Canterbury
District Health Board
Te Poari Hauora ō Waitaha

For the year ended
30 June 2012

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
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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 2011/2012 financial year was a period of constant change in the wake of ongoing quakes which rattled our district, our staff and our patients.

The earthquakes dealt the Canterbury Health System a huge blow (in terms of losing people, buildings, and infrastructure) and based on international evidence we are yet to see the full human impact of the quakes on our community. This is expected to show up over the coming years. The harmful effects of prolonged stress and uncertainty can have a profound impact on both physical and mental health.

We will look back on the past two years and realise that the 24 months post-quake was just the beginning of the challenges.

The repairs and rebuilds taking place are very disruptive for staff and patients. Despite the less-than-ideal working conditions with ongoing building repairs and constant quake-related disruptions on the home front for the 16,500 people who work in health in Canterbury, the DHB has continued to achieve outstanding results and deliver world class services. This is a credit to the professionalism and patient-focus of those working in our health system.

With a perfect storm of stressors, it's remarkable that the Canterbury Health System hasn't imploded. Somehow our people have continued to meet the ongoing challenges of ever-changing health needs of our population.

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 person to provide the right care, in the right place, at the right time.

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.

In the past year we established our first Integrated Family Health Centres in Amuri, Methven and Rakaia, and several more are under development.

We continue to work closely with other South Island District Health Boards to improve the way services are provided across the South Island. Through our own initiatives the South Island Strategic Procurement Group and the South Island Support Service Level Alliance have been responsible for saving an estimated $50M across the South Island over the past three years. During this financial year we also became one of the four foundation members of the New Zealand Health Innovation Hub.

Our goal of providing more services closer to where people live and work, often in a person's own home, is paying dividends. Our Acute Demand Management Services accepted almost 20,000 referrals to allow people to receive urgent care in the community without having to go to Christchurch Hospital's Emergency Department.

Saving patients' time waiting is a key goal of Canterbury District Health Board (CDHB). Investing in improved technology and patient information systems is helping us achieve our goals. An Electronic Referral Management System has seen Canterbury's General Practitioners make almost 49,000 referrals, ensuring prompt care, faster diagnosis, and less time waiting.

The Canterbury Health System is providing more treatment and care for people in their own homes through various programmes including the Community Rehabilitation and Enablement Team (CREST). CREST has provided in-home care and support to over 1,000 people in their own homes. There have

been 1,320 referrals from when the programme began in April 2011 until June 2012. Some people were referred by their general practice team, others were able to return to their own homes sooner, and around 60 people avoided a hospital stay altogether, by having personalised packages of care provided in their own home.

A new hospital complex is a key component of Christchurch's future and late in 2011 the Government gave Canterbury District Health Board the green light to put together a business case for phase one of a staged redevelopment planned for Christchurch and Burwood hospitals. The cost of the first phase of the hospital redevelopment is around $660M. At the time of writing we are awaiting approval of this much-needed redevelopment of our health facilities.

Ongoing building and infrastructure repairs and emerging issues will impact on our ability to continue to meet the Government's Health Targets. Having health facilities looking like building sites for long periods is disruptive for patients and staff. This has become a way of life for Canterbury people.

This is why it's been so important to deliver health services in smarter ways. The Canterbury Health System has regained pre-quake levels in some of its health targets and achieved or even surpassed others. For example, in the past financial year CDHB achieved over 100% of its elective surgery result. It is remarkable that CDHB 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, as we strive to make it better.

Canterbury has a lot to be proud of.

Bruce Matheson
Chair
2 October 2012

David Meates
Chief Executive
2 October 2012

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 Boards of Brannigans Ltd and Fresh Pork New Zealand. He has also held other director roles including Contracting South Canterbury, Canterbury Health Limited, Canterbury Employers Chamber of Commerce and Chair of the Port of Portland, Australia. Bruce is known for his strong team building skills and inclusive management style. He believes that the health sector is very challenging and has the utmost respect for people working in the health sector.
Peter Ballantyne Deputy Chair	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 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 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 28 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 persons 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 10 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 Chair of Brackenridge Estate Ltd, one of Canterbury DHB's 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 35 years experience working in the mental health and disability sector, particularly with people with intellectual disabilities. She has served on the Board since 2000, has been Deputy Chair for two terms and is the Chair of the 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 actions we take in terms of which services to fund and at what level have a significant impact on the health of our population. In achieving our vision 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 as well as the drivers of demand. In doing so we take a long-term view, shifting resources to where they are most needed in order to improve the health of our population, while ensuring the sustainability of Canterbury's health system.

This section provides an overview of the key elements of our outcomes framework, which was confirmed in 2011 to align with the both the strategic direction of the Canterbury DHB and that of the South Island Region. In confirming our direction of travel, we identified three strategic goals or outcomes:

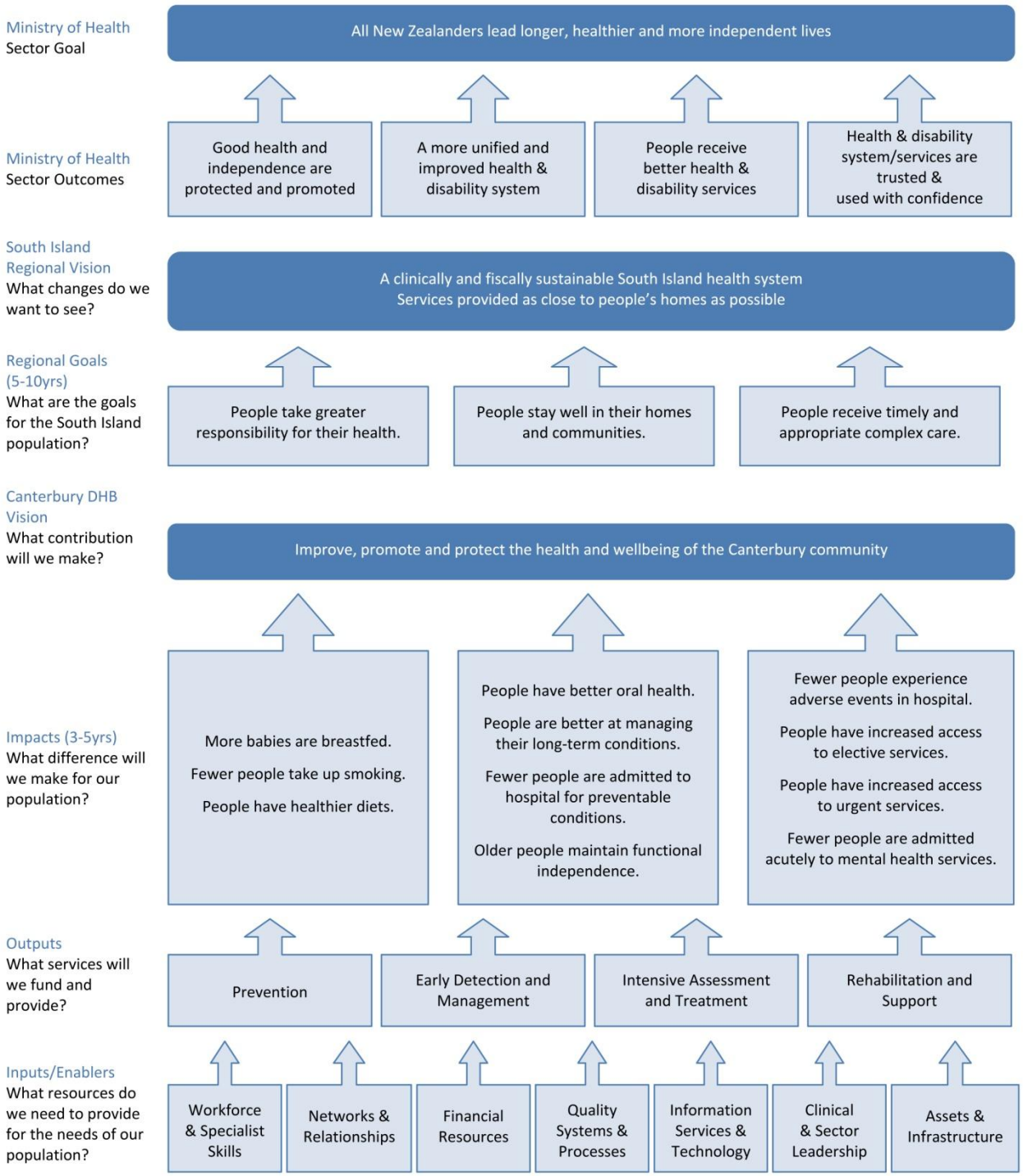
- PEOPLE TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH: The development of services that support people to stay well and take increased responsibility for their own health and wellbeing.
- PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES: The development of primary and community services that support people in community-based settings and provide a point of ongoing continuity of care.
- PEOPLE RECEIVE TIMELY AND APPROPRIATE COMPLEX CARE: The freeing-up of hospital based specialist resources to be responsive to episodic events and the provision of complex care and support and specialist advice to primary care.

These long-term outcomes will be achieved not just through our work alone, but through the combined effects of all of those people working across the Canterbury Health System, central and local government, other regional DHBs and wider health and social services. Evidence about the state of our population's health and the environment in which they live helps us monitor progress towards our intended outcomes. As such, we have identified performance indicators related to each outcome - set out below. Given the long-term nature of these outcomes, the aim is to make a measurable change over time rather than achieve a specific target.

The intervention logic diagram on the following page visually demonstrates how these strategic goals and the outcomes we are seeking will contribute to the overarching sector goals of Government, and how the outputs we fund and provide to achieve these outcomes will have an impact on the health and wellbeing of the Canterbury population. The intervention logic provides both a framework for the way we approach our work and a means of monitoring and demonstrating our success.

LONG-TERM OUTCOME MEASURES

Outcome Goal	Outcome Measure	Comment
People take greater responsibility for their own health	A reduction in smoking rates	*This data is sourced from the NZ Health Survey and the latest results are not yet available from the Ministry of Health.*
	A reduction in obesity rates	
People stay well in their own homes and communities	A reduction in avoidable presentations to hospital emergency departments	*The percentage of the population presenting at ED has remained steady at 17% over the past three years, indicating that growth in ED presentations reflects population growth. Healthcare providers are 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 two years.*
	An increase in the proportion of the population supported to manage their long-term conditions	*At 0.69, Canterbury's standardised acute medical admission rate is the lowest of any large DHB in the country, and well below the national rate (1.0). This reflects the success of our focus on keeping people well in their own homes and communities.*
	An increase in the proportion of the population 65+ supported to live well in their own homes	*The percentage of the population in aged residential care has decreased from 8% over the last several years down to 7%. This brings us in line with the South Island result and is consistent with our strategic direction of supporting people to 'age in place'. The percentage of those receiving home-based support has remained constant over the past two years at 11% - higher than the South Island result of 10%. 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.*
People receive timely and appropriate complex care	A reduction in unplanned acute readmissions to hospital	*Canterbury's acute readmission rate (8.8%) is much lower than the national rate (10.1%), suggesting that people 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.*
	A reduction in the rate of mortality within 30 days of discharge from hospital	*Our intention was to track hospital mortality rate using the national DHB performance measure OS9, 'the rate of mortality within 30 days of discharge from hospital.' However, the Ministry of Health discontinued the use of this national measure from 2012/13. An alternative measure will be sought.*



Strategies, outcome logic and corresponding performance measures are being constantly 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 interventions have been. The outcomes framework will be adjusted to reflect the ongoing development of work plans by our clinically led development groups.

Performance results are broken down by ethnicity wherever possible to assess the impact our strategies and interventions are having on Māori and Pacific health. Further Māori-specific results can be found in our regular reports to the Canterbury DHB Board against our Māori Health Action Plan.

HOW HAVE WE PERFORMED?

MEDIUM-TERM IMPACT MEASURES

Sitting beneath our three strategic goals, we have identified 13 impact areas where we can make a measurable contribution to the longer-term outcomes we are seeking. These impacts reflect areas of activity where the DHB can influence change, and corresponding impact measures help demonstrate the difference we are making in the health of the Canterbury population. We have set targets against these impact measures in order to evaluate the impact of service delivery over a three year period. This section provides an update on our progress.

Overall, these impact indicators would suggest the health status of the Canterbury population has been maintained or has improved over the past year. This is heartening considering the exceptional circumstances under which the health system has been operating and the environment in which our population has been living. Further years' data will be required to establish whether patterns are earthquake-related or reflect the impact of service transformation and health improvement strategies.

OUTCOME: PEOPLE TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

More babies are fully and exclusively breastfed.

The overall percentage of six-week-olds who are fully or exclusively breastfed has remained stable, at 67% in 2011. Considering the difficult post-quake environment under which the population and providers are operating, this is a positive result.

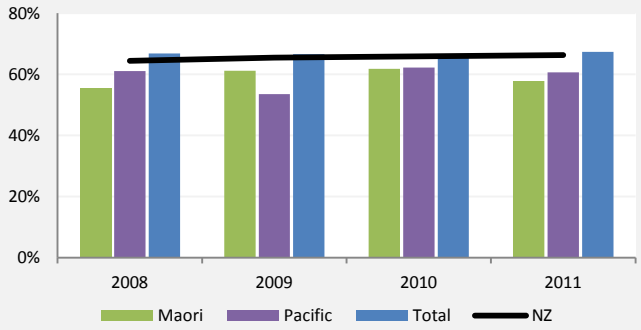
Māori and Pacific breastfeeding rates remain lower than those of the total population, at 58% and 61% respectively. However, some of this may be because the data measured is from Plunket only. Canterbury has several smaller Tamariki Ora providers who specifically target Māori and Pacific mothers. Their data is not included in the results, as there is a risk of 'double-counting' the same children.

Māori and Pacific breastfeeding rates are a key focus for the Canterbury Breastfeeding Steering Group in 2012/13. 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.[1]

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

	Actual 2011	Target 11/12
Māori	58%	64%
Pacific	61%	67%
Total	67%	67%



Fewer young people take up tobacco smoking.

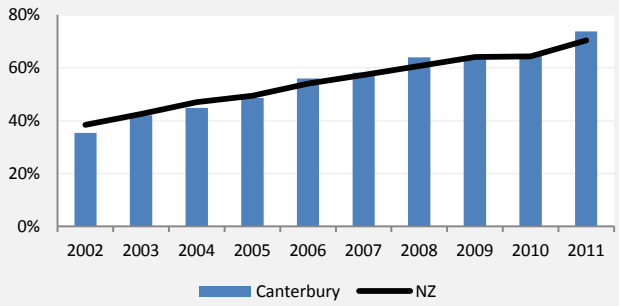
Canterbury continues to make strong progress in reducing the uptake of smoking amongst young people. The 2011 survey results show that 74% of Year 10 students in Canterbury have never smoked – the highest result to date.

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.[2]

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

Actual 2011	Target 11/12
74%	65%



More adults have healthier diets.

This data is sourced from the NZ Health Survey and the latest results are not yet available from the Ministry of Health. Healthier diets and lifestyles continue to be encouraged through local initiatives like Health Promoting Schools and Appetite for Life.

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

	Actual 06/07	Target 11/12
Fruit 2+	62%	62%
Veg 3+	69%	70%

[1] *Breastfeeding data comes from Plunket and is provided to the DHB by the MoH annually by calendar year and is based on the national DHB performance indicator S17. The 2011 breastfeeding data presented is only for the final 6 months of 2011 (i.e. July to December) due to MoH data availability issues. Some data differs from that reported in previous publications as a result of updated data provided by MoH.*

[2] *The ASH survey provides a point prevalence data set and is reported annually on calendar years.*

Outcome: People Stay Well in their Own Homes and Communities

What difference have we made for our population?

More children have good oral health.

The overall percentage of caries-free five-year-olds has remained relatively stable, at 64% in 2011.

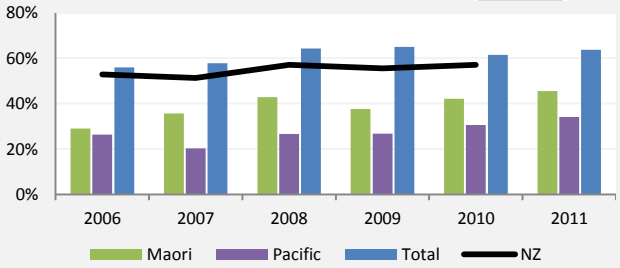
However, the percentage of Māori and Pacific five-year-olds who are caries-free has continued to improve, with 2011 results of 46% and 34% respectively, compared with 38% and 27% in 2009.

This reflects the positive impact of Canterbury's new comprehensive oral health programme, which specifically targets Māori and Pacific children in order to reduce inequalities in oral health. The programme focuses on promoting lifestyle behaviours such as good nutrition and tooth brushing that prevent tooth decay in pre- and primary-school children.

Data sourced from Ministry of Health.[3]

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

	Actual 2011	Target 11/12
Māori	46%	46%
Pacific	34%	30%
Total	64%	67%



More people identified with diabetes have 'satisfactory' management of their diabetes.

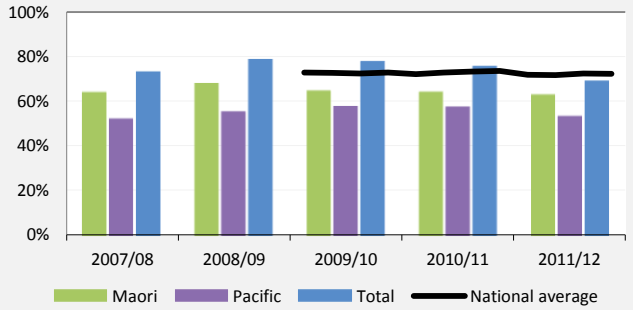
The slight decrease in diabetes management against the previous year shows the impact of broader engagement of people with diabetes. In 2011/12, the number of people having a diabetes annual review has increased substantially: from 55% of the expected diabetic population in 2010/11 to 67% in 2011/12.

This means that 'harder to reach' people who have not previously engaged with health services for regular diabetes monitoring and management support are now having a diabetes annual review for the first time. These people tend to have poorer management of their diabetes, bringing down the overall diabetes management result. However, now that they are engaged in regular diabetes care, we expect to see diabetes management improve in future years.

Data sourced from Ministry of Health and Individual DHBs and is reported one quarter in arrears.[4]

The percentage of the Canterbury population receiving diabetes annual reviews who have HbA1c≤8%.

	Actual 11/12	Target 11/12[5]
Māori	62%	n/a
Pacific	53%	n/a
Total	69%	n/a



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

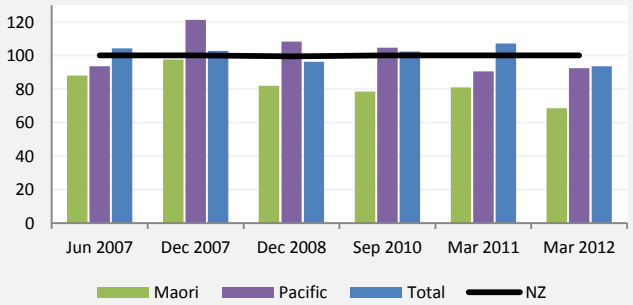
The March 2012 result shows a dramatic decrease in the rate of avoidable hospitalisation in Canterbury across all ethnicities.

This is an excellent result; however, further years' data will be required to establish whether this is earthquake-related, or if it truly reflects the impact of Canterbury's wide range of initiatives to prevent avoidable hospital admissions (such as community-based acute demand services, HealthPathways, CREST and long-term condition management programmes).

Data sourced from the Ministry of Health. [6]

The standardised ratio of actual to expected avoidable hospital admissions for the Canterbury population (<75).

	Actual Mar 12	Target 11/12
Māori	68	≤95
Pacific	93	≤104
Total	94	≤101



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

[4] *This measure is based on the national health target and 'satisfactory' is defined as having HbA1c≤8%.*

[5] *Following the February earthquake a significant number people are displaced from their homes and workplaces. While this group is being supported to attend primary care, this may not be at their usual general practice; hence explicit targets were not set for 2011/12.*

[6] *Avoidable hospital admissions are based on 26 identified conditions including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is based on the national DHB performance indicator SI1 and performance data is supplied to DHB by the Ministry of Health. Data is for the year up to and including the month shown on the axis.*

Older people (75+) are supported to maintain functional independence.

At 8.1%, the percentage of the Canterbury population aged 75+ being admitted to hospital as a result of a fall remains below the national rate.

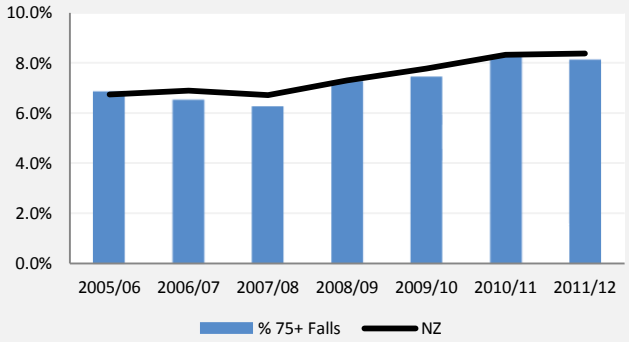
The Canterbury Health System has recently begun a falls prevention campaign with an aspirational goal of 'zero harm' from falls. This system-wide approach uses quality control systems, clinical leadership and evidence-based intervention strategies to reduce the risk and severity of falls in Canterbury.

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.

Data Sourced from National Minimum Data Set.

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

Actual 11/12	Target 11/12
8.1%	n/a[7]



Outcome: People Receive Timely and Appropriate Complex Care

What difference have we made for our population?

Fewer adverse events cause harm to patients in our hospital and specialist services.

As part of Canterbury's 'whole of system' approach to falls prevention, a 'zero harm' safety campaign in our hospital services is focused 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.

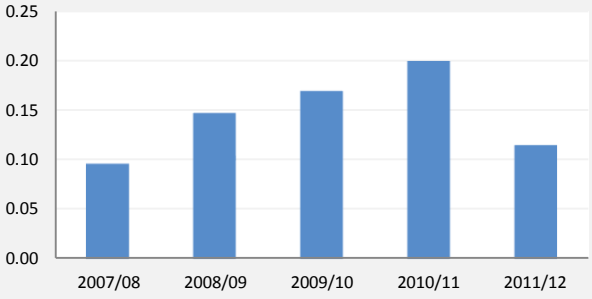
This strong focus on falls prevention has increased staff awareness and resulted in a large reduction of SAC 1 & 2 falls (those considered most serious with the highest consequence and likelihood).

At the same time, there appears to be a slight increase in the overall rate of falls causing harm in 2011/12. This is most likely the result of an increased focus on falls and greater reporting of less serious falls and is seen as a positive result - in line with the DHB's 'no blame' culture, which aims to make harm more visible so that it can be better addressed and prevented in future.

Data sourced from Individual DHBs.[8]

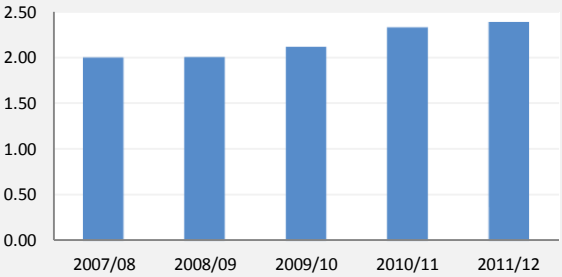
The rate of SAC 1 and 2 level falls in Canterbury Hospitals (65+)

Actual 11/12	Target 11/12
0.11	0.14



The rate of all falls resulting in harm in Canterbury Hospitals.

Actual 11/12	Target 11/12
2.37	1.89



[7] *The intention was for this measure to be based on a planned new national DHB indicator (PP15). Baseline data for 2009/10 was not available from MoH for the planned measure at the time the SOI was published, inhibiting target-setting. The MoH has since discontinued the national indicator but Canterbury has developed a local measure with the same intent to make up for this gap.*

[8] *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*

People receive timely access to urgent care services

This measure is also a national Health Target and Canterbury achieved the Target throughout 2011/12, with at least 95% of people presenting at ED being admitted or discharged within six hours in every quarter of 2011/12.

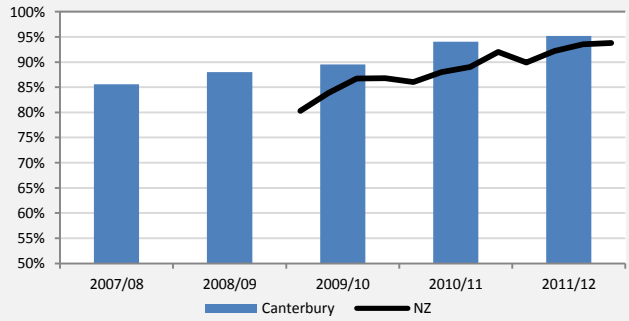
Canterbury's strong ED performance results from taking a 'whole of system' approach, with a wide range of integrated strategies for preload (reducing ED attendances), contractility (effective ED functioning and flow) and afterload (hospital flow and supported discharge).

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 the Ministry of Health.[9]

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

Actual 11/12	Target 11/12
95%	95%



People receive timely access to elective surgical services.

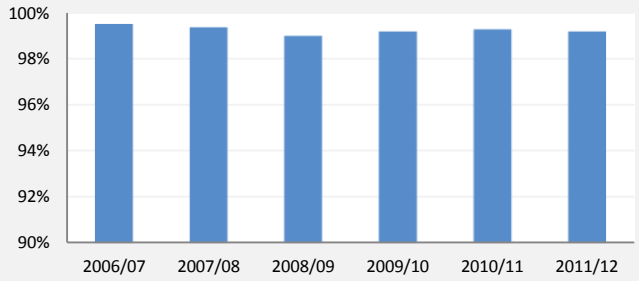
Despite the challenges of having less hospital capacity post-quake, Canterbury has maintained timely service provision for specialist assessment and treatment.

99% of Cantabrians needing a First Specialist Assessment (FSA) received one within 6 months of referral, and 98% of those given a commitment to treat received their treatment within 6 months.

Data sourced from individual DHBs.[10]

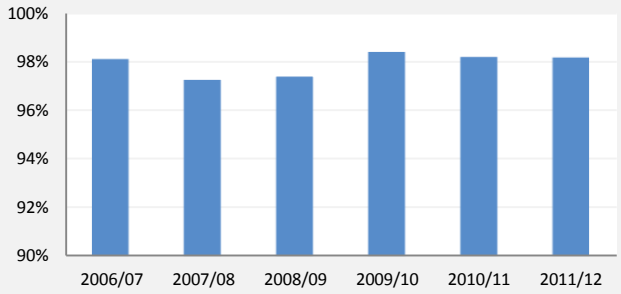
The percentage of people in Canterbury provided with a FSA within 6 months of referral (ESPI 2).[11]

Actual 11/12	Target 11/12
99.1%	98.5%



The percentage of people in Canterbury given a commitment to treat who are treated within 6 months (ESPI 5).

Actual 11/12	Target 11/12
98.1%	>96%



[9] *This measure is based on the national DHB Health Target 'Shorter stays in Emergency Departments.*

[10] *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. National performance data is not made available for these measures.*

[11] *Canterbury's aim is to provide everyone with certainty, but due to the unknown factors around acute demand following the earthquakes, the DHB retained 2010/11 targets (slightly below 100%) with the intention of achieving above this and reaching 100% in the out-years.*

Fewer people have acute readmissions to specialist mental health services.

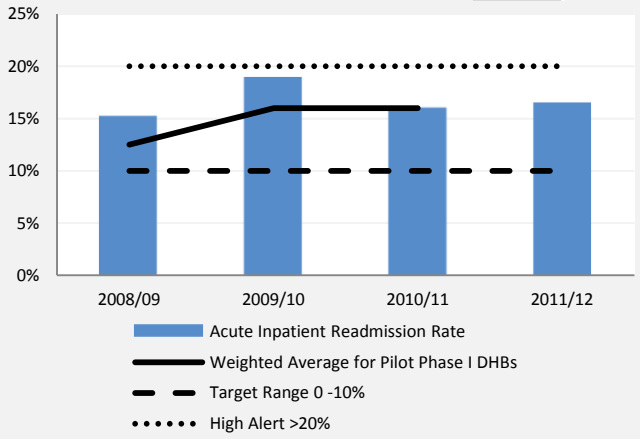
Mental health acute readmission rates have stabilised below the high alert level, at 17%. Considering the difficult post-quake environment in which our population are living and providers are operating, this is a positive result.

Moving into 2012/13, 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 individual DHBs via the Mental Health KPI Project.[12]

The rate of acute readmissions to Canterbury mental health services (within 28 days).

Actual 11/12	Target 11/12
17%	15%



[12] *2011/12 KPI Project results are not yet available; therefore, the NZ results only go to 2010/11, and the 2011/12 Canterbury result is based on preliminary internal data.*

STATEMENT OF SERVICE PERFORMANCE 2011/12

MEASURING OUR NON-FINANCIAL PERFORMANCE

As part of evaluating our performance, we provide an annual forecast of the services we plan to deliver (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 2011-14.

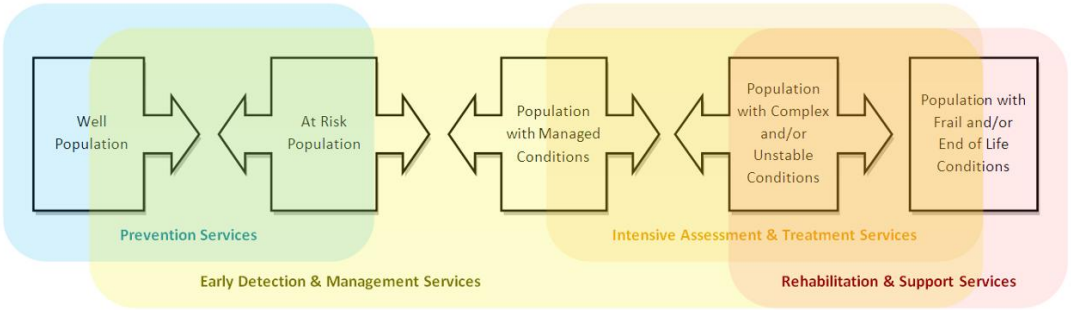
In presenting our performance, it would be overwhelming to measure every output delivered. We therefore choose to measure those activities and services with the greatest potential to contribute to improving the health and wellbeing of our population, those which are markers of broader system changes 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 (to demonstrate capacity), Quality (to demonstrate effectiveness) and Timeliness and Coverage (to demonstrate access). Together, these measures contribute to longer-term health outcomes.

Against these measures, we set targets to demonstrate the standard expected. Wherever possible, we include a prior year's baseline to support evaluation of our performance, and 2011/12 national results to give context in terms of what we are trying to achieve.

The services or '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 year's Statement of Service Performance incorporates more measures than in prior years 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 no 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 2012.

- Some data is collected on calendar rather than financial years and is indicated with the following symbol: **†**. In these cases, the '10/11' result is for the 2010 calendar year, and the '11/12' result is for 2011.

- Any other irregularities have been footnoted.

2011/12 PERFORMANCE OVERVIEW

When we prepared our forecast of service performance in May 2011, Canterbury was only three months on from the most powerful seismic event in our country's history and was still experiencing major aftershocks. Our circumstances were exceptional. We had no comparable experience on which to base our service forecasts, nor to reliably estimate the earthquakes' impact on our population or the time it would take for infrastructure repairs and recovery.

Some of the key quake-related challenges facing our health system include the following:

- 106 inpatient beds were lost at Christchurch Hospital. While office space has been converted to create 73 replacement beds, they are based on another site, meaning patients must be transferred between hospitals. We are still operating with fewer beds than before.
- 635 aged residential care beds were lost.
- General practices and pharmacies were damaged or destroyed, particularly those in the central city and eastern suburbs.
- Many small health and disability service providers were displaced and are still working from temporary and makeshift facilities.
- 200 DHB buildings were damaged, some declared unsafe to occupy. Over 9,000 rooms need to be repaired across our hospitals, and these repairs are a source of significant ongoing disruption to service delivery.
- Over 7,000 homes have been classified as being in the 'red zone'. Some residents have moved away, while others are still to go. Many people are still living in damaged or temporary accommodation or sharing with friends and relatives. Over 700 of our own staff are still displaced.

In setting targets for 2011/12, we had significant capacity restrictions across our health system. We had to be focused on meeting the most immediate needs of a population that was displaced from their usual support systems and health providers.

Knowing that contacting people was going to be especially challenging, we did not set performance targets against population-wide programmes such as immunisations and annual health reviews that rely on recall systems and tracking. Instead, our aim was to target our most vulnerable populations, supporting people to stay well, and try to regain and maintain the performance standards achieved prior to the quakes.

International research shows that those who were vulnerable prior to a disaster have an increased risk of poor health afterwards. Taking this into account, we placed additional focus on services that supported earlier intervention, minimised wait times for treatment and supported people on discharge from hospital to reduce the risk of readmission. We also planned to focus new investment on services and alternative models of care that would support people in their own homes and in the community – to reduce unnecessary admissions into hospital and aged residential care where capacity was most stretched.

We also knew that, as the largest service provider in the South Island, our neighbouring DHBs needed us to continue to provide hospital and specialist services. Even though capacity was severely stretched, we set targets to maintain the same levels of delivery in our hospital services.

WHAT HAVE WE DELIVERED - PERFORMANCE RESULTS

Our performance results for 2011/12 are something that the whole of the Canterbury Health System should be proud of. The impact of the earthquakes has been tremendously disruptive and drawn-out. Even 18 months on, our population remains unsettled and highly stressed, and the majority of the infrastructure with which we deliver services is still damaged and unstable.

In spite of the massive disruption and our significantly reduced capacity, we have achieved much of what we set out to do. While we haven't met every target, we have improved performance in almost all areas:

PEOPLE ARE SUPPORTED TO STAY WELL. We maintained two-year-old immunisation rates at 92% and increased Māori (92%) and Pacific (95%) rates to even higher than they were prior to February 2011. 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. 19,636 packages of care were provided for acutely unwell people in community settings rather than our hospitals. 8,048 people had their needs clinically assessed and 13,913 people were supported in their own homes by home support and district nursing services. The success of this approach is evident in that the number of people presenting in Canterbury emergency departments has dropped, and less activity in our hospital is acute or unplanned. At 0.69, Canterbury's standardised acute medical admission rate is the lowest of any large DHB in the country, and well below the national rate (1.0). Fewer people are being admitted unnecessarily to our hospitals or into aged residential care, and the average length of stay in our hospitals is dropping. Our acute readmission rate (8.8) is also much lower than the national rate (10.1), 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. 5,527 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 new Community Rehabilitation Service Team (CREST) provided additional support to 1,091 older people on discharge from hospital. 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.

PEOPLE ARE WAITING LESS. 95% of people presenting in ED were admitted or discharged in under six hours, and every patient ready for cancer radiation therapy received it within four weeks. In spite of the reduced capacity across our hospital services, 99% of people referred for a first specialist assessment and 98% of people given a commitment for treatment received their assessment or treatment within 6 months.

OUR SYSTEM IS BETTER CONNECTED. 519 integrated pathways have been developed across primary/secondary care to improve patients' care and streamline referral processes. 38,954 community 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. 16,494 elective surgical discharges were delivered – 384 above target – and 39,045 surgical first specialist assessments were undertaken. Access rates to specialist mental health services were maintained, and rates of people not attending hospital appointments have dropped.

The results we have collectively achieved reflect the remarkable efforts and sheer hard work of teams right across the system to stay focused on delivering health services under extraordinarily difficult circumstances. However, this extra effort will be hard to maintain in the longer term. We still have a fragile system, beset with uncertainties. The collective approach needed to maintain health services over the past year has reinforced 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.

Encouraging people to make lifestyle changes has been extraordinarily difficult post-quake, with our population focused on coping day-to-day. Not unexpectedly, targets for measures such as the provision of smoking cessation advice, breastfeeding rates and attendance at lifestyle courses have not been met. However, it is pleasing to note that, in spite of challenging circumstances, performance has improved against the previous year in almost all service areas.

After the February 2011 earthquake, our goal for immunisation was to target the most vulnerable populations and maintain the standard of performance being achieved prior to the earthquakes. We are particularly pleased that two-year-old immunisation rates have been maintained at 92%, and Māori (92%) and Pacific (95%) immunisation rates for 2011/12 are even higher than they were prior to February 2011. HPV immunisation rates were also maintained, and although influenza vaccination rates for people 65+ dropped compared to the previous year, an unplanned programme launched in response to the earthquakes, which targeted young people under 18, delivered an additional 22,109 free 'flu' vaccinations in 2011.

OUTPUT MEASURES

HEALTH PROMOTION AND EDUCATION SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of volunteer mothers trained to provide in Mum 4 Mum breastfeeding peer support	V [13]	22	44	>65	-	
Percentage of new mothers having established breastfeeding on discharge from hospital	Q [14]	86%	88%	>85%	-	
Percentage of Māori infants fully and exclusively breastfed at 6 weeks old	Q [14] †	62%	58%	64%	60%	
Percentage of hospitalised smokers provided with advice and help to quit – Full year results	C [15]	74%	83%	95%	-	
– Quarter 4 results	C [15]	71%	90%	95%	94%	-
Percentage of smokers attending general practice and provided with advice and help to quit	C [16]	14%	25%	90%	34%	
Number of smokers participating in the Aukati Kaipaipa smoking cessation programme	V	279	207	>200	-	
Number of contacts from smokers seeking quit advice through Quitline services	Q [17]	7,337	7,248	>7,000	-	
Percentage of priority schools supported by the Health Promoting Schools framework	C [18]	57%	78%	>70%	-	

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

[14] *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 breastfeeding data for 6-week-olds is only for the final 6 months of 2011 (i.e. July to December) due to Ministry data availability issues. The Ministry sources this data from Plunket. Canterbury also has a number of non-Plunket WellChild providers, but their data is not included in the results, as this would risk 'double-counting' the same children.*

[15] *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. This Health Target is tracked on a quarterly basis; therefore, Quarter 4 results are provided in a separate line to allow comparison with published national results. (Q1: 73%, Q2: 79%, Q3: 86%, Q4: 90%)*

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

[17] *From 2010/11, Quitline now offers online and txt cessation support as well as phone calls. Results include all available modalities. The measure reflects people taking self-responsibility by seeking further cessation support and hence the effectiveness of smoking cessation messages and advice.*

[18] *The 2010/11 result reflects the severe impact of the quakes on the areas where many priority schools are based, while the 2011/12 result shows strong recovery as schools have re-engaged. 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.*

Number of 'Appetite for Life' (AFL) courses provided in the community	V [19]	81	68	80	-	
Number of people accessing Green Prescriptions for additional physical activity support	V [20]	1,621	1,941	>1,900	-	
STATUTORY AND REGULATORY SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Percentage of tobacco retailers compliant with current legislation	Q [21]	90%	97%	>90%	-	
Percentage of alcohol retailers compliant with current legislation	Q [21]	94%	93%	>90%	-	
POPULATION BASED SCREENING SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Percentage of women screened for HIV as part of routine antenatal blood tests	C [22]	74%	69%	>65%	84%	
Percentage of children (age 4) provided with B4 School Checks	C [23]	71%	80%	80%	-	
Percentage of children (age 4) in Quintile 5 provided with B4 School Checks	Q [23]	67%	70%	80%	-	
Percentage of eligible women (20-69) having a cervical cancer screen every three years	C [24]	72%	73%	>75%	75%	
Percentage of eligible women (45-69) having a breast screen examination every two years	C [24]	83%	82%	>70%	70%	
IMMUNISATION SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Percentage of children fully immunised at age two – Full year results	C [25]	91%	92%	-	-	
– Quarter 4 results	C [25]	90%	91%	-	93%	-
Percentage of two year olds 'reached' by immunisation services	Q [26]	97%	97%	-	97%	
Percentage of eligible young women (12-18) engaged in the HPV vaccination programme	C [27]	46%	46%	>45%	55%	
Number of older people (65+) receiving a free vaccination against the 'flu' (influenza)	V [28] †	50,025	49,052	>51,000	-	
Percentage of older people (65+) receiving a free vaccination against the 'flu' (influenza)	C [28] †	74%	71%	>75%	65%	

[19] *AFL is a healthy lifestyle programme that helps participants make positive changes to the habits that have led to their weight gain.*

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

[21] *Youth access to tobacco and alcohol is monitored through controlled purchase operations to test whether retailers require proof of age. Compliance results reflect the quality of the information, training and advice services provided to retailers.*

[22] *The NZ result is for the 2010/11 year, as the 2011/12 national result is not yet available.*

[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. Data collection for Quintile 5 (Q5) began in 2010/11. The Q5 11/12 target was based on the pre-quake Q5 population; however, a tenth of children have had their quintile reclassified since the quake as their families have moved to homes in other quintiles. As a result, some former Q5 children no longer 'count' as Q5, making the Q5 target more difficult to reach.*

[24] *Breast and cervical screening standards are based on national targets. Breast and cervical screening data is subject to availability from the national screening programmes; cervical screen coverage is reported for the three years up to and including June 2011 and March 2012, while breast screen coverage is for the five years up to and including May 2011 and 2012.*

[25] *Following the quakes, a significant number of people have been displaced from their homes and workplaces, and hence from their usual general practices, disrupting normal recall processes. For this reason, no explicit targets were set for 2011/12. This Health Target is tracked on a quarterly basis; therefore, Quarter 4 results are provided in a separate line to allow comparison with published national results. (Q1: 92%, Q2: 92%, Q3: 93%, Q4: 91%)*

[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 12-18 provided with Dose 1. The 'NZ result' is based on the six 'major' DHBs. The target was set to maintain 2010/11 rates, acknowledging the work needed to reconnect people with general practice and re-establish coverage post-quake.*

[28] *The volume target is the number of vaccinations to achieve 75% coverage assuming an enrolled population of 70,105 (April 2011). 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.

Not unexpectedly, targets for services that require connection with a regular health provider were negatively affected by the earthquakes. The earthquakes damaged or destroyed a number of general practices, pharmacies and our oral health service facilities, and they displaced a significant proportion of our population from their usual healthcare providers. Consequently, new enrolments in oral health services, and population-based programmes that rely on contacting and recalling people for appointments (such as CVD risk assessments) have not met the targets set.

However, there has been a significant increase in the number of agreed patient pathways that connect the Canterbury system to ensure people receive the right treatment in the right place; 519 pathways are now in use. 38,954 radiology tests have been completed on direct community referral, without the need for a hospital appointment, and referral acceptance rates indicate that the quality of referrals is high. Access to less complex mental health services in primary and community settings has been prioritised, with capacity significantly increased to cope with post-quake need across our population. 5,527 people have accessed brief intervention counselling in general practice over the past year – more than twice the number accessing these service two years ago.

OUTPUT MEASURES

PRIMARY HEALTH CARE (GP) SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Percentage of the Canterbury population enrolled with a PHO	C [29]	97%	96%	>95%	96%	
Number of integrated patient pathways established across primary/secondary care	V [30]	363	519	350	-	
Number of people accessing Brief Intervention Counselling (BIC)	V [31] Δ	4,873	5,527	>3,500	-	
Rate of ambulatory sensitive (avoidable) hospital admissions for children (0-4)	Q [32]	110	109	<113	100	
ORAL HEALTH SERVICES	**Notes**	**10/11 Result**	**11/12 Result**	**Target 11/12**	**Current NZ result**	**Trend 08/09-11/12**
Percentage of children (<5) enrolled in oral health services	C [33]†	66%	54%	62%	60%	
Percentage of enrolled children (0-12) examined according to planned recall	T [34]†	85%	87%	≥90%	89%	

[29] *The national target for PHO enrolments is 95%, and the aim is to continue to successfully achieve above this level in Canterbury. The NZ result is based on the PHO Performance Programme's June 2012 data.*

[30] *Integrated patient pathways are clinically designed pathways that inform new patient-centred models of care. The HealthPathways website available from GP desktops contains information and resources to help general practice navigate the established pathways, including information on referrals, specialist advice, diagnostic tools, GP-to-GP referral and GP procedure subsidies and patient handouts. Counting in prior years was manual; a more accurate electronic system is now being used. The result 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 expected rate is the national result; a result below 100 indicates better than average performance. Data is subject to availability from the Ministry; results are for the 12 months up to and including March 2010 and 2011.*

[33] *The Ministry's official 2011 oral health enrolment result (54%) uses pre-quake population estimates. Ministry estimates predict an increase in the 0-4 population, when in fact this population has been the most quake-affected. The best post-quake estimate comes from post-quake PHO enrolment, which shows a 4.4% drop in this age group. This would mean an oral health enrolment figure of 59%. While still below target, this is a stronger result in the context of the quakes, which have displaced people and affected their usual health-seeking behaviours. The NZ result is for the 2010 year, as the 2011 national result is not yet available.*

[34] *Service delivery has been delayed after each major earthquake, and school closures have reduced visits. The NZ result is for the 2010 year.*

Number of children (<13 years) requiring hospital dental care with general anaesthetic	Q [35]	540	633	<588	-	
LONG-TERM CONDITIONS PROGRAMMES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of people receiving free diabetes annual reviews	V [36]	10,618	12,412	-	-	
Percentage of people expected to have diabetes receiving free diabetes annual reviews	C [36]	55%	67%	-	70%	
Percentage of eligible population receiving CVD risk assessments every five years	C [37]	14%	20%	45%	49%	
Percentage of the eligible population receiving fasting-lipid/glucose tests every 5 years	C [38]	71%	72%	-	-	
Number of general practice visits delivered through the Māori Diabetes/CVD Screening Programme	V [39]	1,316	2,613	1,042	-	
Number of skin lesions (skin growths, including cancer) removed in primary care	V Δ	2,059	2,318	2,800	-	
Number of spirometry tests delivered in community (rather than hospital) settings	V [40] Δ	1,118	1,136	1,320	-	
PHARMACY SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of medication reviews provided to older people on multiple medications	V [41]	new	632	2,000	-	new
Number of pharmaceutical items dispensed in the community	V Δ	8.4M	8.0M	Est. <9M	-	
COMMUNITY REFERRED AND DELIVERED SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of community-based laboratory tests completed	V Δ	2.3M	2.2M	Est. <2.6M	-	
Number of community radiology tests completed on direct GP referral	V [42]	29,399	38,954	>30,000	-	
Percentage of Community Referred Radiology tests accepted	Q [42]	88%	92%	90%	-	

[35] *A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health.*

[36] *As a result of improved reporting timeliness, diabetes figures have been updated to true financial years (previously a quarter in arrears). No explicit targets were set for 2011/12 due to earthquake displacement (see full explanation in footnote 25). The NZ result is just for the three months January to March 2012, as this is the most recent information available from the Ministry.*

[37] *This refers to CVD risk assessments undertaken in primary care in line with the national PHO Performance Programme (PPP). The late inclusion of Canterbury DHB's largest PHO in the CVD components of the PPP has resulted in lower baseline figures, as CVD Risk Assessment data for over 75% of Canterbury's enrolled population only began to be reported nationally through the PPP in the past 18 months – compared with 5 years among other DHBs. Results prior to 2010/11 excluded Partnership's population and are therefore not directly comparable (and not graphed in the 'trend' column). This measure was introduced as a national Health Target in January 2012, with data for 2010/11 and 2011/12 supplied by MoH on financial (as opposed to the former calendar) years.*

[38] *This data is subject to availability from the Ministry, who discontinued it as a national health target at the end of 2011. The 10/11 result is for the five years up to and including March 2011, while the 11/12 result is for the period up to and including September 2011. No explicit targets were set for 2011/12 due to earthquake displacement (see full explanation in footnote 25).*

[39] *Canterbury's Māori Diabetes/CVD Screening Programme began in 2010/11. It provides general practice visits for at-risk urban and rural Māori.*

[40] *Spirometry is a tool for measuring lung function, assisting in the assessment of a range of respiratory conditions. Community respiratory volumes include delivery by both GPs and mobile community respiratory providers.*

[41] *The Medication Management Service went fully operational on 1 October 2011 - later than planned, owing to more pressing earthquake priorities.*

[42] *Data has been collected electronically since the introduction of the Community Referred Radiology (CRR) service in 2010/11. Trend data is not available historically, except for the number of tests completed in 09/10, which was collected manually to serve as a baseline. The acceptance rate of CRR tests reflects the appropriateness of referrals and hence the quality of referral education/information and clinical referring practices.*

INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Intensive assessment and treatment services are more complex services provided by specialist healthcare professionals. These services are usually 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 almost all service areas under this output class. Most significant is the delivery of 19,636 acute demand packages of care in the community rather than in hospital, the drop in people presenting at our emergency departments 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. People are waiting less, with 95% of those presenting at our EDs admitted or discharged in under six hours and every patient ready for cancer radiation therapy receiving it within four weeks.

OUTPUT MEASURES

SPECIALIST MENTAL HEALTH SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Percentage of young people (0-19) accessing specialist mental health services	C [43] Δ	2.4%	4.0%	≥2%	2.8%	
Percentage of adults (20-64) accessing specialist mental health services	C [43] Δ	3.0%	5.2%	≥2.5%	3.4%	
Percentage of people seen by hospital specialist services in the seven days prior to admission	T [44]	59%	62%	60%	61%	
Percentage of people receiving post-discharge community care within seven days of discharge from hospital services	Q [44]	53%	66%	65%	63%	
Acute inpatient mental health bed occupancy rate	C [45]	84%	87%	>85%	-	
Psychiatric Services for the Elderly (PSE) inpatient bed occupancy rate	C [45]	83%	84%	>85%	-	

[43] *This measure includes more complex and specialised services provided by DHB services and NGOs who submit NHI additional reporting. As the number of NGOs submitting NHI additional reporting increases, this figure grows; this is particularly evident between 2010/11 and 2011/12. Rather than showing a change in access, this shows improvements in our ability to measure actual access. The expectation established is that DHBs will work towards providing access to specialist services to 3% of the population. The NZ result is based on the PP6 national DHB performance measure and is for September 2011, as this was the most recent national figure available.*

[44] *These measures provide an indication of the responsiveness of services to acute need and the integration of services in ensuring a continuum of care for clients after discharge – together these elements will help to reduce acute readmissions to mental health services. These measures use data from the national mental health KPI project; however, 2011/12 KPI results are not yet available. Therefore, the NZ results are for 10/11, and the 11/12 Canterbury results are based on preliminary internal data.*

[45] *Occupancy rates provide an indication of the service's 'capacity to treat'. 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 directly to other areas. Rates above 85% are optimum – too close to 100% would raise issues of capacity.*

Elective Services	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of elective surgical discharges provided	V [46]	14,974	16,494	16,110	-	
Percentage of elective and arranged surgery undertaken on a day case basis	Q [47]	55%	55%	58%	57%	
Percentage of elective and arranged surgery delivered on the day of admission	Q [47]	79%	81%	90%	82%	
Average elective and arranged inpatient length of stay (days)	Q [48]	3.8	3.7	<4.0	4.0	
Number of Surgical First Specialist Assessments (FSA) provided	V	35,006	39,045	Est. >38,000	-	
Percentage of Surgical FSAs that are non-contact (virtual) FSAs	Q [49]	3.5%	6.9%	4.5%	-	
Number of outpatient attendances	V	578,196	611,205	Est. >640,000	-	
Outpatient 'Did Not Attend' rates	Q	5.5%	4.9%	<5%	-	
Quality and Patient Safety Measures *These quality and patient safety measures apply across all CDHB hospital services, not just electives.*	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Reported rate of pressure injuries per 1,000 inpatient bed days	Q [50]	0.28	0.34	0.30	-	
Reported rate of medication, IV and blood incidents per 1,000 inpatient bed days	Q [50]	1.65	1.89	1.99	-	
Rates of *Staph Aureus* hospital-acquired bloodstream infections per 1,000 inpatient bed days	Q [51]	0.066	0.074	≤0.056	-	
Acute Services	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of people presenting at hospital Emergency Departments	V [52]	85,056	84,444	<94,000	-	
Percentage of people admitted or discharged from ED in under six hours – Full year results	T [53]	94%	95%	>95%	-	
– Quarter 4 results	T [53]	96%	96%	>95%	94%	-
Percentage of general practices providing patients with access to telephone triage outside business hours	C [54]	81%	83%	95%	-	

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

[47] *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 due to the earthquakes. These measures are based on the national indicators OS6 and OS7. They have been updated to show true financial years for past years (previously reported a quarter in arrears) and a more recent version of national WIES. This has included a MoH refresh of the day case target to the new WIES. Full 2011/12 year data is not yet available, so the 11/12 result is for the year to March 2012.*

[48] *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 March 2011 and 2012.*

[49] *Non-contact FSA 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] *The targets are 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. Measure is per 1,000 inpatient bed days.*

[51] *Staphylococcus aureus is often found in the nose or on the skin of healthy people, causing them no harm. However, it is possible for Staph aureus to 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. Measured per 1,000 inpatient bed days).*

[52] *The CDHB has moved to the national definition to match the Health Target.*

[53] *This Health Target is tracked on a quarterly basis; therefore, Quarter 4 results are provided in a separate line to allow comparison with published national results. (Q1: 95%, Q2: 95%, Q3: 95%, Q4: 96%)*

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

Number of acute demand packages of care provided via general practice (in community rather than hospital settings)	V [55]	16,510	19,636	>16,800	-	
Acute inpatient average length of stay (days)	Q [56]	3.8	3.7	<4.0	4.0	
Percentage of people receiving radiation oncology treatment within 4 weeks of decision to treat	T	97%	100%	100%	100%	
MATERNITY SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of maternity deliveries in Canterbury	V [57]	6,175	5,736	Est. >6,000	-	
Percentage of total deliveries made in primary birthing units	Q [57]	12%	11%	>13%	-	
Average postnatal length of stay (days)	V [58]	2.9	2.8	>2.4	3.3	
ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of people (65+) accessing inpatient AT&R services	V	2,476	2,410	Est. >2,400	-	
Percentage of admissions into AT&R (PMH) made by direct community referral	Q	20%	16%	>20%	-	
Percentage of AT&R inpatients (65+) discharged to their own homes (not into aged residential care)	Q [59] Δ	72%	73%	>88%	-	

[55] *Refers to acute admission avoidable packages of care that 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). The 2010/11 figure differs from the one published in the previous Annual Report due to a data error which has since been corrected.*

[56] *Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision. National indicator OS4 data is provided by the Ministry one quarter in arrears, so results are for the year to March 2011 and 2012.*

[57] *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. Maternity delivery figures exclude home births.*

[58] *The DHB offers longer stays for women who have a clinical need. Despite tight capacity constraints after the loss of the St George's primary birthing unit, we have continued to identify women with a clinical need and offer this service across the region, as reflected by our average postnatal length of stay each year consistently sitting between 2.8 and 2.9 days.*

[59] *Aged residential care data is now in the DHB's Data Warehouse, providing greater accuracy; however, this clearer picture has yielded substantially different results to those initially published.*

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, including two new services: the Community Rehabilitation Enablement and Support Team (CREST) and the Community-Based Falls Prevention Programme. CREST services support 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. A lower rate of acute hospital admissions from Aged Residential Care (ARC) is also evident, indicating quality residential care for those who need it. A drop in the overall number of people entering ARC suggests more people are being supporting to stay safe and well in their own homes.

It is pleasing to note the increased use of evidence-based and evidence-informed programmes and tools such as the Liverpool Care Pathway, mental health relapse prevention plans 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 COORDINATION SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of people (65+) provided with a clinical assessment of need	V [60] Δ	7,564	8,048	Est. >6,000	-	
Percentage of people entering ARC having received a clinical assessment of need using InterRAI	Q [61] Δ	91%	90%	>90%	-	
PALLIATIVE CARE SERVICES	**Notes**	**10/11 Result**	**11/12 Result**	**Target 11/12**	**Current NZ result**	**Trend 08/09-11/12**
Number of people accessing hospice or home-based palliative services	V Δ	3,159	3,229	Est. >2,000	-	
Number of ARC facilities trained to provide the Liverpool Care Pathway (LCP)	C [62]	23	27	>20 sites	-	
REHABILITATION SERVICES	**Notes**	**10/11 Result**	**11/12 Result**	**Target 11/12**	**Current NZ result**	**Trend 08/09-11/12**
Percentage of people referred to stroke rehabilitation services after an acute event	C [63]	71%	75%	69%	-	
Percentage of people referred to cardiac rehabilitation services after an acute event	C	27%	25%	30%	-	
Number of people accessing pulmonary rehabilitation courses in the community	V	108	83	180	-	
Number of older people (65+) accessing the Community-Based Falls Prevention Programme	V [64]	new	753	800	-	new

[60] *An error in the original calculation of this measure, which excluded a number of non-complex clients, has now been corrected.*

[61] *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. Data excludes clients from Ashburton and direct hospital referrals.*

[62] *The Liverpool Care Pathway is an international programme adopted nationally and reflects best-practice care. It began in Canterbury in September 2009. By February 2011, 23 facilities were trained and delivering LCP, but this dropped to 18 post-quake due to facility damage. The 2011/12 result of 27 therefore shows strong improvement after quake-related setbacks.*

[63] *2010/11 result is for quarters 1-3 only, as data capture was compromised by the splitting of wards across two sites post-quake.*

[64] *Canterbury's new integrated approach to falls prevention commenced 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.*

HOME-BASED SUPPORT SERVICES	Notes	10/11 Result	11/12 Result	Target 11/12	Current NZ result	Trend 08/09-11/12
Number of people supported by home support services	V Δ	8,440	8,080	Est. >9,400	-	
Number of people supported by district nursing services	V Δ	6,008	5,833	Est. >4,200	-	
Number of eligible people (65+) supported upon direct GP referral by CREST services	V [65]	new	63	600	-	new
Number of eligible people (65+) supported upon hospital discharge by CREST services	V [65]	166	1,091	900	-	
Rate of acute readmissions to hospital services: for CREST (65+) patients for non-CREST (65+) patients **Difference**	Q [66]		16.5% 19.8% **-3.3%**	-10%	-	new
RESIDENTIAL CARE SERVICES	**Notes**	**10/11 Result**	**11/12 Result**	**Target 11/12**	**Current NZ result**	**Trend 08/09-11/12**
Number of (subsidised) ARC rest home beds provided (days)	V [67] Δ	666,643	608,350	Est. <676,374	-	
Number of (subsidised) ARC hospital beds provided (days)	V Δ	495,513	462,113	Est. <507,576	-	
Number of (subsidised) ARC dementia beds provided (days)	V Δ	212,566	211,757	Est. >208,000	-	
Number of (subsidised) ARC psycho-geriatric beds provided (days)	V Δ	62,429	64,714	Est. >68,000	-	
Rate of acute admissions into hospital from ARC facilities	Q [68] Δ	3.9%	3.2%	≤3.73%	-	
RESPITE AND DAY SERVICES	**Notes**	**10/11 Result**	**11/12 Result**	**Target 11/12**	**Current NZ result**	**Trend 08/09-11/12**
Number of people accessing day services	V Δ	670	664	Est.>550	-	
Occupancy rate of mental health planned and crisis respite beds	C [69] Δ	77%	72%	>85%	-	
Percentage of long-term mental health clients (0 -19) who have current relapse prevention plans	Q [70]	78%	90%	>95%	79%	
Percentage of long-term mental health clients (20-64) who have current relapse prevention plans	Q [70]	94%	99%	>95%	93%	

[65] *The Community Rehabilitation Enablement and Support Team (CREST) facilitates earlier discharge from hospital to appropriate home-based rehabilitation services. It has been expanded in 2011/12 to support people who can be rehabilitated at home to avoid hospital admission altogether. The rollout of CREST to general practice began in November 2011 and has been slower than expected due to the loss of several key staff members. New staff have now been recruited and trained, giving the capacity to begin actively rolling CREST out to the remaining practices in 2012/13.*

[66] *The effectiveness of CREST is measured by comparing readmission rates for CREST clients with rates for the 65+ population not receiving CREST care.*

[67] *These measures are based on estimates made prior to the earthquakes and loss of ARC capacity it is likely that they will drop against an increase in home based support, district nursing and CREST services as people are supported in their own homes. These bed-day measures are included to give a sense of the volume of DHB-funded ARC; access to ARC is demand driven, so there are no targets, just estimates of expected demand.*

[68] *The denominator for this measure is the total number of acute admissions into hospital.*

[69] *The large drop in the mental health respite occupancy rate is the result of additional beds being provided; utilisation remains steady at around 6,000 occupied bed days per year. See footnote 45 for more information on interpretation of occupancy rates.*

[70] *Relapse prevention planning minimises the medium to longer-term impacts of serious mental illness, improving outcomes for clients. Accordingly, all clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what actions to take. Previously reported adult 10/11 figures mistakenly omitted some clients and have now been corrected. The NZ result is for 2011.*

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2012.

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, the Canterbury DHB Group recorded a net deficit of $0.043M against the budgeted deficit of $25M (2010/11 result was a net deficit of $0.105M).

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 30/06/12 $'000	Committee Fees Year ended 30/06/12 $'000
Peter Ballantyne	32	5
Anna Crighton	26	5
Elizabeth Cunningham	26	4
Wendy Dallas-Katoa	-	1
Jonathan Darby	-	2
Andrew Dickerson	26	6
Wendy Gilchrist	26	5
Matea Gillies	-	2
Aaron Keown	26	4
David Kerr	-	1
Bob Lineham	-	3
Bruce Matheson	52	4
Chris Mene	26	5
David Morrell	26	5
Trevor Read	-	2
Mary Richardson	-	1
William Tate	-	5
Susan Wallace	26	-
Olive Webb	26	4
	318	**64**

Total fees paid for the year were $382,000 (2010/11 - $370,000). The limit of fees authorised for the year ended 30 June 2012 was $422,875 (2010/11 - $395,375).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	Board		QFARC		HAC		CPH&DSAC	
	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended
Bruce Matheson	14	13	11	9	8	6	7	6
Peter Ballantyne	14	13	11	11	8	7	7	5
Olive Webb	14	9	11	7	3[71]	2	7	5
David Morrell	14	11	11	7	8	6	2[71]	1
Anna Crighton	14	11	5[71]	5	8	8	7	7
Elizabeth Cunningham	14	12	11	8	8	5	2[71]	2
Andrew Dickerson	14	14	11	11	3[71]	3	7	7
Susan Wallace	14	8	5[71]	0	3[71]	0	2[71]	0
Chris Mene	14	11	5[71]	5	8	6	7	7
Aaron Keown	14	8	5[71]	5	8	6	7	6
Wendy Gilchrist	14	12	11	8	8	6	2[71]	2
Wendy Dallas-Katoa							7	5
Jonathan Darby							7	6
Mary Richardson							5[72]	5
Bob Lineham			11	9				
Bill Tate			11	11	8	8		
Matea Gillies					8	5		
Trevor Read					8	6		
David Kerr [73]					4[73]	2		

DIRECTOR FEES

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

	Year Ended 30/06/12 $'000	Year Ended 30/06/11 $'000
David Morrell	10	10
Brian Wood	20	20
	30	**30**

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2012

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

Bruce Matheson

Brannigans Ltd - founding shareholder/director. Brannigans Ltd is a human resource consulting business – a potential conflict of interest may exist in the provision of any consulting services to the Canterbury DHB.

Freshpork NZ Ltd – Director. Is engaged in farming, processing and marketing of pork meats in New Zealand – no obvious conflict of interest is anticipated.

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

[71] *Start date – 1 January 2012*
[72] *Start date – 19 August 2011*
[73] *End date – 4 November 2011*

	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 –Consultant. This company is an internet provider which provides services to the Canterbury DHB.
Peter Ballantyne	West Coast District Health Board - Appointed Member. 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 – Director - governance of Christchurch Heritage. Historic Places Aotearoa Inc – President.
Elizabeth Cunningham	University of Otago, Christchurch – Research Manager, Māori (0.6FTE) - part of the Senior Management Team. The University has various relationships with the Canterbury DHB, including medical training, research, the provision of library services, and leasing of premises. Te Runanga o Ngai Tahu (TRONT) – Director - governance body for Ngai Tahu. 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 – Member - 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. Canterbury District Police Advisory Group – Member. South Island Oncology Research Group – Member.
Wendy Dallas-Katoa	Te Runanga O Ngai Tahu - Programme Leader – Health and Social Wellbeing.

	Partnership Health PHO "Te Kei o te Waka"– Board Member – iwi/manawhenua representative. Partnership Health Canterbury is a Primary Health Organisation (PHO). The PHO has entered into an agreement with the Canterbury DHB under which the PHO agreed to provide a range of health care services and the management tasks associated with the delivery and funding of these services. The PHO has the power to subcontract the delivery of any or all such services and associated management tasks. Pegasus Health/Partnership Health (PHO) – Māori Health Advisory Group Member. Manawhenua Ki Waitaha – Ōnuku Rūnanga Representative - Manawhenua Ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the Canterbury DHB area. There is a Memorandum of Understanding between Manawhenua and the Canterbury DHB. Healthy Christchurch – Steering Committee - Ngāi Tahu representative to this Committee.
Jonathan Darby	Toastmasters International - a member of two Toastmasters clubs and holds an executive role in one. No conflicts of interest are anticipated regarding 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.
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. CERA Community Forum – Member – community based forum formed under the Canterbury Earthquake Recovery Act to provide the Canterbury Earthquake Recovery Minister with information and advice on earthquake recovery matters. 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.
Matea Gillies	Pegasus Health (Charitable) Ltd – Member - Pegasus Health is an Independent Practice Association (IPA) that supports General Practitioners delivering care to approximately 290,000 patients. Pegasus Health is part of Partnership Health Canterbury PHO. Much of the organisation's work is funded either from the Ministry of Health and the DHB via Partnership Health. Dr Gillies has a small contract with Pegasus Health as an advisor on Māori health that may pose a possible conflict of interest. Taupunga Ltd – Director - Taupunga Ltd provides General Medical Services. Dr Gillies is employed by Taupunga Ltd to provide General Practitioner services. Taupunga has a contract with the Pegasus Charitable Trust, Pegasus 24 Hrs Clinic and Dr James Shanks. Manawhenua ki Waitaha – Chairperson - Manawhenua ki Waitaha is a collective of health representatives of the seven Ngai Tahu Papatipu Runanga that are in the Canterbury DHB area. There is a memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB. Te Poho o Tamatea - Board Member - Te Poho o Tamatea is a charitable company which is the investment company for Te Hapu o Ngati Wheke, distributing money for primarily education, health, and cultural purposes. MIHI (Māori/Indigenous Health Institute) - Senior Clinical Lecturer - University of Otago Christchurch School of Medicine
Aaron Keown	Christchurch City Council and Shirley Papanui Community Board – Member - elected member of the Christchurch City Council (CCC) and also a member of the Shirley Papanui Community Board and a member of a number of other Council committees. Canterbury Development Corporation – Director. No conflicts of interest are anticipated from these roles but will be discussed at the appropriate time should they arise.

David Kerr	Centercare Limited – Chair - Centercare purchases supplies for Medical Practitioners. General Medical Practitioner - doctor providing primary care services. Health Education Trust – Trustee - Health Education Trust develops and provides educational materials and training programmes for those caring for the elderly within the health sector. Medical Protection Society (MPS) – Advisor - organisation that advises and provides legal support to doctors. The MPS role is to support the doctor, which can occasionally conflict with the DHB. Should an issue of conflict arise, that will be disclosed at the time. Partnership Health PHO – Contractor - contracted to Partnership Health PHO to assist in developing an improved hospital referral process and interface between hospital and community providers. Pegasus Health – Advisor - provides a management services organisation for primary medical providers and other primary care providers. Ryman Healthcare Limited – Chair - provides residential aged care services under contracts with the Canterbury DHB. Pharmaceutical Management Agency (Pharmac) – Board Member - Pharmac is a Crown Entity which purchases pharmaceuticals for New Zealand (including on behalf of DHBs within New Zealand) for the New Zealand Pharmaceutical schedule. NZ Medical Association Services Ltd – Director - publishes NZ Medical Journal and related publications. Purchases services and supplies for members of NZ Medical Association. Canterbury Initiative Project – involved with this project which is a joint Canterbury DHB/Canterbury PHO initiative focused on the elective services interface between general practice and hospital clinicians.
Bob Lineham	Civic Assurance (New Zealand Local Government Insurance Corporation Ltd) – Director - this is a specialist insurance company servicing Local Government 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.
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	Brackenridge Estate Limited – Chairman (appointed by Canterbury DHB). Wholly owned subsidiary of the Canterbury DHB - provides intellectual disability services under contracts with the Ministry of Health, Work and Income New Zealand, Accident Compensation Corporation and the Child, Youth and Family Service. 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 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.
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 $182,299 to 4 employees (2010/11 – 12 employees totalling $275,145) 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:

	30/06/12 (including benefits) Total	30/06/11 (including benefits) Total
100,000-109,000	**136**	**108**
110,000-119,000	**82**	**85**
120,000-129,000	**64**	**77**
130,000-139,000	**70**	**61**
140,000-149,000	**54**	**30**
150,000-159,000	**41**	**38**
160,000-169,000	**37**	**40**
170,000-179,000	**37**	**26**
180,000-189,000	**24**	**26**
190,000-199,000	**22**	**30**
200,000-209,000	**36**	**22**
210,000-219,000	**23**	**15**
220,000-229,000	**22**	**27**
230,000-239,000	**27**	**26**
240,000-249,000	**25**	**13**
250,000-259,000	**14**	**17**
260,000-269,000	**13**	**17**
270,000-279,000	**19**	**13**
280,000-289,000	**18**	**13**
290,000-299,000	**19**	**7**
300,000-309,000	**4**	**4**
310,000-319,000	**11**	**7**
320,000-329,000	**6**	**5**
330,000-339,000	**6**	**7**
340,000-349,000	**6**	**2**
350,000-359,000	**5**	**3**
360,000-369,000	**4**	**2**
370,000-379,000	**3**	**2**
380,000-389,000	**2**	**1**
400,000-409,000	**1**	**-**
410,000-419,000	**3**	**-**
440,000-449,000	**1**	**-**
450,000-459,000	**-**	**1**
490,000-499,000	**-**	**1**
500,000-509,000	**-**	**1**
530,000-539,000	**1**	**-**
540,000-549,000	**1**	**-**
Total	**837**	**727**

Of the 837 (2010/11 727) positions identified above, 750 (2010/11 660) positions were predominantly clinical and 87 (2010/11 67) positions were management/administrative.

During the financial year the operations of the South Island Shared Service Agency Limited were aligned into Canterbury DHB. The staff are employed by Canterbury DHB and are included in the figures above for 2012.

STATUTORY INFORMATION

This Annual Report outlines the Canterbury DHB's financial and non-financial performance for the year ended 30 June 2012 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (e) of the same Act.

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

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

GOOD EMPLOYER

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

Leadership, Accountability and Culture

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

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

Staff Mix by Average Age	Average age
Medical	40.5
Nursing	46.8
Allied Health	43.9
Support	51.1
Management & Administration	48.6

Staff Mix by Gender	Number	Percentage
Female	7,663	81
Male	1,791	19
Total	9,454	

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

Staff Ethnicity	Number
Australian	76
British	569
Chinese	101
Indian	75
Latin American	4
Māori	174
Middle Eastern	19
New Zealander	438
NZ European	3,782
Pacific Peoples	63
South African	56
Other African	42
Other Asian	203
Other European	843
Other	1
Not Stated	3,008
Total	9,454

Recruitment, Selection and Induction

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

Safe and Healthy Environment

The Canterbury DHB is committed to providing a safe and healthy workplace with a dedicated Health and Safety team to provide advice and support to management and staff.

We operate a health monitoring programme including 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.

In July 2012, Canterbury DHB's re-certification audit was conducted by HealthCert, Ministry of Health . This provided the Ministry of Health with the opportunity to experience first-hand the challenges to the provision of services and infrastructure due to the on-going seismic events. The DHB is currently awaiting the final certification report and certification time period.

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

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

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

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

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

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

STATEMENT OF RESPONSIBILITY

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

a) The preparation of financial statements and statement of service performance of Canterbury DHB and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2012, are our responsibility.

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

Bruce Matheson
Chair
2 October 2012

Peter Ballantyne
Deputy Chair
2 October 2012

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2012

	Notes	Group			Parent	
		Actual 30/06/12 $'000	Budget 30/06/12 $'000	Actual 30/06/11 $'000	Actual 30/06/12 $'000	Actual 30/06/11 $'000
Income						
Ministry of Health revenue		1,369,837	1,363,714	1,333,681	1,358,473	1,323,125
Patient related revenue	2	44,786	40,959	40,550	44,786	39,721
Other operating income	3	50,366	21,404	25,254	47,651	23,123
Interest income		7,337	5,800	6,207	7,179	6,068
Total income		**1,472,326**	**1,431,877**	**1,405,692**	**1,458,089**	**1,392,037**
Operating expenses						
Employee benefit costs	4	583,999	585,373	563,628	571,519	551,157
Treatment related costs		138,428	128,162	125,645	142,460	129,509
External service providers		581,046	598,622	570,452	581,046	570,452
Depreciation and amortisation		46,454	47,036	46,866	45,087	45,578
Interest expenses on loans		4,529	4,700	4,668	4,529	4,668
Other expenses	5	102,858	76,384	79,684	98,948	76,182
Total operating expenses		**1,457,314**	**1,440,277**	**1,390,943**	**1,443,589**	**1,377,546**
Operating surplus before capital charge		15,012	(8,400)	14,749	14,500	14,491
Capital charge expense	6	(15,055)	(16,600)	(14,854)	(15,055)	(14,854)
Surplus/(deficit)		**(43)**	**(25,000)**	**(105)**	**(555)**	**(363)**
Other comprehensive income						
Impairment of property, plant & equipment	7,14&16	(14,297)	-	(33,845)	(14,297)	(33,845)
Total other comprehensive income		**(14,297)**	**-**	**(33,845)**	**(14,297)**	**(33,845)**
Total comprehensive income		**(14,340)**	**(25,000)**	**(33,950)**	**(14,852)**	**(34,208)**

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2012

	Notes	Group			Parent	
		Actual 30/06/12 $'000	Budget 30/06/12 $'000	Actual 30/06/11 $'000	Actual 30/06/12 $'000	Actual 30/06/11 $'000
Total equity at beginning of the period		198,815	211,491	229,352	196,618	227,413
Total comprehensive income		(14,340)	(25,000)	(33,950)	(14,852)	(34,208)
Total recognised revenues and expenses		(14,340)	(25,000)	(33,950)	(14,852)	(34,208)
Other movements:						
Contribution back to Crown		-	(1,861)	(1,861)	-	(1,861)
Contribution from Crown		850	-	5,274	850	5,274
Total equity at end of the period	7	**185,325**	**184,630**	**198,815**	**182,616**	**196,618**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2012

	Notes	Group Actual as at 30/06/12 $'000	Group Budget as at 30/06/12 $'000	Group Actual as at 30/06/11 $'000	Parent Actual as at 30/06/12 $'000	Parent Actual as at 30/06/11 $'000
CROWN EQUITY						
General Funds	7	131,154	184,630	130,304	131,292	130,442
Revaluation Reserve	7	131,404	-	145,701	131,404	145,701
Retained earnings/(losses)	7	(77,233)	-	(77,190)	(80,080)	(79,525)
TOTAL EQUITY		**185,325**	**184,630**	**198,815**	**182,616**	**196,618**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and cash equivalents	8	51,819	81,386	87,803	50,408	86,870
Trade and other receivables	9	57,959	41,011	61,727	56,539	60,801
Inventories	10	8,493	9,641	8,916	8,397	8,851
Investments	11	74,329	-	18,132	71,500	15,744
TOTAL CURRENT ASSETS		192,600	132,038	176,578	186,844	172,266
CURRENT LIABILITIES						
Trade and other payables	12	121,059	116,570	120,294	120,725	119,935
Owing to the Ministry of Health		2,514	7,229	4,355	2,333	4,355
Employee benefits	13	152,422	125,000	141,039	150,145	139,347
Borrowings	18	30,000	-	30,000	30,000	30,000
TOTAL CURRENT LIABILITIES		305,995	248,799	295,688	303,203	293,637
NET WORKING CAPITAL		(113,395)	(116,761)	(119,110)	(116,359)	(121,371)
NON CURRENT ASSETS						
Investments	11	54,650	12,066	1,927	60,171	7,442
Property, plant and equipment	14	349,700	373,950	368,284	344,412	362,822
Intangible assets	15	939	-	698	938	692
Restricted assets	17	15,012	12,483	13,686	15,012	13,547
TOTAL NON CURRENT ASSETS		420,301	398,499	384,595	420,533	384,503
NON CURRENT LIABILITIES						
Employee benefits	13	6,919	9,625	7,984	6,896	7,967
Restricted funds	17	15,012	12,483	13,686	15,012	13,547
Borrowings	18	99,650	75,000	45,000	99,650	45,000
TOTAL NON CURRENT LIABILITIES		121,581	97,108	66,670	121,558	66,514
NET ASSETS		**185,325**	**184,630**	**198,815**	**182,616**	**196,618**

For and on behalf of the Board

Bruce Matheson
Chair
2 October 2012

Peter Ballantyne
Deputy Chair
2 October 2012

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 2012

	Notes	Group Actual 30/06/12 $'000	Group Budget 30/06/12 $'000	Group Actual 30/06/11 $'000	Parent Actual 30/06/12 $'000	Parent Actual 30/06/11 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,383,792	1,363,712	1,308,321	1,372,835	1,297,762
Other receipts		84,856	62,363	64,172	82,242	61,214
Interest received		7,337	5,800	6,207	7,179	6,068
		1,475,985	1,431,875	1,378,700	1,462,256	1,365,044
Cash was applied to:						
Payments to employees		573,681	585,373	549,164	561,792	536,814
Payments to suppliers		819,299	803,168	750,155	819,539	750,524
Interest paid		4,363	4,700	4,663	4,363	4,663
Capital charge		18,926	16,600	15,428	18,926	15,428
GST - net		(2,983)	-	(1,544)	(2,976)	(1,542)
		1,413,286	1,409,841	1,317,866	1,401,644	1,305,887
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	62,699	22,034	60,834	60,612	59,157
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant & equipment		30	-	53	20	44
Receipts from restricted assets		3,552	-	3,794	3,552	3,787
		3,582	-	3,847	3,572	3,831
Cash was applied to:						
Purchase of investments & restricted assets		112,472	-	13,407	112,037	12,993
Purchase of property, plant & equipment		45,293	38,300	35,960	44,109	34,774
		157,765	38,300	49,367	156,146	47,767
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		(154,183)	(38,300)	(45,520)	(152,574)	(43,936)
CASH FLOW FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		54,650	-	-	54,650	-
Equity injection		850	-	5,274	850	5,274
		55,500	-	5,274	55,500	5,274
Cash was applied to:						
Equity repaid to Crown		-	1,861	1,861	-	1,861
		-	1,861	1,861	-	1,861
NET CASH INFLOW/ (OUTFLOW) FROM FINANCING ACTIVITIES		55,500	(1,861)	3,413	55,500	3,413
Net (decrease)/increase in cash and cash equivalents		(35,984)	(18,127)	18,727	(36,462)	18,634
Cash and cash equivalents at beginning of year		87,803	99,513	69,076	86,870	68,236
CASH & CASH EQUIVALENTS AT END OF YEAR	8	**51,819**	**81,386**	**87,803**	**50,408**	**86,870**

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 2012

1. STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY AND STATUTORY BASE

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

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand 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), and associate entity South Island Shared Service Agency Ltd (47% owned). From 1 December 2011, the South Island Shared Service Agency Ltd's operations and staff were transferred over to Canterbury DHB, and managed under the South Island Alliance Program Office.

The financial statements of Canterbury DHB are for the year ended 30 June 2012 and were authorised for issue by the Board on 2 October 2012.

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 adopted during the year

- NZ IAS 24 *Related Party Disclosures (Revised 2009)* replaces *NZ IAS 24 Related Party Disclosures (Issued 2004)* was applied for the first time in the DHB group's 30 June 2012 financial statements. Changes to disclosure requirements include:
  More information is required to be disclosed about transactions between the DHB and entities controlled, jointly controlled, or significantly influenced by the Crown;
  Clarifies that related party transactions include commitments with related parties;
  Information is required to be disclosed about any related parties with Ministers of the Crown.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments). The adoption of this standard did not result in any additional disclosures being required.

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

- NZ IFRS 9 *Financial Instruments* will eventually replace *NZ IAS 39 Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is effective for reporting period beginning on or after 1 January 2013. Canterbury DHB has not yet assessed the impact of the new standard and expects it will not be early adopted.

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

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

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

Subsidiaries

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

included in the consolidated financial statements from the date that control commences until the date that control ceases.

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the 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 IFRS, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

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

Additions

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

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

Depreciation

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

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

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

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

Expenditure on software development activities, 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 the DHB commits to purchase/sell the investments.

Trade and other receivables

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

Inventories

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

Other inventories are stated at cost (calculated using the weighted average method).

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on

demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

Impairment

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

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

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

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

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

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on 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 the DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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

Trade and other payables

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

Derivative financial instruments

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

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are remeasured to fair value at each balance date. The gain or loss on a remeasurement to fair value is recognised immediately in the surplus/deficit.

Income tax

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

Goods and services tax

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

Revenue

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

Revenue relating to service contracts

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

Services rendered

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

Interest income

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

Operating lease payments

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

Non-current assets held for sale

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus/deficit.

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

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

Borrowing costs

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

Critical judgements in applying Canterbury DHB's accounting policies

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

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

Property, plant and equipment useful lives and residual value

At each balance date Canterbury DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, 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	
	30/06/12 $'000	30/06/11 $'000	30/06/12 $'000	30/06/11 $'000
ACC Revenue	23,599	20,390	23,599	20,390
Other patient related revenue	21,187	20,160	21,187	19,331
	44,786	**40,550**	**44,786**	**39,721**

3. OTHER OPERATING INCOME

	Group		Parent	
	30/06/12 $'000	30/06/11 $'000	30/06/12 $'000	30/06/11 $'000
Gain/(loss) on sale of property, plant and equipment	(226)	(128)	(240)	(129)
Donations and bequests received	1,158	1,822	1,158	1,821
Insurance	24,708	772	24,708	772
Other	24,726	22,788	22,025	20,659
	50,366	**25,254**	**47,651**	**23,123**

4. EMPLOYEE BENEFIT COSTS

	Group		Parent	
	30/06/12 $'000	30/06/11 $'000	30/06/12 $'000	30/06/11 $'000
Wages and salaries	568,627	543,799	556,775	531,487
Contributions to defined contribution plans	5,054	5,365	5,016	5,327
Increase/(decrease) in employee benefit provisions	10,318	14,464	9,728	14,343
	583,999	**563,628**	**571,519**	**551,157**

5. OTHER EXPENSES

	Group		Parent	
	30/06/12 $'000	30/06/11 $'000	30/06/12 $'000	30/06/11 $'000
Remuneration of auditor:				
Financial statement audit fees	240	212	194	173
Board members' fees	318	354	318	354
Directors' fees	30	30	-	-
Rental costs	5,300	4,905	4,626	4,245
Facilities and infrastructure costs (note 16)	56,519	41,404	54,543	39,617
Other non-clinical costs	40,451	32,779	39,267	31,793
	102,858	**79,684**	**98,948**	**76,182**

6. CAPITAL CHARGE

Canterbury DHB pays capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the year. The capital charge rate for the period ended June 2012 was 8%. (June 2011 8%).

7. CAPITAL AND RESERVES

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
General Funds				
Opening Balance	130,304	126,891	130,442	127,029
Equity repayment to Ministry of Health	-	(1,861)	-	(1,861)
Equity injection by Ministry of Health	850	5,274	850	5,274
	131,154	**130,304**	**131,292**	**130,442**
Retained earnings				
Opening balance	(77,190)	(78,585)	(79,525)	(80,662)
Operating surplus/(deficit)	(43)	(105)	(555)	(363)
Transfer (to)/from revaluation reserve	-	1,500	-	1,500
Closing balance	(77,233)	(77,190)	(80,080)	(79,525)
Represented by:				
Accumulated deficit in parent and subsidiary	(77,311)	(77,268)	(80,158)	(79,603)
Accumulated surplus in associates	78	78	78	78
	(77,233)	**(77,190)**	**(80,080)**	**(79,525)**
Revaluation reserve				
Opening balance	145,701	181,046	145,701	181,046
Impairment charges	(14,297)	(33,845)	(14,297)	(33,845)
Revaluation of land, building including fitout	-	-	-	-
Transfer to retained earnings	-	(1,500)	-	(1,500)
Closing balance	131,404	145,701	131,404	145,701
Represented by:				
Revaluation of land	57,108	57,108	57,108	57,108
Revaluation of building including fitout	74,296	88,593	74,296	88,593
	131,404	**145,701**	**131,404**	**145,701**
Total Equity	**185,325**	**198,815**	**182,616**	**196,618**

8. CASH AND CASH EQUIVALENTS

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Bank balances and call deposits	17,819	34,303	16,408	33,370
Term deposits less than 3 months	34,000	53,500	34,000	53,500
	51,819	**87,803**	**50,408**	**86,870**

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

9. TRADE AND OTHER RECEIVABLES

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Trade receivables	9,343	11,048	9,240	10,961
Receivable from the Ministry of Health	25,553	39,508	24,407	38,769
Prepayments	1,950	1,914	1,947	1,911
Other receivables	21,113	9,257	20,945	9,160
	57,959	**61,727**	**56,539**	**60,801**

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 $15.8M (June 2011 $nil) insurance receivable.

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

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Balance at 1 July	3,676	2,932	3,676	2,932
Additional provisions made during the year	595	1,015	592	1,015
Receivables written-off during period	(666)	(271)	(666)	(271)
Balance at 30 June	**3,605**	**3,676**	**3,602**	**3,676**

The ageing of the impairment provisions are as follows:

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Current	937	262	934	262
1-30 days	198	145	198	145
31-60 days	187	280	187	280
> 61 days	2,283	2,989	2,283	2,989
Balance at 30 June	**3,605**	**3,676**	**3,602**	**3,676**

As at 30 June 2012 and 2011, 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 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Current	8,582	7,454	8,532	7,418
1-30 days	711	2,393	693	2,367
31-60 days	169	1,155	154	1,145
> 61 days	(119)	46	(139)	31
Balance at 30 June	**9,343**	**11,048**	**9,240**	**10,961**

10. INVENTORY

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Pharmaceuticals	2,554	2,730	2,554	2,730
Surgical and medical supplies	4,542	4,976	4,542	4,976
Other supplies	2,919	2,641	2,823	2,576
	10,015	10,347	9,919	10,282
Provision for obsolescence	(1,522)	(1,431)	(1,522)	(1,431)
	8,493	**8,916**	**8,397**	**8,851**

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 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Current investments are represented by:				
Term deposits	74,329	14,888	71,500	12,500
Bonds	-	3,244	-	3,244
Total current portion	74,329	18,132	71,500	15,744
Non-current investments are represented by:				
Term Deposits	54,650	-	54,650	-
Investment in Subsidiaries	-	-	5,521	5,515
Bonds	-	1,927	-	1,927
Total non-current portion	54,650	1,927	60,171	7,442
	128,979	**20,059**	**131,671**	**23,186**

Investment in Associates

a) General information

Name of entity	Principal activities	Interest held at 30/06/12	Balance date
South Island Shared Service Agency Limited	Non Trading Company	47%	30 June

South Island Shared Service Agency Limited is an unlisted company.

b) Investment in associate entities

	2012 Actual $'000	2011 Actual $'000
Carrying amount at beginning of year	-	-
Carrying amount at end of year	**-**	**-**

c) Summarised financial information of associate entity

	2012 Actual $'000	2011 Actual $'000
Assets	944	2,229
Liabilities	20	1,142
Revenues	1,035	2,877
Surplus/(deficit)	(163)	295
Group's interest	47%	47%

d) Share of associates' contingent liabilities and commitments

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

e) Subsequent events

The South Island Shared Service Agency Limited 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.

Investments in subsidiaries

	Parent	
	As at 30/06/12 $'000	**As at 30/06/11 $'000**
Equity - Canterbury Linen Services Ltd	5,436	5,416
Advances - Canterbury Linen Services Ltd	(42)	(22)
Advances - Brackenridge Estate Ltd	127	121
	5,521	**5,515**

At 30 June 2012 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) have established a national Health Innovation Hub. The Hub will engage 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 30/06/12 $'000	**As at 30/06/11 $'000**	**As at 30/06/12 $'000**	**As at 30/06/11 $'000**
Term deposits	128,979	14,888	126,150	12,500
Bonds	-	5,171	-	5,171

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

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

	Group	
	30/06/12 $'000	**30/06/11 $'000**
Term deposits with maturities of 1-12 months	74,329	14,888
Weighted average effective interest rates	4.50%	4.62%
Term deposits with maturities later than 1 year but no more than 5 years	54,650	-
Weighted average effective interest rates	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 30/06/12 $'000	**As at 30/06/11 $'000**	**As at 30/06/12 $'000**	**As at 30/06/11 $'000**
Trade payables	10,616	12,481	10,745	12,436
Other payables	110,443	107,813	109,980	107,499
	121,059	**120,294**	**120,725**	**119,935**

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 30/06/12 $'000	**As at 30/06/11 $'000**	**As at 30/06/12 $'000**	**As at 30/06/11 $'000**
Non-current liabilities				
Liability for long service leave	3,843	3,478	3,820	3,461
Liability for retirement gratuities	3,076	4,506	3,076	4,506
	6,919	**7,984**	**6,896**	**7,967**
Current liabilities				
Annual leave accruals	61,746	56,047	60,833	55,317
Unpaid days accruals	15,786	11,968	15,572	11,924
ACC accruals	10,038	9,497	9,962	9,421
Conference/sabbatical leave and expenses	22,237	20,986	22,237	20,986
Sick leave	10,437	10,429	10,278	10,228
Other	32,178	32,112	31,263	31,471
	152,422	**141,039**	**150,145**	**139,347**

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

11/12 financial year	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Reversionary interest in buildings $'000	Work in progress $'000	Total $'000
Cost or valuation							
Balance at 1 July 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**

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

Carrying amount	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings $'000	Reversionary interest in buildings $'000	Work in progress $'000	Total $'000
At 1 July 2011	94,337	208,631	53,548	-	3,000	8,768	368,284
At 30 June 2012	**94,337**	**192,071**	**52,401**	**251**	**-**	**10,640**	**349,700**

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

11/12 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation							
Balance at 1 July 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**

10/11 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation							
Balance at 1 July 2010	103,682	249,040	164,412	894	3,000	5,468	526,496
Additions	-	15,185	17,254	-	-	3,300	35,739
Disposals/transfers	-	(109)	(3,596)	-	-	-	(3,705)
Revaluation							
Balance at 30 June 2011	**103,682**	**264,116**	**178,070**	**894**	**3,000**	**8,768**	**558,530**
Depreciation & impairment losses							
Balance at 1 July 2010	-	-	119,637	894	-	-	120,531
Depreciation	-	31,344	13,519	-	-	-	44,863
Impairment	9,345	24,500	-	-	-	-	33,845
Disposals/transfer	-	(32)	(3,499)	-	-	-	(3,531)
Balance at 30 June 2011	**9,345**	**55,812**	**129,657**	**894**	**-**	**-**	**195,708**

Carrying amount	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Reversionary interest in buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
At 1 July 2011	94,337	208,304	48,413	-	3,000	8,768	362,822
At 30 June 2012	**94,337**	**191,770**	**47,467**	**251**	**-**	**10,587**	**344,412**

Revaluation

Canterbury DHB revalued its land, buildings and plant fitouts as at 30 June 2010. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of Telfer Young (Canterbury) Ltd), which is consistent with NZ IAS 16 Property Plant & Equipment. The movements in land and buildings and plant fitout were recognised in the Revaluation Reserve. The Canterbury earthquakes have caused significant damage to some of Canterbury DHB's buildings and assets, and a $14.297M impairment has been recognised in the period to 30 June 2012 ($33.845M 30 June 2011). See note 16 for further details.

Canterbury DHB owns land which it has allowed a third party to construct a car park on. In lieu of rental foregone, ownership of the car park building will revert to Canterbury DHB in 2019. This interest was valued as at 30 June 2010 however has been subsequently impaired due to earthquake damage.

15. INTANGIBLE ASSETS

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Software				
Cost				
Opening balance	19,298	18,562	19,284	18,555
Additions	1,654	801	1,654	794
Disposals	(423)	(65)	(417)	(65)
Closing balance	20,529	19,298	20,521	19,284
Amortisation and impairment losses				
Opening balance	18,600	17,950	18,592	17,943
Amortisation charge for the year	1,407	716	1,408	715
Disposals	(417)	(66)	(417)	(66)
Closing balance	19,590	18,600	19,583	18,592
Carrying amounts	**939**	**698**	**938**	**692**

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 2012. There has been no change since last year.

16. IMPAIRMENT AND THE EFFECTS OF THE CONTINUING CANTERBURY EARTHQUAKES

A 7.1 magnitude earthquake occurred in the Canterbury region on 4 September 2010, with subsequent large aftershocks, including a 6.3 magnitude earthquake on 22 February 2011, and a further 6.3 magnitude earthquake on 13 June 2011. These events caused significant damage to many of Canterbury DHB's buildings and assets. For example, over 9,000 hospital rooms need some level of repair. Canterbury DHB needed to install a number of temporary infrastructure facilities to ensure continued operations, such as emergency boilers, and water supplies for fire sprinkler systems.

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

While the DHB has received assessments on the level of damage to its buildings, it is still working through estimates of the cost of damage, and how repairs will be undertaken with the insurers.

These costs exclude extra costs required to upgrade the buildings under the new building codes that have taken effect after the February earthquakes, or other strengthening where required. Quantification of these costs has yet to be determined, but the costs associated with making buildings compliant under the new building codes will be significant.

Canterbury DHB considered whether the carrying value of land and buildings exceeded the recoverable amount. As a result, the DHB has recognised a $14.297M ($33.845M 30 June 2011) asset impairment in Other Comprehensive Income, with a corresponding decrease to the land and buildings Asset

Revaluation Reserve and to Property, Plant and Equipment in the Statement of Financial Position. The total carrying amount of Property, Plant, and Equipment for the Group is $349.7M ($368.284M 30 June 2011), and would have been $397.842M ($402.129M 30 June 2011) had we not impaired our assets. For buildings, where the recoverable amount is determined on a depreciated replacement cost basis, Canterbury DHB has based the impairment on the best available estimate of the likely repair costs to restore buildings to their previous condition, excluding any ancillary operating cost increases.

Canterbury DHB incurred a range of other earthquake related costs for the year to 30 June 2012, including the cost of care for patients having to be relocated outside the Canterbury region, as well as other community based costs. The Ministry of Health provided additional funding of $10M ($16M 30 June 2011) to cover a deficit that Canterbury DHB would otherwise have incurred as a direct result. This $10M has been recorded as revenue in our results to 30 June 2012.

Insurance claims recognised during the year as revenue to 30 June 2012 total $24.708M ($0.772M 30 June 2011), and primarily relate to initial structural engineering costs incurred. There will be further claims for material damage as a detailed assessment of buildings is completed throughout 2012 by structural engineers, and other costs resulting from the earthquake are identified and incurred. Some damage, such as to roading and car parks, is not covered by insurance, and the costs of repair will be met by Canterbury DHB within its reserves. Additionally, Canterbury DHB's insurance policy provides cover for costs to repair damage to the building code applying at the date of the earthquakes. Costs to repair damage to the new building code are not covered, and will need to be met from Canterbury DHB's reserves. Business interruption claims have not yet been fully quantified, and these claims will be submitted once they can be reasonably quantified. Our insurers are aware that our claims submitted to date are initial claims only.

From 1 July 2012 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. 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 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Balance at beginning of year	13,686	12,626	13,547	12,494
Interest received	826	834	826	827
Donations and funds received	2,726	2,960	2,726	2,960
Funds spent	(2,226)	(2,734)	(2,087)	(2,734)
Balance at end of year	**15,012**	**13,686**	**15,012**	**13,547**

Residents' trust accounts	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Residents' trust account balance	**1,030**	**984**	**304**	**328**

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 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Non-current				
Crown Health Financing Agency loans	99,650	45,000	99,650	45,000
Total non current borrowings	99,650	45,000	99,650	45,000
Current				
Crown Health Financing Agency loans	30,000	30,000	30,000	30,000
Total current borrowings	30,000	30,000	30,000	30,000
Total borrowings	**129,650**	**75,000**	**129,650**	**75,000**

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 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	
	30/06/12 $'000	**30/06/11 $'000**	**30/06/12 $'000**	**30/06/11 $'000**
Crown Health Financing Agency loans				
Less than one year	30,000	30,000	30,000	30,000
Weighted average effective interest rate	*5.92%*	*6.53%*	*5.92%*	*6.53%*
Later than one year but not more than five years	15,000	45,000	15,000	45,000
	5.99%	*5.99%*	*5.99%*	*5.99%*
Later than five years	84,650		84,650	
Weighted average effective interest rate	*3.80%*		*3.80%*	

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

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

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

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Net (deficit)/ surplus	(43)	(105)	(555)	(363)
Add back non-cash items:				
Depreciation and amortisation	46,454	46,866	45,087	45,578
Loss/(Gain) of reversionary interest	3,000	-	3,000	-
Donated assets	(371)	(1,759)	(371)	(1,759)
Add back items classified as investing activities:				
Loss/(Gain) on asset sale	226	128	240	129
	49,266	45,130	47,401	43,585
Movement in term portion provisions/staff entitlements	(1,065)	622	(1,071)	624
Movements in working capital:				
Decrease/(increase) in receivables & prepayments	3,768	(25,964)	4,262	(25,964)
Decrease/(increase) in stocks	423	(272)	454	(304)
Increase/(decrease) in creditors & other accruals	2,794	28,048	2,638	28,069
Decrease/(increase) in capital charge due to crown	(3,870)	(572)	(3,870)	(572)
Increase/(decrease) in staff entitlements	11,383	13,842	10,798	13,719
Net cash inflow/(outflow) from operating activities	**62,699**	**60,834**	**60,612**	**59,157**

20. COMMITMENTS

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Capital commitments				
Property	46,587	15,148	46,587	15,148
Intangible assets	4,546	1,332	4,546	1,332
Other capital commitments	8,322	12,400	8,242	12,400
Total capital commitments at balance date	**59,455**	**28,880**	**59,375**	**28,880**
Non cancellable operating lease commitments				
Accommodation leases	10,800	7,643	7,818	4,345
Other	29	11	-	-
	10,829	**7,654**	**7,818**	**4,345**
Supply commitments	**363**	**2,253**	**-**	**-**
Total non cancellable operating lease and supply commitments	**11,192**	**9,907**	**7,818**	**4,345**
For expenditure within:				
Not later than one year	2,560	2,006	1,535	1,078
Later than one year and not later than five years	6,170	5,840	4,688	2,428
Later than five years	2,462	2,061	1,595	839
	11,192	**9,907**	**7,818**	**4,345**

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

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

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

Operating leases as lessee

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

21. CONTINGENCIES

Contingent assets
Canterbury DHB has a contingent asset for the financial year ended 30 June 2012 for insurance recoveries in respect of earthquake costs and business interruption that will be brought to account as and when there is certainty of receipt. See note 16 for further details. (2011: nil)

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

- Outstanding Legal Proceedings
  The Group has outstanding legal proceedings at year end. The Group disputes these claims and believe that it is unlikely any material financial loss will eventuate. Information is not disclosed on these claims, as this may prejudice the legal position of the DHB.

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

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

22. CATEGORIES OF FINANCIAL ASSETS AND LIABILITIES

	Group		Parent	
	As at 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Investments in subsidiaries and associates	-	-	5,521	5,515
Loans and receivables				
Cash and cash equivalents	51,819	87,803	50,408	86,870
Debtors and other receivables	57,959	61,727	56,539	60,801
Bonds	-	5,171	-	5,171
Term deposits (term>3 months)	128,979	14,888	126,150	12,500
Total loans and receivables	**238,757**	**169,589**	**238,618**	**165,342**
Fair value through profit and loss				
Restricted assets	15,012	13,686	15,012	13,547
Restricted liabilities	(15,012)	(13,686)	(15,012)	(13,547)
Total fair value through profit and loss	**-**	**-**	**-**	**-**
Other financial liabilities				
Creditors and other payables	123,573	124,649	123,058	124,290
Borrowings – Crown Health Financing Agency loans	129,650	75,000	129,650	75,000
Total other financial liabilities	**253,223**	**199,649**	**252,708**	**199,290**

23. FINANCIAL INSTRUMENT RISKS

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

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2012, the Ministry of Health owed Canterbury DHB $25.553M (2011 $39.508M).

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 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Counterparties with credit rating				
Cash				
AA	51,819	87,803	50,408	86,870
Term deposits				
AA	-	14,888	-	12,500
AA-	128,979	-	126,150	-
Total cash at bank and term deposits	180,798	102,691	176,558	99,370
Marketable securities-Bonds				
A	-	1,335	-	1,335
AA	-	1,909	-	1,909
AA-	-	1,927	-	1,927
Total marketable securities-Bonds	-	5,171	-	5,171
Restricted assets				
A	-	466	-	466
A+	600	600	600	600
A-	480	-	480	-
AA	680	10,680	680	10,541
AA-	12,684	1,138	12,684	1,138
BBB+	350	452	350	452
Unrated	218	350	218	350
Total restricted assets	15,012	13,686	15,012	13,547

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 2012 (2011: 1)

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

Canterbury DHB has a maximum amount that can be drawn down against its loan facility of $129.650M 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
11/12 financial year						
Creditors and other payables	121,059	121,059	121,059	-	-	-
Borrowings - 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**
10/11 financial year						
Creditors and other payables	124,649	124,649	124,649	-	-	-
Borrowings - Crown Health Financing Agency loans	75,000	79,653	31,958	31,776	15,919	-
Restricted liabilities	13,686	13,686	11,375	481	1,550	280
Total	**213,335**	**217,988**	**167,982**	**32,257**	**17,469**	**280**

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
11/12 financial year						
Creditors and other payables	120,725	120,725	120,725	-	-	-
Borrowings - 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**
10/11 financial year						
Creditors and other payables	124,290	124,290	124,290	-	-	-
Borrowings - Crown Health Financing Agency loans	75,000	79,653	31,958	31,776	15,919	-
Restricted liabilities	13,547	13,547	11,236	481	1,550	280
Total	**212,837**	**217,490**	**167,484**	**32,257**	**17,469**	**280**

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
11/12 financial year						
Cash and cash equivalents	51,819	51,819	51,819	-	-	-
Debtors and other receivables	57,959	57,959	57,959	-	-	-
Bonds	-	-	-	-	-	-
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**
10/11 financial year						
Cash and cash equivalents	87,803	87,803	87,803	-	-	-
Debtors and other receivables	61,727	61,727	61,727	-	-	-
Bonds	5,171	5,171	3,244	-	1,927	-
Term deposits (term > 3 months)	14,888	14,888	14,888	-	-	-
Restricted assets	13,686	13,686	11,375	481	1,550	280
Total	**183,275**	**183,275**	**179,037**	**481**	**3,477**	**280**

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
11/12 financial year						
Cash and cash equivalents	50,408	50,408	50,408	-	-	-
Debtors and other receivables	56,539	56,539	56,539	-	-	-
Bonds	-	-	-	-	-	-
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**
10/11 financial year						
Cash and cash equivalents	86,870	86,870	86,870	-	-	-
Debtors and other receivables	60,801	60,801	60,801	-	-	-
Bonds	5,171	5,171	3,244	-	1,927	-
Term deposits (term > 3 months)	12,500	12,500	12,500	-	-	-
Restricted assets	13,547	13,547	11,236	481	1,550	280
Total	**178,889**	**178,889**	**174,651**	**481**	**3,477**	**280**

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			
	30/06/12 $'000		30/06/11 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(19)	19	(144)	144
Total sensitivity	**(19)**	**19**	**(144)**	**144**

	Parent			
	30/06/12 $'000		30/06/11 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(19)	19	(144)	144
Total sensitivity	**(19)**	**19**	**(144)**	**144**

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 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Financial Assets				
Bonds	-	5,521	-	5,521
Restricted assets	15,012	13,889	15,012	13,750
Financial Liabilities				
Borrowing- Crown Health Financing Agency loans	135,939	78,617	135,939	78,617
Restricted liabilities	15,012	13,889	15,012	13,750

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 $1,393.4M to provide health services in the Canterbury area for the year ended 30 June 2012 ($1,354.1M, 30 June 2011).

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 $108.4M for the year ended 30 June 2012 ($107.7M, 30 June 2011). Expenditure to other DHBs for their care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $38.8M for the year ended 30 June 2012 ($46.5M, 30 June 2011).

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 2012 totalled $24.5M ($20M, 30 June 2011). These purchases included the purchase of services from the University of Otago, air travel from Air New Zealand, pharmacy services from the Pharmaceutical Management Agency (Pharmac), and blood products from the New Zealand Blood Service.

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

	Group		Parent	
	30/06/12 $'000	30/06/11 $'000	30/06/12 $'000	30/06/11 $'000
Revenue				
Interest on advance and director's fees from/to Canterbury Linen Services Ltd	-	-	6	6
Interest on advance to Brackenridge Estate Ltd	-	-	-	4
Service fees to Brackenridge Estate Ltd	-	-	60	60
Services to Canterbury Linen Services Ltd	-	-	427	425
Service fees to Canterbury Linen Services Ltd	-	-	11	11
Services to South Island Shared Service Agency Ltd	29	48	29	48
Expenses				
Linen services and rentals from Canterbury Linen Services Ltd	-	-	4,746	4,545
Interest on advance from Brackenridge Estate Ltd	-	-	8	2
Services from South Island Shared Service Agency Ltd	322	1,084	322	1,084

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 30/06/12 $'000	As at 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Amount receivable owing by associates				
South Island Shared Service Agency Ltd (relates to expenses paid on their behalf and recharged)	-	7	-	7
Amount payable owing to associates				
South Island Shared Service Agency Ltd	71	4	71	4
Amount payable owing to subsidiaries				
Canterbury Linen Services Ltd	-	-	433	449
Amount receivable owing by subsidiaries				
Canterbury Linen Services Ltd – debtor	-	-	56	55
Brackenridge Estate Ltd – advance	-	-	127	121

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 (2011 $nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	Year ended 30/06/12 $'000	Year ended 30/06/11 $'000	As at 30/06/12 $'000	As at 30/06/11 $'000
Services purchased by Canterbury DHB:				
Heart Centre at St George's	3,009	791	-	-
Heart Vision Ltd	-	2	-	-
Services purchased from Canterbury DHB:				
Heart Centre at St George's	7	9	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 30/06/12 $'000	Year ended 30/06/11 $'000
Salaries & other short term employee benefits	3,145	2,914
Post-employment benefits	56	36
Total key management personnel compensation	**3,201**	**2,950**

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. SUBSEQUENT EVENTS

There were no events after 30 June 2012 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 30/06/12 $'000	Budget 30/06/12 $'000
Early detection & management	423,988	417,696
Intensive assessment & treatment	754,660	717,227
Prevention	23,477	32,343
Support & rehabilitation	270,202	264,611
Total revenue	**1,472,327**	1,431,877
Early detection & management	424,968	430,520
Intensive assessment & treatment	753,157	729,403
Prevention	23,481	32,343
Support & rehabilitation	270,764	264,611
Total expenditure	**1,472,370**	1,456,877
Surplus/(Deficit)	**(43)**	(25,000)

Independent Auditor's Report

To the readers of
Canterbury District Health Board and group's
financial statements and statement of service performance
for the year ended 30 June 2012

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

We have audited:

- the financial statements of the Health Board and group on pages 41 to 79, that comprise the statement of financial position as at 30 June 2012, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board and group on pages 8 to 26.

Opinion

In our opinion:

- the financial statements of the Health Board and group on pages 41 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 2012; and
        - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board and group on pages 8 to 26:
    - complies with generally accepted accounting practice in New Zealand; and
    - fairly reflects the Health Board and group's service performance for the year ended on 30 June 2012, including:
        - the performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
        - the revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 2 October 2012. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

An audit also involves evaluating:

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

Matters relating to the electronic presentation of the audited financial statements and statement of service performance

This audit report relates to the financial statements and statement of service performance of Canterbury District Health Board (the Health Board) and group for the year ended 30 June 2012 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 2 October 2012 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

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


our health system