22%

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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Trade payables	13,533	10,616	13,244	10,745
Other payables	107,818	110,443	107,782	109,980
	121,351	**121,059**	**121,026**	**120,725**

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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Non-current liabilities				
Liability for long service leave	4,284	3,843	4,254	3,820
Liability for retirement gratuities	3,470	3,076	3,470	3,076
	7,754	**6,919**	**7,724**	**6,896**
Current liabilities				
Annual leave accruals	65,761	61,746	64,675	60,833
Unpaid days accruals	7,947	15,786	7,684	15,572
ACC accruals	10,112	10,038	10,046	9,962
Conference/sabbatical leave and expenses	23,623	22,237	23,623	22,237
Sick leave	10,613	10,437	10,446	10,278
Other	45,449	32,178	44,585	31,263
	163,505	**152,422**	**161,059**	**150,145**

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

14. PROPERTY, PLANT AND EQUIPMENT

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

12/13 financial year	Freehold land	Freehold buildings & fit-out	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 2012	**103,682**	**291,385**	**199,212**	**1,267**	**-**	**10,640**	**606,186**
Additions	-	37,338	17,512	-	-	740	55,590
Disposals/transfers	-	-	(2,555)	-	-	-	(2,555)
Revaluation	19,656	(62,035)	-	-	-	-	(42,379)
Balance at 30 June 2013	**123,338**	**266,688**	**214,169**	**1,267**	**-**	**11,380**	**616,842**
Depreciation & impairment losses							
Balance at 1 July 2012	9,345	99,314	146,811	1,016	-	-	256,486
Depreciation	-	28,838	16,993	70	-	-	45,901
Revaluation	(9,345)	(126,234)	(45)	-	-	-	(135,624)
Impairment	-	25,108	-	-	-	-	25,108
Disposals/transfer	-	-	(2,512)	-	-	-	(2,512)
Balance at 30 June 2013	**-**	**27,026**	**161,247**	**1,086**	**-**	**-**	**189,359**

11/12 financial year	Freehold land	Freehold buildings & fit-out	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 2011	103,682	264,693	188,002	894	3,000	8,768	569,039
Additions	-	27,032	14,745	373	-	1,872	44,022
Disposals/transfers	-	(340)	(3,535)	-	(3,000)	-	(6,875)
Balance at 30 June 2012	**103,682**	**291,385**	**199,212**	**1,267**	**-**	**10,640**	**606,186**
Depreciation & impairment losses							
Balance at 1 July 2011	9,345	56,062	134,454	894	-	-	200,755
Depreciation	-	29,038	15,887	122	-	-	45,047
Impairment	-	14,297	-	-	-	-	14,297
Disposals/transfer	-	(83)	(3,530)	-	-	-	(3,613)
Balance at 30 June 2012	**9,345**	**99,314**	**146,811**	**1,016**	**-**	**-**	**256,486**

Carrying amount	Freehold land	Freehold buildings & fit-out	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
At 1 July 2012	94,337	192,071	52,401	251	-	10,640	349,700
At 30 June 2013	**123,338**	**239,662**	**52,922**	**181**	**-**	**11,380**	427,483

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.

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

12/13 financial year	Freehold land	Freehold buildings & fit-out	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 2012	**103,682**	**290,788**	**188,791**	**1,267**	**-**	**10,587**	**595,115**
Additions	-	37,320	14,792	-	-	789	52,901
Disposals/transfers	-	-	(1,170)	-	-	-	(1,170)
Revaluation	19,656	(62,035)	-	-	-	-	(42,379)
Balance at 30 June 2013	**123,338**	**266,073**	**202,413**	**1,267**	**-**	**11,376**	**604,467**
Depreciation & impairment losses							
Balance at 1 July 2012	**9,345**	**99,018**	**141,324**	**1,016**	**-**	-	**250,703**
Depreciation	-	28,791	15,421	70	-	-	44,282
Revaluation	(9,345)	(126,234)	(45)	-	-	-	(135,624)
Impairment	-	25,108	-	-	-	-	25,108
Disposals/transfer	-	-	(1,130)	-	-	-	(1,130)
Balance at 30 June 2013	**-**	**26,683**	**155,570**	**1,086**	**-**	**-**	**183,339**

11/12 financial year	Freehold land	Freehold buildings & fit-out	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 2011	103,682	264,116	178,070	894	3,000	8,768	558,530
Additions	-	27,011	13,623	373	-	1,819	42,826
Disposals/transfers	-	(339)	(2,902)	-	(3,000)	-	(6,241)
Balance at 30 June 2012	**103,682**	**290,788**	**188,791**	**1,267**	**-**	**10,587**	**595,115**
Depreciation & impairment losses							
Balance at 1 July 2011	9,345	55,812	129,657	894	-	-	195,708
Depreciation	-	28,992	14,565	122	-	-	43,679
Impairment	-	14,297	-	-	-	-	14,297
Disposals/transfer	-	(83)	(2,898)	-	-	-	(2,981)
Balance at 30 June 2012	**9,345**	**99,018**	**141,324**	**1,016**	**-**	-	**250,703**

Carrying amount	Freehold land	Freehold buildings & fit-out	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
At 1 July 2012	94,337	191,770	47,467	251	-	10,587	344,412
At 30 June 2013	**123,338**	**239,390**	**46,843**	**181**	**-**	**11,376**	**421,128**

Revaluation

Canterbury DHB revalued its land, buildings and plant fitouts as at 30 June 2013. 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. 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 reversionary interest was valued as at 30 June 2010 however was impaired due to earthquake damage in 2012.

15. INTANGIBLE ASSETS

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Software				
Cost				
Opening balance	20,529	19,298	20,521	19,284
Additions	3,443	1,654	3,441	1,654
Disposals	(54)	(423)	(54)	(417)
Closing balance	23,918	20,529	23,908	20,521
Amortisation and impairment losses				
Opening balance	19,590	18,600	19,583	18,592
Amortisation charge for the year	2,290	1,407	2,289	1,408
Disposals	(7)	(417)	(7)	(417)
Closing balance	21,873	19,590	21,865	19,583
Health Benefits Limited	2,993	-	2,993	-
Carrying amounts	**5,038**	**939**	**5,036**	**938**

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 2013. There has been no change since last year.

Canterbury DHB has made payments totalling $2.993M (2012: Nil) to Health Benefits Limited (HBL) in relation to the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by HBL, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

HBL has issued B Class Shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain Shared Service. The following rights are attached to these shares;

- Class B Shares confer no voting rights
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

The rights attached to the "B" Class share include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and, therefore, the benefits

conferred through this access. The service level agreement will contain five provisions specific to the recognition of the investment within the financial statements of DHBs. The five provisions are:

- The service level agreement is renewable indefinitely at the option of the DHBs; and
- The DHBs intend to renew the agreement indefinitely; and
- There is satisfactory evidence that any necessary conditions for renewal will be satisfied; and
- The cost of renewal is not significant compared to the economic benefits of renewal; and
- The fund established through the on-charging of depreciation by HBL will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

The application of these five provisions mean the investment, upon capitalisation on the implementation of the FPSC Programme, will result in the asset being recognised as an indefinite life intangible asset.

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 Canterbury DHB's buildings and assets. Damage was sustained to more than 200 buildings and over 12,000 rooms need some level of repair. Additionally, 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 in 2010 to assess the amount of damage to Canterbury DHB's buildings and assets. Detailed building by building assessments were completed, and over $500 million of earthquake related repairs were identified 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 level of damage to its buildings, it is progressively working through how and what repairs will be undertaken. As repair work progresses, additional damage is being discovered. As a result, the estimated cost to repair our buildings could increase.

Additional costs are being incurred where repair work is considered to be an upgrade to our buildings under the new building codes that became effective after the February 2011 earthquakes, or where other strengthening work is required. These costs associated with making buildings compliant under the new building codes will be significant, and are in the main not covered by our insurance settlement.

Canterbury DHB continually reviews whether the carrying value of land and buildings exceeds their recoverable amount. Our land and buildings were revalued as at 30 June 2013, although this valuation excluded damage in relation to our buildings being out of level. As a result, the DHB has recognised a $25.108M ($14.297M 30 June 2012) asset impairment for those buildings it intends to relevel 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 $427.483M ($349.7M 30 June 2012), and would have been $452.591M ($397.842M 30 June 2012) 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, but this impairment does not reflect the full cost of making buildings compliant with the new building code.

Repair costs for buildings that have been impaired due to the earthquakes result in an increase in service potential, and have been capitalised.

Canterbury DHB incurred a range of other earthquake related costs for the year to 30 June 2013, including outsourced surgery, aged residential care costs, additional community mental health services, acute demand programs, after hours care, as well as other community based costs. The Ministry of Health (MoH) has

committed to provide additional funding of $35M ($10M 30 June 2012) to cover a deficit that Canterbury DHB would otherwise have incurred as a direct result of these costs. This $35M has been recorded as additional revenue and sits as a receivable from the MoH in our results to 30 June 2013.

Canterbury DHB has been progressively negotiating a settlement for earthquake damage from our insurers, and a final deed of settlement was reached in October 2013. The settlement amount was the full amount available of $320M under the collective DHB insurance policy at the date of loss. Under the accounting standards, the balance of the settlement amount (after deducting progress amounts recognised in earlier years) of $294.672M has been fully recognised as revenue in our results to 30 June 2013.

A significant amount of the repair work is yet to be completed, and these costs will fall in the 2013/14 and later financial years.

From 1 July 2013 new insurance policies were placed for all of the 20 DHB's as part of their Insurance Collective, through Health Benefits Limited. For the Material Damage and Business Interruption Policy the cover provided for Canterbury DHB has been significantly reduced for earth movement. As well as significantly higher deductibles (excesses) than was historically the case, and limited coverage for buildings assessed at less than 33% of New Building Standard (Importance level 3), Canterbury DHB does not have full replacement cover for its buildings. Under the policy cover is restricted to "actual cash value" rather than the replacement cover made available to the other DHB's, unless and until repairs have been completed. This, in the event of further earthquake damage, materially limits insurance coverage, and therefore likely recoveries.

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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Balance at beginning of year	15,012	13,686	15,012	13,547
Interest received	659	826	659	826
Donations and funds received	1,575	2,726	1,575	2,726
Funds spent	(2,480)	(2,226)	(2,480)	(2,087)
Balance at end of year	**14,766**	**15,012**	**14,766**	**15,012**

Residents' trust accounts	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Residents' trust account balance	**980**	**1,030**	**310**	**304**

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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Non-current				
Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	99,650	129,650	99,650
Total non current borrowings	129,650	99,650	129,650	99,650
Current	-		-	
Ministry of Health loans (previously Crown Health Financing Agency loans)	-	30,000	-	30,000
Total current borrowings	-	30,000	-	30,000
Total borrowings	**129,650**	**129,650**	**129,650**	**129,650**

The Crown Health Financing Agency (CHFA) was disestablished on 30 June 2012. The legislation that disestablished the CHFA provided for the Ministry of Health to manage District Health Board loans from 1 July 2012, with no change to the terms and conditions.

The Ministry of Health loans (previously 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	
	30/06/13 $'000	30/06/12 $'000	30/06/13 $'000	30/06/12 $'000
Ministry of Health loans (previously Crown Health Financing Agency loans)				
Less than one year	-	30,000	-	30,000
Weighted average effective interest rate		*5.92%*		*5.92%*
Later than one year but not more than five years	15,000	15,000	15,000	15,000
Weighted average effective interest rate	*6.13%*	*5.99%*	*6.13%*	*5.99%*
Later than five years	129,650	84,650	129,650	84,650
Weighted average effective interest rate	*3.73%*	*3.80%*	*3.73%*	*3.80%*

Security
The Ministry of Health loans (previously Crown Health Financing Agency term liabilities) are secured by a negative pledge. Without the Ministry of Health'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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Net (deficit)/ surplus	286,877	(43)	286,207	(555)
Add back non-cash items:				
Depreciation and amortisation	48,191	46,454	46,573	45,087
Loss/(Gain) of reversionary interest	-	3,000	-	3,000
Donated assets	(1,299)	(371)	(1,298)	(371)
Add back items classified as investing activities:				
Loss/(Gain) on asset sale	(43)	226	(14)	240
	333,726	49,266	331,468	47,401
Movement in term portion provisions/staff entitlements	835	(1,065)	828	(1,071)
Movements in working capital:				
Decrease/(increase) in receivables & prepayments	(316,041)	3,768	(315,833)	4,262
Decrease/(increase) in stocks	510	423	509	454
Increase/(decrease) in creditors & other accruals	(2,222)	(1,076)	(2,032)	(1,232)
Increase/(decrease) in staff entitlements	11,083	11,383	10,914	10,798
Net cash inflow/(outflow) from operating activities	**27,891**	**62,699**	**25,854**	**60,612**

20. COMMITMENTS

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Capital commitments				
Property	34,566	46,587	34,566	46,587
Intangible assets	4,756	4,546	4,756	4,546
Other capital commitments	6,569	8,322	6,569	8,242
Total capital commitments at balance date	**45,891**	**59,455**	**45,891**	**59,375**
Non cancellable operating lease commitments				
Accommodation leases	12,725	10,829	10,258	7,818
Total non cancellable operating lease and supply commitments	**12,725**	**10,829**	**10,258**	**7,818**
For expenditure within:				
Not later than one year	2,734	2,560	2,218	1,535
Later than one year and not later than five years	8,075	6,170	6,636	4,688
Later than five years	1,916	2,462	1,404	1,595
	12,725	**11,192**	**10,258**	**7,818**

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 no contingent assets for the financial year ended 30 June 2013.

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

- Outstanding Legal Proceedings
  The Group has no outstanding legal proceedings at year end.

- 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, Canterbury DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, Canterbury 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.

- Facilities Development Plan
  The Government announced during 2013 that they had approved new facility developments for Christchurch and Burwood hospitals. The construction costs of these are expected to be in the vicinity of $670M, with the Crown financing Canterbury DHB via a mixture of debt and equity to a maximum of $490M, and Canterbury DHB providing cash for the remainder.

22. CATEGORIES OF FINANCIAL ASSETS AND LIABILITIES

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Loans and receivables				
Cash and cash equivalents	87,039	51,819	86,036	50,408
Debtors and other receivables	374,000	57,959	372,372	56,539
Term deposits (term>3 months)	57,334	128,979	54,843	126,150
Total loans and receivables	**518,373**	**238,757**	**513,251**	**238,618**
Fair value through profit and loss				
Restricted assets	14,766	15,012	14,766	15,012
Restricted liabilities	(14,766)	(15,012)	(14,766)	(15,012)
Total fair value through profit and loss	**-**	**-**	**-**	**-**
Other financial liabilities				
Creditors and other payables	121,351	123,573	121,026	123,058
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	129,650	129,650	129,650
Total other financial liabilities	**251,001**	**253,223**	**250,676**	**252,708**

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.

The Board places its cash and term investments with high quality financial institutions via a National DHB shared banking arrangement, facilitated by Health Benefits Limited (refer note 26).

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 2013, the Ministry of Health owed Canterbury DHB Group $55.185M (2012 $25.553M).

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'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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Counterparties with credit rating				
Cash				
AA	901	51,819	(102)	50,408
Term deposits				
AA	-	-	-	-
AA-	57,334	128,979	54,650	126,150
Total cash at bank and term deposits	**58,235**	**180,798**	**54,548**	**176,558**
Restricted assets				
A	-	-	-	-
A+	600	600	600	600
A-	200	480	200	480
AA	680	680	680	680
AA-	12,920	12,684	12,920	12,684
BBB+	350	350	350	350
Unrated	16	218	16	218
Total restricted assets	**14,766**	**15,012**	**14,766**	**15,012**
Counterparties without credit rating				
Balance with Health Benefits Limited				
Existing counterparty with no defaults in the past	86,138	-	86,138	-
Total balance with Health Benefits Limited	**86,138**	**-**	**86,138**	**-**
Debtors and other receivables				
Existing counterparty with no defaults in the past	374,000	57,959	372,372	56,539
Total debtors and other receivables	**374,000**	**57,959**	**372,372**	**56,539**

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 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 were no forward exchange contracts outstanding at 30 June 2013 (2012: nil)

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

Canterbury DHB has a maximum amount that can be drawn down against its loan facility of $129.650M which has not changed from last year.

Contractual maturity analysis of financial liabilities
The tables below analyse Canterbury DHB'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
12/13 financial year						
Creditors and other payables	121,351	121,351	121,351	-	-	-
Borrowings Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	129,650	-	15,000	-	114,650
Restricted liabilities	14,766	14,766	12,920	450	1,396	-
Total	**265,767**	**265,767**	**134,271**	**15,450**	**1,396**	**114,650**
11/12 financial year						
Creditors and other payables	121,059	121,059	121,059	-	-	-
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	129,650	30,000	-	15,000	84,650
Restricted liabilities	15,012	15,012	13,166	816	750	280
Total	**265,721**	**265,721**	**164,225**	**816**	**15,750**	**84,930**

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
12/13 financial year						
Creditors and other payables	121,026	121,026	121,026	-	-	-
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	129,650	-	15,000	-	114,650
Restricted liabilities	14,766	14,766	12,920	450	1,396	-
Total	**265,422**	**265,422**	**133,946**	**15,450**	**1,396**	**114,650**
11/12 financial year						
Creditors and other payables	120,725	120,725	120,725	-	-	-
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	129,650	30,000	-	15,000	84,650
Restricted liabilities	15,012	15,012	13,166	816	750	280
Total	**265,387**	**265,387**	**163,891**	**816**	**15,750**	**84,930**

Contractual maturity analysis of financial assets

The tables below analyse Canterbury DHB'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
12/13 financial year						
Cash and cash equivalents	87,039	87,039	87,039	-	-	-
Debtors and other receivables	374,000	374,000	374,000	-	-	-
Term deposits (term > 3 months)	57,334	57,334	22,684	34,650	-	-
Restricted assets	14,766	14,766	12,920	450	1,396	-
Total	**533,139**	**533,139**	**496,643**	**35,100**	**1,396**	**-**
11/12 financial year						
Cash and cash equivalents	51,819	51,819	51,819	-	-	-
Debtors and other receivables	57,959	57,959	57,959	-	-	-
Term deposits (term > 3 months)	128,979	128,979	74,329	20,000	34,650	-
Restricted assets	15,012	15,012	13,166	816	750	280
Total	**253,769**	**253,769**	**197,273**	**20,816**	**35,400**	**280**

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
12/13 financial year						
Cash and cash equivalents	86,036	86,036	86,036	-	-	-
Debtors and other receivables	372,372	372,372	372,372	-	-	-
Term deposits (term > 3 months)	54,843	54,843	20,000	34,843	-	-
Restricted assets	14,766	14,766	12,920	450	1,396	-
Total	**528,017**	**528,014**	**491,328**	**35,293**	**1,396**	**-**
11/12 financial year						
Cash and cash equivalents	50,408	50,408	50,408	-	-	-
Debtors and other receivables	56,539	56,539	56,539	-	-	-
Term deposits (term > 3 months)	126,150	126,150	71,500	20,000	34,650	-
Restricted assets	15,012	15,012	13,166	816	750	280
Total	**248,109**	**248,109**	**191,613**	**20,816**	**35,400**	**280**

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'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			
	30/06/13 $'000		30/06/12 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(11)	11	(19)	19
Total sensitivity	**(11)**	**11**	**(19)**	**19**

	Parent			
	30/06/13 $'000		30/06/12 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(11)	11	(19)	19
Total sensitivity	**(11)**	**11**	**(19)**	**19**

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 prices.

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

	Group		Parent	
	As at 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Financial Assets				
Restricted assets	14,766	15,012	14,766	15,012
Financial Liabilities				
Borrowing- Ministry of Health loans (previously Crown Health Financing Agency loans)	129,171	135,939	129,171	135,939
Restricted liabilities	14,766	15,012	14,766	15,012

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

All related party transactions have been entered into on an arms' length basis.

Canterbury DHB is a wholly owned entity of the Crown.

Significant transactions with government-related entities
Canterbury DHB has received funding from the Crown and ACC of $1,440.1M to provide health services in the Canterbury area for the year ended 30 June 2013 ($1,393.4M, 30 June 2012).

Revenue earned from other DHBs for the care of patients domiciled outside Canterbury DHB's district as well as services provided to other DHBs amounted to $111.7M for the year ended 30 June 2013 ($108.4M, 30 June 2012). Expenditure to other DHBs for their care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $33.0M for the year ended 30 June 2013 ($38.8M, 30 June 2012).

Collectively, but not individually, significant transactions with government-related entities
In conducting its activities, Canterbury DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. Canterbury DHB is exempt from paying income tax.

Canterbury DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2013 totalled $26.1M ($24.5M, 30 June 2012). These purchases included the purchase of services from ACC, The New Zealand Blood Service, Meridian Energy and Air New Zealand.

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

	Group		Parent	
	30/06/13 $'000	30/06/12 $'000	30/06/13 $'000	30/06/12 $'000
Revenue				
Interest on advance and director's fees from/to Canterbury Linen Services Ltd	-	-	6	6
Interest on advance to Brackenridge Estate Ltd	-	-	-	-
Service fees to Brackenridge Estate Ltd	-	-	82	60
Services to Canterbury Linen Services Ltd	-	-	801	427
Service fees to Canterbury Linen Services Ltd	-	-	11	11
Services to South Island Shared Service Agency Ltd	-	29	-	29
Expenses				
Linen services and rentals from Canterbury Linen Services Ltd	-	-	4,784	4,746
Interest on advance from Brackenridge Estate Ltd	-	-	5	8
Services from South Island Shared Service Agency Ltd	-	322	-	322

Interest charged on advances to/from Canterbury Linen Services 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 Linen Services 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 30/06/13 $'000	As at 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Amount payable owing to associates				
South Island Shared Service Agency Ltd	-	71	-	71
Amount payable owing to subsidiaries				
Canterbury Linen Services Ltd	-	-	436	433
Amount receivable owing by subsidiaries				
Canterbury Linen Services Ltd – debtor	-	-	61	56
Brackenridge Estate Ltd – advance	-	-	233	127

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 (2012 $nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/13 $'000	Year ended 30/06/12 $'000	As at 30/06/13 $'000	As at 30/06/12 $'000
Services purchased by Canterbury DHB:				
Heart Centre at St George's	38	3,009	-	-
Heart Vision Ltd	-	-	-	-
Services purchased from Canterbury DHB:				
Heart Centre at St George's	17	7	-	1

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 30/06/13 $'000	Year ended 30/06/12 $'000
Salaries & other short term employee benefits	3,147	3,145
Post-employment benefits	67	56
Total key management personnel compensation	**3,214**	**3,201**

The above compensation of key management personnel includes Board and Committee members' fees. Board and Committee members' fees are detailed within the Board's Report and Statutory Disclosure section.

26. BANK FACILITY

Canterbury DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Canterbury DHB that equates to $66.207M.

27. SUBSEQUENT EVENTS

There were no events after 30 June 2013 that have not been adjusted for which could have a material impact on the information in Canterbury DHB's financial statements.

SUMMARY OF REVENUES AND EXPENSES BY OUTPUT CLASS

Group	Actual 30/06/13 $'000	Budget 30/06/13 $'000
Early detection & management	439,976	357,447
Intensive assessment & treatment	1,036,289	843,396
Prevention	37,128	29,315
Support & rehabilitation	278,481	220,720
Total revenue	**1,791,874**	**1,450,878**
Early detection & management	362,989	358,639
Intensive assessment & treatment	879,495	876,072
Prevention	34,574	33,294
Support & rehabilitation	227,939	222,879
Total expenditure	**1,504,997**	**1,490,884**
Surplus/(Deficit)	**286,877**	**(40,006)**

NOTE:
Total Revenue includes the recognition of $294.672M of insurance proceeds as a result of an insurance settlement agreement reached with our insurers, and is the balance of the total settlement amount of $320M, less amounts already recognised in prior years.

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Canterbury District Health Board and group's financial statements and performance information for the year ended 30 June 2013

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and group. The Auditor-General has appointed me, Andy Burns, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 44 to 79, that comprise the statement of financial position as at 30 June 2013, 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 performance information of the Health Board that comprises the report about outcomes on pages 9 to 18 and the statement of service performance on pages 19 to 29

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 44 to 79:

- comply with generally accepted accounting practice in New Zealand; and

- fairly reflect the Health Board and group's:

    - financial position as at 30 June 2013; and

    - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, including some of the national health targets, and the corresponding district health board sector averages used as comparators, rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 9 to 29:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2013. 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 performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, 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 performance information 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.

Our audit of the financial statements involved 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; and

- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance;
- the material performance measures, including [the national health targets]; and
- the adequacy of disclosures in, and overall presentation of, the [performance information].

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We obtained all the information and explanations we required about the financial statements. However, as referred in our opinion, we did not obtain all the information and explanations we required about the [performance information]. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information 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 and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and [performance information], whether in printed or electronic form.

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 performance information 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 External Reporting Board.

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

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