CDHB Annual Report

for the year ended 30 June 2014

THE CANTERBURY HEALTH SYSTEM

working together to make it better

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

OUR MISSION

TĀ MĀTOU MATAKITE

- To improve, promote, and protect the health and well-being of the Canterbury community
- 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

NGĀ HUARAHI MAHI

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

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Board Members
Murray Cleverley – Chair (from 10 December 2013)
Steve Wakefield – Deputy Chair (from 10 December 2013)
Sally Buck (from 10 December 2013)
Anna Crighton
Andrew Dickerson
Jo Kane (from 10 December 2013)
Aaron Keown
Edie Moke (from 10 December 2013)
Chris Mene
David Morrell
Susan Wallace

Bruce Matheson – Chair (until 9 December 2013)
Peter Ballantyne – Deputy Chair (until 9 December 2013)
Elizabeth Cunningham (until 9 December 2013)
Wendy Gilchrist (until 9 December 2013)
Olive Webb (until 9 December 2013)

Chief Executive
David Meates

Registered Office
2nd Floor, H Block
The Princess Margaret Hospital
Cashmere Road
Christchurch

Auditor
Audit New Zealand on behalf of the Auditor-General

Banker
Westpac Banking Corporation

REPORT FROM THE CHAIR AND CHIEF EXECUTIVE

The Canterbury Health System has risen to meet some near impossible challenges during this past year as we continue to manage the consequences of the earthquakes. We can all be proud of our outstanding successes and achievements during the 2013/14 financial year, against a backdrop of broken buildings, an ageing population and a stressed community.

People working across the Canterbury Health System deserve huge credit for maintaining world-leading services to our population and stepping up to each new challenge our environment and the ongoing transformation of our health system presents.

Building and Redevelopment
We have embarked on a massive repair and redevelopment building programme, on a scale never before seen in New Zealand. An insurance payout of $320M in October, and the Government's commitment to the $650M for Burwood and Christchurch Hospital developments, has created a unique opportunity to create sustainable health facilities that will allow us to provide services in new ways to respond to the changing needs of Cantabrians.

Things are tough now for many of our staff and our community, but we face a bright future as we continue to develop services and facilities close to people's homes that support people to stay well in their own communities. Here are some of the things we can all look forward to:

- The Design Lab has attracted visitors from all over the world – people have been fascinated to see the 'ground-up' design of facilities to support patient-centred care. The low fidelity cardboard mock-ups have allowed us to 'road test' our ideas before we finalise the design of each state of the art facility.
- By 2018 we will have a new Acute Services Building on the Christchurch Hospital site with modern, purpose-built operating theatres; around 400 inpatient beds, including purpose-designed spaces for children; an expanded intensive care, radiology and emergency department and a roof-top helipad.
- At Burwood purpose-designed facilities will support new ways of working for those providing treatment and care for the growing ranks of older people requiring hospital level rehabilitation and care. These are due to open in early 2016.
- On the Hillmorton site staff have moved into the refurbished Fergusson Building. Oral Health services are set to move from Christchurch Hospital to a refurbished facility on the Hillmorton site and staff, patients and their families are appreciating the more open and remodelled adult mental health inpatient unit.
- Rural Canterbury too is set to benefit from significant investment in our province's health.
- It was a privilege to attend a dawn ceremony in Kaikoura as part of the preparations for their new, eagerly awaited $13M Integrated Family Health Centre. The target date for completion is 2016.
- Birthing and post natal facilities will be among the first of a range of services available when phase one of the new Rangiora Health Hub is completed next year.
- The old outpatients and therapy services building in Ashburton have both been demolished and the design for new facilities is well advanced.
- A business case for Akaroa's Integrated Family Health Centre is being prepared by a specially formed community group. Concept designs are complete and cost estimates are underway. Due diligence around site selection has been completed.

- The new Health Precinct will be located adjacent to Christchurch Hospital. It will help boost our health workforce and provide unique opportunities for cutting edge research and enhance the links between health and education.
- It's intended that our new outpatients facility will be located close to the hospital but within the Health Precinct.
- Car parking emerged as one of the hot topics this year. A new car parking building in St Asaph Street near the hospital is scheduled to open in 2015, and we are working with other agencies to ensure there is adequate parking near both redeveloped Christchurch sites.

At the cutting edge of health innovation

Key to improving the patient experience and reducing waiting and wastage is the provision of reliable, real time information.

HealthPathways has been developed as the principal source of information about Canterbury Health System services for general practice teams. It has been developed by Canterbury Initiative health professionals who are currently involved in the care of Canterbury patients. There are now over 764 clinical pathways and extended support information, leading to consistent management of common conditions.

Shared Care View (eSCRV) has been developed in partnership with Orion Health and Pegasus Health, one of many examples of what can achieved by building health system alliances. eSCRV is a finalist in the Business Innovation category of the 2014 Champion Canterbury Awards. eSCRV was born in the aftermath of the earthquakes which highlighted the need for health professionals to be able to access key patient information at the point of care. Because key clinical groups now have access to the same consistent set of health information, we are tackling the biggest source of waste in health today – people's time. eSCRV enables faster, safer and better informed care wherever and whenever it is needed. Its potential is huge – preparations are well underway that could make it suitable as a solution for secure health information sharing across the South Island and beyond.

Another key achievement has been the new Canterbury DHB website – www.cdhb.health.nz. Creating a workable website for a health system as extensive as ours was a massive undertaking, and special thanks must go to the team of web content editors and publishers from across the Canterbury DHB who work hard to ensure content remains fresh, up to date, accessible and relevant. We have also made significant improvements to HealthInfo – www.healthinfo.org.nz , a website dedicated to providing free and trustworthy health information written specifically for Canterbury people by local health professionals.

eMeds comprises a suite of initiatives that enhance patient safety and enables more efficient and effective medication management. This year we put in the groundwork for a range of innovations and prepared the way for the launch of the first initiative to be ready for use by clinicians at Hillmorton Adult Inpatient services. Put simply, e-Prescribing using MedChart records a patient's meds in a single electronic drug chart that drastically reduces the chances of accidental error, without replacing clinical judgement.

This year we entered the 'proof of concept phase' in developing our own Patient Portal, which will, for the first time, give people direct access to some of their own health data through a home computer or portable smart device. Trials with 50+ members of the public began in August 2014.

A community under stress

The health of Cantabrians has been well and truly put to the test over the past three and a half years. Nowhere is this more evident than in mental health services.

There has been a 35% increase in new patients for psychiatric emergency services since 2011, and a 40% increase demand for our child and youth community mental health services. Every month we see an average of 400 patients needing emergency psychiatric treatment.

Research released by the Canterbury DHB-supported All Right? campaign in June showed that many in our community are struggling with recovery-related issues such as dealing with broken homes, insurance claims, poor roading and the loss of community facilities. All of this is having a big impact on people's health, with one third of those surveyed saying they have more health issues now than they did before the earthquakes.

People working in our health system are not only having to support a more stressed, more fatigued community, but are themselves dealing with their own earthquake related issues. Staff are our most precious resource and as an employer we are committed to supporting wellbeing initiatives and providing whatever support we can. Winning an award at the National Workplace Wellbeing Awards recognised the importance and effectiveness of the programmes and initiatives we have put in place to support staff wellbeing.

Priorities for the year ahead

Health, like other publicly funded services, must make every dollar count. Our resources are limited, while demand for health services is great. To help us meet this challenge we have developed five priorities to ensure we are providing the best possible care through focusing our resources where they will be most effective.

Our priorities to help ensure the efficient flow of people through the health system are:

1. **Frail Elderly**

   Our Frail Older Persons Pathway (FOPP) is a cross sector initiative that aims to improve the quality of care to support the coordination of often complex care for frail older people so they are well and home as soon as possible. Our goal is to achieve the best outcome for the patient, in a timely way with no delays, while avoiding harm and optimising their independence. Important for all patients but particularly frail older people. We will ensure patients know the answers to four key questions about their care plan: What is wrong with me? What is going to happen today and tomorrow? What needs to be achieved to get me home? and When will that happen?

   We have also been effective at managing the number of days people spend in a hospital bed. This has further reduced as community based rehabilitation programmes such as the Community Rehabilitation Enablement Support Team (CREST) supported 2129 mostly elderly people to recover in their own home, rather than in hospital. Thanks to CREST and other initiatives aimed at reducing unplanned demand, acute admissions have decreased this past year by almost a thousand.

2. **ERAS – Enhanced Recovery After Surgery**

   The purpose of the ERAS programme is to ensure that people recover faster and better from major surgery through a range of interventions. On the elective pathway there is a focus on ensuring patients are ready for surgery and that their recovery phase is well planned. The programme also looks to reduce wait times.

3. **Faster Cancer Treatment**

   The Faster Cancer Treatment programme seeks to improve the journey for people with cancer by ensuring patients have timely access to appointments and tests which detect cancer and cancer treatment. The programme will reduce barriers to treatment, to ensure (over time) all patients will have access to the same quality of care within the same timeframes, no matter where they live. As the majority of referrals with a high suspicion of cancer are first seen in the surgical specialities, the Faster Cancer Treatment programme links closely with other programmes of work that improve quality of care across the patient pathway.

4. **Capacity / Theatres**

   Until our new hospital is built, theatre capacity will be our biggest constraint. The Theatre

Utilisation programme is focused on improving the performance and productivity of operating theatres across the Canterbury DHB, reducing cancellations, improving patient flow and achieving shorter waiting times for patients before their treatment.

When people are supported to stay well in the community, they need hospital-level care less often and for shorter periods. There will always be people who, from a clinical perspective, will benefit from surgery. Despite all the damage and upheaval caused by the earthquakes, we are delivering more surgery and people are getting it sooner.

This past year, we performed 40% more elective surgeries than in 2006 - more than ever before. The Canterbury DHB is the largest public health provider of elective surgery in New Zealand, and each year provides over 2500 surgeries for other DHBs.

5. Canterbury's outpatient & surgical flow - 100 days programme

Despite the current constraints caused by ongoing repairs, our aim through this programme is to ensure all patients waiting for an elective first specialist assessment (FSA) receive one within 100 days. As well as providing certainty sooner for people waiting for surgery, reducing waiting times makes a significant contribution to our goal of removing waste (in this case, time) from our system.

He tangata! He tangata! He tangata!

Our collective vision in Canterbury is of a connected and sustainable health system, centred around people. We are working towards a fully integrated system that delivers the right care in the right place at the right time, and by the right person.

Together we are on a journey of transformation and though we still have some way to go, we are one of only a handful of complex health systems in the world today with the combination of vision, courage and innovation to succeed.

Our aim is to keep Canterbury well, but if you have to get sick somewhere - you couldn't be in a better place, or in better hands.

Murray Cleverley
Chair
28 October 2014

David Meates
Chief Executive
28 October 2014

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 also the General Manger for the Greater Christchurch Investment Strategy in the Christchurch Central Development Unit. Murray wears many 'hats' and has experience across a wide range of business sectors. 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. Murray is currently Chair of multiple companies and Director of several businesses. He recently stood down as Chairman of Warbirds over Wanaka, having served 7 years. 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. She served on the City Council for 15 years before retiring in 2013. She is currently serving on the Fendalton/Waimairi Community Board and does voluntary work for several other community organizations. 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 a 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 25 years' experience in the health and disability sectors and is a former Chief Executive of Age Concern Canterbury. He would like to see improved access to elective surgery and better integration of hospital and GP services. Andrew believes the results of rest home audits should be made public and is committed to improving accountability and transparency in the health service. This is his third term on the Board. Andrew also serves as chair of the Hospital Advisory Committee
Aaron Keown	Aaron also currently sits on the Christchurch City Council Shirley/Papanui Community Board. 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 is a Professional Director. She is of Te Arawa. Tuwharetoa, Ngati Apa, Ngati Kuia, Rangitane and Ngai Tahu descent. She is a Director of Health Benefits Ltd and was a long serving member of the Regional Health and Disability Ethics Committee (Upper South A) and Director of the Crown Health Financing Agency. Her 15 years of Governance includes Member, The Broadcasting Commission; Deputy Chair, NZ on Air; Founding Chair, NZ on Screen; and Deputy Chair, The Canterbury Community Trust. She was also an accountant with the Canterbury Area Health Board, and Healthlink South Ltd before becoming a Principal with Ernst & Young.
David Morrell	David Morrell is an experienced Board member with eleven 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 the position of Missioner he established new health funded services for those with drug and alcohol issues, and mental health difficulties. David 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. He is a Member of the Quality, Finance, Audit, and Risk Committee and Deputy Chair of the Hospital Advisory Committee.

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 District Health Board. Susan has a public service and administration background, and has been involved in a number of different voluntary, community, and Maori organisations. A member who serves on two boards, Susan brings a West Coast "face" to this board and a desire to contribute positively.

IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

What are we trying to achieve?

The Canterbury DHB is the largest funder and provider of health and disability services in Canterbury. The decisions we make in terms of which services to fund and at what level, have a significant impact on the health and wellbeing of our population. In making the best possible decisions it is important that we understand the level of need within our population and the drivers of demand so that we can shift resources to where they will have the most effect, and ensure the future sustainability of Canterbury's health system.

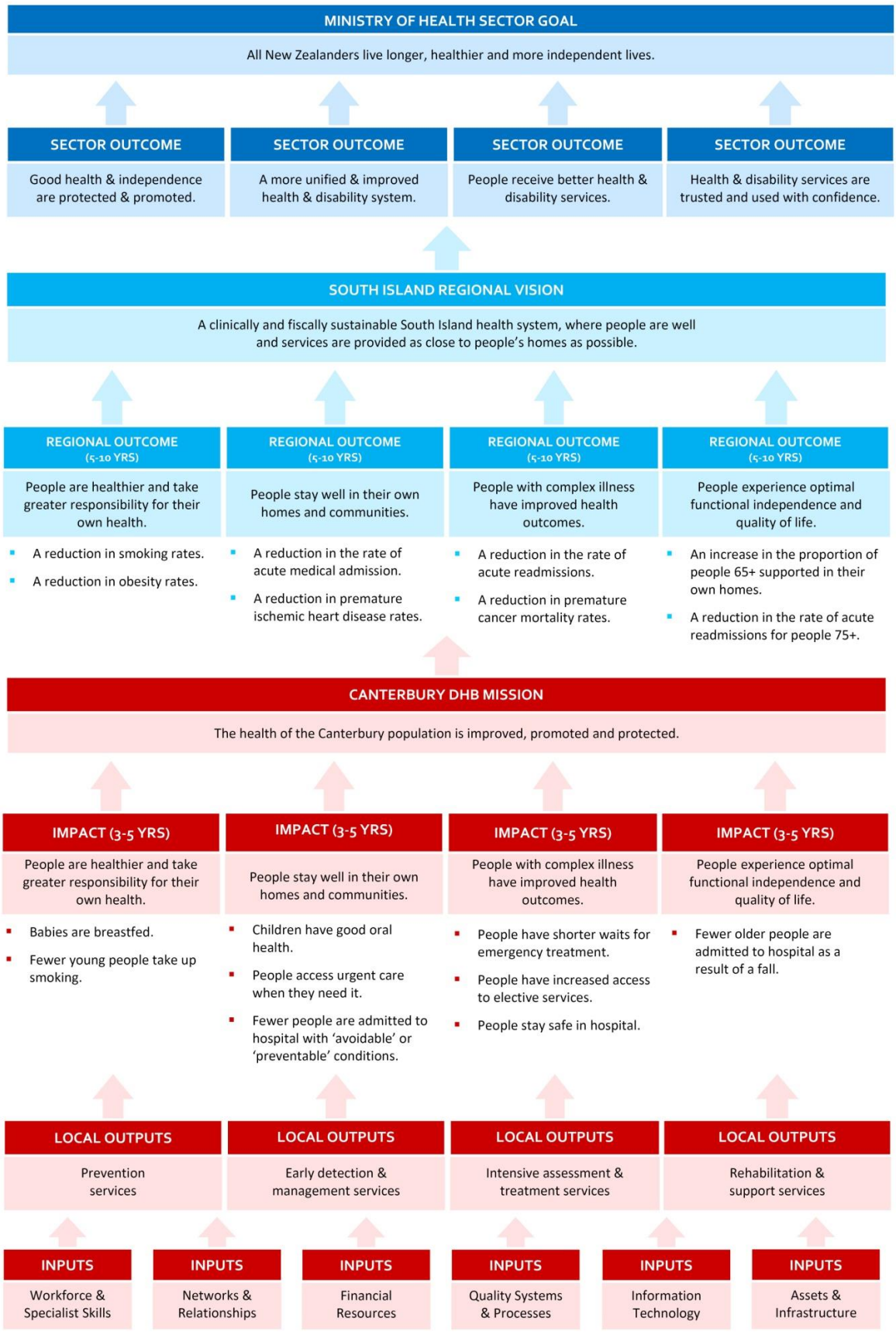
There is no single measure that can demonstrate the impact of the work we do, so we have chosen to use a mix of population health and service access indicators to collectively demonstrate improvements in the health of our population and determine whether we are succeeding in delivering on our goals.

In agreement with the five South Island DHBs, we have identified four strategic outcome goals and a collective set of associated outcome indicators. These are long-term population health outcome goals and are influenced by a number of different factors not just the performance of the DHB. As such, we are aiming for a measurable change over time and positive trends, rather achievement of fixed annual targets.

- 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 the rate of acute medical admission.
  - A reduction in premature ischemic heart disease rates.
- OUTCOME 3: PEOPLE WITH COMPLEX ILLNESS HAVE IMPROVED HEALTH OUTCOMES.
  - A reduction in the rate of acute readmissions.
  - A reduction in premature cancer mortality rates.
- OUTCOME 4: PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE.
  - An increase in the proportion of people over 65 supported in their own homes.
  - A reduction in the rate of acute readmissions for people over 75.

Sitting underneath the long-term outcomes indicators, we have also identified a second set of measures where individual DHB performance will have a more direct impact on success. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'main measures' of performance and the Canterbury DHB has set targets against which to evaluate our performance over the next three years.

The following intervention logic diagram visually presents the value chain: how the services that the DHB chooses to fund or provide have an impact on the health of the population and result in the achievement of the desired long-term outcomes – improving the health of our population and meeting the expectations and priorities of Government.


MINISTRY OF HEALTH SECTOR GOAL
All New Zealanders live longer, healthier and more independent lives.
SECTOR OUTCOME
Good health & independence are protected & promoted.
SECTOR OUTCOME
A more unified & improved health & disability system.
SECTOR OUTCOME
People receive better health & disability services.
SECTOR OUTCOME
Health & disability services are trusted and used with confidence.
SOUTH ISLAND REGIONAL VISION
A clinically and fiscally sustainable South Island health system, where people are well and services are provided as close to people's homes as possible.
REGIONAL OUTCOME (5-10 YRS)
People are healthier and take greater responsibility for their own health.
A reduction in smoking rates.
A reduction in obesity rates.
REGIONAL OUTCOME (5-10 YRS)
People stay well in their own homes and communities.
A reduction in the rate of acute medical admission.
A reduction in premature ischemic heart disease rates.
REGIONAL OUTCOME (5-10 YRS)
People with complex illness have improved health outcomes.
A reduction in the rate of acute readmissions.
A reduction in premature cancer mortality rates.
REGIONAL OUTCOME (5-10 YRS)
People experience optimal functional independence and quality of life.
An increase in the proportion of people 65+ supported in their own homes.
A reduction in the rate of acute readmissions for people 75+.
CANTERBURY DHB MISSION
The health of the Canterbury population is improved, promoted and protected.
IMPACT (3-5 YRS)
People are healthier and take greater responsibility for their own health.
Babies are breastfed.
Fewer young people take up smoking.
IMPACT (3-5 YRS)
People stay well in their own homes and communities.
Children have good oral health.
People access urgent care when they need it.
Fewer people are admitted to hospital with 'avoidable' or 'preventable' conditions.
IMPACT (3-5 YRS)
People with complex illness have improved health outcomes.
People have shorter waits for emergency treatment.
People have increased access to elective services.
People stay safe in hospital.
IMPACT (3-5 YRS)
People experience optimal functional independence and quality of life.
Fewer older people are admitted to hospital as a result of a fall.
LOCAL OUTPUTS
Prevention services
LOCAL OUTPUTS
Early detection & management services
LOCAL OUTPUTS
Intensive assessment & treatment services
LOCAL OUTPUTS
Rehabilitation & support services
INPUTS
Workforce & Specialist Skills
INPUTS
Networks & Relationships
INPUTS
Financial Resources
INPUTS
Quality Systems & Processes
INPUTS
Information Technology
INPUTS
Assets & Infrastructure

Are we making a difference?

Overall the progress against these indicators suggests that the health status of the Canterbury population has remained positive over the last year. Smoking rates continue to drop, emergency department and elective surgery wait times have dropped, acute medical admissions and premature mortality rates for heart disease and cancer remain well below the national average.

However the results also indicate that pressure is beginning to build across the Canterbury health system. The number of people presenting to our emergency departments and being admitted into our hospitals is growing. There has also been less movement than desired against key indicators for child health and, while remaining positive against national results, breastfeeding rates and oral health rates have dropped back against previous years. These are both areas where stressed living environments could impact results and further focus will be placed on supporting our younger populations.

Closer attention will be paid to areas of increased demand in the coming year, with a focus on earlier intervention to provide diagnosis, supporting people to manage their conditions and ensuring that wait times continue to reduce in spite of the increases in demand.

GOAL 1 - PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH

LONG TERM OUTCOME MEASURES

A reduction in smoking rates.

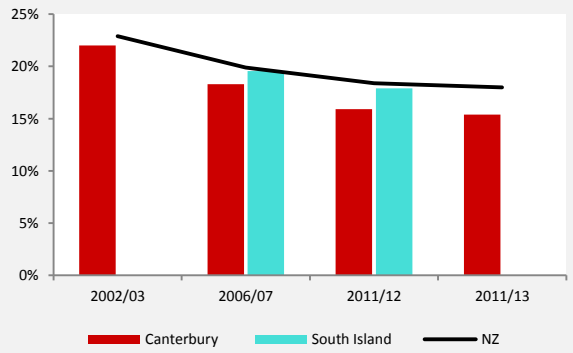
Canterbury's smoking rates continue to decline, with the combined 2011/13[1] New Zealand Health Survey finding that just 15% of the Canterbury population smoke – down from 22% ten years ago.

Canterbury's success in continuing to reduce smoking prevalence 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 in hospital, general practices and pharmacies is now well established and while the Māori rate continues to be higher than the rest of the Canterbury population; more people are registering with Aukati Kaipapa smoking cessation programmes than ever before.

Data sourced from national NZ Health Survey.[1]

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



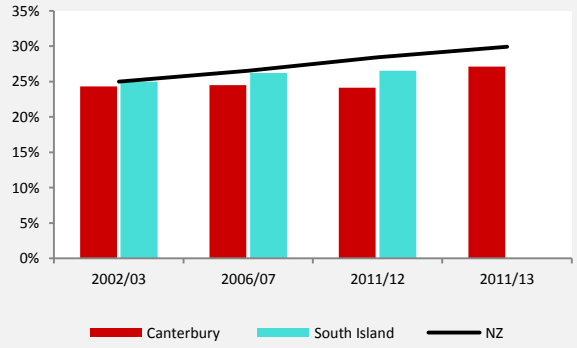
A reduction in obesity rates.

Canterbury's obesity rate has remained relatively stable over the past decade, with a slight increase to 27% seen in the combined 2011/13[1] New Zealand Health Surveys. Despite this increase Canterbury still remains below the national rate of 30%.

Canterbury's 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.

Data sourced from national NZ Health Survey.[2]

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



[1] The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. However results by region and DHB are subject to availability. Results for 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs – hence the different time periods presented. Unfortunately results are unavailable by ethnicity however the 2013 Census results for 'regular smokers' (while not directly comparable) demonstrate rates for Māori are improving but still high, down from 40.2% in 2006 to 30.7% in 2013.

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

MEDIUM TERM IMPACT MEASURES

More babies are breastfed.

Canterbury's breastfeeding rates have remained relatively stable over the past five years, with 66% of all six-week-old babies being fully or exclusively breastfed in 2013/14.

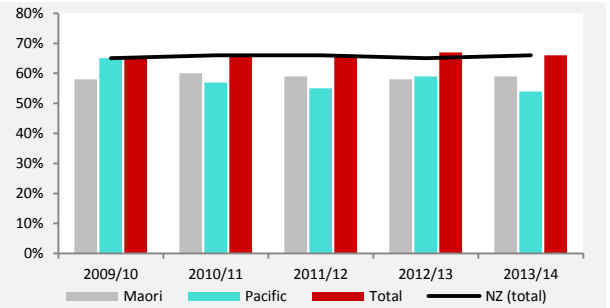
Māori and Pacific breastfeeding rates remain lower than those of the total population, at 59% and 54% respectively. However, some of this may be because the data presented is sourced from Plunket services only. Canterbury has several smaller Tamariki Ora providers who specifically target Māori and Pacific mothers. However at this stage the data sources are not able to be combined (see footnote).

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

Data sourced from Plunket.[3]

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

	Actual 2013/14	Target 2013/14
Māori	59%	69%
Pacific	54%	69%
Total	66%	69%



Fewer young people take up tobacco smoking.

The 2013 ASH survey results show that 74% of Year 10 students (age 14) in Canterbury have never smoked – up slightly from 73% in 2011.

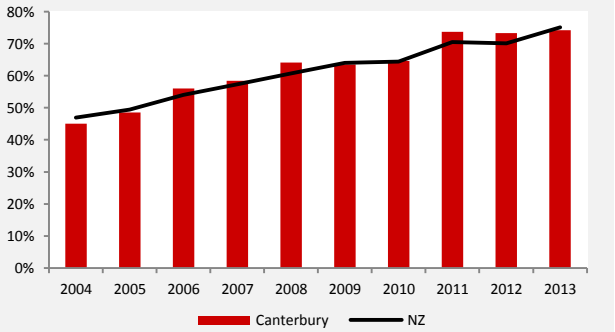
While results have remained relatively stable over the past three years, results are much higher than 10 years ago with an encouraging and positive long-term trend.

This positive trend reflects the impact of supportive legislation and social environments combined with local initiatives such as our Health Promoting Schools programme, smoke free public places (such as parks and marae) and training and advice provided to tobacco retailers to limit youth access to tobacco.

Data sourced from national Year 10 ASH Survey.[4]

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

Actual 2013	Target 2013
74%	75%



[3] This data differs slightly against previously published numbers which were available only by calendar years from the Ministry of Health. Data is now sourced directly from Plunket by financial year. Canterbury has a several small Tamariki Ora providers who operate alongside Plunket and specifically target Maori and Pacific mothers however their data has not been included in the results. At this stage the Plunket data does not identify individuals and as people may be seen by more than one provider we risk double counting babies if the data is combined. While this may mean results for Maori and Pacific babies may be slightly undercounted Plunket is by far the largest well-child provider and as such their data is used as the base result.

[4] The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set (reported by calendar year): www.ash.org.nz.

GOAL 2 - PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES

LONG TERM OUTCOME MEASURES

A reduction in premature ischemic heart disease mortality rates.

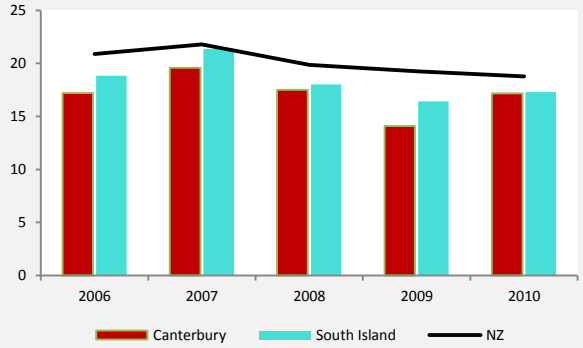
There has been a slight increase in the rate of premature mortality from ischemic heart disease between 2009 (14.1 per 100,000) and 2010 (17.2 per 100,000). However the rate remains relatively stable (the difference is 14 people) and consistently below national rates.

Canterbury has a number of initiatives and programmes in place to reduce smoking and obesity rates and encourage more physical activity, such as Health Promoting Schools, Appetite for Life and Green Prescription programmes.

Canterbury has also dramatically improved the proportion of the eligible population having had cardiovascular risk assessments, as part of delivery against the national More Heart and Diabetes Checks health target in 2013/14.

Data sourced from Ministry of Health mortality collection.[5]
This is a new measure introduced in the 2013/14 year.

The rate of death due to ischemic heart disease in people aged under 65 (per 100,000).



A reduction in acute medical admissions.

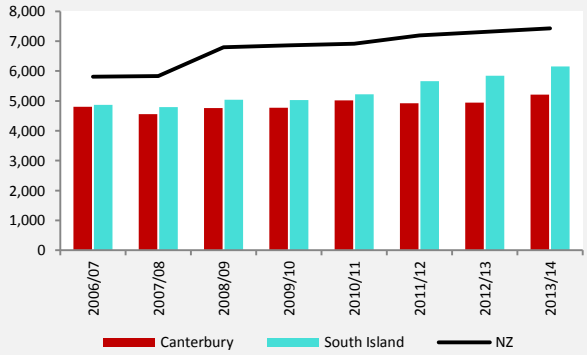
At 5,209 per 100,000 people, Canterbury's standardised acute medical admissions rate is the lowest of any large DHB in the country, and just 70% of the national rate (7,426 per 100,000 people).

This positively reflects the system-wide focus taken in Canterbury to keep people safe and well in their own homes and communities.

There are a number of initiatives and programmes in place to reduce acute admissions into our hospitals, including alternative ambulance pathways and management for patients with respiratory and heart disease and Canterbury's Acute Demand Management Service which provided more than 28,000 packages of care in the community in 2013/14.

Data sourced from the National Minimum Data Set.

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



MEDIUM TERM IMPACT MEASURES

Children have good oral health.

The overall percentage of five-year-olds caries-free has decreased from 64% in 2012 to 62% in 2013. This is consistent with a decrease in the percentage of five-year-olds caries-free across the country.

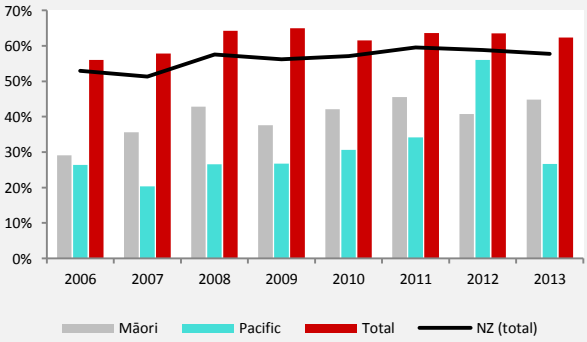
The percentage of Māori five-year-olds has increased slightly, while caries-free rates for Pacific five-year-olds have decreased dramatically. While results for these population groups are subject to a greater degree of variation, due to smaller numbers of children involved, there is still a clear gap between the results for these population groups and the total population.

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

Data sourced from Ministry of Health.[6]

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

	Actual 2013	Target 2013
Māori	45%	65%
Pacific	27%	65%
Total	62%	65%



[5] Mortality data sets are collected and managed by the Ministry of Health and published by calendar year at least three years in arrears.

MEDIUM TERM IMPACT MEASURES

People access urgent care when they need it.

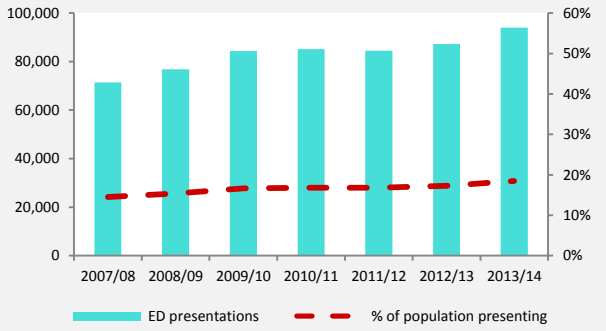
The percentage of the population presenting at an Emergency Department has increased to 18.4% of the Canterbury population, aligned to an increase in the overall number of ED attendances.

Strategies to care for people in the community and closer to their own homes have been imbedded in our health system over the past several years and ED rates had been steady. The recent increase is a concern.

Analysis has demonstrated the strongest growth in attendances has been in adults aged 25-29, in line with a growth in this age group as a result of the Canterbury rebuild. Canterbury DHB has engaged with the Canterbury Earthquake Recovery Authority to ensure employers provide information to new migrants regarding health care, the importance of engaging and enrolling with general practice and the most appropriate places to seek health care.

Data sourced from Canterbury's internal data warehouse.[7]

The percentage of the population presenting at ED.	Actual 2013/14	Target 2013/14
	18.4%	≤18%



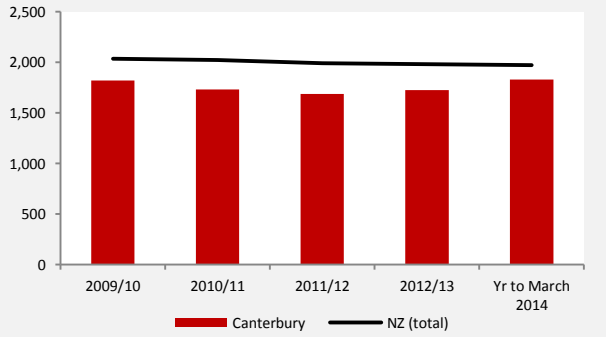
Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

In the year to 31 March 2014, Canterbury's avoidable hospital admission rate was 1,830 per 100,000. Despite a slight increase on the previous year, Canterbury's rate remains below the national rate.

A wide range of local initiatives contribute to preventing unnecessary admissions to hospital, including our community-based Acute Demand Management Services, community-based rehabilitation services and targeted long-term condition management programmes.

Data sourced from the Ministry of Health.[8]

The rate of avoidable hospital admissions per 100,000 population (<75).	Actual 2013/14	Target 2013/14
	1,830	<1,883



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

[7] 'Presenting' is defined by the Ministry of Health national ED health target.

[8] This measure is based on the national indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The results presented differ to those previous published due to revision of the national definition. The measure is now defined as the standardised rate per 100,000 population and as a lower rate of avoidable hospitalisation is better, the target is set to maintain performance at below 95% of the national rate. Canterbury has identified an issue with the new denominator used to identify our Māori and Pacific populations which distorts the results by ethnicity against this measure and as such, results are not provided by ethnicity. The DHB is working with the Ministry to resolve this issue.

GOAL 3 - PEOPLE WITH COMPLEX ILLNESS HAVE IMPROVED HEALTH OUTCOMES.

LONG TERM OUTCOME MEASURES

A reduction in premature cancer mortality rates.

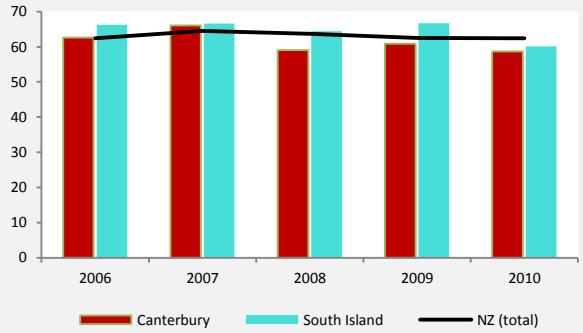
There has been a slight decrease in the rate of premature mortality as a result of cancer between 2009 (61 per 100,000) and 2010 (59 per 100,000). However the rate remains essentially stable (the difference is 7 fewer people) and has been below the South Island and New Zealand rates for the past three years.

Canterbury is currently implementing the national Faster Cancer Treatment programme to reduce the time patients with a high suspicion of cancer wait before receiving their first specialist assessment and their first cancer treatment.

It is expected that this will further reduce mortality rates for those diagnosed with cancer by ensuring swift and effective treatment.

Data sourced from Ministry of Health mortality collection.[9]
This is a new measure introduced in the 2013/14 year.

The rate of deaths due to cancer in people aged under 65 (per 100,000).



A reduction in acute readmissions to hospital.

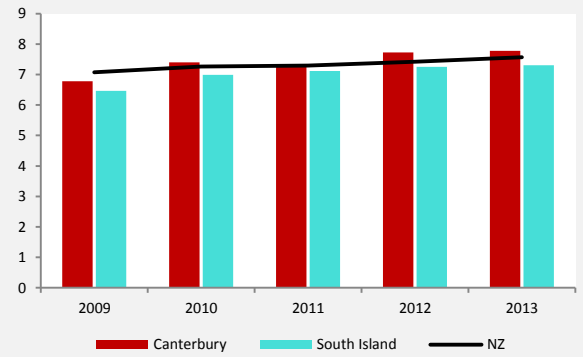
The national definition was revised for this measure in 2013/14, Under the revised definition, Canterbury's acute readmission rate for the calendar year to 31 December 2013 was 7.78. This rate is higher than both the South Island and national averages and presents a different pattern to previous year's results.

Canterbury has a number of local initiatives and programmes in place to reduce readmission rates including its Community-based Rehabilitation Service Team (CREST), falls prevention programmes and restorative homes based support services.

A key focus for the coming year is the implementation of the Enhanced Recovery After Surgery (ERAS) programme designed to optimise surgical outcomes and support recovery.

Data sourced from Ministry of Health.[10]

The rate of acute readmissions to hospital (within 28 days of discharge).



[9] Mortality data sets are collected and managed by the Ministry of Health and published by calendar year at least three years in arrears.

[10] The results differ to those previous published due to a change in the national definition. Canterbury has identified issues with the new measure particularly with regards to transfers between hospitals being identified as readmissions rather than a continued episode of care. The DHB is working with the Ministry to resolve this issue and is monitoring readmission data internally to identify areas of concern.

MEDIUM TERM IMPACT MEASURES

People have shorter waits for treatment.

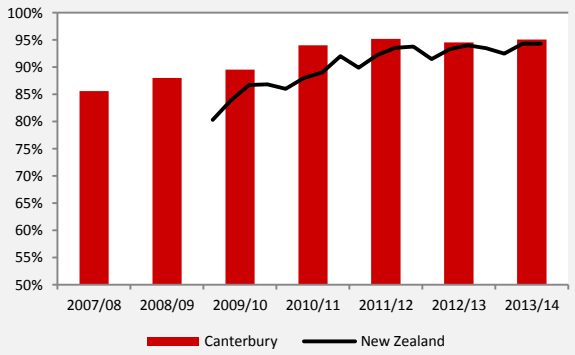
Canterbury has continued to maintain performance against the Shorter Stays in Emergency Departments health target, with 95% of people presenting being admitted or discharged within six hours.

Strong performance results against this target are reflective of the success of our 'whole of system' approach. Canterbury has a wide range of integrated strategies in place for reducing unnecessary ED attendances, ensuring effective functioning and flow within ED and across our hospitals and providing supported discharge to help people back into their own homes.

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

Data sourced from Canterbury's internal data warehouse.[11]

The percentage of patients presenting in ED who are admitted, discharged or transferred within six hours.	Actual 2013/14	Target 2013/14
	95%	95%



People have increased access to elective services.

Waiting time targets have reduced this past year from a maximum of six months to a maximum of five months.

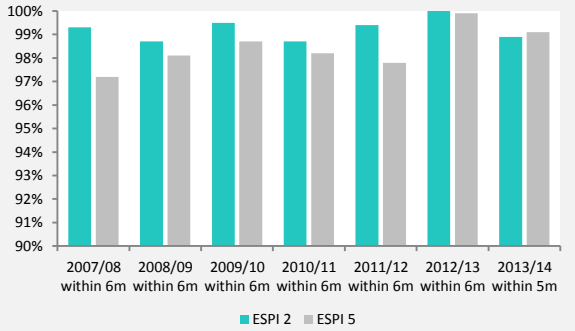
As at June 2014, 98.9% of all Cantabrians referred for an initial specialist assessment received their assessment within five months of referral, and 99.1% of those given a commitment for treatment began their treatment within five months.

Given the challenges of reduced hospital capacity post-earthquake, performance against these targets represents a major achievement for the Canterbury DHB.

Over the coming year we will look to further improve waiting times to a maximum of four months. A number of patient flow initiatives are focused on achieving this further reduction in waiting times.

Data sourced from Ministry of Health.[12]

	Actual 2013/14	Target 2013/14
The time people wait from referral to First Specialist Assessment (ESPI 2).	98.9%	100% < 5m
The time people wait from commitment to treat until treatment (ESPI 5).	99.1%	100% < 5m



[11] This measure is based on 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 summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available. Historical data is against a six month target, while Canterbury's target reduces to 5 months from January 2014 and 4 months from January 2015.

MEDIUM TERM IMPACT MEASURES

People stay safe in hospital.

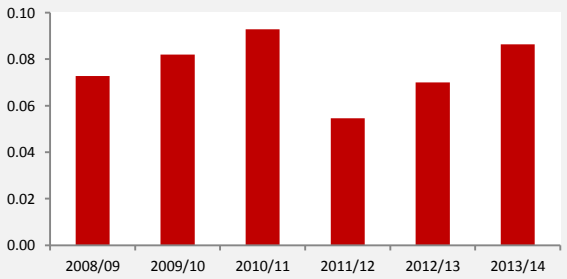
While the rate of falls has increased slightly over the past three years rates still remain low.

In August 2013, a Hospital Fall Prevention Programme Steering Group was established to provide direction and oversight for falls prevention. Key projects have focused on standardising fall prevention visual cues and post-fall care across our hospitals.

The introduction of the new electronic incident management system rL6 in the coming year, is expected to provide access to improved data around falls and assist in informing future project work.

Data sourced from internal quality and incident reporting systems.[13]

The rate of SAC level 1 and 2 falls in Canterbury Hospitals (per 1,000 inpatient bed days).	Actual 2013/14	Target 2013/14
	0.09	≤0.05



[13] This measure differs from that previous published as it has been expanded to include SAC 1 & 2 falls for all people in Canterbury hospitals, rather than just our older (65+) population. The results presented are preliminary and are yet to be finalised this may result in a change to the rates presented.

GOAL 4 - PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE.

LONG TERM OUTCOME MEASURES

An increase in the proportion of the population (65+) supported to stay well in their own home.

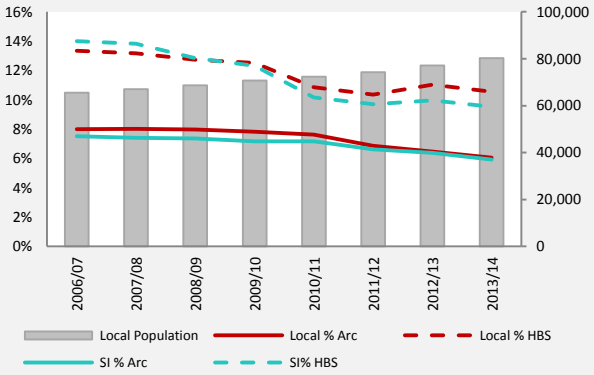
The percentage of the population living in aged residential care continues to drop from a high of 8% seven years ago to 6% in the past year. This has brought Canterbury into line with the South Island rate and is consistent with our strategic direction of supporting people to stay safe and well in their own homes.

The percentage of the population receiving home-based support has remained above 10% for the past four years reaffirming our strategic direction.

A number of programmes support our older population in their own homes and are contributing to these positive results, including our restorative home-based support services, CREST, falls prevention and medication management service.

Data sourced from Client Claims Payments provided by SIAPO.[14]

The percentage of the older population (65+) living in aged residential care compared against those receiving home-based support services.



A reduction in the acute readmissions to hospital (people aged 75+).

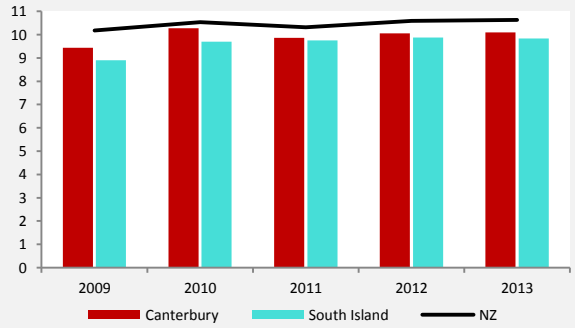
Under the new national definition, Canterbury's acute readmission rate for the calendar year to 31 December 2013 was 10.1. This rate is higher than the South Island rate but lower than the national average.

Canterbury has a number of local initiatives and programmes in place to reduce readmission rates including CREST, falls prevention and medications management programmes and restorative homes based support services.

A key focus for the coming year is the implementation of the Frail Older Person's Pathway, an improvement initiative which aims to better support older people in our hospitals and promote their recovery.

Data sourced from Ministry of Health.[15]

The rate of acute readmissions to hospital for people aged 75+ (within 28 days of discharge).



MEDIUM TERM IMPACT MEASURES

Fewer older people are admitted to hospital as a result of a fall.

At 9%, the percentage of the Canterbury population (75+) admitted to hospital as a result of a fall is higher than the previous year. While sitting at the national average this is still an area where the DHB wishes to improve performance.

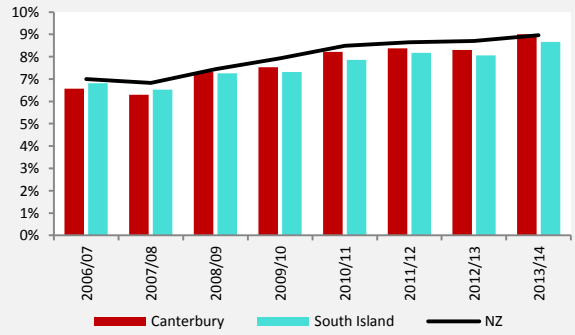
A Falls Prevention Strategy is in place across the Canterbury health system promoting clinically-led falls prevention programmes in the community (with home and community based programmes) and in our hospitals.

Further work will be undertaken in the coming year to look more closely at those people presenting in our hospitals to identify patterns and areas for focus.

Data sourced from the National Minimum Data Set.

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

Actual 2013/14	Target 2013/14
9.0%	7.9%



[14] Result for 2012/13 differs slightly from those previously published due to the addition of late claims from home based support and aged residential care providers.

[15] Canterbury has identified issues with the new denominator for this national measure particularly with regards to transfers between hospitals being picked up as readmissions rather than a continued episode of care. The DHB is working with the Ministry to resolve this issue and is monitoring internal readmission data to identify areas of concern.

STATEMENT OF SERVICE PERFORMANCE

Measuring our Non-financial Performance

As part of evaluating our performance, we provide an annual forecast of the services we plan to fund and provide (and to what standard) and report actual delivery against those expectations at the end of each year. The following section presents Canterbury DHB's actual performance against the forecast services performance expectations presented in our Statement of Intent for 2013-14.

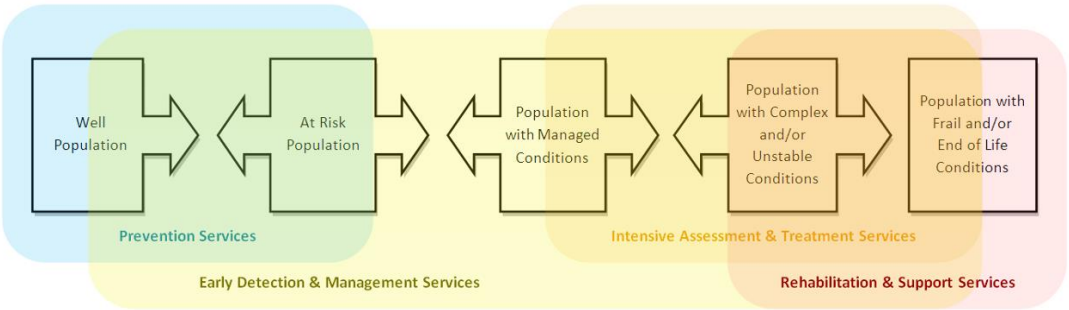
In presenting our performance, it would be overwhelming to measure every service or output delivered. We therefore choose to measure those activities with the greatest potential to contribute to the health and wellbeing of our population, those which are markers of broader system changes and those where 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 received 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 2013/14 results against the targets we set in our Statement of Intent, we have included (wherever possible) prior year's results to enable the reader to assess performance over time and a national result to give wider context in terms of what we are trying to achieve.[16]

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 and Management Services, Intensive Assessment and Treatment Services, and Rehabilitation and Support Services. This helps to provide a picture of overall performance by grouping services with similar aims or goals.

OUTPUT GROUPING SET AGAINST THE CONTINUUM OF CARE FOR OUR POPULATION



2013/14 Performance Overview

Our performance results for 2013/14 show the Canterbury health system's ongoing recovery following the earthquakes. While we haven't met every target, we have improved access and reduced waiting times in many areas. It is positive to see the continued uptake of programmes we have put in place since the earthquake to support our most vulnerable populations, with improved performance against almost all of our prevention service measures. However, it is concerning to see the gradual increase in demand for more complex services across the system. Close monitoring of trends will continue over the coming year in order to respond to increased demand growth and best target service delivery to meet the needs of our population.

[16] Unless otherwise stated, the latest New Zealand results have been sourced from the Ministry of Health.

The results we have achieved reflect the collective commitment of teams right across our health system working to 'make it better' for our population.

In terms of delivery against the national health targets, Canterbury has achieved five of the seven targets, delivering on elective surgery, cancer, immunisation and hospital smoking targets. While not achieving the two primary care targets significant performance has improved dramatically over the past year with 75% of smokers identified in primary care receiving advice and help to quit compared to 35% at the end of 2012/13. The percentage of the eligible population having a CVD Risk Assessment in the last 5 years has also increased significantly from 33% to 66%.

Notes on the Data

This Annual Report incorporates a large number of measures to better reflect the scope and volume of services funded or delivered by the Canterbury DHB. This creates some additional considerations:

- Access to a significant proportion of our health services (such as laboratory tests, emergency care, maternity services and palliative care) is unrestricted or 'demand-driven'. For such services, we cannot set targets. Instead, estimated demand volumes are included to give the reader a more rounded picture of what is happening across our health system. There are not targets for these services, but simply a forecast or estimate of expected demand, indicated by the abbreviation '**est.**'
- Some service data is provided or held by third parties, outside the DHB, and can be affected by a lag in invoicing for the services provided. Rather than footnote every instance, a symbol is used to indicate where this is the case: **Δ** marks data that can be affected by a lag in invoicing and therefore may differ from previously published figures. Such data in this document was run on or before 10 August 2014.
- Some data is collected on calendar, rather than financial, years and is indicated with the following symbol: **†**. In these cases, the '2012/13' result is for the 2012 calendar year, and the '2013/14' result is for 2013.
- The DHB reviews its measures set on an annual basis to ensure that it is presenting a mix of measures that accurately represent where resource and effort is being directed. The symbol '⅄' has been used to signal that a measure was newly introduced for the 2013/14 year. Where possible, results have been calculated for previous years for these new measures in order to give context to the 2013/14 result.
- In terms of the national health targets, both full year and final quarter results are presented, while the aim of the national targets is to achieve an expected standard by the end of the year, performance for some of the targets has increased significantly quarter on quarter, Canterbury has provided its full year performance to give greater context to results.
- Any other irregularities have been footnoted.

OUTPUT CLASS

PREVENTATIVE HEALTH SERVICES

Preventative health services promote and protect the health of the whole population and address individual behaviours by targeting population-wide changes to physical and social environments. In doing so these services support people to make healthier choices, reducing major risk factors that contribute to long-term conditions. High-need and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore our foremost opportunity to target improvements in the health of high-need populations and to reduce inequalities in health status and health outcomes.

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

As our population continues to struggle with the ongoing challenges of earthquake recovery, encouraging people to make lifestyle changes has been difficult. Increased focus has been place on engaging our population and it is pleasing to note that there have been some key successes in this area and improved progress against almost all measures. The number of people enrolling in the Aukati Kaipaipa smoking cessation programme is higher than ever before, compliance with smoking legislation is high, and 2,879 people were supported to increase their physical activity through Green Prescriptions (well above our target of 2,000). While not reaching the national target, smoking advice being delivered in primary care has increased markedly over the past year.

We have also made some key achievements for safeguarding the health of our most vulnerable populations. We have increased breastfeeding support, more schools are engaged in the health promoting schools framework and we reached national targets for delivery of B4 School Checks to ensure children get the best start to school. We are particularly pleased to have met national targets for eight month old immunisations and while not reaching our other immunisation targets we have improved performance across all these measures.

OUTPUT MEASURES

Health Promotion and Education Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Volunteer mothers trained in Mum-4-Mum peer support	V [17]	44	35	84	50	-
Lactation support and specialist consults provided in the community	V ⅄	650	858	1,031	≥580	-
% of mothers establishing breastfeeding on hospital discharge	Q [18]	77%	76%	76%	≥75%	-
% of smokers identified in hospital receiving advice and help to quit						
Quarter 4 results	C	90%	93%	95%	95%	96%
Full year results		83%	90%	95%	95%	-
% of smokers identified in primary care receiving advice and help to quit	C	25%	35%	75%	90%	86%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	207	345	408	≥200	-
% of tobacco retailers compliant with current legislation	Q [19]	97%	83%	98%	≥90%	-
% of priority schools supported by the Health Promoting Schools framework	C [20]	78%	74%	80%	>70%	-
People accessing Green Prescriptions for additional physical activity support	V [21]	1,941	1,936	2,879	>2,000	-
'Appetite for Life' courses provided in the community	V Δ	68	52	56	>50	-

[17] Mum-4-Mum training supports social change by allowing the DHB to significantly increase its capacity to deliver key messages through informal contact facilitated by appropriately trained volunteer mothers.

[18] The percentage of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period. This measure definition differs from the one previously published as this measure has been aligned to the Maternity Quality and Safety Programme (and World Health Organisation target) being babies 'exclusively' breastfed on discharge from hospital.

[19] The proportion of compliant retailers is seen as demonstrating the effectiveness of the information, training, support and advice provided to retailers.

[20] The Health Promoting Schools Framework is used to address health issues with an approach based on activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated, have a high proportion of Māori/Pacific children and/or identified earthquake issues.

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

Population Based Screening Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of four-year-olds provided with a B4 School Check (B4SC)	C [22]	76%	86%	90%	90%	91%
% of referred children receiving a Gateway Assessment	C [23]	new	58%	85%	100%	-
Year 9 students in decile 1-3 schools, alternative education facilities and teen parent units provided with a HEADSSS assessment						
Year 9 students in decile 1-3 schools	C † [24]	new	99.6%	100%	100%	-
Alternative education facilities		new	100%	93%	100%	-
Teen parent units		new	85%	93%	100%	-
% of women (25-69) having a cervical cancer screen in the last 3 years	C [25]	75%	75%	76%	80%	77%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [25]	82%	82%	80%	≥70%	73%

Immunisation Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of children fully immunised at eight months of age						
Quarter 4 results	C	new	92%	93%	90%	92%
Full year results		new	92%	93%	90%	-
% of eight-month-olds 'reached' by immunisation services	Q [26]	new	97%	95%	90%	-
% of Year 8 girls completing HPV vaccinations (i.e. receiving Dose 3)	C† [27]	21%	22%	26%	60%	53%
% of young people (<18) receiving a free influenza ('flu') vaccination	C †	21%	19%	33%	40%	-
% of older people (65+) receive a free influenza ('flu') vaccination	C †	71%	71%	75%	75%	-
% of the older population (65+), deemed high-needs, receiving a flu vaccination	Q† ⅄	69%	70%	73%	75%	-

[22] 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.

[23] Gateway Assessments aim to ensure every child or young person entering Child, Youth and Family care receives an assessment that helps build a comprehensive picture of the child or young person's needs and ensures referral to services that address those needs. The 2012/13 result differs to that previous published (78%) due to an error in transcribing the results.

[24] A HEADSSS assessment covers Home environment, Education/employment; eating and exercise, Activities and peer relationships; Drugs, cigarettes and alcohol; Sexuality; Suicide, depression, mood screen; Safety; and Spirituality.

[25] These national programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. Breast screening data is sourced from Breast Screening New Zealand and cervical screening data is sourced from the National Screening Unit.

[26] 'Reached' is defined as those children fully immunised, as well as those who have declined immunisations or have opted off the NIR. This reflects how well immunisation services are 'reaching' the parents of eligible children and providing advice and support to enable parents to make informed choices.

[27] The 2013/14 result is the percentage of girls born in 2000 receiving Dose 3 by the end of 2013. This measure has been revised from the measure previously published (which measured dose 1) in order to better reflect the delivery of the General Practice based programme which has a longer uptake period. The DHB will look to better capture delivery of this programme in the 2014/15 year.

OUTPUT CLASS

EARLY DETECTION AND MANAGEMENT SERVICES

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

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

Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services, shorter waiting times and the use of clinically agreed referral pathways also reflect improvements.

It is positive to see that measures around access to services in the community rather than in hospital continue to increase, suggesting that our population is engaging with their general practice. In the past year 2,432 skin lesions were removed, 1,533 spirometry tests delivered and 6,535 people accessed brief intervention counselling without the need for a hospital visit. The DHB also met national wait time targets for the delivery of Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) Scans achieving well above the national average.

OUTPUT MEASURES

Primary Health Care (GP) Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of the DHB population enrolled with a Primary Health Organisation	C	96%	96%	96%	≥95%	96%
Maintain current HealthPathways across primary/secondary care	V [28]	519	667	762	≥600	-
People provided Brief Intervention Counselling (BIC) in primary care settings	V Δ [29]	5,750	6,962	6,535	≥4,000	-
Avoidable hospitalisation for children aged 0-4 rate per 100,000	Q [30]	5,021	5,183	5,231	<6,656	4,522

Oral Health Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of children aged under 5 enrolled in DHB-funded oral health services	C †[31]	54%	71%	71%	68%	73%
% of enrolled children (0-12) examined according to planned recall	T †	87%	90%	94%	90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C †[32]	65%	65%	64%	85%	70%

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

[29] The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' psychological intervention from their general practice teams, with the possibility of onward referral to a related community agency if appropriate. The aim is to provide early intervention and help people to reduce the likelihood of developing enduring conditions. Results include face-2-face and phone consultations.

[30] Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of access into primary care and the effectiveness of the interface between primary and secondary services. The measure is based on the national DHB performance indicator SI1, and previous year's results differ from those published as the measure was redefined nationally in 2013 to a standardised rate per 100,000.

[31] The 2011 oral health enrolment result (54%) used pre-quake population estimates, which predicted an increase in the 0-4 population, when in fact this population has been the most quake-affected. The best post-quake estimate comes from post-quake PHO enrolment, which shows a 4.4% drop in this age group. This would mean an oral health enrolment figure of 59% for the 2011/12 year.

[32] The DHB continues to seek opportunities to encourage adolescent uptake of free dental care. Initiatives for the current year include working with high schools to promote free oral health care for young people.

Long-term Conditions Programmes	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of the eligible population having a CVD Risk Assessment in the last 5 years	C	20%	33%	66%	90%	84%
People receiving individual self-management support from their general practice when newly diagnosed with Type 2 diabetes or starting insulin	V Δ ⅄	642	739	799	≥640	-
Skin lesions (skin growths, including cancer) removed in primary care	V Δ	2,320	2,358	2,432	≥2,000	-
Spirometry tests are provided in community rather than hospital	V Δ [33]	1,179	1,503	1,533	≥1,000	-

Pharmacy Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Pharmaceutical items dispensed in the community	V Δ	8.4 mil	6.7 mil	6.2 mil	est. <9mil	-
People on multiple medications receive initial reviews via the Medication Management Service	V Δ[34]	632	1,771	1,703	2,000	-

Referred Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Laboratory tests completed for the Canterbury population	V Δ	2.6 mil	2.0 mil	1.9 mil	est. <2.6mil	-
Community Referred Radiology tests completed	V Δ [35]	36,810	41,913	43,094	est. 30,000	-
% of people receiving their CT scan within 6 weeks	T ⅄ [36]	new	89%	88%	85%	80%
% of people receiving their MRI scan within 6 weeks	T ⅄ [36]	new	83%	88%	75%	61%

[33] Spirometry is a tool for measuring lung function, assisting in the assessment of a range of respiratory conditions and providing this service in the community means people do not need to wait for a hospital appointment. Community spirometry volumes include those delivered by both GPs and mobile community respiratory providers.
[34] The 2012/13 number differs slightly from the previously published number (1,694) due to inclusion of late invoices.
[35] The results differ slightly from those previously stated as the measure has been revised to reflect tests referred and completed as opposed to tests referred and accepted, but not conducted.
[36] These measures are both national measures (aligned to DV2) and results are as at June 2014 in line with national reporting.

OUTPUT CLASS

INTENSIVE ASSESSMENT AND TREATMENT SERVICES

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

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action. With the loss of capacity in our hospitals, it is important that we reduce avoidable demand in order to free up specialist services to undertake more complex and elective interventions in a timely manner.

Success is therefore defined by a reduction in acute demand and an increase in access to planned and elective services. As a major provider of hospital services, the DHB also closely monitors patient safety within our hospitals. Improvements in patient safety are reflected by a reduction in adverse events and delays in treatment, which as well as causing harm to patients drive unnecessary costs.

Performance has been mixed across this output class. An increased level of demand is evident and wait times are becoming harder to maintain. The delivery of 28,378 acute demand packages of care in the community and increases in the proportion of the population accessing mental health services are positive - as these services are supporting people closer to their own homes and ensuring access to services when they are needed. However, combined with increased emergency department, specialist assessment and outpatient attendances they are also demonstrative of an increasing demand that is beginning to stretch the capacity of our system.

There are many positives, Canterbury once again met it elective surgery targets, an increased proportion of our specialist assessment are virtual where specialist advice and assessment is provided without the need for a hospital appointment, 'did not attend' rates have dropped and an increase proportion of our long-term mental health clients have current relapse prevention plans. While admissions into our Assessment Treatment and Rehabilitation Service have increased the proportion of older people being discharged to their own home rather than into aged residential care is positively aligned to the DHB's strategic direction.

Demand and wait time trends will be closely monitored over the coming year in order to ensure that we can continue to respond to the changing needs of our population.

OUTPUT MEASURES

Specialist Mental Health Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of young people (0-19) accessing specialist mental health services	C Δ [37]	2.8%	2.6%	3.2%	3%	3.4%
% of adults (20-64) accessing to specialist mental health services	C Δ [37]	3.6%	3.4%	3.2%	3%	3.8%
% of people referred for non-urgent mental health and alcohol and other drug services seen within 3 weeks	T [38]	69%	72%	70%	75%	79%
% of people referred for non-urgent mental health and alcohol and other drug services seen within 3 weeks	T [38]	85%	87%	86%	90%	93%
% of long-term clients aged 0-19 with current relapse prevention plans	Q [39]	90%	95%	96%	≥95%	-
% of long-term clients aged 20-64 with current relapse prevention plans	Q [39]	99%	99%	98%	≥95%	-

[37] The national expectation is that around 3% of the total population will need to access specialist mental health service.

[38] This measure is the national DHB reporting measure PP8 and results are provided three months in arrears. Results are for the year to March 2013.

[39] Relapse prevention/resiliency plans help to improve outcomes for clients by identifying warning signs and planning ahead what actions to take.

Acute/Urgent Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of children under six with access to free primary care after hours	C	new	100%	100%	100%	-
% of general practices using telephone triage outside business hours	C [40]	83%	86%	89%	95%	-
Acute demand packages of care provided in community settings	V [41]	19,645	25,374	28,378	22,000	-
Attendances at emergency departments (ED)	V [42]	84,444	87,221	94,010	≤91,775	-
% of people ready for treatment waiting less than 4 weeks for radiotherapy or chemotherapy	T [43]					
Quarter 4 results		100%	99.5%	100%	100%	-
Full year's results		100%	99.9%	99.9%	100%	-
Standardised acute inpatient average length of hospital stay	Q [44]	3.92	3.86	3.74	≤4.28	3.94

Elective/Arranged Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Medical and surgical First Specialist Assessments (FSAs) provided	V ⅄ [45]	60,401	60,819	67,122	est. >60,000	-
% of medical and surgical FSAs that are non-contact (virtual)	Q [45,46]	10.6%	12.1%	13.5%	>10%	-
Outpatient attendances	V Δ	611,205	622,837	640,678	est. >600,000	-
Outpatient 'Did not Attend' rates	Q [47]	4.8%	4.4%	4.4%	≤5%	-
Elective surgical discharges (surgeries provided)	V [48]	16,494	17,066	16,961	16,861	-
Percentage of elective/arranged surgeries provided as day cases.	Q [49]	58%	57%	57%	≥54%	56%
Percentage of people who receive their surgery on the day of admission	Q [49]	88%	91%	91%	≥79%	81%
Standardised elective surgical inpatient average length of hospital stay	Q [44]	3.40	3.19	3.15	≤3.21	3.27

[40] Results for 2012/13 differ from those previously stated due to a recalculation of practices which had closed and merged over the year.
[41] Acute demand or acute admission avoidable packages of care allow people who would otherwise require a hospital admission to be treated in their own homes or community through Canterbury's Acute Demand Management Service (ADMS).
[42] This measure is based on the national ED Health Target definition. As such, it counts Christchurch and Ashburton Emergency Departments. The 2012/13 result differs slightly to the previously published number (by 20 people) due to refreshed coding.
[43] The 2012/13 result differs to that published in the 2012/13 Annual Report (99.7%) as this measure includes both radiotherapy and chemotherapy.
[44] This measure is based on the OS3 national DHB performance measure and is balanced against readmissions rates to ensure service quality is appropriate.
[45] This FSA measure has been revised for the 2013/14 year to reflect both medical and surgical First Specialist Assessments rather than just covering surgical services as in previous years. % of medical and surgical FSAs that are non-contact (virtual).
[46] Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity across the system, reducing wait times for patients and taking duplication and waste out of the system.
[47] These results differ slightly from previously published results (4.9% and 4.6%) due to inclusion of those people who presented but did not wait.
[48] This number counts elective surgery volumes based on the national health target definition (excludes cardiology and dental volumes).
[49] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own homes, and frees up hospital beds. The 2011/12 and 2012/13 results differ slightly to those previously published (Day Cases 56%, 55%) (DOSA 82%, 88%) due to an internal definition update after the national measures were phased out.

Maternity Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Maternity deliveries in Canterbury DHB facilities	V	5,736	5,778	5,654	est. 6,000	-
Baby friendly hospital accreditation of Canterbury DHB facilities	Q [50]	Yes	Yes	Yes	Yes	-
% of total deliveries made in Primary Birthing Units	V [51]	11%	9%	9%	13%	-

Assessment, Treatment and Rehabilitation Services (AT&R)	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Admissions into inpatient AT&R services	V	3,261	3,101	3,285	est. >3,000	-
% of admissions into AT&R (PMH) made by direct community referral	Q [52]	16%	18%	16%	20%	-
% of AT&R inpatients discharged to their own home rather than ARC	Q Δ [53]	86%	85%	88%	≥80%	-

Quality and Patient Safety Measures	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Rate of all patient falls resulting in harm – per 1,000 inpatient bed days	Q ⅄	2.40	2.20	2.33	≤2.17	-
Reporting rates for medication, IV & blood incidents – per 1,000 inpatient bed days and day patients	Q [54]	1.9	2.2	2.5	≥2.5	-
Rates of Staph aureus healthcare-associated bloodstream infection – per 1,000 inpatient bed days	Q [55]	0.07	0.09	0.07	≤0.06	-

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

[51] The DHB aims to increase people acceptance and confidence in using primary birthing units whenever it is clinically appropriate, in order to ensure limited secondary services are available for those women who need more complex or specialist intervention.

[52] The 2012/13 result differs to that previously published due to a rounding error (19%).

[53] 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'. These results differ from that previously published as they did not exclude patients who were ARC residents prior to AT&R admission.

[54] Targets for medication, IV and blood incidents are set to increase the rate of reported incidents, in line with our policy of open disclosure of events. Achievement reflects transparency and willingness of staff to learn from events and prevent them from reoccurring.

[55] Staphylococcus aureus is often found in the nose or on the skin of healthy people, causing them no harm. However, Staph aureus can cause infection, and hospitalised patients are at greater risk because they are unwell and have lowered resistance to infection. It is transmitted via contact with people already carrying the bacteria, or through improperly washed hands, surfaces or equipment; therefore, rates of Staph aureus in hospital can reflect the effectiveness of infection control procedures. The result for 2012/13 differs to that previous report due to further review of incident reports.

OUTPUT CLASS

REHABILITATION AND SUPPORT SERVICES

Rehabilitation and support services provide people with the assistance they need to maintain or regain maximum functional independence. Services that support people to manage their needs and live safe and well 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. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

Success is therefore defined by increased access to community-based services, less dependence on hospital and residential care and a reduction in illness or deterioration that leads to an acute event.

Access rates for home-based support, district nursing services and respite services remain high. The Community Rehabilitation Enablement and Support Team (CREST) supported 2,125 people after hospital discharge or on referral from their GP to reduce the likelihood of hospital admission or readmission. Early indications of a lower hospital readmission rate for people supported by CREST are positive and patient survey results will be returned in the coming year to further ascertain the effectiveness of the service.

While the number people being supported by the Liverpool Care Pathway has not been as high as anticipated an increasing number of people are being supported by hospice or home-based palliative services. It is also pleasing to note the increased use of evidence-based and evidence-informed programmes and tools such as the InterRAI (International Residential Assessment Instrument), providing greater assurance that the right services are being provided.

Engagement with pulmonary rehabilitation and falls prevention programmes remains positive, although performance against stroke and cardiac targets is lower than expected. There will be a renewed focus on supporting people after acute events in the coming year with the aim of increased referrals and enrolments.

The increased focus on community-based care appears to be having the desired effect; a drop in the number of people entering lower-level Aged Residential Care (ARC) suggests more people are being supporting to stay in their own homes.

OUTPUT MEASURES

Needs Assessment and Services Coordination Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Older people (65+) provided with a clinical assessment of need using InterRAI	V Δ ⅄ [56]	3,969	3,992	4,347	est. >3,500	-
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	Q Δ [57]	85%	90%	91%	≥95%	-
% of people entering ARC having had a clinical assessment of need using interRAI	Q Δ ⅄	74%	91%	96%	≥95%	-

Palliative Care Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
People supported by hospice or home-based palliative services	V Δ	3,076	3,295	3,815	est. >2,000	-
ARC facilities trained to provide the Liverpool Care Pathway option	V [58]	27	42	38	≥45	-
People in ARC services being supported by the Liverpool Care Pathway	V Δ ⅄	154	134	71	>150	-

[56] These assessment measures have been revised for the 2013/14 year to reflect the use of the InterRAI Assessment tool only, rather than a variety of assessment tools. InterRAI is an evidence-based geriatric assessment tool and the use of this one tool across all services ensures assessments are both high quality and consistent and helps to ensure people receive equitable access to support and care. InterRAI also supports improved integration by providing health professionals with a common language of assessment and an electronic means of transferring information.

[57] This measure is based on the PP18 national DHB performance measure and 2012/13 result differs slightly from those previously published (88%) to better align with the national measure.

[58] The Liverpool Care Pathway is an international programme adopted nationally and reflects best-practice care. It begins with training of staff with the eventual aim of increasing the number of people supported by the pathway.

Rehabilitation Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
% of people referred to an organised stroke service after an acute event	C	75%	74%	74%	80%	-
% of people enrolled in cardiac rehabilitation services after an acute event	C [59]	25%	25%	20%	30%	-
People accessing pulmonary rehabilitation courses	V Δ [60]	170	206	230	≥150	-
People 65+ accessing community-based falls prevention programmes	V [61]	737	1,613	1,505	1,200	-

Home and Community-Based Support Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
People supported by long-term home-based support services	V Δ	8,124	8,860	8,796	est. 8,000	-
People supported by district nursing services	V Δ	5,833	7,911	7,645	est. 6,000	-
People accessing CREST services on hospital discharge or GP referral	V Δ [62]	1,154	1,850	2,125	2,200	-

Respite and Day Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
People supported by day services	V Δ	664	654	672	est. >550	-
People accessing mental health planned and crisis respite	C Δ	754	829	819	est. >750	-
Occupancy rate of mental health planned and crisis respite beds	C Δ[63]	71%	81%	84%	85%	-
People supported with aged care respite services	V Δ	1,119	1192	1,262	est.>1,000	-

Residential Care Services	Notes	2011/12	2012/13	2013/14 Result	Target 2013/14	Latest NZ Result
Subsidised ARC rest home beds provided (days)	V Δ [64]	613,514	573,866	567,703	est. <676,000	-
Subsidised ARC hospital beds provided (days)	V Δ [64]	464,188	453,716	457,571	est. <507,000	-
Subsidised ARC dementia beds provided (days)	V Δ [64]	212,439	222,445	226,120	est. >212,000	-
Subsidised ARC psycho-geriatric beds provided (days)	V Δ [64]	65,369	69,468	69,333	est. >62,000	-
% of ARC residents receiving vitamin D supplements	C	63%	73%	68%	75%	-

[59] This measure counts those enrolled in Phase 2 (outpatient) Cardiac Rehabilitation on discharge.
[60] These results differ slightly to previous years as they now include all people attending pulmonary rehabilitation, whether through DHB-run courses in Ashburton and Christchurch or through community-based courses in other parts of Canterbury.
[61] Canterbury's Integrated Falls Prevention Service seeks to support older people to maintain their independence and live safely in their own homes and communities, reducing harm as a result of falls.
[62] CREST provides a range of home-based rehabilitation services to facilitate early discharge from hospital or avoid admission entirely (via GP referral).
[63] 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. The result for 2012/13 differs to that previous published (85%) due to an error found in start and finish dates.
[64] The subsidised ARC bed day results for 2012/13 have all been updated to include late invoices in order to better reflect the actual demand for these services.

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 will require a continued and collaborative effort from across the whole of our health system, and while few of the targets have been met this year good progress is evident. PHO enrolments are increasing and significant improvements have been made in the delivery of both primary care Health Targets. Screening rates for cancer have improved as have childhood immunisation rates, oral health rates and the delivery of B4 School Checks.[65]

Māori Health Action Plan Indicators	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target 2013/14	Latest NZ Result
% of PHO enrolees with ethnicity 'not stated' is maintained	Q	0.9%	0.67%	0.68%	≤2%	-
% of the population enrolled with a PHO	C	78%	81%	83%	≥95%	-
% of tamariki exclusively and fully breastfed Age 6 weeks	Q [66]	59%	58%	59%	≥67%	60%
Age 3 months		46%	45%	49%	≥57%	44%
Age 6 months		18%	21%	17%	≥28%	16%
% of the eligible population having had a CVD Risk Assessment in the last 5 years	C	19%	31%	60%	90%	80%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [67]	79%	78%	80%	≥70%	73%
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [67]	51%	53%	56%	80%	-
% of smokers identified in hospital receive advice and help to quit						
Quarter 4 results	C	89%	92%	93%	95%	-
Full year results		83%	91%	95%	95%	-
% of smokers identified in primary care receiving advice and help to quit	C [68]	new	34%	62%	90%	-
% of tamariki fully immunised at eight months of age						
Quarter 4 results	C	new	85%	88%	90%	88%
Full year results		new	87%	88%	90%	-
% of the eligible population (65+) who have had an influenza vaccination	C [69]	69%	70%	73%	75%	-
Number of new rheumatic fever cases	Q [70]	0	1	2	n/a	-
% of tamariki aged four provided with a B4 School Check (B4SC)	C [71]	68%	84%	90%	80%	90%
% year 8 girls receiving dose 3 of the HPV vaccination programme	C†	18%	20%	23%	60%	59%
% of tamariki caries-free (no holes or fillings) at age 5	Q†	46%	41%	45%	65%	38%

[65] Results for two of the national measures outlined in the 2013/14 Māori Health Action Plan have not been included in this report (Acute Coronary and Ambulatory Sensitive Hospital Admissions). In regards to the Acute Coronary Measures the data collection is still relatively new and confirmed national results have not yet been made available by ethnicity. In regards to Ambulatory Sensitive Hospital Admissions, there has been a change to the national definition and Canterbury has identified an issue with the new denominator used to identify our Māori and Pacific populations which distorts the results by ethnicity against this measure. The DHB is working with the Ministry to resolve this issue and has chosen in the meantime not to publish this result.

[66] These results differ from previous years due to a change of reporting to the financial rather than calendar year. Data source: Plunket.

[67] These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality; Standards are based on national targets. Data source: National Screening Units.

[68] All data for this measure is sourced from the PHO Performance Programme. Results for 2013/14 are as at March 2014.

[69] These results are not available by ethnicity, instead the 'high needs' population is used. Data is sourced from the PHO Performance Programme.

[70] The results are for Canterbury Māori. However, due to the very low numbers of rheumatic fever cases, South Island DHBs have a combined regional target rather than individual DHB targets. The South Island target is 0.4 per 100,000.

[71] Results here have been broken down by ethnicity, these may differ from previously reported 'High Deprivation' results. Data source: Pegasus Health (Charitable) Ltd. 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.

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2014.

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, the Canterbury DHB Group recorded a break even result against the budgeted deficit of $25M (2012/13 result was a net surplus of $286.877M).

BOARD FEES

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

	Board Fees 2014 $'000	Committee Fees 2014 $'000
Bruce Matheson	28	2
Murray Cleverley	26	2
Peter Ballantyne	17	4
Sally Buck	13	1
Anna Crighton	26	4
Elizabeth Cunningham	14	3
Wendy Dallas-Katoa	-	1
Jonathan Darby	-	2
Andrew Dickerson	26	6
Wendy Gilchrist	14	3
Jo Kane	13	2
Aaron Keown	26	5
Bob Lineham	-	3
Chris Mene	26	4
Edie Moke	13	2
David Morrell	26	5
Trevor Read	-	1
Mary Richardson	-	1
William Tate	-	4
Susan Wallace	26	1
Steve Wakefield	16	2
Olive Webb	14	3
	324	**61**

Total fees paid for the year were $385,347 (2012/13 - $381,100). The limit of fees authorised for the year ended 30 June 2014 was $390,965 (2012/13 - $422,875).

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BOARD AND COMMITTEE MEMBER ATTENDANCE

	Board		QFARC		HAC		CPH&DSAC		CPHAC		DSAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Bruce Matheson	5	5	4	6	1	3	3	3	-	-	-	-
Murray Cleverley	6	6	5	6	1	1	-	-	-	-	-	-
Peter Ballantyne	5	5	11	11	3	3	3	3	-	-	-	-
Sally Buck	6	6	1	2	-	1	-	-	2	2	2	2
Anna Crighton	11	11	6	8	6	6	2	3	2	2	-	-
Elizabeth Cunningham	5	5	6	6	3	3	3	3	-	-	-	-
Wendy Dallas-Katoa	-	-	-	-	-	-	2	3	2	2	2	2
Jonathan Darby	-	-	-	-	-	-	3	3	2	2	2	2
Andrew Dickerson	11	11	12	12	6	6	3	3	-	-	2	2
Wendy Gilchrist	3	5	5	6	3	3	2	3	-	-	-	-
Jan Edwards	-	-	-	-	1	1	-	-	-	-	-	-
Jo Kane	6	6	2	2	1	1	-	-	2	2	2	2
Aaron Keown	10	11	8	8	6	6	3	3	2	2	-	-
Bob Lineham	-	-	11	12	-	-	-	-	-	-	-	-
Chris Mene	10	11	6	8	4	4	3	3	2	2	2	2
Edie Moke	4	6	6	6	1	1	-	-	-	-	2	2
David Morrell	11	11	10	12	5	6	3	3	-	-	-	-
Trevor Read	-	-	-	-	5	6	-	-	-	-	-	-
Mary Richardson	-	-	-	-	-	-	3	3	1	2	-	1
Ana Rolleston	-	-	-	-	4	6	-	-	-	-	-	--
William Tate	-	-	10	12	4	6	-	-	-	-	-	-
Susan Wallace	8	11	2	8	-	-	-	-	-	-	-	-
Steve Wakefield	6	6	5	6	1	3	-	-	-	-	-	-
Olive Webb	5	5	6	6	3	3	3	3	-	-	-	-

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

The CPHAC and DSAC committees were previously combined (CPH&DSAC). From February 2014 they have been run as separate committees as approved by the Board at its February 2014 meeting.

DIRECTOR FEES

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

	2014 $'000	2013 $'000
Brian Wood	28	20
Jane Cartwright	21	5
	49	**25**

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2014

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 Holdings Ltd – Director District Health Boards NZ - Director South Island Neurosurgical Services Board - Director KCL Properties - Director Warbirds Over Wanaka - Director CERA – Employee South Canterbury DHB – Board Chairman
Steve Wakefield Deputy Chair	Deloitte – Partner - Partner of professional services including accounting, tax, auditing and consulting services. Trustee – Anglican Church Property Trustees - Holds all property on behalf of the Anglican Church in the Diocese of Christchurch Trustee - Court Theatre Trust - Professional Theatre Company National Board Member – YHA New Zealand Ltd - Operates around 50 youth hostels throughout New Zealand Board Member – Canterbury Cricket Association - Operates all professional and amateur cricket in Canterbury. Developing Hagley Oval as an international cricket ground. Director CropLogic Ltd - Start up company in the provision of systems to enhance food production efficiency. Vestry Member (Board of Trustees) St Barnabas Church - Local Anglican Parish Church Board of Trustees. Trustee – Greater Christchurch Schools Network Trust - Objectives are to facilitate improved digital teaching and learning in Christchurch. I am a trustee and a beneficiary of a family trust that holds various investments, one of which is a shareholding in listed company Fletcher Building Limited, which may supply building materials or construction services, or tender to provide such services to Canterbury DHB.

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. Wainoni Avonside Community Support Trust - Board Member - community organisation affiliated to the Methodist Church in Wainoni – runs programmes for older people. Just Dirt Trust – Board Member
Anna Crighton	Christchurch Heritage Trust – Chair - Governance of Christchurch Heritage. Historic Places Aotearoa Inc - President
Andrew Dickerson	Health Care of the Elderly Education Trust – Chair - Promotes and supports teaching and research in the area of care of older people. Recipients of financial assistance for research, education or training could include employees of the Canterbury DHB. Canterbury Medical Research Foundation – Member - Provides financial assistance for medical research and research facilities in Christchurch. Recipients of financial assistance for research, education or training could include employees of the Canterbury DHB. NZ Historic Places Trust – Member - The Trust promotes the identification, preservation and conservation of the historical & cultural heritage of New Zealand. Canterbury DHB owns buildings that may be considered by the Trust to have historical significance. No Conflicts of Interest are envisaged for the following interests, but should a conflict arise this will be discussed at the time. ▪ NZ Gerontology Association – Member - Professional association that promotes the interests of older people and an understanding of ageing. ▪ Hope Foundation for Research on Ageing – Member - Promotes research on New Zealand's ageing population and its implications for the future. ▪ Osteoporosis (Canterbury) Inc. – Member - Provides support, information and advice to people with osteoporosis. ▪ Neurological Foundation of New Zealand Inc. – Member - Provides support and information to people with diseases and disorders of the brain and nervous system. ▪ Abbeyfield New Zealand Inc. – Member - Promotes and establishes community housing for lonely and socially isolated older people using the Abbeyfield model. Consultant - I have 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 I sit 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 – I undertake consultancy work for this trust.
Aaron Keown	Christchurch City Council - Shirley Papanui Community Board – Member - I am an elected member of the Shirley Papanui Community Board. Grouse Entertainment Ltd – Director and Shareholder Grouse Films Ltd – Director
Edie Moke	Director - Health Benefits Ltd (HBL) - also Chair of the Finance Audit and Risk Committee of HBL. The role of HBL is to work in partnership with DHBs to reduce their administrative, support and procurement costs. Canterbury DHB holds shares in HBL and HBL is also a shareholder in Health Alliance NZ Ltd, which provides shared services to Northern Region DHBs. Board Member South Canterbury DHB – Appointed 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 All Right? Campaign – Pacific health and wellbeing research contract with Community and Public Health. Environment Canterbury – Facilitation of land contamination community workshops. Also acting as facilitator ECan Air Plan review – July 2014.
David Morrell	British Honorary Consul - Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of the Canterbury DHB, including Mental Health Services. In addition a conflict of interest may arise from time to time in respect to Coroners' Inquest hearings involving British nationals. Nurses Memorial Chapel Trust –Chair - (Canterbury DHB Appointee) - Trust responsible for Memorial on the Christchurch Hospital site. Historic Places Trust – Subscribing Member - The Trust's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. The Trust identifies records and acts in respect of significant ancestral sites and buildings. The Trust has already been involved with Canterbury DHB buildings. My wife is a member of the Hospital Ladies Visitors Association – no potential conflict of interest is expected and should this arise it will be declared at that time. 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	Member – West Coast DHB - Appointed board member West Coast DHB Te Rūnanga o Ngāi Tahu - Affiliated Member of TRONT. Māori Women's Welfare League (MWWL) - Member of Maori Women's Welfare League, is a recipient of Ministry of Health funding for HEHA programmes. Chair – Poutini Waiora Trust - 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. Te Runanga o Ngai Tahu – Te Atawhai o Te Ao – Wanganui - Contract researcher NSP Kaitiaki Advisory Group – Ministry of Health Appointed Member Whakaruruhau Komiti – National Breastfeeding Maori Advisory Group Te Reo Kotahi: Pan - NGO sector delegate to CERA National Health Promotion Forum – Chair, Maori Advisory Group Community Services Service Level Alliance Pegasus Health Community Board Otago University Christchurch - Maori Strategic Framework advisor
Pauline Barnett	Chair, Comcare Charitable Trust - Mental health and housing Deputy Chair, St John of God Hauora Trust - Disability and Youth Service Board Member, 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

Ben Lucas	New Zealand Spinal Trust – CEO Parafed Canterbury – Board Member CCS Disability Action Canterbury/West Coast – Patron ACC Serious Injury Advisory Group – Member - Provides comment on policy, identifies systemic issues, and forms recommendations to present to ACC Executive. 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.
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.
Olive Webb	Private Consulting Business - I sometimes work with Canterbury DHB patients and services.
Baden Ewart	Canterbury GP Ltd – Shareholder and Director - General practice trading as Merivale Medical Practice – holds primary care contracts. 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.
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

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.
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. The South Island Alliance Programme office contracts the Canterbury DHB to provide hosting functions. 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.

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. To the best of my knowledge this does 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.

QUALITY, FINANCE, AUDIT & RISK COMMITTEE

Peter Ballantyne	West Coast District Health Board – Appointed Member Bishop Julius Hall of Residence -Trust Board Member University of Canterbury - Council Member - The University of Canterbury provides certain services to the Canterbury DHB Deloitte – Retired partner - Deloitte carries out certain consulting assignments for the Canterbury DHB from time to time. Brackenridge Estate Ltd – Director and Acting Chairperson Spouse, Claire Ballantyne is a Canterbury DHB employee (Ophthalmology Department).
Bill Tate	Pulp Kitchen – Director Pulp Kitchen Catering Limited – Director New Zealand Institute of Management Foundation – Trustee New Zealand Institute of Management Life Fellows Committee
Bob Lineham	New Zealand Local Government Finance Corp Ltd – Director - This involves investing and borrowing on behalf of local authorities (currently in wind down mode). Christchurch City Holdings (CCHL) – Chief Executive - This is an infrastructure Investment Company. Also acts as a director in a number of non-operating CCHL shelf companies. Red Bus Limited - Director

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 $127,342 to 6 employees (2012/13 – 8 employees totalling $451,854) 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:

	2014 (including benefits) Total	2013 (including benefits) Total
100,000-109,000	192	135
110,000-119,000	118	101
120,000-129,000	112	80
130,000-139,000	89	75
140,000-149,000	64	50
150,000-159,000	40	54
160,000-169,000	39	30
170,000-179,000	22	30
180,000-189,000	21	23
190,000-199,000	22	24
200,000-209,000	25	22
210,000-219,000	32	33
220,000-229,000	28	27
230,000-239,000	24	23
240,000-249,000	16	10
250,000-259,000	19	30
260,000-269,000	29	21
270,000-279,000	16	16
280,000-289,000	21	13
290,000-299,000	12	12
300,000-309,000	15	17
310,000-319,000	16	14
320,000-329,000	7	10
330,000-339,000	12	3
340,000-349,000	3	7
350,000-359,000	5	3
360,000-369,000	11	7
370,000-379,000	3	7
380,000-389,000	2	1
390,000-399,000	2	3
400,000-409,000	2	2
410,000-419,000	-	1
420,000-429,000	1	2
430,000-439,000	2	1
440,000-449,000	1	1
450,000-459,000	-	-
460,000-469,000	1	1
470,000-479,000	1	-
480,000-489,000	1	-
500,000-509,000	1	-
530,000-539,000	-	1
560,000-569,000	1	1
Total	**1,028**	**891**

Of the 1,028 (2012/13 891) positions identified above, 880 (2012/13 776) positions were predominantly clinical and 148 (2012/13 115) positions were management/administrative.

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STATUTORY INFORMATION

This Annual Report outlines the Canterbury DHB's financial and non-financial performance for the year ended 30 June 2014 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (e) of the same Act.

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

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

GOOD EMPLOYER

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

Leadership, Accountability and Culture

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

Staff Mix by Average Age	Average age
Medical	40.7
Nursing	46.9
Allied Health	44.5
Support	52.9
Management & Administration	49.2

Staff Mix by Gender	Number	Percentage
Female	7,633	81
Male	1,770	19
Total	9,403	

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 work in a way so as to deliver positive patient outcomes.

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

Staff Ethnicity	Number
Americas	79
Australian	95
British	696
Chinese	119
Filipino	123
Indian	111
Irish	69
Maori	205
Middle Eastern	27
New Zealand European	4,835
New Zealander	523
Pacific Peoples	96
South African	51
Other African	45
Other Asian	127
Other European	192
Not Stated	2,007
Other	3
Total	9,403

Integrated Talent Management

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

Workplace Safety, Health and Wellness

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by a professional Health and Safety team that includes experts in workplace safety, occupational health and rehabilitation, as well as employee 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 with safety training encourages all employees to be responsible for building and maintaining a healthy and safe environment at work. Canterbury DHB continues to participate in the ACC Partnership Programme and is focussed on developing and implementing injury prevention programmes that address high risk areas and in the rehabilitation of employees back to work following an injury or illness. We do not tolerate any form of harassment or workplace bullying and ensure all staff is aware of harassment policies and procedures to deal with such a situation. This includes discussions with new employees at orientation, information and the training of managers to facilitate early intervention.

Remuneration and Recognition

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

Employee Engagement

In June 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 TANZ network (10 SI and lower NI polytechnic institutes) to make available a common curriculum of development to all employees. These programmes are additional to the extensive skills development initiatives that come through the various professional groups for both clinical and non-clinical employees. The rollout of an online performance appraisal process that ensures that all employees are focussed on the right things and expected behaviours at an individual level is continuing with rollout continuing in 2014/15. This process also identifies and provides input to the development needs of individuals.

STATEMENT OF RESPONSIBILITY

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

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

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2014, are our responsibility.

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

For and on behalf of the Board

Murray Cleverley
Chair
28 October 2014

Steve Wakefield
Deputy Chair
28 October 2014

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2014

		Group			Parent	
	Notes	Actual 2014 $'000	Budget 2014 $'000	Actual 2013 $'000	Actual 2014 $'000	Actual 2013 $'000
Income						
Ministry of Health revenue		1,445,433	1,408,932	1,417,954	1,432,160	1,399,457
Patient related revenue	2	42,649	45,335	42,739	42,649	42,739
Other income	3	32,349	31,416	320,016	27,425	315,776
Interest income		15,795	7,020	9,417	15,661	9,253
Total income		**1,536,226**	**1,492,703**	**1,790,126**	**1,517,895**	**1,767,225**
Operating expenses						
Employee benefit costs	4	637,283	624,240	599,959	621,148	585,355
Treatment related costs		133,379	129,852	128,613	137,501	127,844
External service providers		584,312	605,000	581,255	584,312	581,255
Depreciation and amortisation		58,423	51,007	48,191	56,480	46,573
Interest expenses on loans		5,454	6,324	5,765	5,454	5,765
Other expenses	5	98,385	87,781	126,447	93,494	121,207
Total operating expenses		**1,517,236**	**1,504,204**	**1,490,230**	**1,498,389**	**1,467,999**
Operating surplus before capital charge		18,990	(11,501)	299,896	19,506	299,226
Capital charge expense	6	(18,990)	(13,500)	(13,019)	(18,990)	(13,019)
Surplus/(deficit)		**-**	**(25,001)**	**286,877**	**516**	**286,207**
Other comprehensive income						
Impairment of property, plant & equipment	7 & 14 & 16	-	-	(25,108)	-	(25,108)
Revaluation of property, plant & equipment	7 & 14	(383)	-	93,245	(383)	93,245
Total other comprehensive income		**(383)**	**-**	**68,137**	**(383)**	**68,137**
Total comprehensive income		**(383)**	**(25,001)**	**355,014**	**133**	**354,344**

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2014

	Notes	Group			Parent	
		Actual 2014 $'000	Budget 2014 $'000	Actual 2013 $'000	Actual 2014 $'000	Actual 2013 $'000
Total equity at beginning of the year		536,617	181,603	185,325	533,238	182,616
Surplus/ (deficit) for the year		-	(25,001)	286,877	516	286,207
Other comprehensive income		(383)	-	68,137	(383)	68,137
Total comprehensive income		(383)	(25,001)	355,014	133	354,344
Total recognised revenues and expenses		536,234	156,602	540,339	533,371	536,960
Other movements:						
Repayment of capital to the Crown		(351,861)	(1,861)	(3,722)	(351,861)	(3,722)
Capital Contribution from the Crown		20,000	25,001	-	20,000	-
Total equity at end of the year	7	**204,373**	**179,742**	**536,617**	**201,510**	**533,238**

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2014

	Notes	Group Actual 2014 $'000	Group Budget 2014 $'000	Group Actual 2013 $'000	Parent Actual 2014 $'000	Parent Actual 2013 $'000
CROWN EQUITY						
General Funds	7	(204,429)	150,572	127,432	(204,291)	127,570
Revaluation Reserve	7	199,158	131,404	199,541	199,158	199,541
Accumulated surpluses/ (deficits)	7	209,644	(102,234)	209,644	206,643	206,127
TOTAL EQUITY		**204,373**	**179,742**	**536,617**	**201,510**	**533,238**
REPRESENTED BY:						
CURRENT ASSETS						
Cash and cash equivalents	8	90,044	39,651	87,039	88,916	86,036
Trade and other receivables	9	75,171	50,852	374,000	73,435	372,372
Inventories	10	9,128	7,338	7,983	9,033	7,888
Investments	11	3,064	5,682	2,491	1,850	-
TOTAL CURRENT ASSETS		177,407	103,523	471,513	173,234	466,296
CURRENT LIABILITIES						
Trade and other payables	12	113,017	123,015	121,351	112,645	121,026
Ministry of Health		-	485	-	-	-
Employee benefits	13	158,012	148,066	163,505	156,237	161,059
Borrowings	18	15,000	30,000	-	15,000	-
TOTAL CURRENT LIABILITIES		286,029	301,566	284,856	283,882	282,085
NET WORKING CAPITAL		(108,622)	(198,043)	186,657	(110,648)	184,211
NON-CURRENT ASSETS						
Investments	11	34,650	61,933	54,843	40,141	60,237
Property, plant and equipment	14	406,667	437,365	427,483	400,310	421,128
Intangible assets	15	9,784	53	5,038	9,783	5,036
Restricted assets	17	13,760	15,012	14,766	13,760	14,766
TOTAL NON-CURRENT ASSETS		464,861	514,363	502,130	463,994	501,167
NON-CURRENT LIABILITIES						
Employee benefits	13	7,121	6,916	7,754	7,091	7,724
Restricted funds	17	13,760	15,012	14,766	13,760	14,766
Borrowings	18	130,985	114,650	129,650	130,985	129,650
TOTAL NON-CURRENT LIABILITIES		151,866	136,578	152,170	151,836	152,140
NET ASSETS		**204,373**	**179,742**	**536,617**	**201,510**	**533,238**

For and on behalf of the Board

Murray Cleverley
Chair
28 October 2014

Steve Wakefield
Deputy Chair
28 October 2014

This statement is to be read in conjunction with the Notes to the Financial Statements

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2014

	Notes	Group Actual 2014 $'000	Group Budget 2014 $'000	Group Actual 2013 $'000	Parent Actual 2014 $'000	Parent Actual 2013 $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health		1,447,684	1,290,637	1,391,426	1,434,465	1,372,997
Other receipts		75,268	230,046	54,257	70,398	50,449
Interest received		15,795	7,020	9,417	15,661	9,253
		1,538,747	1,527,703	1,455,100	1,520,524	1,432,699
Cash was applied to:						
Payments to employees		643,409	624,240	588,041	626,603	573,626
Payments to suppliers		821,550	822,633	834,162	820,835	828,235
Interest paid		5,439	6,324	5,685	5,439	5,685
Capital charge		18,990	13,500	13,019	18,990	13,019
GST - net		4,059	-	1,363	4,052	1,341
		1,493,447	1,466,697	1,442,270	1,475,919	1,421,906
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	45,300	61,006	12,830	44,605	10,793
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant & equipment		55	-	-	55	-
Earthquake insurance receipts		295,250	-	15,061	295,250	15,061
Receipts from restricted assets & investments		24,104	-	73,341	22,730	73,613
		319,409	-	88,402	318,035	88,674
Cash was applied to:						
Purchase of investments & restricted assets		4,484	7,000	1,774	4,484	2,179
Purchase of property, plant & equipment		41,694	153,156	60,516	39,750	57,938
		46,178	160,156	62,290	44,234	60,117
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		273,231	(160,156)	26,112	273,801	28,557
CASH FLOW FROM FINANCING ACTIVITIES						
Cash was provided from:						
Loans Raised		16,335	7,500	-	16,335	-
Capital contribution from the Crown		20,000	25,001	-	20,000	-
		36,335	32,501	-	36,335	-
Cash was applied to:						
Repayment of capital to the Crown		351,861	1,861	3,722	351,861	3,722
		351,861	1,861	3,722	351,861	3,722
NET CASH INFLOW/ (OUTFLOW) FROM FINANCING ACTIVITIES		(315,526)	30,640	(3,722)	(315,526)	(3,722)
Net increase/ (decrease) in cash and cash equivalents		3,005	(68,510)	35,220	2,880	35,628
Cash and cash equivalents at beginning of year		87,039	108,161	51,819	86,036	50,408
CASH & CASH EQUIVALENTS AT END OF YEAR	8	**90,044**	**39,651**	**87,039**	**88,916**	**86,036**

This statement is to be read in conjunction with the Notes to the Financial Statements

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2014

1. STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY AND STATUTORY BASE

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

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

Canterbury DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community.

The consolidated financial statements of Canterbury DHB 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 2014 and were authorised for issue by the Board on 28 October 2014.

BASIS OF PREPARATION

Statement of compliance

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

Measurement basis

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

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

Functional and presentation currency

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

Changes in accounting policies

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

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

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

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

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Canterbury DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards have been developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. This means Canterbury DHB will transition to the new standards in preparing its 30 June 2015 financial statements. Canterbury DHB has not assessed the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

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

Subsidiaries

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus /deficit.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

The budget figures are those approved by Canterbury DHB in its Annual Plan (incorporating the Statement of Intent) which is tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

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

Additions

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

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

Depreciation

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

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

Class of Asset	**Years**	**Depreciation Rate**
Freehold Buildings & Fitout	10 - 50	2 - 10%
Leasehold 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. Other development expenditure is recognised in the surplus/deficit when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Amortisation

Amortisation is charged to the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	2 years	50%

Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in other comprehensive income.

Other financial assets held are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the surplus/deficit. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the surplus/deficit.

Financial assets classified as held for trading or available-for-sale are recognised/derecognised on the date Canterbury DHB commits to purchase/sell the investments.

Trade and other receivables

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

Inventories

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

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

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

Impairment

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

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

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

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in other comprehensive income even though the financial

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

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

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where Canterbury DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in other comprehensive income, a reversal of the impairment loss is also recognised in other comprehensive income.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Restricted assets and liabilities

Donations and bequests received with restrictive conditions are treated as a liability until the specific terms from which the funds were derived are fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus/deficit over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

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

Defined benefit plans

Canterbury DHB makes contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocations. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave, retirement gratuities and sick leave

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the year end date. Canterbury DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. The sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at

balance date to the extent Canterbury DHB anticipates it will be used by staff to cover those future absences.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

Provisions

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

ACC Partnership Programme

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

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

Trade and other payables

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

Derivative financial instruments

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

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

Income tax

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

Goods and services tax

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

Revenue

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

Revenue relating to service contracts

Canterbury DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the

money or Canterbury DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Services rendered

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

Interest income

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

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

Critical judgements in applying Canterbury DHB's accounting policies

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

Critical accounting estimates and assumptions

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

Property, plant and equipment useful lives and residual value

At each balance date Canterbury DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, advance in medical technology, and expected disposal proceeds from the future sale of the assets.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the surplus/deficit, and carrying amount of the asset in the statement of financial position. Canterbury DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets;
- Asset replacement programs;
- Review of second hand market prices for similar assets; and
- Analysis of prior asset sales.

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

Retirement and long service leave

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

Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Canterbury DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Canterbury DHB has exercised its judgement on the appropriate classification of its leases and, has determined all lease arrangements are operating leases.

Non-government grants

Canterbury DHB must exercise judgement when recognising grant income to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

2. PATIENT RELATED REVENUE

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
ACC Revenue	23,395	22,822	23,395	22,822
Other patient related revenue	19,254	19,917	19,254	19,917
	42,649	**42,739**	**42,649**	**42,739**

3. OTHER INCOME

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Gain/(loss) on sale of property, plant and equipment	39	43	39	14
Donations and bequests received	3,367	1,299	3,367	1,299
Insurance revenue	3,028	294,672	3,028	294,672
Other	25,915	24,002	20,991	19,791
	32,349	**320,016**	**27,425**	**315,776**

4. EMPLOYEE BENEFIT COSTS

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Wages and salaries	639,421	583,537	622,366	569,157
Contributions to defined contribution plans	4,303	4,503	4,236	4,456
Increase/(decrease) in employee benefit provisions	(6,441)	11,919	(5,454)	11,742
	637,283	**599,959**	**621,148**	**585,355**

5. OTHER EXPENSES

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Remuneration of auditor:				
Financial statement audit fees	253	239	204	196
Board members' fees	324	319	324	319
Directors' fees	49	25	-	-
Rental costs	6,765	6,364	5,869	5,583
Facilities and infrastructure costs (note 16)	52,459	61,244	50,119	59,014
Other non-clinical costs	38,535	58,256	36,978	56,095
	98,385	**126,447**	**93,494**	**121,207**

6. CAPITAL CHARGE

Canterbury DHB pays capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the year ended June 2014 was 8%. (June 2013 8%).

7. CAPITAL AND RESERVES

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
General Funds				
Opening Balance	127,432	131,154	127,570	131,292
Repayment of capital to the Crown	(351,861)	(3,722)	(351,861)	(3,722)
Capital contribution from the Crown	20,000	-	20,000	-
	(204,429)	**127,432**	**(204,291)**	**127,570**
Retained earnings				
Opening balance	209,644	(77,233)	206,127	(80,080)
Operating surplus/(deficit)	-	286,877	516	286,207
Closing balance	209,644	209,644	206,643	206,127
Represented by:				
Accumulated surplus in parent and subsidiaries	209,566	209,566	206,565	206,049
Accumulated surplus in associates	78	78	78	78
	209,644	**209,644**	**206,643**	**206,127**
Revaluation reserve				
Opening balance	199,541	131,404	199,541	131,404
Impairment charges	-	(25,108)	-	(25,108)
Revaluation of land, building including fitout	(383)	93,245	(383)	93,245
Closing balance	199,158	199,541	199,158	199,541
Represented by:				
Revaluation of land	86,109	86,109	86,109	86,109
Revaluation of buildings including fitout	113,049	113,432	113,049	113,432
	199,158	**199,541**	**199,158**	**199,541**
Total Equity	**204,373**	**536,617**	**201,510**	**533,238**

8. CASH AND CASH EQUIVALENTS

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Bank balances and call deposits (refer note 26)	89,889	87,039	88,916	86,036
Term deposits less than 3 months	155	-	-	-
	90,044	**87,039**	**88,916**	**86,036**

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

9. TRADE AND OTHER RECEIVABLES

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Trade receivables	13,287	18,635	12,883	18,371
Receivable from the Ministry of Health	49,830	52,081	48,562	50,867
Prepayments	3,221	2,776	3,219	2,773
Other receivables	8,833	300,508	8,771	300,361
	75,171	**374,000**	**73,435**	**372,372**

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

Other receivables includes $nil (June 2013 $295.25M) insurance receivable.

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

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Balance at 1 July	3,312	3,605	3,312	3,602
Additional provisions made during the year	680	1,339	680	1,342
Receivables written-off during period	(925)	(1,632)	(925)	(1,632)
Balance at 30 June	**3,067**	**3,312**	**3,067**	**3,312**

The ageing of the impairment provisions are as follows:

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Current	159	121	159	121
1-30 days	565	612	565	612
31-60 days	202	225	202	225
> 61 days	2,141	2,354	2,141	2,354
Balance at 30 June	**3,067**	**3,312**	**3,067**	**3,312**

As at 30 June 2014 and 2013, all overdue receivables have been assessed for impairment and appropriate provisions have been applied. The net ageing of trade receivables are:

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Current	10,752	15,488	10,512	15,293
1-30 days	2,847	2,491	2,751	2,455
31-60 days	210	(472)	183	(502)
> 61 days	(522)	1,128	(563)	1,125
Balance at 30 June	**13,287**	**18,635**	**12,883**	**18,371**

10. INVENTORY

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Pharmaceuticals	2,203	4,445	2,203	4,445
Surgical and medical supplies	4,878	4,806	4,878	4,806
Other supplies	3,220	509	3,125	414
	10,301	9,760	10,206	9,665
Provision for obsolescence	(1,173)	(1,777)	(1,173)	(1,777)
	9,128	**7,983**	**9,033**	**7,888**

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

11. INVESTMENTS

Canterbury DHB has the following investments:

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Current investments are represented by:				
Term deposits	3,064	2,491	1,850	-
Total current investments	3,064	2,491	1,850	-
Non-current investments are represented by:				
Term Deposits	34,650	54,843	34,650	54,650
Investment in Subsidiaries	-	-	5,491	5,587
Total non-current investments	34,650	54,843	40,141	60,237
	37,714	**57,334**	**41,991**	**60,237**

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		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Term deposits with maturities of 1-12 months	3,064	2,491	1,850	-
Weighted average effective interest rates	4.29%	4.31%	4.29%	-
Term deposits with maturities later than 1 year but no more than 5 years	34,650	54,843	34,650	54,650
Weighted average effective interest rates	5.31%	5.22%	5.31%	5.22%

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 2014	Balance date
South Island Shared Service Agency Limited	Non Trading Company	47%	30 June

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

b) Share of associates' contingent liabilities and commitments

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

Investments in subsidiaries

	Parent 2014 $'000	Parent 2013 $'000
Equity - Canterbury Linen Services Ltd	5,394	5,394
Advances - Canterbury Linen Services Ltd	(34)	(40)
Advances - Brackenridge Estate Ltd	131	233
	5,491	**5,587**

At 30 June 2014 subsidiary companies comprise:

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

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

Joint Ventures

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

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

12. TRADE AND OTHER PAYABLES

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Trade payables	15,412	13,533	15,557	13,244
Other payables	97,605	107,818	97,088	107,782
	113,017	**121,351**	**112,645**	**121,026**

Trade and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of trade and other payables approximates their fair value.

13. EMPLOYEE BENEFITS

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Current liabilities				
Annual leave accruals	68,226	65,761	67,198	64,675
Unpaid days accruals	8,678	7,947	8,334	7,684
ACC accruals	8,318	10,112	8,263	10,046
Conference/sabbatical leave and expenses	24,692	23,623	24,692	23,623
Sick leave	10,406	10,613	10,231	10,446
Other	37,692	45,449	37,519	44,585
	158,012	**163,505**	**156,237**	**161,059**
Non-current liabilities				
Liability for long service leave	4,236	4,284	4,206	4,254
Liability for retirement gratuities	2,885	3,470	2,885	3,470
	7,121	**7,754**	**7,091**	**7,724**

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

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**

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

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 2013	123,338	239,662	52,922	181	11,380	427,483
At 30 June 2014	**123,338**	**227,063**	**49,661**	**111**	**6,494**	**406,667**

The disposal of certain properties may be subject to the Ngai Tahu Claims Settlement Act 1995, or the provision of section 40 of the Public Works Act 1981.

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

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	266,073	202,413	1,267	11,376	604,467
Additions	-	26,974	11,700	-	-	38,674
Disposals/transfers	-	(1,001)	(3,456)	(859)	(5,059)	(10,375)
Revaluation	-	-	-	-	-	-
Balance at 30 June 2014	**123,338**	**292,046**	**210,657**	**408**	**6,317**	**632,766**
Depreciation & impairment losses						
Balance at 1 July 2013	-	26,683	155,570	1,086	-	183,339
Depreciation	-	39,135	14,884	70	-	54,089
Revaluation	-	383	-	-	-	383
Impairment	-	-	-	-	-	-
Disposals/transfer	-	(990)	(3,507)	(858)	-	(5,355)
Balance at 30 June 2014	**-**	**65,211**	**166,947**	**298**	**-**	**232,456**

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

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 2013	123,338	239,390	46,843	181	11,376	421,128
At 30 June 2014	**123,338**	**226,835**	**43,710**	**110**	**6,317**	**400,310**

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 is 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 is negotiating with the third party on a settlement that will have ownership revert back to Canterbury DHB in late 2014.

15. INTANGIBLE ASSETS

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Software				
Cost				
Opening balance	23,918	20,529	23,908	20,521
Additions	5,422	3,443	5,423	3,441
Disposals	-	(54)	-	(54)
Closing balance	29,340	23,918	29,331	23,908
Amortisation and impairment losses				
Opening balance	21,873	19,590	21,865	19,583
Amortisation charge for the year	2,392	2,290	2,391	2,289
Disposals	(57)	(7)	(56)	(7)
Closing balance	24,208	21,873	24,200	21,865
Health Benefits Limited	4,652	2,993	4,652	2,993
Carrying amounts	**9,784**	**5,038**	**9,783**	**5,036**

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 2014. There has been no change since last year.

Canterbury DHB has made payments totalling $1.659M in the year to 30 June 2014 (2013: $2.993M) 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.

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 12,000 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 relevel in Other Comprehensive Income, with a corresponding decrease to the land and buildings Asset Revaluation Reserve, and to Property, Plant and Equipment in the Statement of Financial Position. Existing assets were again reviewed for impairment as at 30 June 2014, but no further impairment was deemed necessary. The total carrying amount of Property, Plant, and Equipment for the Group is $406.667M (2013: $427.483M), and would have been $406.667M (2013: $452.591M) had we not impaired our assets. For buildings, where the recoverable amount is determined on a depreciated replacement cost basis, Canterbury DHB has based the impairment on the best available estimate of the likely repair costs to restore buildings to their previous condition, excluding any ancillary operating cost increases, but this impairment does not reflect the full cost of making buildings compliant with the new building code.

Repair costs for buildings that have been impaired due to the earthquakes 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 2014, 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 additional funding of $22.912M (2013: $35.150M) to cover a deficit that Canterbury DHB would otherwise have incurred as a direct result of these costs. This $22.912M has been recorded as additional revenue and sits as a receivable from the Ministry of Health in our results to 30 June 2014.

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, leaving a further $270M that can be drawn upon in future periods to cover earthquake 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		Parent	
	2014 $’000	**2013 $’000**	**2014 $’000**	**2013 $’000**
Balance at beginning of year	14,766	15,012	14,766	15,012
Interest received	889	659	889	659
Donations and funds received	2,589	1,575	2,589	1,575
Funds spent	(4,484)	(2,480)	(4,484)	(2,480)
Balance at end of year	**13,760**	**14,766**	**13,760**	**14,766**

Residents' trust accounts	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Residents' trust account balance	**954**	**980**	**320**	**310**

Residents' trust account comprises bank balances representing funds managed on behalf of residents of Canterbury DHB. These funds are held in separate bank accounts and any interest earned is allocated to individual residents' balances. Therefore, transactions occurring during the year are not included in the Statement of Comprehensive Income, Financial Position or Cash Flow of Canterbury DHB's own financial statements.

18. BORROWINGS

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Current				
Ministry of Health loans (previously Crown Health Financing Agency loans)	15,000	-	15,000	-
Total current borrowings	**15,000**	**-**	**15,000**	**-**
Non-current				
Ministry of Health loans (previously Crown Health Financing Agency loans)	130,985	129,650	130,985	129,650
Total non-current borrowings	**130,985**	**129,650**	**130,985**	**129,650**
Total borrowings	**145,985**	**129,650**	**145,985**	**129,650**

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

The Ministry of Health loans (previously Crown Health Financing Agency loans) are issued at fixed rates of interest. The carrying amounts of borrowings approximate their fair values. The details of terms and conditions are as follows:

Interest rates

Average interest rates on the groups' borrowing for the year are as follows:

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Ministry of Health loans (previously Crown Health Financing Agency loans)				
Less than one year	15,000	-	15,000	-
Weighted average effective interest rate	*6.13%*		*6.13%*	
Later than one year but not more than five years	40,000	15,000	40,000	15,000
Weighted average effective interest rate	*3.39%*	*6.13%*	*3.39%*	*6.13%*
Later than five years	90,985	114,650	90,985	114,650
Weighted average effective interest rate	*4.06%*	*3.73%*	*4.06%*	*3.73%*

Security

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

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

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

	Group		Parent	
	2014 $'000	**2013 $'000**	**2014 $'000**	**2013 $'000**
Net (deficit)/ surplus	-	286,877	516	286,207
Add back non-cash items:				
Depreciation and amortisation	58,423	48,191	56,480	46,573
Loss/(Gain) of reversionary interest		-		-
Donated assets	(1,058)	(1,299)	(1,058)	(1,298)
Add back items classified as investing activities:				
Loss/(Gain) on asset sale	(39)	(43)	(39)	(14)
	57,326	333,726	55,899	331,468
Movement in term portion provisions/staff entitlements	(633)	835	(633)	828
Movements in working capital:				
Decrease/(increase) in receivables & prepayments	3,579	(331,102)	3,687	(330,894)
Decrease/(increase) in stocks	(1,145)	510	(1,145)	509
Increase/(decrease) in creditors & other accruals	(8,334)	(2,222)	(8,381)	(2,032)
Increase/(decrease) in staff entitlements	(5,493)	11,083	(4,822)	10,914
Net cash inflow/(outflow) from operating activities	**45,300**	**12,830**	**44,605**	**10,793**

20. COMMITMENTS

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Capital commitments				
Property	73,732	34,566	73,732	34,566
Intangible assets	7,053	4,756	7,053	4,756
Other capital commitments	11,941	6,569	11,761	6,569
Total capital commitments at balance date	**92,726**	**45,891**	**92,546**	**45,891**
Non-cancellable operating lease commitments				
Accommodation leases	10,340	12,725	7,985	10,258
Total non-cancellable operating lease and supply commitments	**10,340**	**12,725**	**7,985**	**10,258**
For expenditure within:				
Not later than one year	2,746	2,734	1,993	2,218
Later than one year and not later than five years	6,957	8,075	5,512	6,636
Later than five years	637	1,916	480	1,404
	10,340	**12,725**	**7,985**	**10,258**

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

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

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

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

21. CONTINGENCIES

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 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.

For the year ended 30 June 2013

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.

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

22. CATEGORIES OF FINANCIAL ASSETS AND LIABILITIES

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Loans and receivables				
Cash and cash equivalents	90,044	87,039	88,916	86,036
Debtors and other receivables	75,171	374,000	73,435	372,372
Term deposits (term>3 months)	37,714	57,334	36,500	54,843
Total loans and receivables	**202,929**	**518,373**	**198,851**	**513,251**
Fair value through profit and loss				
Restricted assets	13,760	14,766	13,760	14,766
Restricted liabilities	(13,760)	(14,766)	(13,760)	(14,766)
Total fair value through profit and loss	**-**	**-**	**-**	**-**
Other financial liabilities				
Creditors and other payables	113,017	121,351	112,645	121,026
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	145,985	129,650	145,985	129,650
Total other financial liabilities	**259,002**	**251,001**	**258,630**	**250,676**

23. FINANCIAL INSTRUMENT RISKS

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

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

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2014, the Ministry of Health owed Canterbury DHB Group $49.830M (2013 $52.081M).

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		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Counterparties with credit rating				
Cash				
AA	750	901	(378)	(102)
Term deposits				
AA	-	-	-	-
AA-	37,714	57,334	36,500	54,650
Total cash at bank and term deposits	**38,464**	**58,235**	**36,122**	**54,548**
Restricted assets				
A	-	-	-	-
A+	350	600	350	600
A-	200	200	200	200
AA	280	680	280	680
AA-	12,714	12,920	12,714	12,920
BBB+	200	350	200	350
Unrated	16	16	16	16
Total restricted assets	**13,760**	**14,766**	**13,760**	**14,766**
Counterparties without credit rating				
Balance with Health Benefits Limited				
Existing counterparty with no defaults in the past	89,294	86,138	89,294	86,138
Total balance with Health Benefits Limited	**89,294**	**86,138**	**89,294**	**86,138**
Debtors and other receivables				
Existing counterparty with no defaults in the past	75,171	374,000	73,435	372,372
Total debtors and other receivables	**75,171**	**374,000**	**73,435**	**372,372**

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 2014 (2013: 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 (2013 $129.650M).

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
13/14 financial year						
Creditors and other payables	113,017	113,017	113,017	-	-	-
Borrowings Ministry of Health loans (previously Crown Health Financing Agency 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**
12/13 financial year						
Creditors and other payables	121,351	121,351	121,351	-	-	-
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	165,141	1,059	25,205	12,840	126,037
Restricted liabilities	14,766	14,766	12,920	450	1,396	-
Total	**265,767**	**301,258**	**135,330**	**25,655**	**14,236**	**126,037**

Contractual maturity analysis of financial liabilities for the Parent

	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	2-5 years $'000	More than 5 years $'000
13/14 financial year						
Creditors and other payables	112,645	112,645	112,645	-	-	-
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency 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	**272,390**	**308,843**	**139,393**	**12,865**	**54,749**	**101,836**
12/13 financial year						
Creditors and other payables	121,026	121,026	121,026	-	-	-
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	129,650	165,141	1,059	25,205	12,840	126,037
Restricted liabilities	14,766	14,766	12,920	450	1,396	-
Total	**265,422**	**300,933**	**135,005**	**25,655**	**14,236**	**126,037**

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
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**
12/13 financial year						
Cash and cash equivalents	87,039	87,039	87,039	-	-	-
Debtors and other receivables	374,000	374,000	374,000	-	-	-
Term deposits (term > 3 months)	57,334	57,334	22,684	34,650	-	-
Restricted assets	14,766	14,766	12,920	450	1,396	-
Total	**533,139**	**533,139**	**496,643**	**35,100**	**1,396**	**-**

Contractual maturity analysis of financial assets for the Parent

	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	2-5 years $'000	More than 5 years $'000
13/14 financial year						
Cash and cash equivalents	88,916	88,916	88,916	-	-	-
Debtors and other receivables	73,435	73,435	73,435	-	-	-
Term deposits (term > 3 months)	36,500	36,500	-	1,850	34,650	-
Restricted assets	13,760	13,760	10,674	2,040	-	1,046
Total	**212,611**	**212,611**	**173,025**	**3,890**	**34,650**	**1,046**
12/13 financial year						
Cash and cash equivalents	86,036	86,036	86,036	-	-	-
Debtors and other receivables	372,372	372,372	372,372	-	-	-
Term deposits (term > 3 months)	54,843	54,843	20,000	34,843	-	-
Restricted assets	14,766	14,766	12,920	450	1,396	-
Total	**528,017**	**528,017**	**491,328**	**35,293**	**1,396**	**-**

Sensitivity Analysis

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

	Group			
	2014 $'000		2013 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(22)	22	(11)	11
Total sensitivity	**(22)**	**22**	**(11)**	**11**

	Parent			
	2014 $'000		2013 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(22)	22	(11)	11
Total sensitivity	**(22)**	**22**	**(11)**	**11**

Fair value hierarchy disclosure:

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

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

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Financial Assets				
Restricted assets	13,760	14,766	13,760	14,766
Financial Liabilities				
Borrowing- Ministry of Health loans (previously Crown Health Financing Agency loans)	143,367	129,171	143,367	129,171
Restricted liabilities	13,760	14,766	13,760	14,766

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 $1,468.8M to provide health services in the Canterbury area for the year ended 30 June 2014 ($ 2013: $1,440.1M).

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 $106.9M for the year ended 30 June 2014 ($111.7M, 30 June 2013). Expenditure to other DHBs for their care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $34.6M for the year ended 30 June 2014 (2013 $33.0M,).

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 2014 totalled $15.3M ($15.3M, 30 June 2013). These purchases included the purchase of services from ACC, Genesis Power New Zealand Limited, and Air New Zealand Limited.

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

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Revenue				
Interest on advance and director's fees from/to Canterbury Linen Services Ltd	-	-	6	6
Interest on advance to Brackenridge Estate Ltd	-	-	12	-
Service fees to Brackenridge Estate Ltd	-	-	60	82
Services to Canterbury Linen Services Ltd	-	-	790	801
Service fees to Canterbury Linen Services Ltd	-	-	11	11
Expenses				
Linen services and rentals from Canterbury Linen Services Ltd	-	-	4915	4,784
Interest on advance from Brackenridge Estate Ltd	-	-	-	5

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

Canterbury DHB pays for items such as power, rates and insurance on behalf of Canterbury Linen Services Ltd, and is reimbursed the full amount. These amounts are not included in the above numbers.

The amounts outstanding for all related party transactions as at 30 June are as follows:

	Group		Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Amount payable owing to subsidiaries				
Canterbury Linen Services Ltd	-	-	504	436
Amount receivable owing by subsidiaries				
Canterbury Linen Services Ltd – debtor	-	-	65	61
Brackenridge Estate Ltd – advance	-	-	131	233

Key Management Personnel

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

Below are the aggregate value of transactions and outstanding balances relating to key management personnel and entities over which they have control or significant influence. Balances outstanding are per the Accounts Payable and the Accounts Receivable ledgers, and exclude any provisions made. No provision has been required, nor any expense recognised, for impairment of receivables from related parties (2013 $nil).

	Transaction value – Group & Parent		Balance outstanding – Group & Parent	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Services purchased by Canterbury DHB:				
Heart Centre at St George's	13	38	-	-
Heart Vision Ltd	-	-	-	-
Services purchased from Canterbury DHB:				
Heart Centre at St George's	22	17	1	-

Heart Centre at St George's is an unincorporated joint venture between St George's Hospital and Heart Centre (2003) Ltd. When clinical demand requires, "excess" cardiac surgery services are outsourced to this joint venture. These services are provided at St George's Hospital. Graham (Jock) Muir is both a director and shareholder of Heart Centre (2003) Ltd.

Compensation of key management personnel:

	Parent	
	2014 $'000	2013 $'000
Salaries & other short term employee benefits	3,403	3,324
Post-employment benefits	103	71
Total key management personnel compensation	**3,506**	**3,395**

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

26. BANK FACILITY

Canterbury DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at 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 $68.348M (2013 $66.207M).

27. SUBSEQUENT EVENTS

There were no events after 30 June 2014 which could have a material impact on the information in Canterbury DHB's financial statements.

SUMMARY OF REVENUES AND EXPENSES BY OUTPUT CLASS

Group	Actual 2014 $'000	Budget 2014 $'000
Early detection & management	354,499	313,701
Intensive assessment & treatment	909,280	928,364
Prevention	26,400	27,005
Support & rehabilitation	246,047	223,633
Total revenue	**1,536,226**	**1,492,703**
Early detection & management	348,352	317,011
Intensive assessment & treatment	944,587	947,541
Prevention	17,191	27,337
Support & rehabilitation	226,096	225,815
Total expenditure	**1,536,226**	**1,517,704**
Surplus/(Deficit)	**-**	**(25,001)**

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
Canterbury district health board and group's
financial statements and performance information
for the year ended 30 June 2014

The Auditor-General is the auditor of Canterbury District Health Board (the Health Board) and 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 performance information of the Health Board and group on her behalf.

We have audited:

- the financial statements of the Health Board and group on pages 49 to 84, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board that comprises the report about outcomes on pages 11 to 20, the statement of service performance on pages 21 to 32 and the summary of revenues and expenses by output class on page 85.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board and group on pages 49 to 84:

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

- fairly reflect the Health Board and group's:

    - financial position as at 30 June 2014; and

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

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

Reason for our qualified opinion

Some significant performance measures of the Health Board and 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 Health Board and group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For

example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board and group for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 11 to 20, pages 21 to 32 and page 85:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board and group's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 28 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Our audit of the financial statements involved evaluating:

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

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

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

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

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

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

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

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our

responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

Independence

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

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

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