Canterbury DHB Annual Report

for the year ended 30 June 2015

THE CANTERBURY HEALTH SYSTEM

Working together to make it better

Our Mission

TĀ MĀTOU MATAKITE

To promote, enhance and facilitate the health and wellbeing of the people of Canterbury.
Ki te whakapakari, whakamanawa me te tiaki i te hauora mō te oranga pai o ngā tāngata o te rohe o Waitaha.

Our Values

Ā MĀTOU UARA

- Care and respect for others.
  Manaaki me te whakaute i te tangata.
- Integrity in all we do.
  Hāpai i ā mātou mahi katoa i runga i te pono.
- Responsibility for outcomes.
  Te Takohanga i ngā hua.

Our Way of Working

KĀ HUARI MAHI

- Be people and community focused.
  Arotahi atu ki te tangata me te hapori.
- Demonstrate innovation.
  Whakaatu te ihumanea hou.
- Engage with stakeholders.
  Kia tau ki ngā tāngata whai pānga.

our health system

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DIRECTORY

Board Members
Murray Cleverley – Chair
Steve Wakefield – Deputy Chair
Sally Buck
Anna Crighton
Andrew Dickerson
Jo Kane
Aaron Keown
Edie Moke
Chris Mene
David Morrell
Susan Wallace

Chief Executive
David Meates

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

Banker
Westpac Banking Corporation

REPORT FROM THE CHAIR AND CHIEF EXECUTIVE

The 2014/15 financial year has seen the Canterbury health system continue on its journey of innovation and transformation. By becoming more integrated and reorienting our services, we're closer to achieving our vision of keeping people healthy and well in their own homes by providing the right care and support, to the right person, at the right time and in the right place.

A population under strain

The ongoing recovery from Canterbury's earthquakes has continued to have a major impact on the health of Cantabrians. Nowhere has this been more evident than in the demand for mental health services, which has increased significantly.

Over the past three years there has been more than a 60% increase in demand for child and youth mental health services and a 102% increase in mental health presentations to the emergency department[1]. In the past 12 months we have seen a significant increase in acute admissions of women aged over 45, many have not had contact with our services before.

Despite significant increases in demand for mental health services post-quake, services, including general practice teams have stepped up and met the demand, with an increased range of community-based mental health services.

The demand for mental health services is not abating and we don't, based on international research on post-disaster psycho-social recovery, expect it to for another 5 to 10 years.

Building and redevelopment

The quakes left 200 Canterbury DHB buildings damaged, 14,000 hospital rooms damaged, and we lost 14% of rest home beds and 106 acute inpatient beds. This has created a unique opportunity to build back better, to modernise Christchurch's health facilities using a "long life, loose fit" model.

Since May 2013 just about every ward in Christchurch Hospital has had to be moved to allow quake repairs, strengthening and upgrades to firewalls to take place. This has been hugely disruptive and is most likely the largest hospital move ever undertaken in New Zealand. Our staff have worked tirelessly to ensure that health services continue to be provided despite these challenges.

Burwood and Christchurch Hospitals are currently being redeveloped as part of the largest ever public health investment in New Zealand. In total the redevelopment of both hospitals will cost more than $650 million, in addition to $383 million of an earthquake related programme of works.

There's also plenty happening in our rural areas as well with new facility developments beginning to take shape. There is huge community interest and financial support for a new health centre in Kaikoura which will see public and private providers working from the same new facilities. The Rangiora Health Hub is also nearing completion. Once again there is significant community backing for the project. A new acute admitting unit and theatre block, as well as quake repairs and refurbishing wards is underway in Ashburton.

[1] *Percentage of change between year to 31 May 2012 and 31 May 2015*

Re-orientating our health system

While our environment has provided challenges it has also provided opportunities to reorientate our system around supporting people to stay well and healthy and in their own homes and communities for as long as possible.

By working in partnership with general practice and community teams we have been able to increase the range of services provided within primary care. This has allowed general practice to deliver services sooner and closer to home, and has helped prevent disease through education, screening, and early detection.

We are refining and continuing to improve programmes aimed at keeping people well and out of hospital. Key initiatives include Community Rehabilitation Enablement Support Team (CREST), an Acute Demand programme which allows people to receive urgent care in their own homes and communities, and a Falls Prevention Programme to support older people avoid falls.

Our approach is working. Last year alone over 30,000 people who would previously have been admitted to hospital received treatment and care in the community.

A large number of technology projects are underway throughout the Canterbury health system designed to save staff and patient's time and improve the quality of information gathered and available to inform clinician's decision-making.

HealthPathways is a clinically led tool which helps ensure timely, consistent and equitable treatment and access to health care by mapping out a pathway for a patient with a specific condition. It is always up to date and viewed by Canterbury clinicians 1.3 million times each year.

HealthOne has been developed so GPs, pharmacists, community nurses and hospital specialists can quickly access the relevant parts of their patients' health records. It's giving care professionals across settings access to a more complete picture and case history of a patient allowing better, faster decisions to be made.

Electronic Request Management System (ERMS) is an electronic referral tool developed in Canterbury to improve the way general practices make requests for specialist advice and referred services across both public and private sectors. It handles around 22,600 requests a month, every one of which facilitates a faster, safer patient experience.

Another major reason for our success has been our focus on being clinically led and using principles such as alliancing. As a system we are more closely integrated than ever before. We have continued to remove traditional boundaries and barriers in order to improve outcomes for Canterbury's population.

The Canterbury Clinical Network is the broadest health alliance in New Zealand with nine partner organisations and whole of system engagement. It plays a crucial role in developing new service delivery models, funding and contracting mechanisms that are based on principles of high trust, low bureaucracy, openness and transparency.

Putting people at the centre underpins everything we do

Through providing more care in community settings, investing in technology, and forming partnerships and alliances, the Canterbury Health System is helping us work towards our three strategic goals:

1. People take greater responsibility for their own health
   The development of services that support people/whānau to stay well and take increased responsibility for their own health and wellbeing.

2. People stay well in their own homes and communities
   The development of primary care and community services to support people/whānau in a community-based setting and provide a point of ongoing continuity, which for most people will be general practice.
3. 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.

Our aim is to reduce the time people waste waiting for care and support. Providing the right care, in the right place at the right time delivered by the right person is the way our system is designed to work. This means more care in peoples' homes, communities and primary care, to free up hospital based resources allowing better patient flow.

International acclaim

Over the past year we've had unprecedented interest in our health system. We have hosted overseas dignitaries from a wide range of countries and territories, including representatives from Britain's National Health Service, the Isle of Man, Qatar, Australia and Singapore. The Canterbury DHB was also invited to participate in an inquiry into health systems by the Australian Senate Committee on Health.

David Albury, from the UK's innovation lab had this to say about our health system:

"It seems like where ever I travel - from Rio to Sydney - many people in health know the Canterbury story. I've worked with numerous wonderful public sector innovation programmes around the world, and I still regard the Canterbury transformation programme as one of the most inspiring, innovative and incredibly effective programmes I've seen."

A journey with no end

The Canterbury health system is on a journey of transformation and though we still have some way to go, we can be very proud of our outstanding successes and achievements during the 2014/15 financial year.

Our health system has worked incredibly hard to make it better for people: to cut waste out of the system and improve the patient journey by putting people at the centre of everything we do. Innovation, change and courage have been vital elements of our journey to date. We still have some way to go until we are a fully integrated system however, we have made exceptional progress.

Murray Cleverley
Chair
29 October 2015

David Meates
Chief Executive
29 October 2015

BOARD MEMBERS

Murray Cleverley Chair	Murray is currently Chair of the Canterbury DHB and also Chair of the South Canterbury DHB. He is a professional Director; and has experience across a wide range of business sectors. Murray is currently Chair of multiple companies and Director of several businesses. He is a specialist in governance, economic development and change management. Murray established his first business at 20 years of age and was the 2007 winner of the New Zealand Vero Business Excellence Support Awards in the Individual Category. He is a Fellow of New Zealand Institute of Management, a Fellow of the New Zealand Institute of Directors and a life member of South Canterbury Chamber of Commerce. He has a MBA through Massey University, is Past Chairman of both the Economic Development Association of New Zealand, and of Escalator (a Government capital raising scheme); is a founding Director of BIZ Networks Ltd and past Director of NZ Chambers of Commerce. In 2014 he was made a Member of the New Zealand Order of Merit for his services to business and the community.
Steve Wakefield Deputy Chair	Steve is a Chartered Accountant and business consultant with over 30 years of experience working with large and complex organisations. He is a director on several corporate and not-for-profit Boards, and a senior partner in Deloitte, which is one of the largest accounting and business consulting firms in NZ and globally. Steve has a big heart for our community, and believes in successful professionals providing their expertise and service to the community. He has demonstrated this with many years of service to the Court Theatre, YHA, CERA, church, and sports administration. In 2012 Steve was recognised as the NZ Chartered Accountant of the Year. Steve is the Canterbury DHB Deputy Chairman, and chairs the Quality, Finance, Audit and Risk Committee. His focus is on supporting the delivery of a complex array of services that are responsive to the health needs of our region. Since we must live within our means, the Board must ensure that the systems and processes in place are able to deliver the most effective health services possible with the best quality.
Sally Buck	Sally has a background working in the area of special needs, early intervention, and speech and language therapy. Sally is involved in the intellectual disability sector and volunteers on the Board of a residential/supported living provider. She also does voluntary work for several other community organizations. She served on the City Council for 15 years before retiring in 2013, and is currently serving on the Fendalton/Waimairi Community Board.As a Board member of the Canterbury DHB, Sally is interested in delivering best practice medical care, ensuring that this care is accessible to all, and that there is accountability and community involvement.

Anna Crighton	Anna Crighton served 12 years as a Christchurch City Councillor. Anna is committed to the Canterbury DHB continually improving its health care and services especially aged care services, elective surgery and for the 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 Chair of the Community and Public Health Advisory Committee and a member of the Hospital Advisory Committee. This is her third term on the Board.
Andrew Dickerson	Andrew has 31 years' experience in the health and disability sectors and is a former Chief Executive of Age Concern Canterbury. This is Andrew's third term on the Board. He has served on all of the Board's sub-committees and currently chairs the Hospital Advisory Committee. He also chairs the University of Otago Healthcare for the Elderly Education Trust. As well as this background in the health sector Andrew has a Master of Management Degree and is a Member of the Institute of Directors (MInstD).
Jo Kane	Jo is an elected member of the Canterbury DHB Board and served two previous terms as a Board member, from 2004 to 2010. She is also a former Environment Canterbury Council member and a former Deputy Mayor of the Waimakariri District Council.
Aaron Keown	Aaron currently sits on the CCC Shirley/Papanui Community Board and is a former Christchurch Council Councillor. He is keen to see more community involvement in Canterbury DHB decisions.
Chris Mene	Chris Mene is a facilitator, coach, trainer, and professional director. He has recent health experience in public and community health, pharmacy, smoking cessation, alcohol harm reduction, youth health, and stakeholder engagement. Chris has more than 20 years' experience in community relations and stakeholder engagement. His community service also includes health, social service, local government, and education. He brings diverse experiences and knowledge from government, business, community and philanthropic sectors.
Edie Moke	Edie has been involved in the Health and Disability sectors for more than 25 years, starting out with the Canterbury Area Health Board as an industrial engineer and then accountant. During the Health Sector reforms of 1993 she continued her accountant role for a few years with Healthlink South Ltd before becoming a principal with Ernst and Young. She is now a professional director with nearly 20 years governance experience in a variety of health, education, economic development, funding, broadcasting, research and philanthropic organisations. As a first term appointed member of the Canterbury DHB she serves as Deputy Chair of the Quality, Finance, Audit, and Risk Committee and is a member of the Disability Support Advisory Committee. Edie is also a first term appointed member of the South Canterbury DHB; there she serves as a member of the Audit and Maori Health Advisory Committees. Edie is of Te Arawa, Tuwharetoa, Ngati Apa, Ngati Kuia, Rangitane and Ngai Tahu descent. She resides in Te Pataka o Rakaihautu which is also known as Horomaka but is more commonly referred to as the Banks Peninsula.
David Morrell	David Morrell is an experienced Board member with fourteen years on the Canterbury DHB Board. Much of this time was spent chairing the Hospital Advisory Committee. David was previously a Hospital Chaplain, and subsequently held the position of

City Missioner for 22 years. While in that position he established new health funded services for those with drug and alcohol issues, and mental health difficulties.

He is committed to the Canterbury DHB's current redevelopment of health services to meet post-quake challenges in Canterbury, and he is stimulated by the quality and vision of the DHB's staff. Morrell is a member of the Quality, Finance, Audit, and Risk Committee and Deputy Chair of the Hospital Advisory Committee.

David has also been British Honorary Consul at Christchurch since 2007.

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 as an appointed member of the West Coast DHB.

Susan has a public service and administration background, and has been involved in a number of different voluntary, community, and Maori organisations.

A member who serves on two boards, Susan brings a West Coast "face" to this board and a desire to contribute positively.

MEASURING OUR PROGRESS

How will we know if we are making a difference?

DHBs are expected to deliver against the national health sector outcomes: '*All New Zealanders lead longer, healthier and more independent lives'* and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability, we need to demonstrate whether we are succeeding in meeting those commitments and in improving the health and wellbeing of our population. There is no single measure that can demonstrate the impact of the work we do, so we have chosen to use a mix of population health and service access indicators to demonstrate improvements in the health status of our population and the effectiveness of our health system.

In agreement with the other four South Island DHBs we have identified four collective long-term outcome goals, along with a set of associated outcomes indicators, which will demonstrate whether we are making a positive change in the health of our populations. As we expect to effect change against these indicators over the longer-term (up to 10 years in the life of the health system) the aim is for a measurable change in health status over time, rather than a fixed target.

- ***Outcome 1: People are healthier and take greater responsibility for their own health.***

  A reduction in smoking rates.

  A reduction in obesity rates.

- ***Outcome 2: People stay well in their own homes and communities.***

  A reduction in acute medical admission rates.

- ***Outcome 3: People with complex illnesses have improved health outcomes.***

  A reduction in avoidable mortality rates.

  A reduction in acute readmission rates.

- ***Outcome 4: People experience optimal functional independence and quality of life.***

  An increase in the proportion of the population living in their own homes.

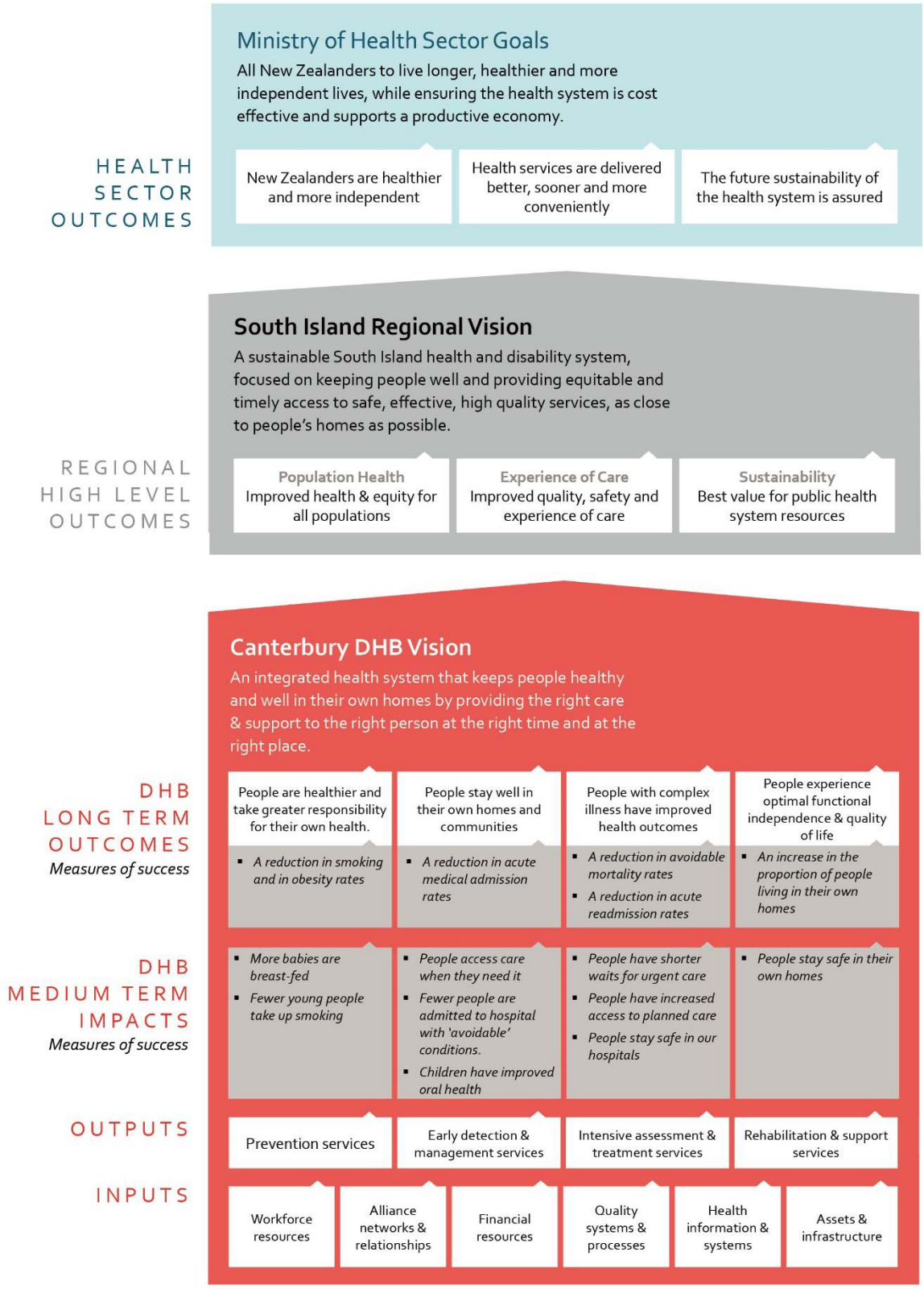
The five South Island DHBs have also identified a core set of associated set of medium-term impact indicators. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance. We have set targets against each of the impact measures to support the evaluation of our performance. Both the outcome and impact indicators sit alongside our Statement of Performance Expectations in our Annual Plan and are reported in our Annual Report at the end of every year.

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (*outputs*) will have an *impact* on the health of their population and result in the achievement of desired longer-term *outcomes* and the expectations and priorities of Government.

The DHB also has a Māori Health Action Plan which is a companion document to the Annual Plan and sets out a further set of performance indicators to support and identify improvements in Māori health outcomes. The 2014/15 Māori Health Action Plan is available on the Canterbury DHB's website and performance against the key measures in the Action Plan are presented in this report.

Note: In the graphs presented the South Island result includes all five South Island DHB (including Canterbury). This presents the regional performance picture rather than Canterbury's performance compared to the rest of the South Island. The same methodology applies to the national result this includes Canterbury.

Overarching intervention logic



ARE WE MAKING A DIFFERENCE?

The progress against these indicators suggests that the health status of the Canterbury population has remained relatively positive over the last year. Smoking rates continue to drop, obesity levels remain below national rates, acute medical admissions, avoidable hospital admissions and premature mortality rates remain on track and below national averages. In line with our strategic direction, the proportion of older people living in their own homes continues to increase as we support more people in their own homes and communities

In spite of an increased load in our emergency department and across our mental health services, waiting times for specialist assessments, elective surgery and emergency care have all improved indicating a positive focus on patient flow between general practice and specialist services and a remarkable achievement by teams experiencing significant additional pressure.

While remaining positive against national results, there has been less movement than desired against key indicators for child health. Breastfeeding rates and oral health rates are not as positive as we would have liked. These are both areas where stressed living environments could impact results and it would seem further focus is still needed to support families and younger population groups as we rebuild our city.

GOAL 1: People are healthier and take greater responsibility for their own health

Why is this outcome a priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major drivers of poor health and account for a significant proportion of presentations across primary care and hospital and specialist services. Because we are more likely to develop long-term conditions as we age, and have an ageing population, the burden on our health system will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions. Supporting people to make healthy choices will not only enable our population to attain a higher quality of life by avoiding, delaying or reducing the impact of long-term conditions, but will also help to reduce the growing demand for health services.

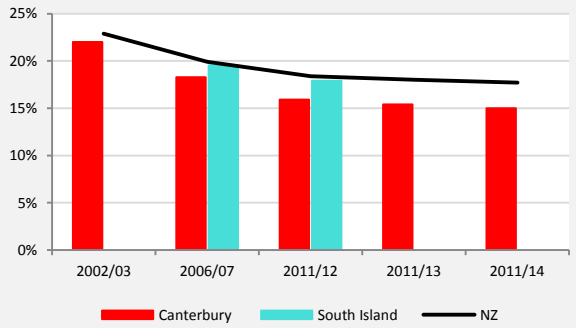
OUTCOME MEASURES LONG TERM

Outcome: A reduction in smoking rates.

- *Canterbury's smoking rates continue to decline, with the combined 2011/14 NZ Health Survey finding that just 15% of the Canterbury population smoke – compared to 17.7% of the New Zealand population.*
- *Canterbury's success in continuing to reduce smoking rates can be attributed to two factors - fewer young people taking up smoking and current smokers being encouraged to quit.*
- *Our focus on ABC quit initiatives continues and while our Māori smoking rates continue to be higher than the rest of the Canterbury population, registrations with the Aukati Kaipaipa smoking cessation programmes remain high.*

Data sourced from national NZ Health Survey.[2]

Measure: The percentage of the population (15+) who smoke.

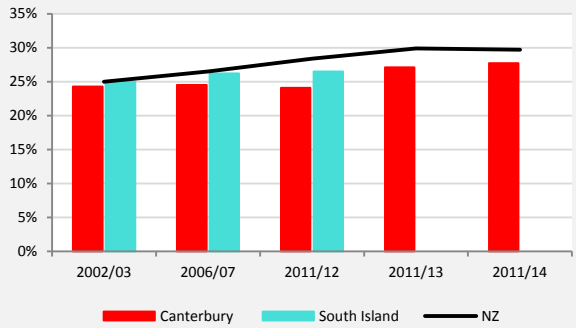


Outcome: A reduction in obesity rates.

- *Canterbury's obesity rate remains below the national average of 29.7%. However a slight increase to 27.7% is evident across the most recent combined NZ Health Survey.*
- *Lower rates of obesity are supported by local initiatives that encourage healthier diets and more physical activity, such as our Health Promoting Schools, Appetite for Life and Green Prescription programmes.*
- *In the coming year all five South Island DHBs will implement a Child Obesity Action Plan, aiming to support the adoption of positive attitudes and behaviours from a young age and create a strong foundation for good health in adulthood.*

Data sourced from national NZ Health Survey.[3]

Measure: The percentage of the population (15+) who are obese.



[2] *The NZ Health Survey is completed by the Ministry of Health and results are subject to availability. From 2011 surveys were combined year-on-year in order to provide more robust results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity and by region. The 2013 Census results for smoking (while not directly comparable) demonstrate that while rates for Māori are improving they are still high; 30.7% of Canterbury Māori (15+) identified as regular smokers down from 40.2% in 2006 but high compared to 14.5% of the total population.*

[3] *'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.*

IMPACT MEASURES MEDIUM TERM

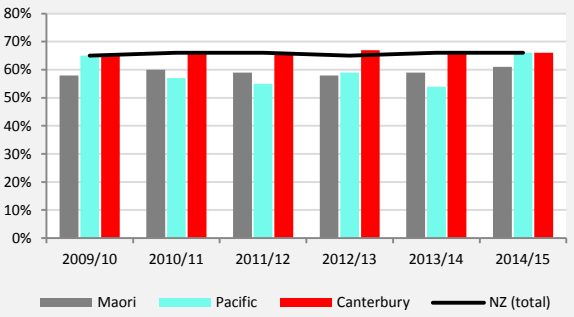
Impact: More babies are breastfed.

- *Canterbury's breastfeeding rates have remained relatively stable with little change in the rates over time.*
- *Maori and Pacific results have improved on the previous year which is a positive sign. The data presented is from Plunket only and while Plunket is the largest provider, there are a number of smaller Tamariki Ora providers in Canterbury who target Maori and Pacific mothers. It is likely that these results under-report performance for these population groups.*
- *Improving breastfeeding rates continues to be a key focus for the Canterbury Breastfeeding Steering Group. A range of services are available to encourage and support women in Canterbury to breastfeed including peer support programmes and community based lactation support.*

Data sourced from Plunket via the Ministry of Health.[4]

Measure: The percentage of babies exclusively or fully breastfed at 6 weeks.

	13/14	Result 14/15	Target 14/15
Maori	59%	62%	68%
Pacific	54%	66%	68%
Total	66%	66%	68%



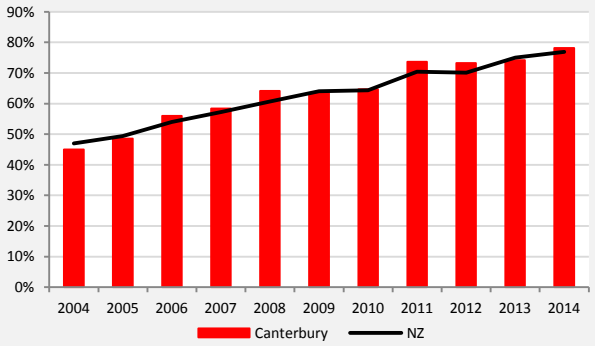
Impact: Fewer young people take up tobacco smoking.

- *The 2014 ASH survey results continue to show a positive trend for Canterbury with 78% of Year 10 students (age 14) having never smoked.*
- *This trend reflects the impact of supportive legislation and social environments combined with local initiatives such as our Health Promoting Schools programme, smokefree public places (such as parks and marae) and training and advice provided to tobacco retailers to limit youth access to tobacco. A continued decline in adult smoking rates will also be having a positive influence on these rates.*

Data sourced from national Year 10 ASH Survey.[5]

Measure: The percentage of 'never smokers' amongst Year 10 students.

2012	2013	Result 2014	Target 2014
73%	74%	78%	75%



[4] *Provider data is currently not able to be combined so performance data from the largest provider (Plunket) is presented. While this covers the majority of mothers, because the smaller local WellChild/Tamariki Ora providers primarily target Maori and Pacific mothers - results for these ethnicities are likely to be under-stated. The target is based on national Well-Child standards for breastfeeding at 6 weeks.*

[5] *The ASH Survey is a national survey used to monitor student smoking since 1999. Run by Action on Smoking and Health it provides an annual point preference snapshot of students aged 14 or 15 years at the time of the survey – see www.ash.org.nz.*

GOAL 2: People stay well in their own homes and communities

Why is this outcome a priority?

When people are supported to stay well and access the care they need close to home and in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population, but it enables early intervention and reduces the demand for specialist assessment and care and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on a specialist level response.

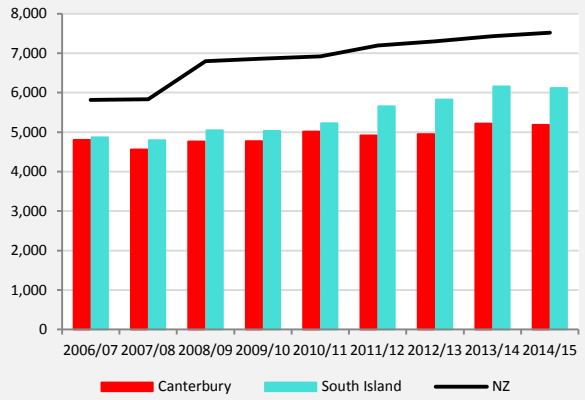
OUTCOME MEASURES LONG TERM

Outcome: A reduction in acute medical admission rates.

- *At 5,184 per 100,000 people, Canterbury's standardised acute medical admissions rate remains the lowest of any large DHB in the country and increasingly below the national rate (7,516 per 100,000 people).*
- *This is a positive reflection of the system-wide focus taken in Canterbury to keep people safe and well in their own homes and communities and out of hospital.*
- *There are a number of local programmes specifically established to ensure people receive the right care at the right time and in the most appropriate place. This includes our community-based Acute Demand Management Service which in the past year provided more than 28,000 packages of care for people in the community - preventing many unnecessary admissions into our hospitals in 2014/15.*

Data sourced from National Minimum Data Set.

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



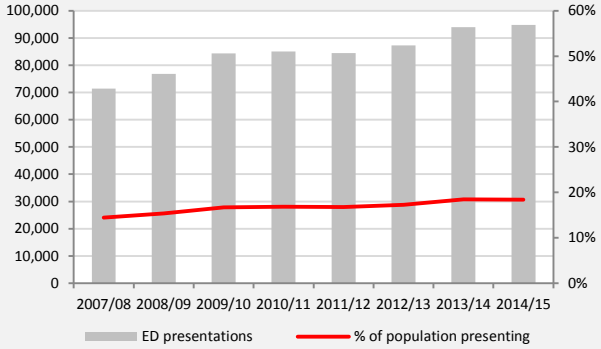
IMPACT MEASURES MEDIUM TERM

Impact: People access care when they need it.

- *The percentage of the population presenting at an Emergency Department has remained static at 18.4%.*
- *However the number of people presenting continues to grow and the age breakdowns shows a disproportionate growth in attendances for adults aged 25-29.*
- *This pattern is in line with the growth of migrants in this age group supporting the rebuild. Unfortunately there has not been a corresponding growth in PHO enrolments (many may not be eligible) and many of these people are not going to general practice, placing an additional unnecessary load on our ED services.*
- *Younger adults continue to have lower admission rates potentially indicating that these people do not require specialist level care and their needs could be better managed by after hours and general practice services.*
- *The DHB is actively engaging with Canterbury employers to provide information to new migrants regarding the importance of enrolling with general practice and the most appropriate places to seek health care, with the aim of reducing this load in the coming year.*

Data sourced from individual DHBs.[6]

Measure: The percentage of the population presenting at ED.	12/13	13/14	Result 14/15	Target 14/15
	17%	18.4%	18.4%	<18%



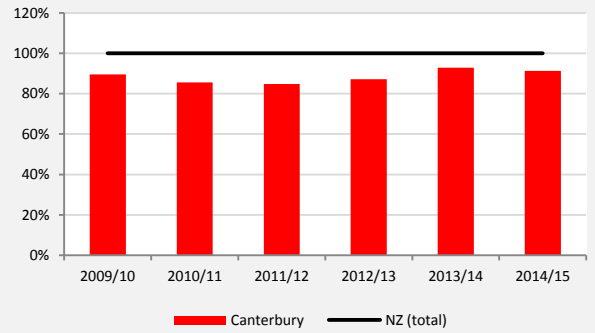
[6] *The proportion of the population 'presenting' at ED is defined by the Ministry of Health national ED health target.*

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

- *In the year to 31 March 2015, Canterbury's avoidable hospital admission rate was 1,831 per 100,000. This is a slight improvement on the previous year dropping to 91% of the national rate (2,005 per 100,000).*
- *A wide range of local initiatives contribute to preventing unnecessary admissions in Canterbury, including our community-based Acute Demand Management Services, alternative ambulance pathways for people with respiratory or heart disease, targeted long-term conditions programmes and community-based rehabilitation services.*

Data sourced from the Ministry of Health. [7]

Measure: The ratio of actual to expected avoidable hospital admissions for our population (<75).	12/13	13/14	Result 14/15	Target 14/15
	87%	94%	91%	≤95%

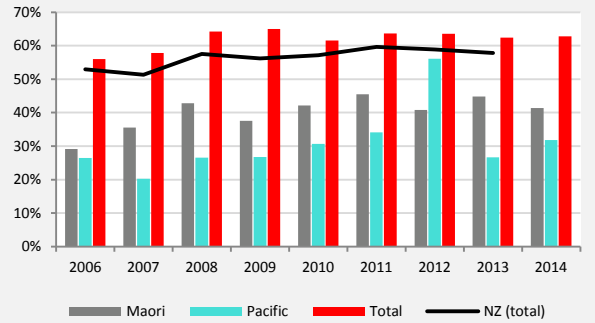


Impact: Children have improved oral health.

- *The percentage of all five-year-olds caries-free has increased slightly from 62% to 63%. However the result for Māori five-year-olds has dropped from 45% to 41%.*
- *The small number of children involved means these results are subject to a greater degree of variation, however a positive trend is not yet evident and there remains a clear gap between the different population groups.*
- *A new model of care for high-risk children was introduced in 2012, which provides more intensive preventive care in high-risk children aged 12-24 months. We are expecting to see improvements in these rates as the children targeted by this programme begin to reach five years of age.*

Data sourced from Ministry of Health. [8]

Measure: The percentage of children caries-free at age 5 (no holes or fillings).		2013	Result 2014	Target 2014
	Maori	45%	41%	≥63%
	Pacific	27%	32%	≥63%
	Total	62%	63%	≥63%



[7] *This measure is a national performance indicator (SI1) and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance below the national rate, which reflects less people presenting. There continues to be a definition issue with regards to the use of self-identified vs. prioritised ethnicity. While this has little impact on total population results it does have a material impact on Māori and Pacific results against this measure hence they have not been displayed. The Ministry is working to resolve this issue and reset the definitions for this measure. Target setting for 2015/16 has been postponed against this measure while the definitions are reset.*

[8] *This measure is a national performance indicator (PP11) and is reported annually for the school year (i.e. calendar year) – national results were not available at the time of publishing.*

GOAL 3: People with complex illness have improved health outcomes

Why is this outcome a priority?

For people who need a higher level of intervention, timely access to high quality care and treatment to support recovery, helps to slow the progression of illness and can reduce reliance on residential care. This not only leads to restored functionality and a better quality of life for those individuals but also reduces unnecessary costs and improves public confidence in the health system. This goal is also reflective of the quality of care and treatment provided by the DHB. Adverse events or ineffective treatment can cause harm, resulting in longer hospital stays, unnecessary complications and readmissions that have a negative impact on the health of our population and increase costs across the system.

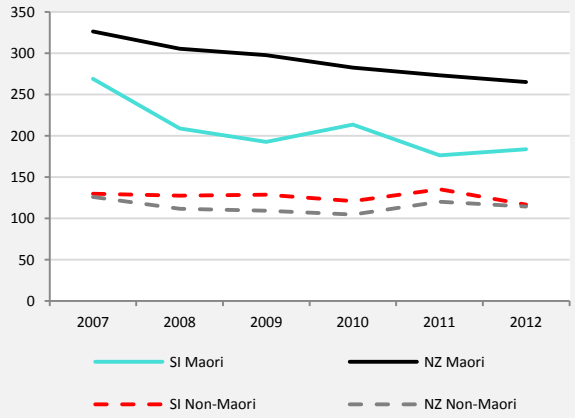
OUTCOME MEASURES LONG TERM

Outcome: A reduction in avoidable mortality rates.

- *There has been a slight increase in the rate of all-cause mortality for South Island Maori between 2011 (176 per 100,000) and 2012 (184 per 100,000). However, the overall trend rate remains positive (the difference between years is 14 people) and is consistently below national rates.*
- *A number of factors influence mortality rates and as such positive trends are influenced by a range of programmes and initiatives in place across our health system.*
- *Programmes to reduce smoking and obesity rates contribute to these lower rates. Community-based acute demand and long-term condition management programmes, reduced wait times for treatment and increased access to elective surgery also make a difference by improving people's health outcomes.*
- *Lower lengths of stay, fewer adverse events while in our hospitals and improved rehabilitation and support on discharge are also all factors which will be positively influencing these results.*

Data sourced from MoH mortality collection 2015 update.[9]

Measure: The rate of all-cause mortality for people aged under 65 (age-standardised per 100,000).

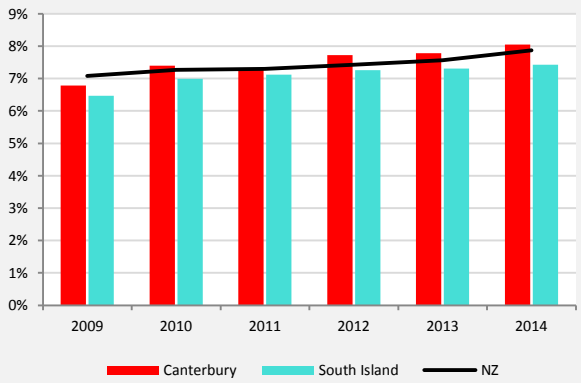


Outcome: A reduction in acute readmission rates.

- *The national definition for this measure was revised in 2013/14 and Canterbury's rates look higher than previously indicated and appear higher than the national rate.*
- *We believe these results are disproportionately high due to calculation issues which are being addressed nationally- however internal data also shows a slight increase in our readmission rates. We continue to track these carefully alongside length of stay measures.*
- *The DHB has continued to focus on community-based rehabilitation, falls prevention, access to restorative home-based support and has implemented the Enhanced Recovery After Surgery initiatives to support people after discharge from hospital.*

Data sourced from Ministry of Health.[10]

Measure: The rate of acute readmissions to hospital within 28 days of discharge.



[9] *The data presented is the most current available sourced from the national mortality collection which is three years in arrears.*

[10] *This measure is a national performance indicator (OS8). A number of inconsistencies have been identified in comparison to local calculations for this measure, particularly with regards to patient transfers between hospitals being coded as readmissions. The Ministry of Health is currently reviewing the definition and target setting has been delayed for 2015/16 while the definition is reset.*

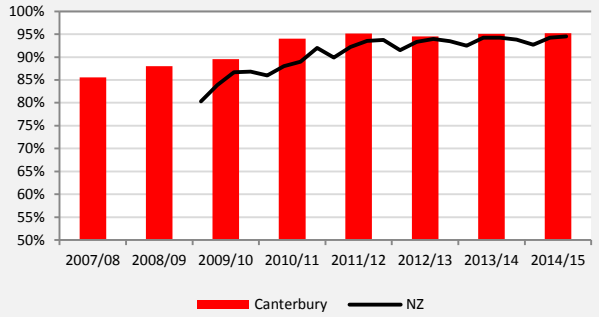
IMPACT MEASURES MEDIUM TERM

Impact: People have shorter waits for acute (urgent) care.

- *Canterbury has continued to maintain performance against the Shorter Stays in ED health target, with 95% of people presenting being admitted or discharged within six hours over the year and 96% in the fourth quarter (April-June).*
- *Hospital services are well supported by community-based services such as free after hours care for under six year olds, after hours nurse-led telephone triage and our Acute Demand Management Services which aim to reduce ED presentations.*
- *However strong performance results are also reflective of the success of targeted inter-departmental work ensuring effective functioning and flow within ED and across the hospital and enabling the ED teams to respond to an increasing number of people within the target timeframes.*
- *Although generally not complex, the increased number of younger people presenting in ED leads to greater risk due to over-crowding reducing patient flow. Initiatives are underway to try and alleviate some of this pressure and more appropriately link people with general practice.*

Data sourced from individual DHBs.[11]

Measure: The percentage of people presenting at ED who are admitted, discharged or transferred within six hours.	12/13	13/14	Result 14/15	Target 14/15
	95%	95%	95%	95%

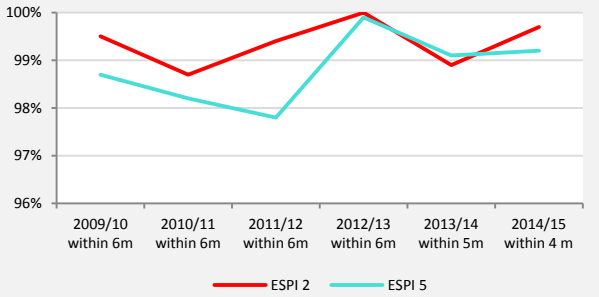


Impact: People have increased access to planned care.

- *Waiting time targets have reduced this past year from a maximum of five months to a maximum of four months for time to First Specialist Assessment and time to treatment.*
- *As at June 2015, 99.7% of all Cantabrians referred for a specialist assessment received their assessment within four months of referral, and 99.2% of those given a commitment for treatment began their treatment within four months.*
- *Given the continued challenges of reduced hospital capacity post-earthquake, performance against these targets represents a major achievement for the Canterbury DHB.*
- *It will be several years before the Burwood and Christchurch Hospital rebuilds are complete and capacity is fully restored. Maintaining these targets during the rebuild and transition to the new facilities will continue to be a challenge.*

Data sourced from Ministry of Health.[12]

Measure: Wait time from referral to First Specialist Assessment (ESPI 2).	12/13 <6mths	13/14 <5mths	Result 14/15	Target 14/15
	100%	98.9%	99.7%	<4 mths
Measure: Wait time from commitment to treatment (ESPI5).	99.9%	99.1%	99.2%	<4 mths

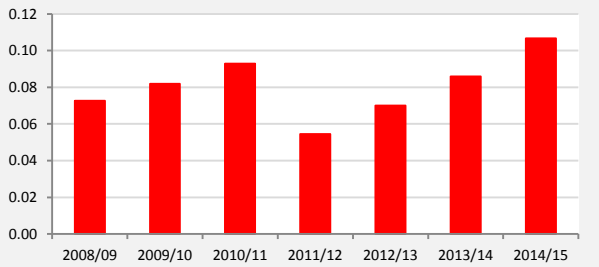


Impact: People stay safe in our hospitals.

- *The rate of serious falls continues to increase, however overall rates remain low.*
- *Key projects have focused on standardising fall prevention visual cues, post-fall care and adoption of the national Falls Assessment process with 96% of all inpatients (aged 75+) receiving a falls assessment in the fourth quarter of this year.*
- *The introduction of a new electronic incident management system is also likely to have raised awareness around falls and improved reporting; making trends difficult to interpret.*
- *All serious incidents are individually reviewed by the quality and clinical teams in each department to identify cause and improvements.*

Data sourced from individual DHBs.[13]

Measure: The rate of SAC level 1 and 2 falls in Canterbury Hospitals.	12/13	13/14	Result 14/15	Target 14/15
	0.07	0.09	0.11	0.07



[11] *This measure is the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10.*

[12] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive individual performance reports from the Ministry of Health. The wait time target for 2014/15 was mixed - being a maximum of 5 months for Q1 and Q2 and 4 months from January 2015. In line with the ESPIs target reporting the annual results presented are those from the final quarter of the year (April-June).*

[13] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days and the 2014/15 result relates to 40 serious falls incidents.*

GOAL 4: People experience optimal functional independence and quality of life

Why is this outcome a priority?

Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence. There are also a number of services or interventions that focus on improving the quality of people's lives, such as pain management or palliative services. This goal is not only about better health outcomes for individuals but is also about improved support for their families and a better use of health resources by reducing the rate of acute hospital admissions and reliance on residential care.

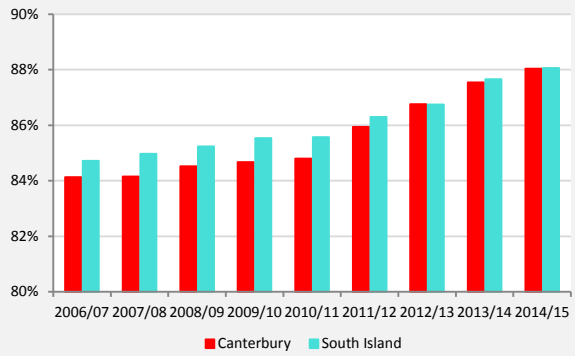
OUTCOME MEASURES LONG TERM

Outcome: An increase in the proportion of the population living in their own home.

- *The percentage of the population living in aged residential care continues to drop and the proportion of the Canterbury population (aged 75+) living in their own homes has reached 88%.*
- *This has brought Canterbury into line with the South Island rate and is consistent with our strategy of supporting people to stay safe and well in their own homes.*
- *A number of local programmes support our older population to age in place and are contributing to these positive results including: our restorative home-based support services, district nursing services, respite services and medication management and CREST.*

Data sourced from Client Claims Payments provided by SIAPO.

Measure: The percentage of the population (75+) living in their own home.



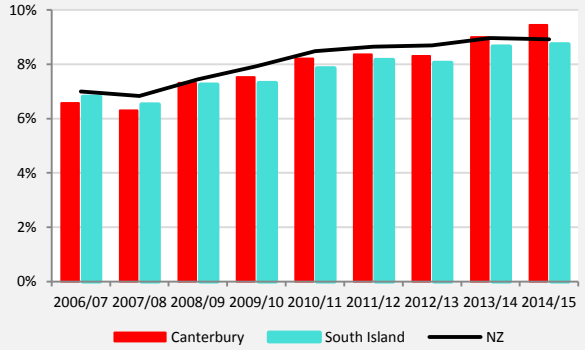
IMPACT MEASURES MEDIUM TERM

Impact: People stay safe in their own homes.

- *At 9.5%, the percentage of the Canterbury population (75+) admitted to hospital as a result of a fall is higher than the previous year and higher than the national average.*
- *Significant focus has been placed on falls over last three years, a Falls Prevention Strategy is in place across the Canterbury health system promoting clinically-led falls prevention programmes in the community (with home and community based programmes) and in our hospitals.*
- *Improved coding and awareness has very likely influenced increased reporting of falls admissions and although the rate of falls reported has increased, the associated outcomes may be less serious with fewer than expected fractured hips.*
- *An evaluation of the Community Falls Prevention Programme in February 2015 demonstrated that there were 373 fewer than expected admissions for hip fractures based on previous trends over the past 3 years.*
- *Compared with previous trends, there have also been 86 fewer deaths at 180 days post discharge after treatment for fractured hips than expected.*

Data sourced from National Minimum Data Set.[14]

Measure: The percentage of the population (75+) admitted to hospital as a result of a fall.	12/13	13/14	Result 14/15	Target 14/15
	8.3%	9.0%	9.5%	7.9%



[14] *The baseline data for 2012/13 differs slightly to that previously published due to the addition of late coding.*

STATEMENT OF SERVICE PERFORMANCE

Measuring our Non-financial Performance

As the major funder and provider of health services in Canterbury, we are strongly motivated to ensure we are delivering the most effective and efficient services possible. Understanding the dynamics of our population and the drivers of demand are fundamental when determining which services to fund and at what level. Just as fundamental is our ability to evaluate whether our investment is making a measureable difference in the health and wellbeing of our population.

As part of evaluating our performance, we provide an annual forecast of the services we plan to fund and provide and then report actual delivery against those expectations at the end of each year. The following presents the DHB's performance against the forecast presented in the Statement of Service Expectations from our 2014/15 Statement of Intent.

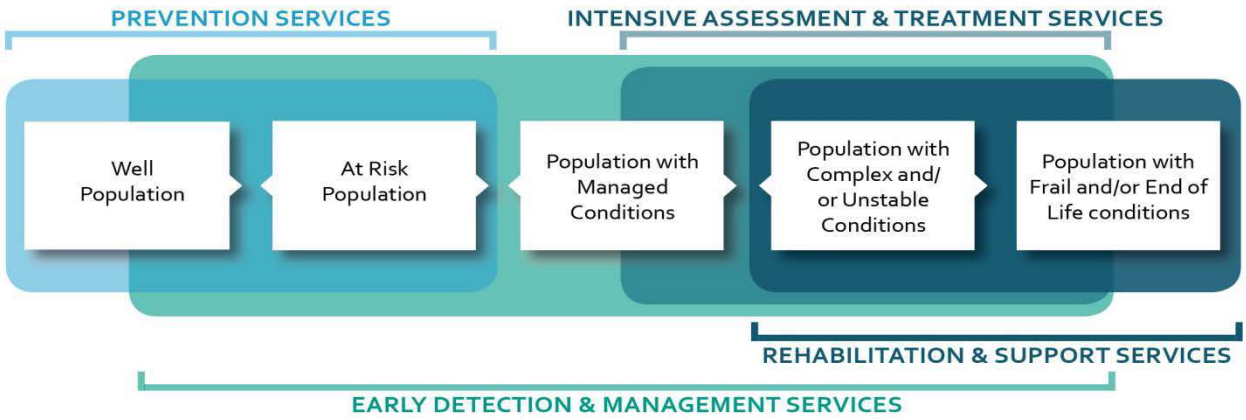
In presenting a picture of our performance, it would be overwhelming to measure every service or output delivered. We therefore choose to measure those activities with the greatest potential to contribute to the health and wellbeing of our population, those which are markers of broader system changes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

In doing so, we measure more than just volumes. Often the number of something delivered or the number of people who receive a service is 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, Quality, Timeliness and Coverage. Together, these measures demonstrate how we are contributing to the longer-term health outcomes we seek.

As well as comparing our 2014-15 results against the targets we set in our Statement of Intent, we have included (wherever possible) prior year's and national results to give wider context in terms of what we are trying to achieve and to enable the reader to assess performance over time.[15]

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

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



2014-2015 Performance Overview

Our performance result for 2014-15 demonstrates continued performance delivery across many areas. While we have not achieved every target, results identify challenges not unexpected four years on from the earthquakes.

We have made good progress against most of our prevention targets, and smoking cessation and immunisation coverage are positive. We also continue to deliver services closer to home with brief intervention counselling, spirometry testing, skin lesion removal and diabetes support remaining high.

It is concerning to see the continued increase in demand for services across our system, in particular the increased presentations to our emergency services, growing referrals to our Acute Demand Management Service and sustained pressure on our mental health services. However, results demonstrate improved access and reduced waiting times in almost every area, in spite of the increased pressure across the system.

Waiting times for diagnostic tests have dropped and are shorter than national averages and we continue to provide 100% of patients with radiation and chemotherapy within four weeks of the decision to treat. We have also delivered more first specialist assessments, more elective surgery and more outpatient consultations.

[15] *Unless otherwise stated, the latest New Zealand results have been sourced from the Ministry of Health, national service units or national datasets.*

The average length of stay in our hospitals has dropped and we met all but one of our rehabilitation targets, meaning more people are accessing these programmes and improving their recovery outcomes after an acute or serious event. In line with our strategic direction long-term home based support and rest home use has dropped with increases in the use of short-term care and respite.

In terms of delivery against the national health targets, Canterbury has achieved three of the seven targets, delivering on the elective surgery target, the hospital smoking target and shorter ED wait times. We missed the eight month immunisation target but by only 0.5% (1 child). A new Faster Cancer Treatment target was introduced part way through the year (the percentage of patients to receive their first cancer treatment or management within 62 days of treatment) and the DHB has reached 73% against the target of 85%. Importantly performance has improved dramatically against the two primary care targets. Results against the primary care smoking target lifted by 14% compared to last year, missing the target by just 1%. We also improved performance against the CVD Risk Assessment target by 16% on last year from 66% to 82%.[16]

There are many positives in terms of our performance, but demand trends will continue to be closely monitored. The capacity of our system is stretched and teams across all of our services and our health system have been working hard for a long time. We need not only to ensure that we are responding to the changing needs of our population but also that we are responding to the needs of our staff and the wider health workforce in a recovery context.

Notes on the Data

This Annual Report incorporates a large number of measures related to services provided by the DHB, or funded by the DHB but provided by third parties. This creates some additional considerations:

- Access to some health services is by necessity unrestricted or 'demand-driven' (such as emergency care, maternity services and palliative or dementia care). Due to the nature of these services we do not set targets. However, to give the reader an understanding of this demand and the use of resources across our health system estimated volumes are included in our forecasts. Rather than footnote every instance, these are indicated by the abbreviation '**est.**'
- Some services are funded by the DHB but provided by third parties and performance results can be affected by a lag in invoicing or reporting. Rather than footnote every instance, a symbol is used to indicate where this is the case: **Δ.**
- Some service data is reported by calendar rather than financial years. In these cases, the '2013/14' result relates to the 2013 calendar year and the '2014/15' result to 2014. These are indicated with the following symbol: **†**.
- With regards to the national health targets, in line with national reporting and expectations final quarter results are presented (April-June). The following symbol indicates which measures are national health targets**◇.**
- Any other irregularities have been footnoted.

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child Health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental Health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs' 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

[16] *Detail on the Health Target performance can be found on the Ministry of Health website – www.moh.health.nz.*

OUTPUT CLASS
Prevention Services

Why is this output class significant for the DHB?

Preventative health services help to promote and protect the health of the population by targeting changes to physical and social environments that engage, influence and support people to make healthier choices. In doing so these services help to reduce behaviours and major risk factors that contribute to the development of long-term conditions. Because at-risk and high-need population groups are more likely to engage in risky behaviours and live in environments less conducive to making healthier choices, prevention services are our foremost opportunity to reduce inequalities in health status. Prevention services are also often designed to disseminate consistent messages to large numbers of people and can therefore be cost-effective.

Performance Summary

Increased focus has been placed on engaging our population in positive behaviours following the earthquakes and it is pleasing to note that there continues to be high engagement in these areas and improved progress against almost all measures. Smoking prevention continues to be a major highlight as does the high number of people enrolling in the Aukati Kaipaipa smoking cessation programme. The number of people accessing Green Prescriptions remains high and while volumes have dropped slightly against the previous year, more of those people taking up the referral are remaining active.

We have achieved the national target for delivery of B4 School Checks to ensure children get the best start to school and our breast screening coverage remains high. We are also pleased to have almost met the national targets for eight month old immunisations, missing by 0.5%.

We are beginning to make gains in the uptake of HPV vaccinations although numbers are still below target. The number of women presenting for cervical screening also needs further focus. Results are similar to national rates but continue to be disappointing compared to our coverage target and engagement in other population health programmes. A recent move to align the cervical and breast cancer screening teams is anticipated to improve results in the coming year.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of babies exclusively breastfeeding on hospital discharge	Q [17]	76%	76%	80%	≥75%	-	▲
Lactation support and specialist advice consults provided in community settings	V	858	1,031	1,058	>580	-	▲
'Appetite for Life' nutrition courses provided in the community	V Δ	52	56	59	≥50	-	▲
People accessing Green Prescriptions for additional physical activity support	V [18]	1,936	2,879	2,797	3,000	-	▼
% of Green Prescription participants more active 6-8 months after referral	Q [19]	50%	57%	62%	≥50%	61%	▲
% of smokers identified in primary care receiving advice and help to quit (ABC)	C ◇	35%	75%	89%	90%	90%	▲
% of smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	93%	95%	96%	95%	96%	▲
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	345	408	418	≥240	-	▲
% of priority schools supported by the Health Promoting Schools framework	C [20]	74%	80%	91%	≥70%	-	▲

[17] *The percentage of babies breastfed demonstrates the effectiveness of consistent health promotion messages delivered during the antenatal, birthing and early postnatal period. Standards are set to align with national targets.*

[18] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Analysis is currently underway with Sports Canterbury and the PHOs to review current referral patterns and identify opportunities to increase referral rates across both urban and rural Canterbury in order to meet targets in the coming year.*

[19] *Results are taken from national Green Prescription patient survey completed by Research NZ on behalf of the Ministry of Health.*

[20] *The Health Promoting Schools Framework addresses health issues with an approach based on 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.*

Population-Based Screening Services *These services help identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, indicated by high coverage rates.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of four-year-olds provided with a B4 School Check (B4SC)	C [21]	86%	90%	91%	90%	92%	▲
% of Year 9 students in decile 1-3 schools provided with a HEADSSS assessment	C † [22]	99.6%	100%	98%	100%	-	▼
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [23]	75%	76%	75%	80%	76%	▼
% of women aged 50-69 having a breast cancer screen in the last 2 years	C [24]	82%	80%	79%	≥70%	72%	–

Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of newborns enrolled on the National Immunisation Register at birth	C [25]	98%	99%	98%	≥95%	-	▼
% of children fully immunised at eight months of age	C ◇	92%	93%	94.5%	95%	93%	▲
% of eight-month-olds 'reached' by immunisation services	Q [26]	97%	95%	98%	95%	97%	▲
% of eligible girls completing HPV vaccinations (receiving Dose 3)	C † [27]	43%	26%	49%	60%	56%	▲
% of older people (65+) receiving a free influenza vaccination	C † [28]	71%	75%	74%	75%	69%	▼

[21] *The B4 School Check 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. The check allows health concerns to be identified and addressed early in a child's development.*

[22] *A HEADSSS assessment is provided to Year 9 students it is free and covers: Home, Education/Employment/Eating/Exercise, Activities; Drugs, Sexuality; Suicide, Safety; and Spirituality. The assessment allows health concerns to be identified and addressed early. There were 8 children missed by the public health team in 2014/2015.*

[23] *This is a national screening programme and standards are set to align with national screening targets. Cervical Screening results are to Q3 2014/15 being the most recent national results available. The DHB has recently supported a shift of the cervical screening service to sit alongside the breast screening service and anticipate an improvement in rates in the coming year as experience and processes are shared between the programme teams.*

[24] *This is a national screening programme and standards are set to align with national screening targets. The national breast screening eligibility criteria was changed mid 2014/15 to women 50-69 years rather than 45-69 and so the latest year's result is not directly comparable to the previous years.*

[25] *Of the 2% of children not enrolled on the NIR all but 9 were later picked up by general practice and vaccinated at eight months. There are a number of reasons a child might not be enrolled at birth including being born overseas, parents opting off the NIR system and infant death.*

[26] *'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children but have chosen to decline immunisations or opt off the NIR.*

[27] *The baseline is the percentage of girls born in 1996 receiving Dose 3 by the end of 2012, and the target for 2014 is girls born in 1998. Canterbury's programme is slightly different to that delivered elsewhere as it is primarily general practice rather than school based. Results are not directly comparable to the national numbers.*

[28] *While the percentage of the population 65+ being immunised has dropped this is affected by our increasing ageing population — compared to last year the actual number of immunisations delivered has increased from 53,344 or 54,113 (769 additional vaccinations having been delivered).*

OUTPUT CLASS
Early Detection and Management Services

Why is this output class significant for the DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age. By promoting regular engagement with health services, we can support people to maintain good health, and through earlier diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes.

Because these services can better support people to stay well and stabilise or manage their condition people are able to reduce complications, acute illness or crises and therefore avoid hospital appointments and admissions. Reducing this demand has a major impact in freeing up hospital and specialist services to allow for more planned interventions and reduces waiting times.

Performance Summary

It is positive to see that access to services in the community remains high, suggesting that our population is engaging with their general practice. Access to skin lesion removal, spirometry testing, diabetes and mental health support (brief intervention counselling) without the need for hospital visits reduces waiting times and enables earlier intervention.

Canterbury met almost all national wait time targets for the delivery of diagnostic tests which facilitate early intervention and improve clinical decision making. An increase in both the number and complexity of patients presenting for Magnetic Resonance Imaging (MRI) has led to increased waiting times in this area and the DHB will review the capacity of this service in the coming year.

Oral Health Targets for examinations have not been met this year. In term 2 of 2014, the mobile dental clinic vans were pulled off the road for 10 weeks due to the identification of a formaldehyde risk with the vans, which negatively affected our performance and created a backlog which has since been worked through. We anticipate returning to previous year's rates in 2015/16.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Primary Health Care (GP) Services *These services are offered in local community settings by general practice teams and are aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake are indicative of engagement and accessibility.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of the population enrolled with a Primary Health Organisation	C	96%	96%	95%	≥95%	-	▼
Avoidable hospital admission rate for children aged 0-4	Q [29]	114%	117%	108%	<111%	100%	▼
Young people (0-19) accessing Brief Intervention Counselling	V Δ[30]	758	786	754	≥500	-	▼
Adults (20+) accessing Brief Intervention Counselling	V Δ	5,023	5,712	5,652	≥3500	-	▼
Skin lesions (growths, including cancer) removed in primary care	V Δ	2,358	2,432	2,583	≥2,000	-	▲
Number of clinical HealthPathways in place across the health system	V [31]	667	762	811	>600	-	▲

Oral Health Services *These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of pre-school children (0-4) enrolled in DHB oral health services	C †[32]	71%	71%	69%	75%	73%	▼
% of enrolled children (0-12) examined according to planned recall	T †	90%	94%	86%	≥90%	90%	▼
% of adolescents (13-17) accessing DHB-funded oral health services	C †	65%	64%	62%	85%	68%	▼

[29] *Some admissions to hospital are seen as preventable through appropriate early intervention and therefore provide an indication of access to and effectiveness of primary care the interface between primary and secondary services. The measure is a national DHB performance indicator (SI1), and is defined as the standardised rate per 100,000. The result is 3 months in arrears to March 2015.*

[30] *The Brief Intervention Coordination Service provides people with mild to moderate mental health issues free 'early' intervention from their general practice teams for issues including depression and anxiety. Results include face-2-face and phone consultations but may undercount people accessing BIC where dates of birth have not been provided. The numbers above do not include extended consultations which are also provided in primary care for those people with more complex issues needing further ongoing help – 4,834 extended consultations were provided by general practitioners in 2014/15.*

[31] *The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.*

[32] *The oral health measures are national DHB performance measures and are reported by calendar year - national results for 2014 year are yet to be released those presented relate to 2013. Canterbury has been focused on enrolling children from 12 months of age but in the coming year will implement a birth registration system which is anticipated to improve performance against this indicator.*

Long-term Conditions Programmes *These services are targeted at people with high health need due to having a long-term condition and aim to reduce deterioration, crises and complications through good management (and control) of that condition. Success is demonstrated through early intervention, monitoring and management strategies which reduce negative impacts and the need for hospital admission.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Spirometry tests provided in community rather than hospital settings	V Δ[33]	1,503	1,533	1,682	≥1,000	-	▲
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇[34]	33%	66%	82%	90%	89%	▲
% of the population identified with diabetes having an HbA1c test in the last year.	C [35]	86.5%	94%	90%	≥90%	-	▼
% of the population identified with diabetes with acceptable glycaemic control.	Q	75.6%	77%	76%	≥75%	-	▼
People receiving subsidised diabetes self-management support from their general practice team when newly diagnosed with Type 2 diabetes or starting insulin	V Δ	739	799	880	≥739	-	▲

Pharmacy and Referred Services *These are services which a health professional may prescribe or refer a person to help diagnose a health condition, or as part of treatment. They are provided by allied health personnel such as laboratory technicians, medical radiation technologists and pharmacists. While pharmaceuticals are largely demand driven, to improve performance we will target primary care access to diagnostics and shorter wait times to aid decision-making and improve referral processes.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Subsidised pharmaceutical items dispensed in the community	V Δ[36]	6.7m	6.2m	6.3m	est.<8m	-	▲
Laboratory tests completed for the Canterbury population	V Δ[37]	2.0m	2.4m	2.4m	est.<2.6m	-	–
People on multiple medications receiving a Medication Management Review	V Δ[38]	1,771	1,703	1,326	2,000	-	▼
GP requested Community Referred Radiology tests completed	V Δ	41,913	43,094	44,720	est.>30k	-	▲
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T [39]	30%	85%	96%	75%	75%	▲
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T [40]	89%	92%	96%	90%	85%	▲
% of people receiving their Magnetic Resonance Imaging (MRI) within 6 weeks	T	83%	88%	75%	≥80%	54%	▼
% of people receiving their elective coronary angiography within 3 months	T	82%	99%	95%	90%	94%	▼

[33] *Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment. Volumes include those delivered by both GPs and mobile community respiratory providers.*
[34] *This refers to CVD risk assessments undertaken in primary care in line with the national 'More heart and diabetes checks' health target. Additional effort has gone into achieving this national target over the past year with the introduction of electronic dashboards and support from practice liaison teams to assist general practice in delivering and recording the delivery of cardiovascular risk assessments.*
[35] *Part of good diabetes management includes an annual test of patient's blood glucose levels (via an HbA1c test) to monitor management of their condition. HbA1c ≤64mmol/mol reflects an acceptable blood glucose level. The results are those most recently available for the six months to December 2014, full year results were not available at the time of printing.*
[36] *This measure covers all items dispensed in the community not in hospital however it may still include some non-Canterbury residents who had prescriptions filled while in Canterbury.*
[37] *The 2013/14 number differs from that previously published as the result now reflects the inclusion of data from both the community laboratory provider and the DHB's laboratory.*
[38] *This result reflects a shift in focus from the medication management service to the development and introduction of a new higher level service and intense medication therapy services for more complex patients needing additional support launched in May 2015.*
[39] *All diagnostic result baselines are the June 2015 result published by the Ministry of Health. Targets are set to national standards.*
[40] *The result for 2013/14 differs from that previously published being the Q3 result this has been updated with Q4 (not available at the time of publishing.*

OUTPUT CLASS
Intensive Assessment and Treatment Services

Why is this output class significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve health outcomes either through early intervention or through corrective action. People are then able to establish more stable lives, resulting in improved quality of life and increased public confidence in the health system. As an owner of these services, the DHB is also committed to providing high quality services which will not only ensure patient safety, but reduce adverse events and delays in treatment — all of which, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services.

Performance Summary

Performance has been impressive across this output class, particularly considering the demand driven nature of many of these services and the capacity issues being experienced by the DHB while the new hospitals are being built.

Demand is evident, with an increased number of births, the delivery of an increasing number of acute demand packages of care in the community, more presentations in our emergency departments and more specialist assessments and outpatient appointments. We are also experiencing increased demand for mental health services and have increased access to services to meet that need, aligned with the recovery patterns following other major disasters across the word.

While the patterns of demand are concerning our system's response has been positive. Services are changing the way they work, telemedicine technology is supporting more virtual assessments meaning patients and specialists have to travel less. More women are accessing primary birthing units and both primary care and after hours care is now free for children under 13. Lengths of stay in our hospitals have all dropped as patient flow improvements are taking effect and people are being supported to return to their own homes.

In spite of the increased load wait times are dropping, ensuring access to services when they are needed. Elective surgery volumes have increased and the DHB has delivered on its national surgery target. Wait time targets for mental health services have not been met, however results have improved on the previous year. This reflects an impressive effort by our specialist teams considering the additional demand for services.

Performance has also been positive against the new national quality markers with improvement evident in almost all areas and performance also looking good compared to national results.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in Canterbury DHB hospitals and are the national quality and safety markers championed and monitored by the Health Quality & Safety Commission.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Rate of compliance with good hand hygiene practice	Q ◇[41]	68%	67%	73%	80%	77%	▲
% of hip and knee replacement patients receiving cefazolin ≥2g	Q ◇[42]	65%	96%	98%	95%	90%	▲
% of hip and knee replacement patients who have appropriate skin preparation	Q ◇[43]	99%	99%	99%	100%	98%	–
% of time all three parts of the surgical safety checklist are used	Q ◇[44]	40%	88%	77%	90%	93%	▼
% of inpatients (aged 75+) who received a falls assessment	Q ◇[45]	97%	93%	90%	≥90%	90%	▼

[41] *This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. Baseline results differ due to alignment with national results and financial years. The 2014/15 result relates to the June 2015 audit period.*
[42] *Cefazolin ≥2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications. Results are the most recent quarter available nationally to December 2014.*
[43] *Results are the most recent quarter available nationally to December 2014.*
[44] *The surgical safety checklist, developed by the World Health Organisation, is a common sense approach to ensuring the correct surgical procedures are carried out on the correct patient. Previously published results differ due to alignment with national results and financial years. The 2014/15 result is the most recent quarter available nationally at the time of publishing to March 2015.*
[45] *While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and acting accordingly. The 2014/15 result is the most recent quarter available nationally at the time of publishing to March 2015.*

Maternity Services *These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided by a range of health professionals, including lead maternity carers, general practice teams and obstetricians.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of women registered with an LMC by 12 weeks of pregnancy	C †	74%	75%	77%	80%	66%	▲
Maternity deliveries in Canterbury DHB facilities	V	5,778	5,654	5,895	est.6k	-	▲
% of total deliveries made in Primary Birthing Units	V [46]	9%	9%	12%	13%	-	▲
Baby friendly hospital accreditation of DHB facilities maintained	Q [47]	yes	yes	yes	yes	-	–

Acute/Urgent Services *These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly (that may or may not lead to hospital admission). Services include accident & emergency responses, short-stay acute assessment and observation, acute care packages, acute medical, surgical and intensive care services.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of children under six with access to free primary care after hours	C	100%	100%	100%	100%	-	–
% of general practices providing telephone triage outside business hours	C	86%	89%	92%	95%	-	▲
Acute demand packages of care provided in community settings	V [48]	25,374	28,378	28,944	>25,000	-	▲
Attendances at Canterbury Emergency Departments	V [49]	87,221	94,010	94,832	≤93,000	-	▲
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T ◇ [50]	99.5%	100%	100%	100%	100%	–
Acute inpatient average length of hospital stay (standardised)	Q [51]	3.86	3.74	3.42	≤3.86	3.89	▼

[46] *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 more complex or specialist intervention.*

[47] *The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises achievement of the standard.*

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

[49] *This measure is a national performance measure (the ED Health Target). It counts both Christchurch and Ashburton Emergency Departments.*

[50] *This measure is a national performance measure (PP30) and refers to all people 'ready for treatment' excluding Category D patients, whose treatment is scheduled with other treatments or part of a trial.*

[51] *This measure is a national performance measure (OS3). When seeking to reduce average length of hospital stay performance should be balanced against readmissions rates to ensure earlier discharge is appropriate and service quality remains high.*

Elective/Arranged Services *These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also non-surgical interventions and specialist assessments.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
First Specialist Assessments provided (medical and surgical)	V [52]	60,819	67,122	70,151	est.>60k	-	▲
% of First Specialist Assessments that were non-contact	Q [53]	12.1%	13.5%	15.4%	>10%	-	▲
Elective surgical discharges delivered (surgeries provided)	V [54]	17,066	16,961	17,714	≥17,484	-	▲
% of elective/arranged surgeries provided as day cases	Q [55]	57%	57%	58%	≥57%	-	▲
% of people who receive their surgery on the day of admission	Q [55]	91%	91%	91%	≥90%	-	–
Elective inpatient average length of hospital stay (standardised)	Q [51]	3.19	3.15	2.99%	≤3.18	3.19	▼
Outpatient attendances	V	622,837	640,678	647,323	est.>600k	-	▲
Outpatient 'Did not Attend' rates	Q	4.4%	4.4%	4.6%	≤5%	-	▲
Outpatient 'Did not Attend' rates (Māori)	Q [56]	8.6%	7.2%	7.8%	≤5%	-	▲

Specialist Mental Health Services *These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of young people (0-19) accessing specialist mental health services	C Δ [57]	2.9%	3.2%	3.5%	≥3.1%	3.5%	▲
% of adults (20-64) accessing to specialist mental health services	C Δ	3.0%	3.2%	3.2%	≥3.1%	3.8%	–
% of people referred for non-urgent MH and AOD services seen within 3 weeks	T [58]	72%	70%	73%	80%	79%	▲
% of people referred for non-urgent MH and AOD services seen within 8 weeks	T	87%	86%	90%	95%	93%	▲

Assessment, Treatment and Rehabilitation Services (AT&R) *These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units and outpatient clinics. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
Admissions into inpatient AT&R services	V [59]	3,101	3,313	3,450	est.>3k	-	▲
% of admissions into AT&R (PMH) made by direct community referral	Q [60]	21%	19%	21%	20%	-	▲
% of AT&R inpatients discharged to their own home rather than ARC	Q Δ [61]	85%	87%	87%	>80%	-	▲

[52] *This measure counts both medical and surgical assessments but counts only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred.*
[53] *Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment.*
[54] *This measure is a national performance measure (the electives health target) and excludes 'arranged' cardiology and dental volumes.*
[55] *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 home and it frees up hospital resources. These rates are balanced against readmission rates to ensure service quality is appropriate.*
[56] *There is currently a project underway around the high level of DNAs for Pacific and Maori. Patients have been surveyed in order to understand the drivers behind their non-attendance. These results will be collated in order to identify trends. The 100 days project is also now looking into DNA rates.*
[57] *This measure is a national performance measure (PP8) and targets are based on the assumption that 3% of the population will need access to specialist mental health services. The 2012/13 result differs to that previously published to align to national reporting data. Results reflect only those specialist services (DHB and NGO) reporting through to the national PRIMHD database and in Canterbury undercounts service provision as a number of local providers are not currently reporting to the national system but report to the DHB. Locally collected DHB and NGO data demonstrates access rates of 4.26% for 20-64 year olds and when including primary care 3.7% for 0-19 year olds and 5.95% for 20-64 year olds.*
[58] *This measure is a national performance measure (PP8). Results are provided three months in arrears, the results stated are to March 2015.*
[59] *Results for 2013/14 differ slightly to those previously published due to the addition of 28 late-coded long-term patients. The total number of admissions into AT&R includes people of all ages admitted into all DHB facilities.*
[60] *Results differ to those previously published due to improved coding and a move from manual to automated data sources. Admissions into AT&R for this measure and the following one are those into aged related AT&R at The Princess Margaret Hospital.*
[61] *A discharge from AT&R to home (rather than ARC) reflects the quality of AT&R and community support services in terms of assisting that person to regain their functional independence so that, with appropriate community supports, the person is able to safely 'age in place'. The 2013/14 result differs slightly from that previously published due to late invoicing from ARC facilities.*

OUTPUT CLASS
Rehabilitation and support services

Why is this output class significant for the DHB?

Services that support people to live safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. Even when returning to full health is not possible, timely access to support enables people to maximise their function and independence. In preventing deterioration and crisis, these services have a major impact on the sustainability of the health system by reducing acute demand, avoidable hospital admissions and the need for more complex intervention. These services also support the flow of patients by enabling them to go home earlier and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

Performance Summary

In line with our strategic direction access rates for long-term home-based support and rest homes bed numbers continue to drop while access to short-term restorative support, district nursing services and respite services remain high.

Increased use of evidence-based and evidence-informed tools such as InterRAI (International Residential Assessment Instrument) provide greater assurance that the right services are being provided to best meet people's needs. Engagement with stroke rehabilitation and falls prevention programmes remains positive, although performance against cardiac and pulmonary targets is lower than expected — the availability of community venues having had an impact on results in these areas.

Utilisation of the Liverpool Care Pathway has dropped following the release of a negative evaluation of the programme overseas. While the delivery of the programme is slightly different in this country uptake has not surprisingly been effected. The number of people supported by hospice and palliative care programmes remains high and new national End of Life Guidelines are being developed and will be implemented in Canterbury in the coming year.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. Success is measured through increased referral of the right people to these services.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	74%	74%	80%	80%	-	▲
% of people enrolled in cardiac rehabilitation after an acute event	C [62]	25%	20%	15%	30%	-	▼
People accessing pulmonary rehabilitation courses	V [63]	206	230	222	>150	-	▼
People (65+) accessing community-based falls prevention programmes	V [64]	1,613	1,505	1,686	>1,200	-	▲

Home and Community-Based Support Services *These are services designed to support people to continue living in their own homes by restoring functional independence. Success is measured against decreased/delayed entry into residential or hospital services.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of older people (65+) receiving long-term home and community support who have had a clinical assessment using InterRAI	Q Δ [65]	90%	91%	94%	95%	-	▲
People accessing CREST services on hospital discharge or GP referral	V Δ [66]	1,850	1,992	1,770	2,200	-	▼
People supported by long-term home-based support services	V Δ	8,860	8,796	8,641	est.<8k	-	▼
People supported by district nursing services	V Δ	7,911	7,645	7,765	est.>6k	-	▲

[62] *The cardiac rehabilitation courses were compromised this past year due to a number of the usual venues not being available and a change was made in the types of rehab offered and the way in which people were invited to sessions. This has negatively impacted on performance against this measure. This measure counts those enrolled in Phase 2 (outpatient) Cardiac Rehabilitation on discharge but does not include those people attending one-off evening sessions – if these were also included the percentage would lift to 17.8%. The department will be resuming previous re-enrolment methods in the coming year and we anticipate seeing a lift in these results.*

[63] *This measure now includes all people attending pulmonary rehabilitation (Ashburton, Christchurch, Community-based).*

[64] *This measure refers to Canterbury's Integrated Falls Prevention Service and counts all those attending aged 65+.*

[65] *InterRAI is an evidence based geriatric assessment tool the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care.*

[66] *The CREST service provides a range of home-based rehabilitation services to facilitate early discharge from hospital or avoid admission entirely (via pro-active GP referral). The 2013/14 baseline differs to that previously published following a review of definitions and methodology – the results measure the number of clients having received unique packages of care.*

Respite and Day Services *These services provide people with a break from a routine or regimented programme so that crisis can be averted or a specific health need addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. They may also include support and respite for families and caregivers. Services are expected to increase over time, as more people are supported to remain in their own homes.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
People supported by day services	V Δ	654	672	832	est.>550	-	▲
People accessing mental health planned and crisis respite	V Δ[67]	829	819	935	est.>750	-	▲
Occupancy rate of mental health planned and crisis respite beds	C Δ[68]	81%	84%	86%	85%	-	▲
People supported with aged care respite services	V Δ	1,192	1,262	1,424	est.>1k	-	▲

Palliative Care Services *These are services that improve the quality of life of patients and their families facing end of life, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
People supported by hospice or home-based palliative services	V Δ	3,295	3,815	3,934	est.>2k	-	▲
ARC facilities trained to provide the Liverpool Care Pathway	C [69]	42	38	38	≥45	-	–
People in ARC services supported by the Liverpool Care Pathway	V	134	71	44	>150	-	▼

Residential Care Services *These services are provided to meet the needs of people assessed as requiring long-term residential care in a hospital or rest home. With an ageing population, a decrease in the number of subsidised bed days for lower-level care is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home and community-based support.*	Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of people entering ARC having had a clinical assessment of need using interRAI	Q Δ[65]	91%	96%	99%	95%	-	▲
% of ARC residents receiving vitamin D supplements	C [70]	73%	68%	70%	75%	-	▲
Subsidised ARC rest home beds provided (days)	V Δ[71]	573,866	569,643	538,229	est.<676k	-	▼
Subsidised ARC hospital beds provided (days)	V Δ[71]	453,716	487,687	502,950	est.<507k	-	▲
Subsidised ARC dementia beds provided (days)	V Δ[71]	222,445	244,581	243,785	est.>212k	-	▼
Subsidised ARC psycho-geriatric beds provided (days)	V Δ[71]	69,468	72,450	70,362	est.>62k	-	▼

[67] *This measure includes the new mental health mobile respite service, launched in 2013.*
[68] *Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directed to other areas.*
[69] *The Liverpool Care Pathway is an international palliative care programme adopted nationally. The total number of people supported by palliative services indicates that people are still receiving appropriate support, however the drop off in use of the Liverpool Care Pathway reflects the reputational damage resulting from a negative review of the programme overseas. The DHB is now focusing on supporting the development of national End of Life Guidelines which will include appropriate training and a local referral pathway.*
[70] *ARC Vitamin D supplementation results are provided by ACC. The result provided is for the three months to June 2015.*
[71] *ARC results for 2013/14 differ to that previously published for all ARC beds provided due to the inclusion of late invoices.*

MĀORI HEALTH ACTION PLAN PRIORITIES

Sitting alongside our Annual Plan the Canterbury DHB has a standalone Māori Health Action Plan which outlines the key areas of focus in terms of improving outcomes for our Māori population. Achieving the goals in the Māori Health Action Plan requires a continued and collaborative effort from across the whole of our health system.

Good progress is evident across most of the measures, while many of the targets have yet to be met performance is moving in the right direction. Immunisation rates for children have increased significantly, PHO enrolments are increasing and significant improvements have been made in the delivery against the CVD and primary care smoking targets. Breastfeeding rates, cancer screening rates and oral health results are all areas needing additional focus in the coming year.

Māori Health Action Plan Indicators		Notes	2012/13	2013/14	2014/15 Result	2014/15 Target	Latest NZ Result	Trend
% of the population enrolled with a PHO		C	81%	83%	87%	≥95%	-	▲
Avoidable hospital admission rate for children aged 0-4 years		Q	142%	159%	138%	<111%	100%	▼
Avoidable hospital admission rate for adults aged 45-64 years		Q	170%	165%	161%	<95%	100%	▼
Avoidable hospital admission rate for adults aged 0-74 years		Q	154%	160%	142%	<95%	100%	▼
% of tamariki fully and exclusively breastfed	Age 6 weeks	Q	58%	59%	62%	≥68%	66%	▲
% of tamariki fully and exclusively breastfed	Age 3 months	Q	45%	49%	46%	≥54%	56%	▼
% of tamariki fully, exclusively and partially breastfed	Age 6 months	Q	55%	53%	53%	≥59%	66%	–
% of the eligible population having had a CVD Risk Assessment in the last 5 years		C ◇	31%	60%	76%	90%	85%	▲
% of high-risk patients receiving an angiogram within 3 days of admission		T [72]	new	n/a	n/a	70%	n/a	–
% of patients presenting with ACS who undergo angiography have completion of register data collection within 30 days		T [72]	new	n/a	n/a	95%	n/a	–
% of women aged 50-69 having a breast cancer screen in the last 2 years		C [73]	78%	80%	74%	≥70%	64%	▼
% of women aged 25-69 having a cervical cancer screen in the last 3 years		C [74]	53%	56%	54%	80%	63%	▼
% of smokers identified in primary care receiving advice and help to quit		C ◇ [75]	34%	62%	67%	90%	-	▲
% of smokers identified in hospital receiving advice and help to quit		C ◇	92%	93%	95%	95%	-	▲
% of tamariki fully immunised at eight months of age		C ◇	85%	88%	96%	95%	90%	▲
% of the eligible population (65+) who have had an influenza vaccination		C † [76]	66%	70%	71%	75%	-	▲
Rate of Rheumatic Fever in the South Island (per 100,000)		Q	0.7	0.4	0.4	0.3	3.0	–
Rate of Compulsory Treatment Orders (per 100,000)		V	185	206	203	n/a	277	▼
% of tamariki (0-4) enrolled in school and community dental services		C † [77]	31%	31%	33%	75%	59%	▲
% of tamariki caries-free (no holes or fillings) at age 5		Q † [78]	41%	45%	41%	75%	37%	▼
% of tamariki aged four provided with a B4 School Check (B4SC)		C ◇ [79]	81%	92%	92%	90%	92%	–
% eligible girls receiving dose 3 of the HPV vaccination programme		C † [80]	50%	40%	47%	60%	62%	▲

[72] *At the time of publishing this data was not available by ethnicity. For the month of June 2015, 107 of 120 people (89%) received an angiogram within 3 days of admission and the registry was completed for 96 of 120 people (80%) within 30 days of undergoing angiography.*
[73] *The national breast screening eligibility criteria was changed mid 2014/15 to women 50-69 years rather than 45-69. The 2014/15 result is therefore not directly comparable to the previous years which relate to a wider population group.*
[74] *The cervical screening results are to Q2 2014/15 (Oct-Dec) being the most recent results available.*
[75] *Results against the national primary care smoking health target are not available by ethnicity this data is not from the same source so not directly aligned.*
[76] *These results differ from those previously reported which were 'high need' population results – this now reflects Maori only results and is taken from the Q2 result (Oct-Dec) being the end of the calendar year from PHO Performance Reporting.*
[77] *These result are provided annually for the calendar year – the NZ results are 2013/14 being the most recent available at the time of printing.*
[78] *The 2012/13 baseline differs from that previously published (31%) due to a typing error.*
[79] *Results differ to those previously published having been revised to match 'High Need' population results to align with national reporting.*
[80] *This result is presented for calendar year to Dec 2014. Canterbury's programme is slightly different to the national programme -being general practice rather than school based, the result is those girls born in 1998 having received dose 3 (i.e. having been fully immunised by age 16).*

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2015.

PRINCIPAL ACTIVITIES

Canterbury DHB is a New Zealand based District Health Board (DHB), 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 deficit of $17.936M against the budgeted deficit of $12.550M. (2013/14 deficit of $22.9M before Ministry of Health Revenue Deficit Funding against the budgeted deficit of $25M).

BOARD FEES

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

	Board Fees 2015 $'000	Committee Fees 2015 $'000
Murray Cleverley	54.600	2.250
Peter Ballantyne	-	2.750
Pauline Barnett	-	1.000
Sally Buck	26.520	3.750
Anna Crighton	26.520	2.785
Elizabeth Cunningham	-	1.500
Wendy Dallas-Katoa	-	0.750
Andrew Dickerson	26.520	5.625
Jan Edwards	-	1.250
Baden Ewart	-	1.000
Rochelle Faimalo	-	1.500
Susan Foster-Cohen	-	1.250
Jo Kane	26.520	4.250
Aaron Keown	26.520	2.500
Bob Lineham	-	2.500
Ben Lucas	-	1.000
Chris Mene	26.520	3.125
Edie Moke	26.520	3.750
David Morrell	26.520	3.250
Yvonne Palmer	-	1.500
Trevor Read	-	1.500
Ana Rolleston	-	-
William Tate	-	2.250
Susan Wallace	26.520	-
Steve Wakefield	33.150	3.750
Olive Webb	-	1.500
	326.430	**56.285**

Total fees paid for the year were $382,715 (2013/14 - $385,347). The limit of fees authorised for the year ended 30 June 2015 was $391,189 (2013/14 - $390,965).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	Board		QFARC		HAC		CPHAC		DSAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Murray Cleverley	12	12	10	13	-	-	-	-	-	-
Peter Ballantyne	-	-	13	13	-	-	-	-	-	-
Pauline Barnett	-	-	-	-	-	-	3	5	-	-
Sally Buck	12	12	-	-	4	4	3	3	5	5
Anna Crighton	11	12	-	-	5	6	5	5	-	-
Elizabeth Cunningham	-	-	-	-	-	-	-	-	5	5
Wendy Dallas-Katoa	-	-	-	-	-	-	3	5	-	-
Andrew Dickerson	12	12	13	13	6	6	-	-	5	5
Jan Edwards	-	-	-	-	5	6	-	-	-	-
Baden Ewart	-	-	-	-	-	-	-	-	3	5
Rochelle Faimalo	-	-	-	-	-	-	5	5	-	-
Susan Foster-Cohen	-	-	-	-	-	-	-	-	4	5
Jo Kane	11	12	6	6	-	-	5	5	5	5
Aaron Keown	10	12	-	-	4	6	5	5	-	-
Bob Lineham	-	-	11	13	-	-	-	-	-	-
Ben Lucas	-	-	-	-	-	-	-	-	3	5
Chris Mene	11	12	-	-	-	-	4	5	5	5
Edie Moke	9	12	10	13	-	-	-	-	5	5
David Morrell	10	12	9	13	5	6	-	-	-	-
Yvonne Palmer	-	-	-	-	-	-	5	5	-	-
Trevor Read	-	-	-	-	6	6	-	-	-	-
Ana Rolleston	-	-	-	-	2	6	-	-	-	-
William Tate	-	-	12	13	-	-	-	-	-	-
Susan Wallace	11	12	-	-	-	-	-	-	-	-
Steve Wakefield	10	12	13	13	0	6	-	-	-	-
Olive Webb	-	-	-	-	-	-	-	-	5	5

QFARC – Quality, Finance, Audit & Risk Committee
HAC – Hospital Advisory Committee
CPHAC – Community & Public Health Advisory Committee
DSAC – Disability Support Advisory Committee

DIRECTOR FEES

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

	2015 $'000	2014 $'000
Brian Wood	28	28
Jane Cartwright	18	21
Peter Ballantyne	13	-
Kath Fox	7	-
Graeme McNally	11	-
Garth Bateup	6	-
	83	**49**

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2015

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

BOARD

Murray Cleverley Chair	Trust Aoraki – Director Business Class Ltd – Managing Director Opihi Vineyard Ltd - Chairman Canterbury Economic Development Co Ltd - Director Shoe Shield Ltd - Director Animal Care Solutions - Director Sky Solar Holdings Ltd – Director District Health Boards NZ - Director South Canterbury DHB – Board Chairman NZ Innovation Health Hub Ltd - Director HBL Transition Governance Group- Member Holloway Builders Ltd - Director
Steve Wakefield Deputy Chair	Deloitte – Partner - Partner of professional services including accounting, tax, auditing and consulting services. Deloitte may be engaged to undertake work in the Health Sector from time to time. Anglican Church Property Trustees – Trustee - Holds all property on behalf of the Anglican Church in the Diocese of Christchurch. Heritage NZ – Subscribing Member - Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. The Canterbury DHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with some Canterbury DHB buildings.
Sally Buck	Christchurch City Council – Community Board Member - member of the Fendalton/Waimairi Community Board which has delegated responsibilities from the Christchurch City Council. Independence House – Board Member - Independence House is funded through the Ministry of Health to provide Supported Independent Living and residential care for intellectually disabled youth and adults.

Anna Crighton	Christchurch Heritage Trust – Chair - Governance of Christchurch Heritage. Historic Places Aotearoa Inc – President Christchurch Heritage Limited - Chair
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. Heritage NZ – Subscribing Member - Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical & cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. Canterbury DHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with some Canterbury DHB buildings. 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 - Has a private consultancy 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.
Jo Kane	Latimer Community Housing Trust – Project Manager - Delivers social housing in Christchurch for the vulnerable and elderly in the community. Registered Resource Management Act Commissioner - From time to time sits on RMA panels throughout Canterbury. If any conflicts of interest arise from this they will be advised. NZ Royal Humane Society – Director - Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise. HurriKane Consulting – Project Management Partner/Consultant - private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. Key to Life Charitable Trust – undertakes consultancy work for this trust.

Aaron Keown	Christchurch City Council - Shirley Papanui Community Board – Member - elected member and Deputy Chair of the Shirley Papanui Community Board which has delegated responsibilities from the Christchurch City Council. Grouse Entertainment Ltd – Director and Shareholder Grouse Films Ltd – Director Horticultural Society Board - Member
Chris Mene	Christchurch Polytechnic Institute of Technology (CPIT) - Advisory Board Member to Bachelor of Applied Science - CPIT is a tertiary institution and I contribute 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. Canterbury Clinical Network – Child & Youth Workstream 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. Sport Canterbury – Board Member Core Education – Director - Has an interest in the interface between education and health.
Edie Moke	South Canterbury DHB – Board Member - appointed member.
David Morrell	British Honorary Consul - Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of the Canterbury DHB, including Mental Health Services. In addition a conflict of interest may arise from time to time in respect to Coroners' Inquest hearings involving British nationals. Nurses Memorial Chapel Trust –Chair - (Canterbury DHB Appointee) - Trust responsible for Memorial on the Christchurch Hospital site (Note: the chapel is now owned by the CCC). Heritage NZ – Subscribing Member - Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. Canterbury DHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with Canterbury DHB buildings. Hospital Ladies Visitors Association – spouse is a member – no potential conflict of interest is expected and should this arise it will be declared at that time. Honorary Canon- Christchurch Cathedral - The Cathedral congregation runs a food programme in association with Canterbury DHB staff. Great Christchurch Buildings Trust – Trustee - The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing.

Susan Wallace	West Coast DHB – Member - Appointed board member West Coast DHB. Te Rūnanga o Ngāi Tahu - Affiliated Member of TRONT. Māori Women's Welfare League (MWWL) - Member. Poutini Waiora Trust – Chair - a West Coast Maori provider affiliated with He Oranga Pounamu and recipient of Ministry of Health funding. Te Waipounamu MWWL -Area Representative to National Executive of MWWL.

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wendy Dallas-Katoa	Te Kahui o Papaki ka Tai – Deputy Chair, Manawhenua Representative - Maori Advisory Group to Pegasus Health/PHO Manawhenua Ki Waitaha – Chair, Representative of Onuku Runanga - Manawhenua Ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the Canterbury DHB area. There is a memorandum of understanding between Manawhenua and the Canterbury DHB. NSP Kaitiaki Advisory Group – Ministry of Health Appointed Member Whakaruruhau Komiti – National Breastfeeding Maori Advisory Group Community Services Service Level Alliance Pegasus Health Community Board - Member Otago University Christchurch - Maori Strategic Framework advisor
Pauline Barnett	Comcare Charitable Trust - Chair - Mental health and housing St John of God Hauora Trust – Deputy Chair - Disability and Youth Service Burwood Academy for Independent Living - Disability research and service development
Rochelle Faimalo	Hurunui District Council – Employee - As Hurunui Youth Programme Coordinator coordinates youth programmes, running various events and sourcing a variety of funding. Hurunui District Council – Hurunui Youth Council (HYC) - Officer in Charge - oversees HYC, influencing discussions and subjects covered, events, and funding. Pegasus Residents Group Inc – Board Member - Addressing the needs of Pegasus town and residents. Particular interest in youth needs.
Yvonne Palmer	Age Concern Canterbury – Project Coordinator - Staff member responsible for education courses and events. Canterbury Community Justice Panels – Facilitator/Panel Member/Member Steering Group Community service – non-paid.

DISABILITY SERVICES ADVISORY COMMITTEE

Elizabeth Cunningham	Te Runanga Koukourarata – Company Director Rapaki Branch Maori Women's Welfare League – President South Island Maori Cancer Leadership Committee – Chairperson Te Runanga O Ngai Tahu – Director C.E.R.A Recovery Strategy Advisory Committee – Committee Member Canterbury Commanders Police Maori Focus Group – Member Kawa Whakaruruhau Roopu Bachelor of Nursing/Midwifery Committee CPIT – Chairperson Registered RMA (Resource Management Act) Commissioner
Baden Ewart	Better Health Ltd – Shareholder and Director - General practice organisation which holds primary care contracts, and a management contract with West Coast DHB. Rannerdale Trust –Trustee – Veterans' residential care organisation, the management company of which holds contracts with Canterbury DHB. CERA – Deputy Director CCDU (Christchurch Central Development Unit) - Appointee to the Health Precinct Advisory Council; Appointee to the Hospital Redevelopment Partnership Group. Mitchell Notley & Associates – Shareholder and Director - Management services company which, from time to time, may contract with the Canterbury DHB. Spouse – Kathryn Mullock - Employee of Christchurch School of Medicine University of Otago. EA to Professor Tim Anderson who provides clinical services in the Neurology Department.
Susan Foster-Cohen	Dyspraxia Support Group – Patron - Parent Support Group for families/children with dyspraxia. New Zealand Institute of Language Brain and Behaviour – Member - Researcher with NZILBB through Champion Centre partnership. University of Canterbury – Adjunct Associate Professor - Researcher and graduate student supervisor in Linguistics and in Communication Disorders. (Lecturer on short term contracts as needed.) New Zealand Speech Therapy Association – Associate Member - Professional body for Speech and Language therapists. Early Intervention Association of Aotearoa New Zealand – Trustee - Professional Association that aims to support early intervention professionals through professional development and information sharing. Has representation on ECAC and Early Childhood Federation. Champion Centre – Director - Receives funding from both the Ministry of Health and Canterbury DHB.
Ben Lucas	New Zealand Spinal Trust – CEO Parafed Canterbury – Board Member CCS Disability Action Canterbury/West Coast – Patron ACC Serious Injury Advisory Group – Chair - Provides comment on policy, identifies systemic issues, and forms recommendations to present to ACC Executive.

	Halberg Trust - Trustee Paralympics New Zealand – Chef de Mission NZ-Rio 2016 Paralympic Games Team Earthquake Disability Leadership Group – Member - Provides advice and lobbying for an 'accessible and universally re-built Christchurch' post-quakes.
Olive Webb	Private Consulting Business - sometimes work with Canterbury DHB patients and services.

HOSPITAL ADVISORY COMMITTEE

Jan Edwards	Integrated Family Health Service Programme, Canterbury Clinical Network – Project Manager - The programme supports primary care teams to develop integrated models of care that better support at risk individuals in their own communities. The programme is hosted by Pegasus Health (Charitable) Ltd and funded by the Canterbury DHB. To the best of my knowledge this does not present a conflict of interest with my role on HAC but should a conflict arise this will be discussed at the time.
Trevor Read	Lightfoot Solutions Ltd – Global Director of Clinical Services - Lightfoot Solutions has contracts with the Canterbury DHB, and other health providers who have contracts with the Canterbury DHB, to provide business intelligence tools and related consulting services. This should not present a general conflict of interest with my role on the Canterbury DHB, Hospital Advisory Committee, but should a conflict arise this will be discussed at the time.
Ana Rolleston	Manawhenua ki Waitaha – Trustee - Representative of Wairewa Rūnanga. Manawhenua ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the Canterbury DHB area. There is a memorandum of Understanding between Manawhenua ki Waitaha and the Canterbury DHB. Christchurch PHO – Board Member - The Christchurch PHO is mostly funded by either the Ministry of Health and/or the Canterbury DHB. The Christchurch PHO supports General Practitioners delivering primary health care in Christchurch. Māori Women's Welfare League – Member - The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori. South Island Alliance Programme Office, Southern Cancer Network – Inequalities Project Manager (Staff Member) - The Southern Cancer Network is one of four Regional Cancer Networks in New Zealand established to support the implementation of cancer control strategies and action plans in New Zealand and is funded by the Ministry of Health. The Southern Cancer Network works closely with the Nelson/Marlborough DHB, West Coast DHB, Canterbury DHB, South Canterbury DHB and Southern DHB. West Coast Local Cancer Network/Team – Member - The West Coast Local Cancer Network/Team provides a forum for key stakeholders to discuss, debate and plan local cancer initiatives through a partnership approach. Canterbury DHB provides some cancer services to the West Coast.

QUALITY, FINANCE, AUDIT & RISK COMMITTEE

Peter Ballantyne	West Coast DHB – Appointed Member and Board Chair University of Canterbury - Council Member - The University of Canterbury provides certain services to the Canterbury DHB. Deloitte – Retired partner - Deloitte carries out certain consulting assignments for the Canterbury DHB from time to time. Brackenridge Estate Ltd – Director Health Care of the Elderly Education Trust – Trustee - 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. Spouse, Claire Ballantyne is a Canterbury DHB employee (Ophthalmology Department).
Bob Lineham	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. Red Bus Limited – Director. District Energy Scheme – member of the Alliance Committee.
Bill Tate	Pulp Kitchen – Director Pulp Kitchen Catering Limited – Director New Zealand Institute of Management Life Fellows Committee

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 $93,974 to 3 employees (2013/14 – 6 employees totalling $127,342) 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:

	2015 (including benefits) Total	2014 (including benefits) Total
100,000-109,999	170	192
110,000-119,999	131	118
120,000-129,999	92	112
130,000-139,999	79	89
140,000-149,999	63	64
150,000-159,999	52	40
160,000-169,999	50	39
170,000-179,999	33	22
180,000-189,999	23	21
190,000-199,999	33	22
200,000-209,999	19	25
210,000-219,999	26	32
220,000-229,999	23	28
230,000-239,999	32	24
240,000-249,999	22	16
250,000-259,999	18	19
260,000-269,999	26	29
270,000-279,999	24	16
280,000-289,999	13	21
290,000-299,999	17	12
300,000-309,999	15	15
310,000-319,999	20	16
320,000-329,999	10	7
330,000-339,999	12	12
340,000-349,999	9	3
350,000-359,999	8	5
360,000-369,999	4	11
370,000-379,999	2	3
380,000-389,999	1	2
390,000-399,999	1	2
400,000-409,999	3	2
410,000-419,999	4	-
420,000-429,999	-	1
430,000-439,999	1	2
440,000-449,999	3	1
450,000-459,999	-	-
460,000-469,999	2	1
470,000-479,999	-	1
480,000-489,999	1	1
500,000-509,999	-	1
530,000-539,999	-	-
560,000-569,999	1	1
590,000-599,999	1	-
Total	**1,044**	**1,028**

Of the 1,044 (2013/14 1,028) positions identified above, 890 (2013/14 880) positions were predominantly clinical and 154 (2013/14 148) positions were management/administrative.

STATUTORY INFORMATION

This Annual Report outlines the Canterbury DHB's financial and non-financial performance for the year ended 30 June 2015 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 (n) of the same Act.

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

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

GOOD EMPLOYER

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

Leadership, Accountability and Culture

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

Staff Mix by Average Age	Average Age
Medical	41.2
Nursing	46.6
Allied Health	44.2
Support	52.1
Management & Administration	49.1

Staff Mix by Gender	Number	Percentage
Female	7,801	81%
Male	1,807	19%
	9,608	

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

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

Staff Ethnicity	Number
Americas	87
Australian	102
British	708
Chinese	175
Filipino	147
Indian	144
Irish	59
Maori	223
Middle Eastern	28
New Zealand European	5,120
New Zealander	543
Not Stated / Don't Know	1,698
Other	2
Other African	41
Other Asian	153
Other European	234
Pacific Peoples	88
South African	56
	9,608

Integrated Talent Management

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

Workplace Safety, Health and Wellbeing

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by a professional Health Safety and Wellbeing team that includes experts in workplace safety, occupational health and rehabilitation, as well as employee wellbeing. In addition to working with our employees this dedicated team also provides advice and support to management and staff. There is a health monitoring programme which includes screening and immunisation and employees are encouraged to access the Employee Assistance Programme if they are faced with personal problems that may impact their work situation. Wellbeing programmes and activities to encourage and support employees in terms of healthier lifestyles are available throughout the organisation. An employee participation programme that includes health and safety committees and safety training encourages all employees to be responsible for building and maintaining a healthy and safe environment at work. Canterbury DHB continues to participate in the ACC Partnership Programme and is focussed on developing and implementing injury prevention programmes that address high risk areas and in the rehabilitation of employees back to work following an injury or illness. We do not tolerate any form of harassment or workplace bullying and ensure all staff 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

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

Employee Engagement

In June 2013, the Canterbury DHB undertook a staff survey to measure the engagement of our workforce. Employee engagement illustrates the commitment and energy that employees bring to work and is a key indicator of their involvement and dedication to the organisation. International research suggests that highly engaged people put forth 57% more effort and are 87% less likely to leave an organisation. The survey was well represented by all demographics and professional groups. The results demonstrated that 80% of Canterbury's overall workforce is either engaged or highly engaged, with only 2% reported as disengaged. The areas that people reported to be most happy with were:

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

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

Canterbury's focus on engaging and empowering our workforce is evident in our improvement since 2010. Engagement has improved by 2.5% across the board and in all factors measured. Turnover rates also remain relatively low: the average time spent working in Canterbury DHB services is 9.17 years, compared to an average of 8.3 years across all DHBs.

Employee Development

We continue to develop an integrated workforce approach across the Canterbury Health System by engaging with primary and community providers on common HR systems, leadership development and workforce planning. This work is underpinned by a capability framework that has identified the management and leadership knowledge, skills, and behavioural attributes that will be required by all employees as we transform our system. To enable this work we have formed a tertiary alliance with the

University of Otago, the University of Canterbury, and the CPIT, a member of the TANZ network (10 South Island and lower North Island polytechnic institutes) to make available a common curriculum of development to all employees. These programmes are additional to the extensive skills development initiatives that come through the various professional groups for both clinical and non-clinical employees. The rollout of an online performance appraisal process that ensures that all employees are focussed on the right things and expected behaviours at an individual level is continuing in 2015/16. This process also identifies and provides input to the development needs of individuals.

STATEMENT OF RESPONSIBILITY

We are responsible for the preparation of Canterbury DHB financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Canterbury DHB under section 19A of the Public Finance Act 1989. We have not included the end of year performance information on all appropriations as required by this section. As stated in the Statement of Service Performance, the Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of Canterbury DHB for the year ended 30 June 2015.

For and on behalf of the Board

Murray Cleverley
Chair
29 October 2015

Steve Wakefield
Deputy Chair
29 October 2015

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE
FOR THE YEAR ENDED 30 JUNE 2015

	Notes	Group Actual 2015 $'000	Budget 2015 $'000	Actual 2014 $'000
Revenue				
Patient care revenue	2	1,512,862	1,512,642	1,465,170
Other revenue	3	27,379	29,638	32,349
Earthquake repair revenue redrawn from the Ministry of Health	16	13,150	52,000	-
Interest revenue		5,260	7,620	15,795
Total revenue		**1,558,651**	**1,601,900**	**1,513,314**
Expense				
Employee benefit costs	4	659,665	656,865	637,283
Treatment related costs		140,756	142,068	133,379
External service providers		586,846	590,499	584,312
Depreciation and amortisation		61,135	58,330	58,423
Finance costs		5,886	5,772	5,454
Other expenses	5	96,303	95,208	98,385
Earthquake building repair costs	16	13,150	52,000	-
Capital charge expense	6	12,846	13,708	18,990
Total expense		**1,576,587**	**1,614,450**	**1,536,226**
Surplus/(deficit) before Ministry of Health Revenue Deficit Funding		**(17,936)**	**(12,550)**	**(22,912)**
Ministry of Health Revenue Deficit Funding received		**-**	**-**	**22,912**
Surplus/(deficit) after Ministry of Health Revenue Deficit Funding		**(17,936)**	**(12,550)**	**-**
Other comprehensive revenue & expense				
Items that will not be reclassified to surplus/(deficit)				
Impairment of property, plant & equipment	7,14,16	(62)	-	-
Revaluation of property, plant & equipment	7,14	-	-	(383)
Total other comprehensive revenue & expense		**(62)**	**-**	**(383)**
Total comprehensive revenue & expense		**(17,998)**	**(12,550)**	**(383)**

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2015

	Notes	Group Actual 2015 $'000	Group Budget 2015 $'000	Group Actual 2014 $'000
Total equity at beginning of the year		204,373	204,756	536,617
Total comprehensive revenue & expense for the year		(17,998)	(12,550)	(383)
Equity injections:				
Operating deficit support		12,500	12,550	-
Earthquake repair capital redrawn		-	12,000	20,000
Equity repayments:				
Annual depreciation funding repayment		(1,861)	(1,861)	(1,861)
Earthquake insurance remitted to the Ministry of Health		-	-	(290,000)
CDHB capital contribution towards Burwood and Christchurch facilities redevelopment		(120,000)	(120,000)	(60,000)
Total equity at end of the year	7	**77,014**	**94,895**	**204,373**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2015

	Notes	Group Actual 2015 $'000	Budget 2015 $'000	Actual 2014 $'000
CROWN EQUITY				
Contributed Capital	7	(313,790)	(276,742)	(204,429)
Revaluation Reserve	7	199,096	199,541	199,158
Accumulated surpluses	7	191,708	172,096	209,644
TOTAL EQUITY		**77,014**	**94,895**	**204,373**
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8	3,640	42,808	90,044
Trade and other receivables	9	56,827	42,204	75,171
Inventories	10	8,593	8,536	9,128
Restricted assets	17	13,769	9,937	10,674
Investments	11	400	1,221	3,064
TOTAL CURRENT ASSETS		83,229	104,706	188,081
CURRENT LIABILITIES				
HBL sweep bank account	8	9,278	-	-
Trade and other payables	12	83,554	98,704	113,017
Employee benefits	13	160,732	155,047	158,012
Restricted funds	17	14,049	9,937	13,760
Borrowings	18	-	-	15,000
TOTAL CURRENT LIABILITIES		267,613	263,688	299,789
NET WORKING CAPITAL		(184,384)	(158,982)	(111,708)
NON-CURRENT ASSETS				
Investments	11	-	2,090	34,650
Property, plant and equipment	14	401,277	401,020	406,667
Intangible assets	15	12,284	4,506	9,784
Restricted assets	17	280	-	3,086
TOTAL NON-CURRENT ASSETS		413,841	407,616	454,187
NON-CURRENT LIABILITIES				
Employee benefits	13	6,458	7,754	7,121
Borrowings	18	145,985	145,985	130,985
TOTAL NON-CURRENT LIABILITIES		152,443	153,739	138,106
NET ASSETS		**77,014**	**94,895**	**204,373**

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2015

	Notes	Group Actual 2015 $'000	Budget 2015 $'000	Actual 2014 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Ministry of Health		1,468,333	1,474,933	1,447,684
Earthquake repair revenue redrawn from Ministry of Health		12,300	21,000	-
Other receipts		104,369	98,347	75,268
Interest received		5,260	7,620	15,795
		1,590,262	1,601,900	1,538,747
Cash was applied to:				
Payments to employees		657,120	656,865	643,409
Payments to suppliers		862,299	879,775	821,550
Interest paid		5,907	5,772	5,439
Capital charge		12,845	13,708	18,990
GST - net		5,137	-	4,059
		1,543,308	1,556,120	1,493,447
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	46,954	45,780	45,300
CASH FLOW FROM INVESTING ACTIVITIES				
Cash was provided from:				
Sale of property, plant & equipment		10	-	55
Earthquake insurance receipts		-	-	295,250
Receipts from restricted assets & investments		50,998	33,366	24,104
		51,008	33,366	319,409
Cash was applied to:				
Purchase of investments & restricted assets		14,657	-	4,484
Purchase of property, plant & equipment		57,126	42,001	41,694
		71,783	42,001	46,178
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		(20,775)	(8,635)	273,231
CASH FLOW FROM FINANCING ACTIVITIES				
Cash was provided from:				
Loans raised		15,000	-	16,335
Equity injections:				
Operating deficit support		-	12,550	-
Earthquake repair capital redrawn		-	12,000	20,000
		15,000	24,550	36,335
Cash was applied to:				
Loans repaid		15,000	-	-
Equity repayments:				
Earthquake insurance remitted to the Ministry of Health		-	-	290,000
Annual depreciation funding repayment		1,861	1,861	1,861
CDHB capital contribution towards Burwood and Christchurch facilities redevelopment		120,000	120,000	60,000
		136,861	121,861	351,861
NET CASH INFLOW/ (OUTFLOW) FROM FINANCING ACTIVITIES		(121,861)	(97,311)	(315,526)
Net increase/ (decrease) in cash and cash equivalents		(95,682)	(60,166)	3,005
Cash and cash equivalents at beginning of year		90,044	102,974	87,039
CASH & CASH EQUIVALENTS AT END OF YEAR	8	**(5,638)**	**42,808**	**90,044**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2015

1. STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB ("Canterbury DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities (PBEs) for financial reporting purposes.

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. Canterbury DHB does not operate to make a financial return.

The consolidated financial statements of Canterbury DHB consist of Canterbury DHB, its subsidiaries - Canterbury Linen Services Ltd (formerly Canterbury Laundry Service Ltd) (100% owned) and Brackenridge Estate Ltd (100% owned).

The financial statements of Canterbury DHB are for the year ended 30 June 2015 and were authorised for issue by the Board on 29 October 2015.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

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 the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There were no material adjustments arising on transition to the new PBE accounting standards.

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: 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 NZD.

Changes in accounting policies

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

Transition to PBE accounting standards.

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. Canterbury DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Canterbury DHB will apply these updated standards in preparing its 30 June 2016 financial statements. Canterbury DHB expects there will be minimal or no change in applying these updated accounting standards.

Refer to note 28 for adjustments made in preparing the 30 June 2015 financial statements arising from transition to the new PBE accounting standards.

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.

Budget figures

The budget figures are those approved by the Board of Canterbury DHB in its Statement of Performance Expectations. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings and fitout
- plant, equipment and vehicles
- leasehold buildings
- 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.

Revaluations

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 revenue and expense. 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 revenue. Additions to land and buildings between valuations are recorded at cost.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

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 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.

Work in progress is recognised at cost less impairment and is not depreciated.

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 or 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.

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 Buildings	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. Staff training and other costs associated with maintaining computer software are recognised as an expense 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	2-10 years	10 - 50%

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

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.

A receivable is considered impaired when there is evidence that Canterbury DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

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. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

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

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

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.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

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.

Impairment of property, plant, and equipment and intangible assets

Canterbury DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Borrowings

Borrowings are recognised initially at fair value plus transaction costs. Subsequent to initial recognition, borrowings are stated at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Canterbury DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Employee entitlements

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or 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 or 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.

Presentation of employee entitlements

Non vested long service leave and retirement gratuities are classified as non-current liabilities; all other employee entitlements are classified as current liabilities.

Provisions

A provision is recognised when Canterbury DHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

ACC Partnership Programme

Canterbury DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme Canterbury DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, Canterbury DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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

Trade and other payables

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

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.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Contributed capital;
- Revaluation reserve; and
- Accumulated surpluses/(deficits).

Revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

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.

The net GST paid to, or received from Inland Revenue, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed as exclusive of GST.

Revenue

The specific accounting policies for significant revenue items are explained below.

Ministry of Health population-based revenue

Canterbury DHB receives annual funding from the Ministry of Health, which is based on population levels within the Canterbury DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

Ministry of Health contract revenue

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Canterbury DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the Ministry of Health to receive or retain funding.

Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the Ministry of Health. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Inter-district flows

Inter-district patient inflow revenue occurs when a patient treated within Canterbury DHB's district is domiciled outside of the district. Inter-district patient inflow revenue is recognised when eligible services are provided.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Lease revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of other services

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion at the balance date, based on the actual service provided as a percentage of the total services to be provided.

Donations and bequests

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.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Donated services

Volunteer services received are not recognised as revenue or expenses by the group.

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 or 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 or 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 accounting estimates and assumptions

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. Any adjustments are disclosed in note 14.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the surplus or 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. Further information is disclosed in note 13.

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. Further information is disclosed in note 20.

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 CARE REVENUE

	Group	
	2015 $'000	**2014 $'000**
Ministry of Health population based funding	1,258,622	1,226,889
Inter-district flows	100,549	90,332
Ministry of Health other contracts	105,309	105,300
ACC revenue	25,749	23,395
Other patient related revenue	22,633	19,254
	1,512,862	**1,465,170**

3. OTHER REVENUE

	Group	
	2015 $'000	2014 $'000
Gain/(loss) on sale of property, plant and equipment	(63)	39
Donations and bequests received	586	3,367
Insurance revenue	4	3,028
Pathology tests	7,155	7,307
Research & development	5,128	5,030
External rental revenue	1,439	1,381
Meals on Wheels	1,005	911
Other	12,125	11,286
	27,379	**32,349**

4. EMPLOYEE BENEFIT COSTS

	Group	
	2015 $'000	2014 $'000
Wages and salaries	653,076	639,421
Contributions to defined contribution plans	4,532	4,303
Increase/(decrease) in employee benefit provisions	2,057	(6,441)
	659,665	**637,283**

Employer contributions to defined contribution plans include contributions to KiwiSaver, the State Sector Retirement Savings Scheme, the Government Superannuation Fund, and the DBP Contributors Scheme.

5. OTHER EXPENSES

	Group	
	2015 $'000	2014 $'000
Remuneration of auditor:		
Financial statement audit fees	231	253
Board members' fees	419	324
Directors' fees	83	49
Rental costs	6,919	6,765
Facilities and infrastructure costs (note 16)	47,832	52,459
Other non-clinical costs	40,819	38,535
	96,303	**98,385**

6. CAPITAL CHARGE

Canterbury DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the year ended June 2015 was 8%. (June 2014 8%).

7. EQUITY

	Group 2015 $'000	Group 2014 $'000
Contributed capital		
Opening balance	(204,429)	127,432
Annual depreciation funding repayment	(1,861)	(1,861)
Earthquake insurance remitted to the Ministry of Health	-	(290,000)
CDHB capital contribution towards Burwood and Christchurch facilities redevelopment	(120,000)	(60,000)
Operating deficit support	12,500	-
Earthquake repair capital redrawn	-	20,000
Closing balance	**(313,790)**	**(204,429)**

In accordance with IPSAS 1, repayments of capital to the Crown, as well as contributions from the Crown under Vote Health capital appropriations, are recorded in Contributed capital.

Accumulated surplus/(deficit)		
Opening balance	209,644	209,644
Operating surplus/(deficit)	(17,936)	-
Closing balance	191,708	209,644
Represented by:		
Accumulated surplus in parent and subsidiaries	191,630	209,566
Accumulated surplus in associates	78	78
	191,708	**209,644**
Revaluation reserve		
Opening balance	199,158	199,541
Impairment charges	(62)	-
Revaluation of land, building including fitout	-	(383)
Closing balance	199,096	199,158
Represented by:		
Revaluation of land	86,109	86,109
Revaluation of buildings including fitout	112,987	113,049
	199,096	**199,158**
Total equity	**77,014**	**204,373**

8. CASH AND CASH EQUIVALENTS

	Group	
	2015 $'000	2014 $'000
Current assets		
Bank balances and call deposits	3,040	595
HBL sweep bank account	-	89,294
Term deposits less than 3 months	600	155
	3,640	**90,044**
Current liabilities		
HBL sweep bank account	(9,278)	-
	(9,278)	**-**

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

Bank facility
Canterbury DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at a credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Canterbury DHB that equates to $84.049M (2014 $78.600M).

As from 1 July 2015, the operations of Health Benefits Limited transferred under the Health Sector (Transfers) Act 1993 to a new company called NZ Health Partnerships Ltd.

9. TRADE AND OTHER RECEIVABLES

	Group	
	2015 $'000	2014 $'000
Trade receivables	11,508	13,287
Receivable from the Ministry of Health	33,557	49,830
Prepayments	3,987	3,221
Other receivables	7,775	8,833
	56,827	**75,171**

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.

Trade receivables, prepayments and other receivables are from exchange revenue transactions. Receivables from the Ministry of Health are a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in Receivables from the Ministry of Health is $13.513M ($22.912M 2014).

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

	Group	
	2015 $'000	**2014 $'000**
Balance at 1 July	3,067	3,312
Additional provisions made during the year	549	680
Receivables written-off during period	(868)	(925)
Balance at 30 June	**2,748**	**3,067**

The ageing of the impairment provisions are as follows:

	Group	
	2015 $'000	**2014 $'000**
Current	403	159
1-30 days	164	565
31-60 days	258	202
> 61 days	1,923	2,141
Balance at 30 June	**2,748**	**3,067**

As at 30 June 2015 and 2014, all overdue receivables have been assessed for impairment and appropriate provisions have been applied. The net ageing of receivables are:

	Group	
	2015 $'000	**2014 $'000**
Current	48,525	68,703
1-30 days	2,856	3,606
31-60 days	598	210
> 61 days	861	(569)
Balance at 30 June	**52,840**	**71,950**

10. INVENTORY

	Group	
	2015 $'000	**2014 $'000**
Pharmaceuticals	1,846	2,203
Surgical and medical supplies	4,965	4,878
Other supplies	3,086	3,220
	9,897	10,301
Provision for obsolescence	(1,304)	(1,173)
	8,593	**9,128**

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	
	2015 $'000	**2014 $'000**
Current investments are represented by:		
Term deposits	400	3,064
Total current investments	400	3,064
Non-current investments are represented by:	-	-
Term Deposits	-	34,650
Total non-current investments	-	34,650
	400	**37,714**

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	
	2015 $'000	**2014 $'000**
Term deposits with maturities of 3-12 months	400	3,064
Weighted average effective interest rates	3.72%	4.29%
Term deposits with maturities later than 1 year but no more than 5 years	-	34,650
Weighted average effective interest rates	0%	5.31%

The carrying amounts of term deposits with maturities less than 12 months approximate their fair value.

Investment in associates

a) General information

Name of entity	Principal activities	Interest held 2015	Balance date
South Island Shared Service Agency Limited	Non Trading Company	47%	30 June

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

b) Share of associates' contingent liabilities and commitments

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

Investments in subsidiaries

At 30 June 2015 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 DHBs (Counties Manukau, Auckland, Waitemata and Canterbury) established a national Health Innovation Hub. The Hub engages with the DHBs, clinicians and industry to collaboratively realise and commercialise products and services that can make a material impact on healthcare in NZ and internationally.

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

12. TRADE AND OTHER PAYABLES

	Group	
	2015 $'000	2014 $'000
Trade payables	14,998	15,412
Other payables	68,556	97,605
	83,554	**113,017**

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.

Trade payables are from exchange transactions. The value of non-exchange balances in Other payables is $1.154M ($10.189M 2014).

13. EMPLOYEE BENEFITS

	Group	
	2015 $'000	2014 $'000
Current liabilities		
Annual leave accruals	70,904	68,226
Unpaid days accruals	11,179	8,678
ACC accruals	8,577	8,318
Conference/sabbatical leave and expenses	24,763	24,692
Sick leave	10,647	10,406
Other	34,662	37,692
	160,732	**158,012**
Non-current liabilities		
Liability for long service leave	4,174	4,236
Liability for retirement gratuities	2,284	2,885
	6,458	**7,121**

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

14/15 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation						
Balance at 1 July 2014	123,338	292,664	223,403	409	6,494	646,308
Additions	7,850	8,445	10,690	-	24,575	51,560
Disposals/transfers	-	(10)	(36,106)	-	(105)	(36,221)
Revaluation	-	-	-	-	-	-
Balance at 30 June 2015	**131,188**	**301,099**	**197,987**	**409**	**30,964**	**661,647**
Depreciation & impairment losses						
Balance at 1 July 2014	-	65,601	173,742	298	-	239,641
Depreciation	-	40,820	15,894	70	-	56,784
Revaluation	-	-	-	-	-	-
Impairment	-	62	-	-	-	62
Disposals/transfer	-	(1)	(36,116)	-	-	(36,117)
Balance at 30 June 2015	**-**	**106,482**	**153,520**	**368**	**-**	**260,370**

13/14 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation						
Balance at 1 July 2013	123,338	266,688	214,169	1,267	11,380	616,842
Additions	-	26,978	13,480	-	-	40,458
Disposals/transfers	-	(1,002)	(4,246)	(858)	(4,886)	(10,992)
Revaluation	-	-	-	-	-	-
Balance at 30 June 2014	**123,338**	**292,664**	**223,403**	**409**	**6,494**	**646,308**
Depreciation & impairment losses						
Balance at 1 July 2013	-	27,026	161,247	1,086	-	189,359
Depreciation	-	39,182	16,779	70	-	56,031
Revaluation	-	383	-	-	-	383
Impairment	-	-	-	-	-	-
Disposals/transfer	-	(990)	(4,284)	(858)	-	(6,132)
Balance at 30 June 2014	**-**	**65,601**	**173,742**	**298**	**-**	**239,641**

Carrying amount	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
At 1 July 2014	123,338	227,063	49,661	111	6,494	406,667
At 30 June 2015	**131,188**	**194,617**	**44,467**	**41**	**30,964**	**401,277**

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.

Revaluation
Canterbury DHB revalued its land, buildings and plant fitouts as at 30 June 2013. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of Telfer Young (Canterbury) Ltd), which is consistent with NZ IAS 16 Property Plant & Equipment. The movements in land and buildings and plant fitout were recognised in the Revaluation Reserve. See note 16 for further details.

Canterbury DHB owns land which it had allowed a third party to construct a car park on. In lieu of rental foregone, ownership of the car park building was to revert to Canterbury DHB in 2019. This was a reversionary interest that was valued as at 30 June 2010, however was impaired due to earthquake damage in 2012. Due to significant damage to the carpark, Canterbury DHB negotiated with the third party on a settlement that resulted in ownership of the car park building reverting back to Canterbury DHB in late 2014.

15. INTANGIBLE ASSETS

	Group	
	2015 $'000	**2014 $'000**
Software		
Cost		
Opening balance	29,340	23,918
Additions	5,568	5,422
Disposals	(110)	-
Closing balance	34,798	29,340
Amortisation and impairment losses		
Opening balance	24,208	21,873
Amortisation charge for the year	4,351	2,392
Disposals	(109)	(57)
Closing balance	28,450	24,208
Health Benefits Limited	5,936	4,652
Carrying amounts	**12,284**	**9,784**

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 2015. There has been no change since last year.

Canterbury DHB has made payments totalling $1.283M in the year to 30 June 2015 (2014: $1.659M) to Health Benefits Limited (HBL) in relation to the capital requirements of the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by HBL, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

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

- Class B Shares confer no voting rights.
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services.
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service.

- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company.
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

The rights attached to "B" Class shares include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and, therefore, the benefits conferred through this access. The service level agreement will contain five provisions specific to the recognition of the investment within the financial statements of DHBs. The five provisions are:

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

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

As from 1 July 2015, the operations of Health Benefits Limited transferred under the Health Sector (Transfers) Act 1993 to a new company called NZ Health Partnerships Ltd.

16. IMPAIRMENT AND THE EFFECTS OF THE CANTERBURY EARTHQUAKES

A 7.1 magnitude earthquake occurred in the Canterbury region on 4 September 2010, with subsequent large aftershocks, including a 6.3 magnitude earthquake on 22 February 2011, and a further 6.3 magnitude earthquake on 13 June 2011. These events caused significant damage to many of Canterbury DHB's buildings and assets. Damage was sustained to more than 200 buildings, and over 14,000 rooms required some level of repair. Additionally, Canterbury DHB needed to install a number of temporary infrastructure facilities to ensure continued operations, such as emergency boilers, and water supplies for fire sprinkler systems.

Canterbury DHB had structural engineers since the initial earthquake in 2010 to assess the amount of damage to Canterbury DHB's buildings and assets. Detailed building by building assessments were completed, and over $500M of earthquake related repairs were identified to bring the buildings back to the same or better condition than they were in prior to the earthquakes.

While the DHB has received assessments on the level of damage to its buildings, it continues to receive regular updated damage assessments and continues to work through how and what repairs will be undertaken. As repair work progresses, additional damage is being discovered. As a result, the estimated cost to repair our buildings could increase.

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

Canterbury DHB continually reviews whether the carrying value of land and buildings exceeds their recoverable amount. Our land and buildings were revalued as at 30 June 2013, although this valuation excluded damage in relation to our buildings being out of level. As a result, as at 30 June 2013, the DHB recognised a $25.108M asset impairment for those buildings it intended to re-level 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.

Existing assets were further reviewed for impairment as at 30 June 2014, but no further impairment was deemed necessary, and were again reviewed for impairment as at 30 June 2015, and an impairment of $0.062M was recognised.

For buildings, where the recoverable amount is determined on a depreciated replacement cost basis, Canterbury DHB has based the impairment on the best available estimate of the likely repair costs to restore buildings to their previous condition, excluding any ancillary operating cost increases, but this impairment does not reflect the full cost of making buildings compliant with the new building code.

Repair costs for buildings that have been impaired due to the earthquakes which resulted in an increase in service potential have been capitalised.

Canterbury DHB incurred a range of other earthquake related costs for the year to 30 June 2015, including outsourced surgery, aged residential care costs, additional community mental health services, acute demand programs, after hours care, as well as other community based costs. The Ministry of Health has committed to provide earthquake support of $12.500M (2014: $22.912M) to cover a deficit that Canterbury DHB would otherwise have incurred as a direct result of these costs. This $12.500M has been recorded as a capital contribution from the Crown, and differs from the funding received for the 2014 financial year and prior, which was recorded as additional revenue. The $12.500M 2015 contribution is unpaid as at 30 June 2015, and sits as a receivable from the Ministry of Health in our results at that date.

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

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

From 1 July 2013 new insurance policies were placed for all of the 20 DHBs 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 DHBs, unless and until repairs have been completed. This, in the event of further earthquake damage, materially limits insurance coverage, and therefore likely recoveries.

Agreement with Ministry of Health

As part of an agreement with the Ministry of Health, $290M of insurance revenue (being the unspent portion of the earthquake insurance proceeds) was paid to the Ministry of Health in June 2014. Canterbury DHB is able to draw down funds up to $290M from the Ministry of Health over future periods to cover earthquake repair costs incurred. The first draw down of $20M was made in June 2014, with a further $13.150M drawn down in the 2015 financial year, leaving a further $256.850M that can be drawn upon in future periods to cover earthquake repair costs. The variance between the actual and budget draw down of repair revenue is due to the timing of repairs, and correlates to lower than budget repair costs.

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	
	2015 $'000	**2014 $'000**
Balance at beginning of year	13,760	14,766
Interest received	702	889
Donations and funds received	1,448	2,589
Funds spent	(1,861)	(4,484)
Balance at end of year	**14,049**	**13,760**

Residents' trust accounts	Group	
	2015 $'000	**2014 $'000**
Residents' trust account balance	**914**	**954**

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's own financial statements.

18. BORROWINGS

	Group	
	2015 $'000	**2014 $'000**
Current		
Ministry of Health loans	-	15,000
Total current borrowings	**-**	**15,000**
Non-current		
Ministry of Health loans	145,985	130,985
Total non-current borrowings	145,985	130,985
Total borrowings	**145,985**	**145,985**

The Ministry of Health 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	
	2015 $'000	**2014 $'000**
Ministry of Health loans		
Less than one year	-	15,000
Weighted average effective interest rate	*0%*	*6.13%*
Later than one year but not more than five years	40,000	40,000
Weighted average effective interest rate	*3.39%*	*3.39%*
Later than five years	105,985	90,985
Weighted average effective interest rate	*3.97%*	*4.06%*

Security
The Ministry of Health loans are secured by a negative pledge. Without the Ministry of Health's prior written consent Canterbury DHB cannot perform the following actions:

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

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

	Group	
	2015 $'000	2014 $'000
Net (deficit)/ surplus	(17,936)	-
Add back non-cash items:		
Depreciation and amortisation	61,135	58,423
Donated assets	(281)	(1,058)
Add back items classified as investing activities:		
Loss/(Gain) on asset sale	63	(39)
	42,981	57,326
Movement in term portion provisions/staff entitlements	(663)	(633)
Movements in working capital:		
Decrease/(increase) in receivables & prepayments	30,844	3,579
Decrease/(increase) in stocks	535	(1,145)
Increase/(decrease) in creditors & other accruals	(29,463)	(8,334)
Increase/(decrease) in staff entitlements	2,720	(5,493)
Net cash inflow/(outflow) from operating activities	**46,954**	**45,300**

20. COMMITMENTS

	Group	
	2015 $'000	2014 $'000
Capital commitments		
Property	70,241	73,732
Intangible assets	30,516	7,053
Other capital commitments	14,079	11,941
Total capital commitments at balance date	**114,836**	**92,726**
Non-cancellable operating lease commitments		
Accommodation leases	39,455	10,340
Total non-cancellable operating lease and supply commitments	**39,455**	**10,340**
For expenditure within:		
Not later than one year	5,323	2,746
Later than one year and not later than five years	14,955	6,957
Later than five years	19,177	637
	39,455	**10,340**

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.

Of the non-cancellable operating lease commitments $28M relates to the lease of new office space at 32 Oxford Terrace due to the planned shift of all services from the existing Princess Margaret Hospital site commencing early 2016.

21. CONTINGENCIES

For the year ended 30 June 2015:

Contingent assets
Canterbury DHB has no contingent assets at year end.

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

- Outstanding legal proceedings
  The Group has no outstanding legal proceedings.

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

- Canterbury earthquakes
  In respect of the Canterbury earthquakes there are a number of repair 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 for further information.

- Land and building contamination
  Canterbury DHB owns land and buildings that are or may be potentially contaminated. Canterbury DHB is continually assessing the likelihood of actual contamination when it undertakes repairs and maintenance activities. The uncertainty as to the actual contamination, and what associated costs of remediation are probable, means that the future liability cannot be reasonably estimated.

For the year ended 30 June 2014:

Contingent assets
Canterbury DHB has no contingent assets at year end.

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

- Outstanding legal proceedings
  The Group has no outstanding legal proceedings.

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

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

22. CATEGORIES OF FINANCIAL ASSETS AND LIABILITIES

	Group	
	2015 $'000	**2014 $'000**
Loans and receivables		
Cash and cash equivalents	3,640	90,044
Debtors and other receivables	56,827	75,171
Term deposits (term>3 months)	400	37,714
Total loans and receivables	**60,867**	**202,929**
Fair value through profit and loss		
Restricted assets	14,049	13,760
Restricted liabilities	(14,049)	(13,760)
Total fair value through profit and loss	**-**	**-**
Other financial liabilities		
Overdraft	9,278	-
Creditors and other payables	83,554	113,017
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	145,985	145,985
Total other financial liabilities	**238,817**	**259,002**

23. FINANCIAL INSTRUMENT RISKS

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

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

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

The Board places its cash and term investments with high quality financial institutions via a National DHB shared banking arrangement, facilitated by Health Benefits Limited (refer note 8).

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 2015, the Ministry of Health owed Canterbury DHB Group $33.557M (2014 $49.830M).

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 that can be assessed by reference to Standard and Poor's credit rating (if available) or to historical information about counterparty default rates.

	Group	
	2015 $'000	**2014 $'000**
Counterparties with credit rating		
Cash		
AA	3,640	750
Term deposits		
AA	-	-
AA-	400	37,714
Total cash at bank and term deposits	**4,040**	**38,464**
Restricted assets		
A	-	-
A+	100	350
A-	200	200
AA	280	280
AA-	13,453	12,714
BBB+	-	200
Unrated	16	16
Total restricted assets	**14,049**	**13,760**
Counterparties without credit rating		
Balance with Health Benefits Limited		
Existing counterparty with no defaults in the past	(9,278)	89,294
Total balance with Health Benefits Limited	**(9,278)**	**89,294**
Debtors and other receivables		
Existing counterparty with no defaults in the past	56,827	75,171
Total debtors and other receivables	**56,827**	**75,171**

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 2015 (2014: nil)

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

Canterbury DHB has a maximum amount that can be drawn down against its loan facility of $146.401M (2014 $146.401M).

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
14/15 financial year						
HBL sweep bank account	9,278	9,278	9,278	-	-	-
Creditors and other payables	83,544	83,544	83,544	-	-	-
Borrowings Ministry of Health loans	145,985	180,596	5,560	5,560	54,926	114,550
Restricted liabilities	14,049	14,049	14,049	-	-	-
Total	**252,856**	**287,467**	**112,431**	**5,560**	**54,926**	**114,550**
13/14 financial year						
HBL sweep bank account	-	-	-	-	-	-
Creditors and other payables	113,017	113,017	113,017	-	-	-
Borrowings Ministry of Health loans	145,985	182,438	16,074	10,825	54,749	100,790
Restricted liabilities	13,760	13,760	10,674	2,040	-	1,046
Total	**272,762**	**309,215**	**139,765**	**12,865**	**54,749**	**101,836**

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
14/15 financial year						
Cash and cash equivalents	3,640	3,640	3,640	-	-	-
Debtors and other receivables	56,827	59,575	59,575	-	-	-
Term deposits (term > 3 months)	400	400	400	-	-	-
Restricted assets	14,049	14,049	13,769	280	-	-
Total	**74,916**	**77,664**	**77,384**	**280**	**-**	**-**
13/14 financial year						
Cash and cash equivalents	90,044	90,044	90,044	-	-	-
Debtors and other receivables	75,171	75,171	75,171	-	-	-
Term deposits (term > 3 months)	37,714	37,714	-	3,064	34,650	-
Restricted assets	13,760	13,760	10,674	2,040	-	1,046
Total	**216,689**	**216,689**	**175,889**	**5,104**	**34,650**	**1,046**

Sensitivity analysis

The table below illustrates the potential effect on the surplus or deficit for reasonable 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			
	2015 $'000		2014 $'000	
Foreign exchange risk	**-10% Surplus**	**+10% Surplus**	**-10% Surplus**	**+10% Surplus**
Financial assets				
Foreign currency	(49)	49	(22)	22
Total sensitivity	**(49)**	**49**	**(22)**	**22**

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 (Level 1).

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

	Group	
	2015 $'000	2014 $'000
Financial assets		
Restricted assets	14,049	13,760
Financial liabilities		
Borrowing- Ministry of Health loans (previously Crown Health Financing Agency loans)	145,985	143,367
Restricted liabilities	14,049	13,760

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 arm's 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 $1,504.5M to provide health services in the Canterbury area for the year ended 30 June 2015 (2014: $1,486.7M).

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 $ 114.8M for the year ended 30 June 2015 (2014 $106.9M, 30 June 2014). Expenditure to other DHBs for their care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $ 38.2M for the year ended 30 June 2015 (2014 $34.6M).

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 2015 totalled $12.8M ($15.3M, 30 June 2014). These purchases included the purchase of services from ACC, Genesis Power New Zealand Limited, and Air New Zealand Limited.

Canterbury DHB subsidiaries
Canterbury DHB has the following subsidiaries as of 30 June 2015;

- Canterbury Linen Services Limited
- Brackenridge Estate Limited

Key management personnel
Key management personnel include all Board members, the Chief Executive and the other ten members of the executive management team.

Compensation of key management personnel:

	Group	
	2015 $'000	**2014 $'000**
Salaries & other short term employee benefits	3,697	3,403
Post-employment benefits	117	103
Total key management personnel compensation	**3,814**	**3,506**

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.

Key management personnel full time equivalents

	Group	
	2015	**2014**
Full time equivalent Board Members	1.08	1.24
Full time equivalent Leadership Team	10.75	11.0
Total key management personnel full time equivalents	**11.83**	**12.24**

The full-time equivalent for Board members has been determined based on the attendance and length of Board meetings and the estimated time for Board members to prepare for meetings.

West Coast DHB
Canterbury DHB provides key management personnel services (including Chief Executive services) under contract to the West Coast DHB. Canterbury DHB charges the West Coast DHB for these services – 2015 $0.300M (2014 $0.300M). The amount owing by West Coast DHB relating to this agreement at balance date was $0.028M (2014 $0.028M).

26. SUBSEQUENT EVENTS

There were no events after 30 June 2015 which could have a material impact on the information in Canterbury DHB's financial statements.

27. MAJOR VARIANCES TO BUDGET

Statement of comprehensive revenue and expense
The variance between actual and budget "Earthquake repair revenue redrawn from the Ministry of Health" is due to the timing of earthquake repairs, and the categorisation of these repair costs as either operating or capital expenditure. This is offset by an equal and opposite variance in "Earthquake building repair costs".

Additional costs relating to increased demand in mental health have affected a number of expense categories including employee benefit costs, which is the main reason why our actual deficit is higher than our planned deficit.

Depreciation is higher than budget due to the unplanned earthquake repairs that have been capitalised.

Statement of changes in /equity
As noted above, our actual deficit is higher than our planned deficit, mainly as a result of increased demand in mental health expenses.

The earthquake repair capital redrawn budgeted for the year of $12M did not occur until after the end of the financial year, as cashflow did not require an earlier draw down.

Statement of financial position
Cash and cash equivalents, as well as the HBL sweep bank account, are below plan mainly due to:

- additional costs incurred as a result of increased demand in mental health, and
- the earthquake repair capital redrawn of $12M taking place after year end, and
- the $12.5M operating deficit support received after year end, and
- a reduction in trade and other payables.

Trade and Other Receivables are above plan due to the $12.5M operating deficit support accrued at year end, rather than received prior to year end as originally forecast.

28. ADJUSTMENTS ARISING ON TRANSITION TO THE NEW PUBLIC BENEFIT ENTITY (PBE) ACCOUNTING STANDARDS

Reclassification adjustments
There have been no reclassifications on the face of the financial statements in adopting the new PBE accounting standards.

Recognition and measurement adjustments
There have been no recognition and measurement adjustments in adopting the new PBE accounting standards.

SUMMARY OF REVENUES AND EXPENSES BY OUTPUT CLASS

Group	Actual 2015 $'000	Budget 2015 $'000
Early detection & management	324,188	334,222
Intensive assessment & treatment	977,122	1,004,477
Prevention	29,040	30,658
Support & rehabilitation	228,301	232,543
Total revenue	**1,558,651**	**1,601,900**
Early detection & management	327,488	336,016
Intensive assessment & treatment	986,940	1,013,904
Prevention	31,142	30,841
Support & rehabilitation	231,017	233,689
Total expenditure	**1,576,587**	**1,614,450**
Surplus/(Deficit)	**(17,936)**	**(12,550)**

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
Canterbury District Health Board group's financial statements
and statement of performance
for the year ended 30 June 2015

The Auditor-General is the auditor of Canterbury District Health Board and its subsidiaries (collectively referred to as 'the group'). The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the statement of performance, including the performance information for appropriations of the group, on her behalf.

We have audited:

- the financial statements of the group on pages 47 to 83, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive revenue and expense, 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 performance of the group, that comprises the statement of performance (referred to in the group's annual report as the 'statement of service performance') on pages 10 to 30 and the summary of revenues and expenses by output class on page 84.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the group:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2015; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Tier 1 public benefit entity accounting standards.

Qualified opinion on the statement of performance because of limited controls on information from third-party health providers

Some significant performance measures of the group, (including some of the national health targets, and the corresponding district health board sector averages used as comparators),

rely on information from third-party health providers, such as primary health organisations. The group's control over much of this information is limited, and there are no practicable audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the statement of performance of the group for the year ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effects of the matters described above, the statement of performance of the group on pages 10 to 30 and on page 84.

- presents fairly, in all material respects, the group's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 29 October 2015. 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 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 the statement of performance are free from material misstatement.

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and the statement of performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and the statement of performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the group's financial statements and statement of performance 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 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 appropriateness of the reported performance information within the group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the statement of performance; and
- the overall presentation of the financial statements and the statement of performance.

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

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 statement of performance that:

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

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

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

publication of the financial statements and the statement of performance, whether in printed or electronic form.

Responsibilities of the Auditor

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

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

In addition to the audit, we have completed an audit of a group subsidiary on request. This audit was compatible with those independent requirements.

Other than this audit and the audit of a group subsidiary completed on request, we have no relationship with or interests in the group or any of its subsidiaries.

Julian Tan
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand