Canterbury DHB

ANNUAL REPORT 2016/17

Presented to the House of Representatives
pursuant to section 150 of the Crown Entities Act 2004

Our Mission

Tā Mātou Matakite

To promote, enhance and facilitate the health and wellbeing of the people of Canterbury.

Ki te whakapakari, whakamanawa me te tiaki i te hauora mō te oranga pai o ngā tāngata o te rohe o Waitaha.

Our Values

ā Mātou Uara

Care and respect for others.
Manaaki me te whakaute i te tangata.

Integrity in all we do.
Hāpai i ā mātou mahi katoa i runga i te pono.

Responsibility for outcomes.
Te Takohanga i ngā hua.

Our Way of Working

Kā Huari Mahi

Be people and community focused.
Arotahi atu ki te tangata me te hapori.

Demonstrate innovation.
Whakaatu te ihumanea hou.

Engage with stakeholders.
Kia tau ki ngā tāngata whai pānga.

our health system

Table of Contents

Part I
Overview

1.1 Report from the Chair and Chief Executive

558,830 reasons to make a difference

Canterbury has a remarkable health system and remarkable people working in that health system. They haven't missed a beat over the past six years despite continued significant challenges for them and for the people they care for.

A growing population…

Our population is growing quickly. Currently at 558,830, Canterbury's population growth has continued to exceed national forecasts and – five years early – has already reached levels predicted to occur in 2022. We also cover three of the five fastest growing local authority areas in New Zealand: Waimakariri, Selwyn and Ashburton.

Our Māori population is the fastest growing nationally; Canterbury now has the sixth largest proportion of Māori in the country. Canterbury DHB has an older age profile, with the highest number of over-65s in the country – a 31% increase since 2007/08.

…still recovering from disaster

The Canterbury health system continues to manage the complexities resulting from the Canterbury quakes – New Zealand's largest natural disaster. The effects on the population and the DHB are unprecedented. On top of this, Cantabrians have also faced the 7.8 magnitude Kaikoura earthquake in November 2016. Once again, people across our health system responded admirably to the immediate challenges of this far-reaching, violent and damaging event.

In line with the predictions of international post-disaster research, longer-term demands on our mental health services continue to rise. We expect the Canterbury quakes to continue to be a significant psycho-social challenge to our people over the next 5-10 years. Accordingly, we are working hard to put in place the supports and systems to ensure that Cantabrians have timely access to mental health care to aid their recovery and wellbeing.

…needs an innovative, integrated approach to healthcare delivery

This year, we have continued to build upon our reputation as an internationally innovative health system thanks to our sound strategic framework, our alliance-based approach to service delivery and our prudent use of resources.

Part of our success in this area is due to the continued leadership of the Canterbury Clinical Network. This is the broadest health alliance in New Zealand, with twelve partner organisations and whole of system engagement. It plays a crucial role in developing new service delivery models, and funding and contracting based on principles of high trust, low bureaucracy, openness and transparency. Putting people at the centre underpins everything we do through providing more care in community settings, investing in technology, and forming partnerships and alliances.

Strategic investment in services to support general practice and after-hours providers helps us to provide healthcare for people where they need it – in their own homes and communities. Canterbury has lower admissions to hospitals for potentially avoidable conditions thanks to better services in primary care and the community, keeping people well in their own homes.

In Canterbury you are 30% less likely to be admitted medically unwell to hospital than in New Zealand as a whole. If Canterbury admitted at the average rate of the rest of New Zealand, we would have an additional 100+ beds filled on any given day. This year 34,800 people were managed in a community setting instead of in hospital – this is the largest known acute demand management programme there is.

We have also worked hard this year to ensure equal access to healthcare for Māori and Pacific people. Increasingly equitable access can be shown for a number of population programmes including childhood immunisation; we can also demonstrate a decreased incidence of long-term disease. Among adults, all ethnic groups in Canterbury have lower avoidable hospital admissions than nationally.

We are constantly astounded by the level of innovation continuing to be created and delivered across our health system. As just one clinical example, this year our acute coronary care team developed a much more efficient way of ruling out heart attacks in patients presenting with chest pain to Christchurch Hospital's Emergency

Department. This has been such a successful innovation it's now implemented in other emergency departments around the country and internationally. Elsewhere, recent innovations in telehealth have significantly contributed to the quality of care received by patients on the Chatham Islands and the West Coast.

Recent recognition for our health system innovations includes HealthOne, our Shared Care Record system that securely stores health information (including prescribed medications and test results). It won the Best Technology Solution for the Public Sector at the 2017 New Zealand HiTech Awards.

Our HealthPathways online tool was also named as a finalist at the 2017 IPANZ Awards for Improving Public Value through Business Transformation. HealthPathways provide general practice teams with information to consistently assess and manage medical conditions, as well as the criteria for requesting health services in the respective health region. The clinical pathways are developed and agreed by a wide range of health professionals. It helps to improve the quality of care in the community and reduces the time people spend waiting, while supporting the delivery of more services closer to people's own homes. Currently 99% of general practitioners surveyed in Canterbury use HealthPathways weekly in their practice, and 80% use it more than six times a week. Use is also high by practice nurses, pharmacists, physiotherapists, community nurses, and other allied health services. It has been successfully adapted for use by nine other DHBs in New Zealand, in 22 regions across Australia, and now also in the UK.

...and we continue to face unanticipated financial challenges, which we respond to as we are able

Our financial result for the 2016/17 year varied from our planned deficit by $10.846M, a number of key variances were as a direct result of external influences such as the disruption of services caused by the junior doctors strike, and the North Canterbury earthquakes during the year which caused significant financial pressure, this pressure to the DHB was only partially mitigated.

A snapshot of the key items that contributed to this variance follows.

Reconciliation between planned deficit & actual deficit	**2017 Actual $'m**
Planned 2016/17 deficit per approved Statement of Intent	(41.9)
Add/(Less): Key movements	
Additional funding per May 2016 advice	16.2
Additional costs associated with May 2016 tagged funding	(10.5)
Additional cost of Mental Health remaining at TPMH	(1.3)
Other net revenue and cost adjustments	(1.0)
Planned deficit per approved Annual Plan	**(38.5)**
Kaikoura earthquake additional revenue	1.0
Kaikoura earthquake additional costs	(2.3)
Kaikoura donation repaid	(2.0)
Additional outsourcing (e.g. ESPI compliance)	(7.7)
Ashburton Hospital donation revenue	1.1
Provider treatment related costs	(1.0)
Inter-district flow additional revenue	3.3
Mental Health service pressure DHB wide	(2.4)
External providers additional demand driven costs (incl. In-between travel)	(6.7)
RDA strike and RDA MECA higher settlement impact (part year)	(1.8)
Depreciation management	2.9
All other net savings/costs	1.3
Deficit per Statement of Comprehensive Revenue and Expense	**(52.8)**

Further commentary on these variances can be found in note 27 on page 73.

...a well-coordinated, forward-thinking facilities programme

Dealing with infrastructure damage is another long-term challenge for the DHB. Since the earthquakes, we have had to manage 14,000 damaged hospital rooms, 44 buildings either demolished or due to be demolished, and 50% of all clinical services moving an average of four times, while still keeping services going. This damage has placed severe pressure across our health system, on our staff and our patients, coping with repair noise and disruption, ward decanting and multiple service relocations. Nonetheless, we have been very busy repairing, renewing and building. In the past year we have made significant progress on our forthcoming Christchurch Outpatients and Acute Services Building projects at Christchurch Hospital. These projects are on track for completion in 2018.

Our award-winning new facilities at Burwood Hospital were officially opened in August 2016. Thanks to new models of care and the high quality design, we have already demonstrated a 22% reduction in falls among frail elderly patients – a huge improvement that also brings significant hospital bed-day savings. After opening, the Burwood facilities earned an Enviromark Bronze Award for energy sustainability thanks to its ingenious biomass boilers.

This year we also opened our new Acute Assessment Unit at Ashburton Hospital – a facility that challenges traditional models of rural medical provision to allow stabilisation, assessment and a wider range of treatment for acute patients than was previously possible – helping to provide the right care at the right time and in the right place for patients – closer to their communities.

Dr John Wood
CHAIR | CANTERBURY DHB

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

19 October 2017

… and the necessary supports in place for our hard-working and dedicated staff

At Canterbury DHB, we know how important it is to care for those who care so much for others. Staff wellbeing is a mainstay of our health system. This year we have developed and expanded upon existing ways to support our people in the workplace through our Wellbeing Programme.

As we look back over this past year, we thank our alliance partners and the many community providers who support the Canterbury health system to deliver better health care. We also acknowledge our 18,000 people across Canterbury who work so hard to provide high-quality treatment, care and support to our population. We look forward to working with you all to meet the needs of our population in the coming year and into the future.

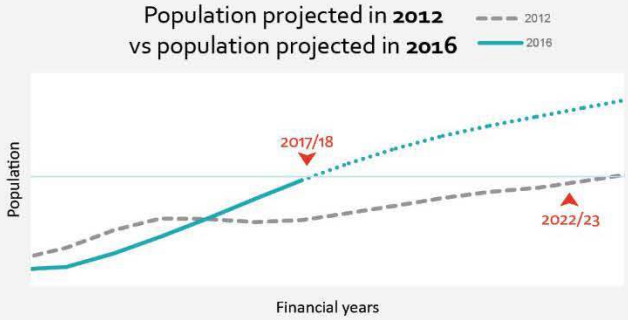
OUR CHALLENGES

Population increases

Canterbury's population growth is exceeding expectations—already reaching levels predicted for 2022[1]

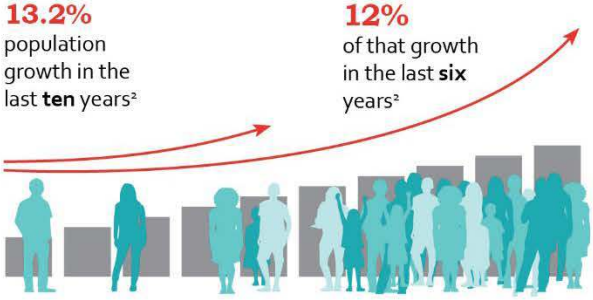
558,830
reasons to make a difference

Population projected in **2012** vs population projected in **2016**



13.2% population growth in the last **ten** years[2]

12% of that growth in the last **six** years[2]



Fastest growing Maori population in NZ[2]

51,630 people

Largest population aged over 65 in NZ[2]

87,560 people

Demand increases

The Canterbury system has experienced unrelenting demand challenges since the earthquakes[3]

36% increase in **adult** presentations to **community** mental health services

94% increase in **adult rural** presentations to **specialist** mental health services

100% increase in **child and youth** presentations to community mental health services

15% increase in total ED presentations

52% increase in ED presentations by 25-29 year-olds

90% increase in ED presentations by people from overseas

Engaged staff under pressure

89% of staff feel they are making a contribution to the success of the DHB[4]

74% of staff feel their jobs are fulfilling[4]

38% felt excessive workload is one of the top five stressors of their job[4]

28% felt being in a damaged environment or surrounded by construction work is having a negative impact on their wellbeing[4]

Damage to health infrastructure

$518m+ in total damages to be funded within a $384m envelope

14,000 rooms damaged

47,000m2 building space demolished

700 staff displaced

50% of clinical services already moved 4 times for repairs

106 inpatient beds lost

1 Stats NZ Dec 2016 Population Projections, CDHB Detailed Business Case Projections (based off Stats NZ & CERA workforce estimates) Oct 2012
2 Stats NZ Intercensal series 2012/13, and Stats NZ Dec 2016 Population Projections | 3 CDHB Patient Management System (2009/10 - 2015/16), mental health numbers refer to new case starts | 4 CDHB 2016 Staff & Family Wellbeing Survey May 2017
Produced 21st July 2017

1.2 Statement of Responsibility

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

We are responsible for any end of year performance information provided by Canterbury DHB under section 19A of the Public Finance Act 1989.

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

In our opinion, these financial statements and the statement of service performance fairly reflect the financial position and operations of Canterbury DHB for the year ended 30 June 2017.

For and on behalf of the Board

Dr John Wood
CHAIR | CANTERBURY DHB

Ta Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB

19 October 2017

Part II
Improving Outcomes

2.1 Measuring Our Progress

DHBs have a number of different roles and associated responsibilities. In our governance role we are striving to improve health outcomes for our population, as a funder we are concerned with the effectiveness of the health system and return on investment, and as an owner and provider of services we are concerned with the quality of the services we deliver and the efficiency with which we deliver them.

As part of our accountability to Government and to our community, we need to demonstrate whether we are succeeding in achieving our objectives. However, there is no single measure that reflects the impact of the work we do.

In 2007, we developed a vision for the Canterbury health system and established three high-level strategic objectives or goals:

Alongside these goals we have identified a set of outcome measures with which to evaluate how well our health system is performing.

Tracking our performance against these indicators helps us to evaluate our success in areas that are important to the Government, our Board and our community. They form an essential part of the way in which we are held to account.

The nature of population health is such that it may take a number of years to see marked improvements against some of these outcome measures. Our focus for the long-term outcomes is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

Working with the rest of the South Island DHBs, we have also collectively identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been identified as our main measures of performance. We have set standards for these measures in order to determine whether we are moving in the right direction.

The statement of service performance, in the annual performance section of this report, provides a snapshot of the services provided for our population in the past year. We monitor performance against these service performance indicators annually. Many of the measures selected are deliberately chosen from national reporting frameworks, to enable comparison with other DHBs and give context to our performance.

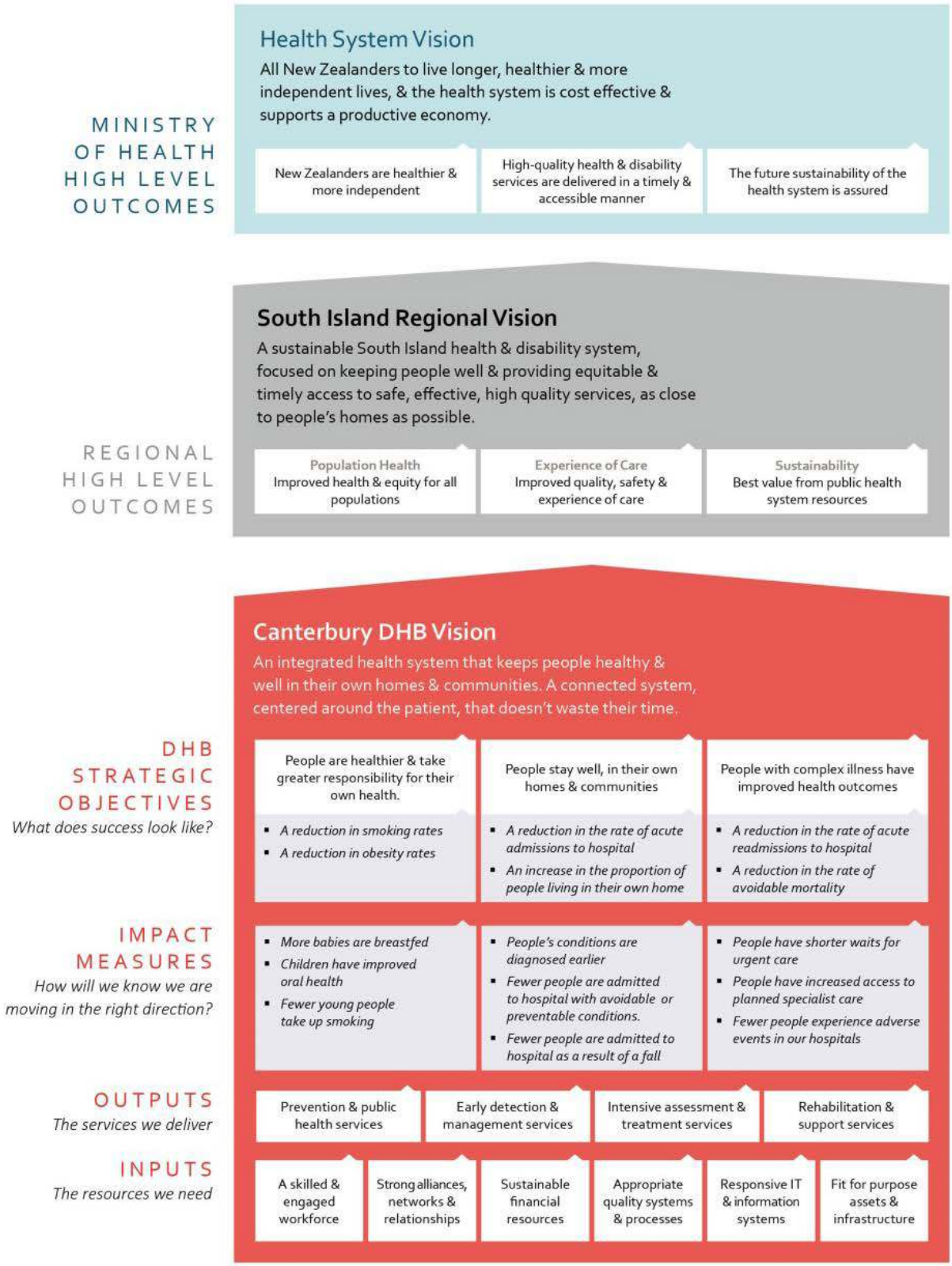
The performance expectations set across all these measures reflect the strategic objectives of our health system: increasing the effectiveness of prevention programmes, reducing acute or avoidable demand for hospital services and maintaining or increasing service access while reducing waiting times and delays in treatment.

As part of our obligations under legislation, DHBs must work towards achieving equity. To promote this goal, the standards set against each measure are the same for all population groups. As a means of evaluating whether we have made a difference for our Māori population over the past year, the DHB presents performance against a core set of measures (captured in the DHB's Māori Health Plan) in the Annual Performance section of this report.

The DHB is also evaluated in terms of its performance against the national health targets. Canterbury's health target results for 2016/17 are also presented in the Annual Performance section of this report.

The intervention logic framework on the following page illustrates how we anticipate the services that we fund or deliver (outputs) will have an impact on the health of our population, result in the longer-term outcomes desired, and deliver the expectations and priorities of Government.

Canterbury DHB - Outcomes Intervention Logic Framework



2.2 Are We Making a Difference?

People are healthier and take greater responsibility for their own health

WHY IS THIS OUTCOME A PRIORITY?

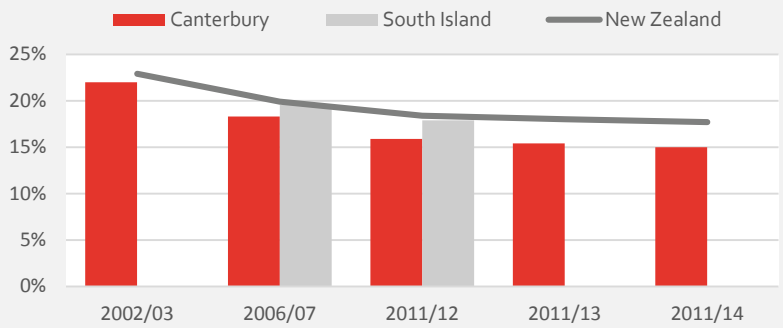
New Zealand is experiencing a growing prevalence of long-term conditions such as respiratory and cardiovascular disease, cancer and diabetes. These conditions are the leading drivers of poor health and premature mortality (death) and place significant pressure on the health system in terms of demand for health services. The likelihood of developing long-term conditions increases with age and these conditions are more prevalent amongst Māori and Pacific Island populations. With our rapidly growing Māori population and Statistics New Zealand predicting that by 2026 one in every five people in Canterbury will be aged over 65 – meeting the health service demand associated with long-term conditions will be a major challenge for our health system.

WHERE ARE WE FOCUSED?

Tobacco consumption, inactivity, poor nutrition and obesity are major contributors to the most prevalent long-term conditions. While tobacco consumption in New Zealand has decreased in recent years, the proportion of adults who lead sedentary lifestyles is increasing and obesity rates are amongst the highest in the world. These avoidable risk factors can be reduced through supportive environments and preventative strategies that improve personal awareness and responsibility for health and wellbeing. Supporting people to make healthier choices will not only improve the quality of people's lives and the health status of our population, but will reduce avoidable pressure on our health system. Our focus is on reducing the two largest risk factors - smoking and obesity.[1]

A reduction in smoking rates

PERCENTAGE OF THE POPULATION (15+) WHO CURRENTLY SMOKE



Data source: National NZ Health Survey [2]

Smoking rates in Canterbury are declining. The latest NZ Health Survey (2014) reported that 15% of the Canterbury population are current smokers, compared to 17.7% of the New Zealand population. Smoking among our Māori and Pacific populations is also reducing, but the prevalence remains considerably higher than that of other ethnicities. The 2013 Census identified 30.7% of Canterbury Māori (15+) as regular smokers, down from 40.2% in 2006 but higher than the total population at 14.5%.

We have continued to focus on delivering brief smoking advice and cessation support at all contact points across our health system, to encourage smokers to quit. Over the past year 90% of smokers identified in general practice, and 95% of smokers identified in our hospitals, have been provided with brief advice and offered cessation support.

We have also increased our focus on supporting pregnant women to quit smoking and have invested in an incentivised smoke free pregnancy programme. In the last quarter of 2016/17, 94% of women who identified as a smoker when registering with a Lead Maternity Carer were offered brief advice and support to quit.

15% of adults were current smokers in 2014 *(down from 22% in 2013)*

51,008 people in primary care and **12,913** people in our hospitals received brief advice & support to quit

56% of people who smoke accepted smoking cessation support in the last 12 months *(the highest result in the country)*

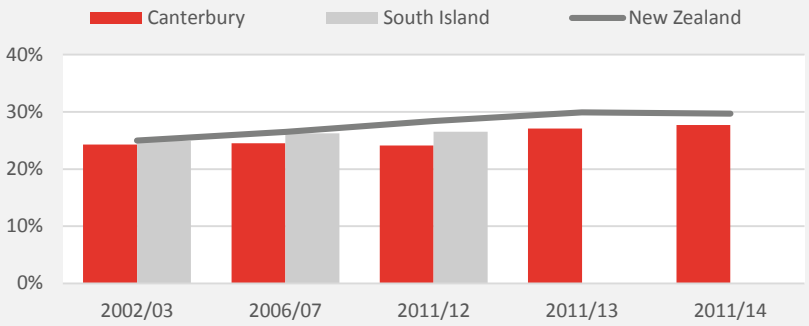
80% of Canterbury year 10 students have never smoked

[1] *The performance graphs in this section present the total South Island and total National results and includes Canterbury DHB, rather than presenting Canterbury compared to the rest of the South Island or the rest of New Zealand.*

[2] *The NZ Health Survey is completed nationally by the Ministry of Health. Since 2011, results have been combined year-on-year, hence the different time periods presented. Results are not made available by ethnicity and the 2014 survey presents the most recent data by DHB.*

A reduction in obesity rates

PERCENTAGE OF THE POPULATION (15+) WHO ARE OBESE



Data source: National NZ Health Survey [3]

Canterbury's obesity rate remains below the national rate of 30%.

Obesity impacts on people's quality of life and is a significant risk factor for many chronic conditions, including cardiovascular disease and respiratory disease. Many of the drivers of obesity sit outside the direct control of the health system, but not outside our influence.

We have continued to focus on supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to adopt healthier lifestyle choices. This includes the DHB's commitment to the Healthy Schools programme with 91% of priority schools now having adopted the framework.

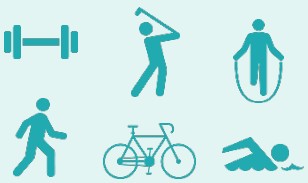
We have invested in the development of a number of lifestyle programmes to tackle obesity, including the Triple P, Active Families, Appetite for Life, Senior Chef and Green Prescription programmes.

The Green Prescription programme supports inactive adults to make healthy lifestyle changes and health professionals refer patients in need of support, to increase their physical activity levels and make healthy food choices. Over 3,800 people across Canterbury were referred to the programme in 2016/17. The latest annual results survey showed 75% of Green Prescription participants were more active 6-8 months after referral.

We have also significantly increased support for children in line with the adoption of the national Healthy Kids health target. Canterbury achieved the health target in quarter four of 2015/16, with 95% of four year old children identified as obese at their B4 School Check being offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle advice.

Oral health and obesity are associated. Positive trends in oral health can be seen as a proxy indicator of improved nutrition and behaviour modification. The DHB reached its target in 2016/17 with 66% of five year old children being caries free (having no holes or filings). Steady improvements were also noted for Māori children with a 4% improvement on 2015 rates.

28% of adults were identified as obese in 2014 *(fewer than the national average, 30%)*



3,800 green prescription referrals were made *(a 23% increase on the previous year)*

3 / 4 people supported by green prescription remained more active 6 months later

95% of children identified as obese at their B4 School Check were referred to family-based healthy lifestyle interventions

[3] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30, or >32 for Māori and Pacific people.*

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

More babies are breastfed

Breastfeeding helps to lay the foundations for a healthier life, contributing positively to infant health and wellbeing, and reducing the likelihood of obesity later in life.

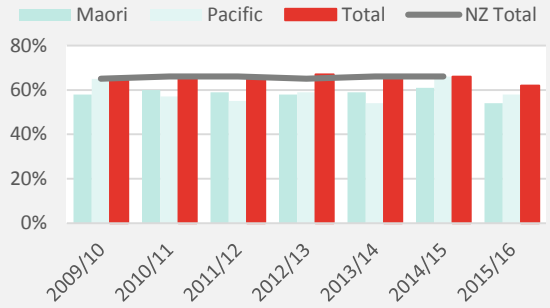
2015/16 results are the latest full year available. Canterbury's rates dropped slightly across all ethnicities in 2015/16, having remained relatively stable for the past several years. This was a disappointing result and a heightened focus is needed to lift these rates.

A range of services are available locally to encourage and support women to breastfeed, including peer support programmes and community-based lactation support.

Over 1,000 women were able to access specialist advice in the community to support breastfeeding in the past year, through Canterbury's lactation support programme.

Data source: Plunket via the Ministry of Health [4]

Percentage of babies exclusively or fully breastfed at six weeks	2014/15	2015/16	2016/17 Target	2016/17 Result
	66%	62%	75%	n.a



Children have improved oral health

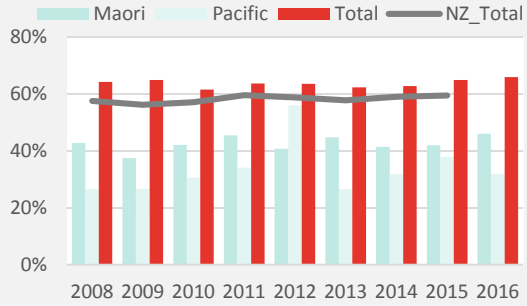
The percentage of five-year-old children whose teeth are caries-free (have no holes or fillings) has continued to improve, and the DHB achieved the 66% target in 2016/17. Improved rates are also evident for our Māori children.

We provide free oral health care for children from birth to 17 years, with a key focus of the school and community oral health service to ensure that all eligible children are enrolled and examined on time.

While 90% of enrolled children are examined according to plan, enrolment data suggests that some children may be missing out. The service is working to address any gaps and in 2017 introduced a multiple enrolment process, sharing data across hearing, well child, immunisation and dental services to better identify children and establish contact with families.

Data Source: DHB School & Community Oral Health Services [5]

Percentage of five-year-olds caries free (no holes or fillings)	2014	2015	2016 Target	2016 Result
	63%	65%	66%	66%



Fewer young people take up smoking

The Action on Smoking and Health (ASH) Survey is one of the largest youth smoking surveys in the world. It is a census style questionnaire that surveys around 30,000 students every year on their smoking behaviour and attitudes.

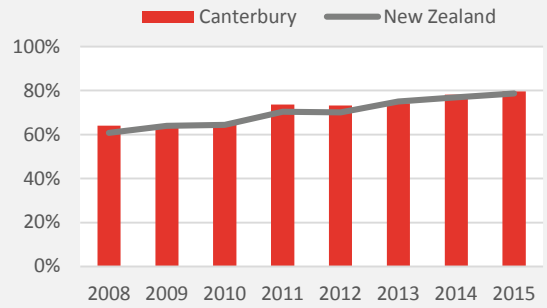
The 2015 ASH survey results are the most recent available and show a continuation of the positive trend for Canterbury students, with 80% of Year 10 students (age 14/15) never having smoked.

This trend reflects the impact of supportive legislation and social environments combined with local health-led initiatives such as our Health Promoting Schools programme.

A continued decline in adult smoking rates will also have a positive influence on these rates.

Data Source: National Year 10 ASH Snapshot Survey [6]

Percentage of 'never smokers' among year 10 students	2014	2015	2016 Target	2016 Result
	78%	80%	>75%	n.a



[4] *The standard for this measure is set nationally as part of the Well-Child Quality Framework. Provider data is not able to be combined for this measure and the performance data presented is from the largest provider (Plunket), which covers the majority of mothers in Canterbury. However, because the smaller local providers primarily target Māori and Pacific mothers, results for these ethnicities may be under-stated. 2016/17 results were unfortunately not available to the DHB at the time of printing.*

[5] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year. National results had not been made available for the 2016 year at the time of printing.*

[6] *The ASH Survey is a national survey used to monitor student smoking rates since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students who are aged 14 or 15 years at the time of the survey. The 2016 survey results were not available as the results had not been released at the time of printing – see www.ash.org.nz.*

People stay well, in their own homes and communities

WHY IS THIS OUTCOME A PRIORITY?

Studies show countries with strong primary and community care systems have lower rates of premature mortality from long-term conditions, and achieve better health outcomes, at a lower cost, than countries that focus more heavily on a specialist level response. When people are supported to stay well, and can access the care they need in the community, they are less likely to experience a deterioration of their condition that could lead to acute illness, hospital admission and the kind of complications that might lead to a long-stay or residential care.

This is not only a better experience and health outcome for our population, but by improving the health system response to meeting people's needs, it reduces pressure on our hospitals and frees up specialist capacity and financial resources.

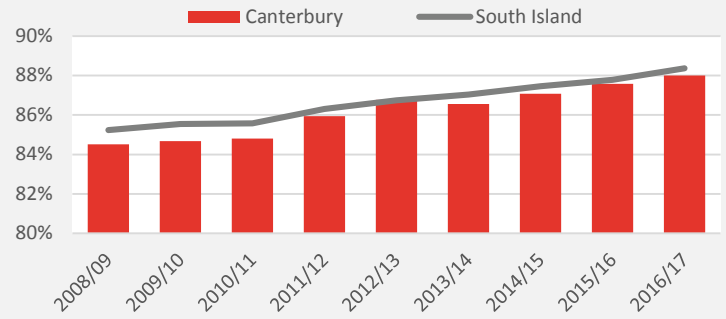
This direction is particularly relevant for Canterbury, where six years on from the first earthquakes, service demand patterns have changed and population growth has been rapid. Canterbury is the second fastest growing region in the country and has three of the five fastest growing local authority areas: Waimakariri, Selwyn and Ashburton. Over the last ten years our population has grown 13.2% and with a population of 558,830 people we have already reached a population level not predicted to occur until 2022. Our hospital capacity is under significant pressure and it will be several years before the redevelopment, repair and remediation of our facilities is complete.

WHERE ARE WE FOCUSED?

With a growing and ageing population, stretched capacity and limited resources, our focus is on reducing two major areas of pressure for our system - supporting more people to stay safe and well in their own homes for longer, and reducing acute medical admissions into our hospitals.

More people living in their own homes

PERCENTAGE OF THE POPULATION (75+) LIVING IN THEIR OWN HOME



Data Source: SIAPO Client Claims Payment System

The proportion of the Canterbury population (aged 75+) living in their own homes continues to steadily increase, reaching 88% in 2016/17. This positive trend has brought Canterbury into line with the rest of the South Island. Consistent with our strategy, this suggests our older population is gradually becoming healthier and are supported to live independently.

A number of local programmes help to support our older population to age-in-place and contribute to these positive results, including: medication management programmes, age-related harm prevention and long-term condition strategies, falls prevention programmes, restorative rehabilitation, and home-based support services and respite services.

In the past year, over 1,300 people on multiple mediations received a medication review to reduce medication related harm and prevent avoidable hospital admission.

Falls in older people are very common. They frequently lead to injury and hospitalisation, a loss of confidence, and an increased risk of admittance to institutional care. Over 1,800 people accessed our community-based falls prevention programme in the last year and 97% of older inpatients received a falls assessment to help them stay safe while in our hospitals.

The return on this investment is reflected in the downward trend in the number of rest home bed-days subsidised by the DHB, which dropped 6% between 2015/16 and 2016/17.

88% of people 75+ are living in their own homes
(up from 85% in 2015/16)

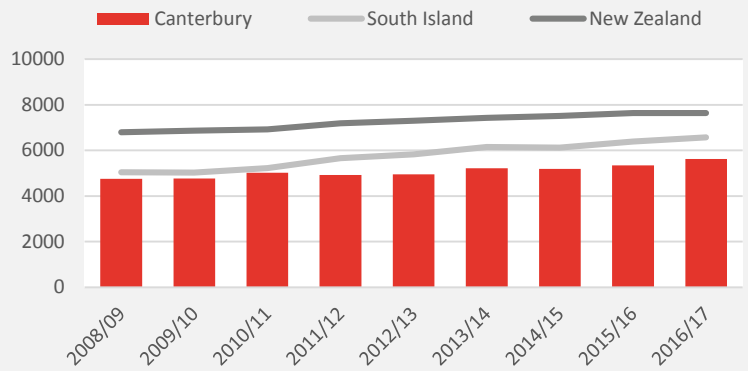
1,815 people attended a falls prevention programme

97% of older patients were given a falls assessment to reduce their risk of harm while in our hospitals

88% of people admitted into our older persons' assessment, treatment and rehab service were discharged back to their own home rather than aged residential care

A reduction in acute medical admissions

RATE OF ACUTE MEDICAL ADMISSIONS TO HOSPITAL



Data Source: National Minimum Data Set [7]

With the right intervention and support, people can avoid deterioration of their condition or reduce the likelihood of an event that leads to hospital admission, unnecessary complications, long-term illness or even premature death.

Canterbury's acute medical admission rates are slowly increasing as our population ages and more people are living with long-term conditions. However, at 5,625 per 100,000 people, Canterbury's rate remains one of the lowest in the country and is well below the national rate (7,638).

This is a positive reflection of the efforts of providers from right across the Canterbury health system to keep people safe and well in their own homes and communities and reduce the need for a hospital visit.

Enrolments with general practice remain high, at 94%. The provision of organised general practice is core to improving the health of our population. High enrolment rates are an indication of good engagement with our health system.

Over 600 integrated clinical HealthPathways are now in place to support the management and referral of patients, which has reduced the time people spend waiting for treatment. This includes access to subsidised services in the community such as spirometry testing (for respiratory illness), diabetes self-management support, and skin lesion removals.

Continued investment in Brief Intervention Counselling services has meant more than 670 young people and 5,600 adults have been able to access free mental health support in primary care over the past year.

The DHB's continued investment in this area also includes the community-based Acute Demand Management Service which provided more than 34,000 packages of care to people in the community in 2016/17 - preventing many unnecessary ED presentations.

9/10 people in Canterbury are enrolled with a general practice team

98% of children under 13 have access to free primary care after-hours

6,540 people received brief intervention counselling in primary care in 2016/17 *(425 more people than in the previous year)*

Canterbury's acute medical admission rate is **30%** lower than the national average.

This means over **13,000** people received treatment in their homes and communities instead of hospital

[7] *This measure is age standardised and presented as a rate per 100,000 people.*

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

People's conditions are diagnosed earlier

Demand for CT and MRI scanning has been exceeding capacity across both the public and private sectors in Canterbury and wait times have increased rapidly.

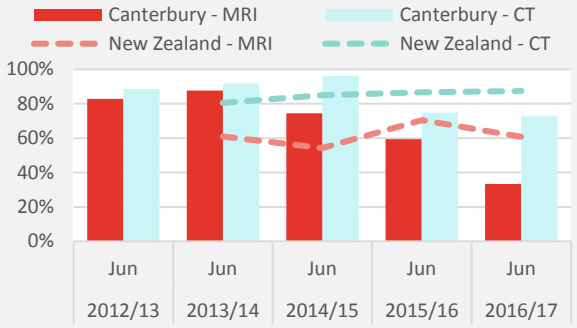
A number of factors are driving this pressure including: increased surgical volumes, new drugs and treatment programmes and population increases. In addition, Canterbury takes the majority of tertiary referrals from other South Island DHBs, who are also experiencing increased demand. There have been over 8,900 more MRI referrals and over 4,000 more referrals for CTs than in 2015/16.

In response to increasing demand, the DHB now has CT and MRI scanners operational at Burwood Hospital and a second MRI scanner at Christchurch Hospital. Radiologist capacity is a key constraint and the DHB is in the process of recruiting additional clinical staff, however this is not a quick fix. While we hope to see some impact in the coming year, it will take time to recruit appropriately trained radiologists.

Data Source: DHB Patient Management System

Percentage of people waiting less than six weeks for non-urgent CT or MRI scans

	2015/16	2016/17 Target	2016/17 Result
CT	75%	95%	73%
MRI	59%	85%	33%



Fewer avoidable hospitalisations

In 2016/17, Canterbury's avoidable admission rate was 2,702 per 100,000 people. This is higher than the target set, but still well below the national rate (3,833).

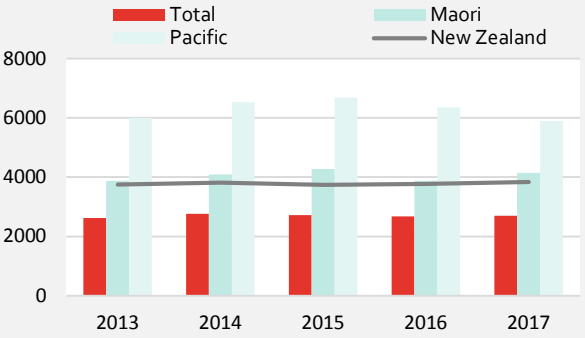
A wide range of initiatives contribute to preventing unnecessary hospital admissions and this measure is seen as a marker of the quality of primary care services and a more integrated and connected health system - particularly in relation to the management of long-term conditions.

The changing patterns of demand following the earthquakes have added a layer of complexity for general practice teams in caring for those with long-term conditions. In spite of the increased demand, 85% of our eligible population had a cardiovascular risk assessment, and 89% of people identified with diabetes had their diabetes monitored in the past year, only 1% below target.

Data Source: Ministry of Health Performance Reporting [8]

Ratio of actual vs expected avoidable hospital admissions for those aged 45-64

	2014/15	2015/16	2016/17 Target	2016/17 Result
	2,716	2,673	<2,637	2,702



Fewer falls-related hospitalisations

At 5.2%, the proportion of our population (75+) admitted to hospital as a result of a fall is lower than the previous year and only 0.2% higher than the national average.

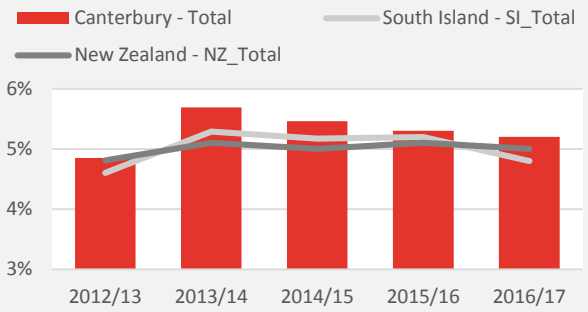
This is a positive trend. With an ageing population and stretched capacity, our focus on falls prevention is crucial in supporting our strategic direction, helping people to stay well and independent, and reducing demand on services.

Over 1,800 people accessed our community-based falls prevention programme in the last year and 97% of older inpatients received a falls assessment to help them stay safe while in our hospitals.

Data Source: National Minimum Data Set [9]

Percentage of the population (75+) admitted to hospital as a result of a fall

	2014/15	2015/16	2016/17 Target	2016/17 Result
	5.5%	5.3%	<5.5%	5.2%



[8] *This measure is a national DHB performance indicator (SI1) and captures hospital admissions for conditions considered preventable, including: diabetes, asthma, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim is to maintain current performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The results differ to those previously presented, being based off the national March 2017 series provided by the Ministry of Health in August 2018 – baselines have been reset to reflect the current series.*

[9] *From 2013/14 results reflect the updated 75+ population in line with the 2013 Census.*

People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

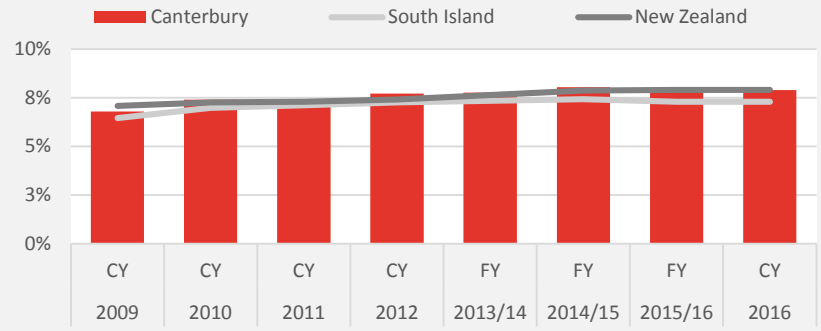
For people who need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning system, matching capacity to demand by managing the flow of patients between services and moving the point of intervention to earlier in the path of illness. This outcome also reflects the importance of the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions and complications that have a negative impact on the health of our population, people's experience of care, and their confidence in the health system. Ineffective or poor quality treatment and long waits also waste resources and add unnecessary cost into the system.

WHERE ARE WE FOCUSED?

Having a strong primary care foundation and managing more people with less-complex conditions in the community is of benefit for our population and a credit to our health system, however it also means that the people we are seeing in our hospitals are likely to be frailer, have more complex conditions, and be at greater risk of readmission and complications. Our focus is to give our community assurance that they are receiving the best and safest care possible – by maintaining low premature mortality rates and reducing readmission rates.

A reduction in acute readmissions

RATE OF ACUTE READMISSIONS TO HOSPITAL WITHIN 28 DAYS



Data Source: National Minimum Data Set [10]

As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative long-term outcomes. Canterbury's readmission trend has levelled off slightly, which is a positive result.

Improved patient safety and quality processes are key factors in reducing acute readmissions and the Canterbury DHB has made a strong commitment to Zero Harm and the implementation of the Health Quality and Safety Commission's Open for Better Care Campaign. The rate of staff compliance with good hand hygiene practices has improved to 83%, above both the target and the most recent national average. The proportion of patients receiving precautionary antiseptic skin treatments prior to surgery is 100% for the third year in a row and 97% of older inpatients (75+) are receiving a falls assessment to reduce their risk of harm while in our hospitals.

We have a particular focus on older people and instances of heart failure, and respiratory disease where readmission rates are higher. In 2016/17, 80% of people experiencing a stroke in Canterbury were referred to our stroke rehabilitation service. While there was a small drop in the proportion of people referred for cardiac rehabilitation after an acute event, the number of people accessing falls prevention programmes remains high. There was a 25% increase in the number of people attending pulmonary rehabilitation.

The Community Rehabilitation Enablement Service Team (CREST) is a community-based supported discharge service providing home-based rehabilitation packages to support older people on discharge from hospital. For the third year in a row, the service supported over 1,700 people to regain their function and independence. It has been expanded to provide proactive support to help people to avoid hospital admission altogether.

325 people attended pulmonary rehabilitation courses in 2016/17 *(a 25% increase on 2015/16)*

80% of our population were referred to stroke rehabilitation after an acute event

1,741 people were supported by CREST on discharge from hospital

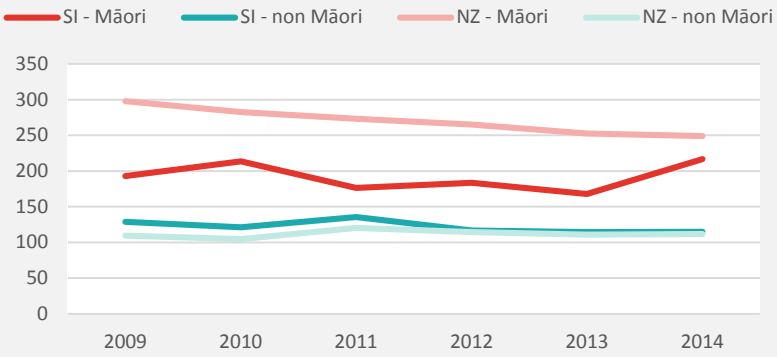
Serious events causing harm in our hospitals have reduced by **15%**

Compliance with good hand hygiene practices increased to **83%**, helping to prevent avoidable infection in our hospitals

[10] *This measure is a national DHB performance indicator (OS8). Because the national definition was still being confirmed at the time the DHB's Annual Plan was produced in 2016, unstandardised rates have been used to enable the calculation of a South Island rate.*

A reduction in avoidable mortality

RATE OF AVOIDABLE MORTALITY FOR PEOPLE UNDER 65 YEARS OF AGE



Data Source: National Mortality Collection [11]

There has been a slight increase in mortality rates across the South Island for Māori, but the overall mortality trend continues to be positive and is consistently below national rates.

Community-based acute demand and long-term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment. As a major provider of complex care in the South Island, the DHB is under pressure to meet increasing demand for services and ensure timely access to treatment.

Cancer is one of the leading causes of mortality in Canterbury and contributes to a high proportion of all premature deaths. Uptake of cancer screening rates was disappointing with 74% women having a cervical cancer screen in the past year against an 80% target and little change in uptake compared to previous years. The uptake of the Human Papillomavirus (HPV) vaccination is steadily improving however, and 59% of young women have completed the full vaccination programme (three doses), a 16% increase on the previous year. In 2016/17, 69% of young women received their first dose in the programme. The DHB also achieved the national Faster Cancer Treatment health target in 2016/17 with 86% of people identified with a high suspicion of cancer being seen and treated within 62 days.

Mental health is an area of concern in Canterbury following the 2011 earthquakes. Mental illness contributes to mortality and many common mental health problems such as depression, anxiety and substance abuse also have life-long consequences on the quality of people's lives. Ensuring access to appropriate services therefore has a positive impact on both health and social outcomes for our population.

The proportion of our population accessing specialist mental health services has increased to 3.7% for 0-19 year olds and 3.8% for adults 20-64 – up from 1.7% and 2.2% respectively prior to the earthquakes (December 2010). Between 2009/10 and 2015/16 there has been a 36% increase in adult presentations to community mental health services and a 100% increase in child and youth presentations (new case starts).

Despite this unprecedented increase in demand, our mental health services have worked hard to meet national wait time targets and have reduced waiting times year on year, with 77% of people waiting less than three weeks for non-urgent mental health and alcohol and other drug services and 94% of people waiting less than eight weeks.

The DHB has also provided more elective surgery than ever before, delivering 21,456 elective surgeries for our population in 2016/17 – 2% higher than target. There were over 72,000 first specialist assessments and 670,000 outpatient appointments with Canterbury specialists in the past year.

More than **72,000** patients attended a first specialist assessment in Canterbury

Of those patients given a commitment for treatment, **99.3%** waited less than four months

21,456 elective surgeries were delivered to Canterbury residents in 2016/17

86% of people identified with a high suspicion of cancer were seen within 62 days *(up from 70% in 2015/16)*

< 3 weeks

77% of non-urgent mental health clients were seen within three weeks

(94% within eight weeks)

[11] *The data presented is the most current available sourced from the national mortality collection which is three years in arrears. The measures are age standardised and presented as a rate per 100,000 people.*

Thanks to theNounProject.com for some of the icons used in this document: Maciej Swierczek, Leonides Delgado, Adrien Coquet, Sandy Priyasa, Irene Hoffman, Arafat Uddin, Vicons Design, Jose Manuel de Laa, icons.design

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

People have shorter waits for urgent care

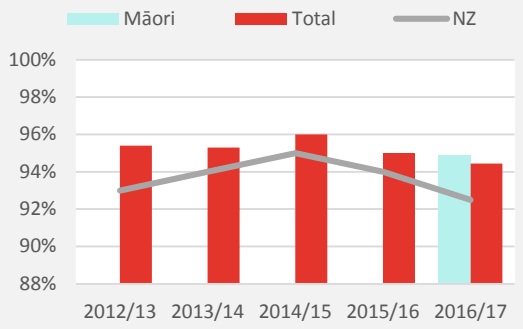
Between 2009/10 and 2015/16 there has been a 15% increase in presentations to Canterbury emergency departments (ED). There were over 96,800 ED presentations in the past year alone.

In spite of this increasing demand the DHB's performance in this area has been consistently high. This strong performance result reflects the commitment of our ED teams and the services across our hospitals that enable the DHB to respond to an increasing number of people within the target timeframes.

A number of community-based urgent care services also support this target including the 98% of general practices that provide free after-hours care for children under 13, and the Acute Demand Management Services providing packages of care to over 34,000 people to reduce avoidable ED presentations.

Data Source: DHB Patient Management Systems [13]

Percentage of people presenting to ED admitted, discharged, or transferred within six hours	2014/15	2015/16	2016/17 Target	2016/17 Result
	96%	95%	95%	94.4%



People have shorter waits for specialist care

More than 72,000 patients attended a first specialist assessment in Canterbury; 99.8% of all those patients were seen within four months (ESPI2).

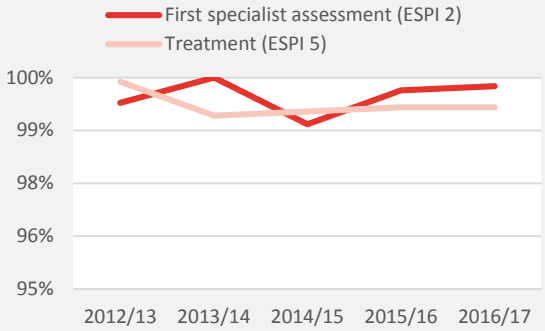
Of those patients given a commitment for treatment, 99.3% waited no longer than four months for treatment (ESPI5). The DHB also met the elective surgery health target, delivering 21,456 elective surgeries in 2016/17.

Over half of surgeries were provided as day cases and 91% of people received their surgery on the day of admission - meaning less disruption for patients, who can spend the night before surgery in their own homes.

Given the continued post-quake challenges, capacity constraints and rebuild disruptions over the past year, performance against these targets represents a major achievement for the DHB.

Data Source: Ministry of Health Quickplace Warehouse [14]

Percentage of people receiving specialist assessment (ESPI 2) or treatment (ESPI 5) within 4 months		2015/16	2016/17 Target	2016/17 Result
	ESPI2	99.8%	100%	99.8%
	ESPI5	99.3%	100%	99.3%



People experience fewer adverse events

The rate of serious falls in our hospitals has continued to reflect a positive downward trend.

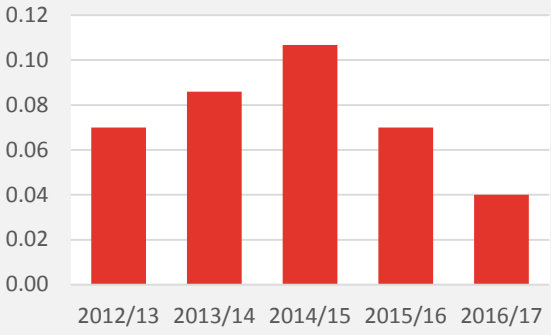
Key quality projects have focused on adoption of the national falls assessment process, standardising fall prevention visual cues and improving post-fall care. Our new electronic incident management system is also helping to raise awareness around falls.

New models of care implemented at Burwood Hospital are also contributing to this impressive result.

Our hospital teams provided 97% of all inpatients aged over 75 with a falls assessment in the third quarter of this year, allowing mitigation strategies and care plans to be put in place for patients at risk and supporting the achievement of this target.[15]

Data Source: Individual DHB Quality Systems [16]

Rate of SAC (level 1 & 2) falls in Canterbury hospitals	2014/15	2015/16	2016/17 Target	2016/17 Result
	0.11	0.07	0.06	0.04



[13] *This indicator is a national DHB health target (Shorter Stays in ED) and excludes those who did not wait in ED or had pre-arranged appointments. In line with national health target reporting, the annual results refer to the final quarter of each year (01 April - 30 June).*

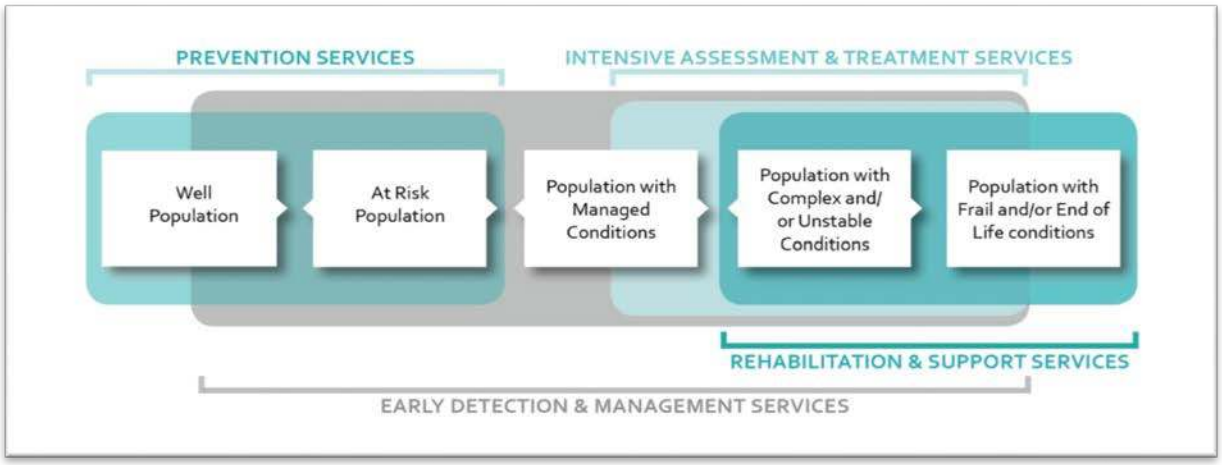
[14] *These indicators are two of the national Elective Services Patient Flow Indicators (ESPIs), established to track system performance. Standards are set nationally and in line with the ESPI reporting, the annual results presented are from the final month (June) of each year.*

[15] *The reference refers to the January to March 2017 period, being the most recently published.*

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

Part III
Delivering on our Plans

3.1 Statement of Service Performance



Evaluating our Performance

Over the longer term we evaluate the effectiveness of our decisions and the quality of our service delivery by tracking performance against the set of desired long-term outcomes presented on the previous pages.

We also evaluate our service performance on an annual basis by providing a forecast of the services we plan to deliver and the standards we expect to meet. This statement of service performance presents the DHB's actual performance against the 2016/17 forecast.[17]

The snapshot covers the services provided for the Canterbury population across the full continuum of care (pictured above) and measures have been grouped into four service (or output) classes that are a logical fit with the continuum:

- prevention services
- early detection and management services
- intensive assessment and treatment services
- rehabilitation and support services.

Each output class includes measures which help to evaluate the DHB's performance over time, recognising the funding received, Government priorities and expectations and system capacity.

Because it would be overwhelming to measure every service delivered, for each output class a mix of services are chosen which are important to our community and stakeholders, and provide a fair representation of how well the DHB is performing.

In presenting our performance picture, we have not simply presented the volumes of services delivered. The number of people who receive a service is often less important than whether enough of the right people received the service, or whether the service was delivered at the right time. We have therefore presented a mix of measures that address four key aspects of performance:

- Access (A)
- Timeliness (T)
- Coverage (C)
- Quality (Q).

The DHB is responsible for funding health services to our population, across the full continuum of care. Some of the measures presented in the statement of service performance therefore reflect the broader scope of services provided to our population, not just those provided directly by the DHB.

As part of our obligations under legislation, DHBs must work towards achieving equity. To promote this goal, the DHB has presented its performance against a core set of performance measures (taken from the DHB's Māori Health Plan) as a means of evaluating whether we have made a difference for our Māori population over the past year. This snapshot follows the statement of service performance.

Nationally, DHB performance is also evaluated by tracking performance against six national health targets. Canterbury's performance over the past year is set out on page 22.

[17] *The 2016/17 Annual Plan, incorporates the Forecast Statement of Service Performance, and is available on the DHB's website: www.cdhb.health.nz.*

Setting standards

In setting performance standards for 2016/17, we considered the changing demographic of our population, areas of increasing demand, and the assumption that resources and funding growth would be limited. Targets reflect the objective of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access while reducing waiting times and delays in treatment.

In Canterbury we are contending with the ongoing consequences of the earthquakes. The impact is being felt most markedly in an increased demand for mental health and emergency services, reduced capacity across our hospitals, and the constant disruption from repairs and construction.

We knew that a number of the standards would be particularly difficult to meet considering our challenging and evolving environment. However, the DHB remains committed to maintaining high standards of service delivery and it is pleasing to see that, in spite of the sustained pressure in many areas, wait times and access rates have been maintained and longer-term population health measures are still improving.

NOTES ON THE DATA

Rather than repeating footnotes, the following symbols have also been used to provide context in the performance tables:

E Some services are demand-driven such as: diagnostics, emergency, maternity, and palliative care services. It is not appropriate to set targets for these services, instead estimated service volumes are provided to give context in terms of the use of resources across our health system.

Δ Performance data provided by external parties can be affected by a delay in invoicing or reporting, and results for previous years are subject to change as a result of incorporating late data.

† Performance data for some programmes relates to the calendar rather than financial year.

◇ National health targets are set for DHBs to achieve by the final quarter, or final month, of the given year. In line with national performance reporting, fourth quarter (April-June) or June results are reported as the annual result.

◆ The measure also appears in the DHB's 2016/17 Māori Health Action Plan. A breakdown of results by ethnicity is presented on page32 .

We also note that the results for some measures, where the performance data comes from third parties or from national reports, was anticipated but unfortunately not available (n.a) at the time of printing this report. We have footnoted these instances through the report.

Performance Key

	Rating	Criteria
✓	**A**chieved	Standard reached
➲	**P**artially Achieved	Standard not reached but performance improved or maintained
✖	**N**ot Achieved	Standard not reached and performance dropped

3.2 National Health Target Performance

This was a positive year for the Canterbury DHB in terms of delivery against national health targets. While we missed one of the six national health targets in the final quarter, we improved or maintained performance on all of the target areas. Results below show the quarterly results across the 2016/17 year. The national average reflects the final quarter.

NATIONAL HEALTH TARGETS								
Success is measured by achievement of the target but also by improved performance across the year.	Notes	2016/17 Target	Q1	Q2	Q3	Q4	National Average	Rating
Children fully immunised at eight months of age	◇	95%	95%	95%	94%	95%	92%	✓
Smokers enrolled with a PHO receiving advice and help to quit	◇	90%	89%	85%	87%	90%	89%	✓
Percentage of people presenting in ED admitted, discharged, or transferred within six hours	◇	95%	93%	95%	94%	94%	95%	✗
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral	◇	85%	78%	85%	87%	85%	81%	✓
Elective surgical discharges delivered (surgeries provided)	◇	20,982	4,936	9,782	15,004	21,456	-	✓
Percentage of obese children identified at B4SC offered a referral for clinical assessment and healthy lifestyle interventions	◇	95%	46%	78%	93%	95%	91%	✓

The national Shorter Stays in ED target was the only national target that Canterbury DHB did not achieve in the final quarter. This has been a big year for our emergency department with over 96,800 patients presenting to our ED in 2016/17. Considering the increased demand and constant disruptions experienced across our main hospital sites (as we shift services and wards to accommodate earthquake repairs), missing the target by only 0.6% is an impressive performance.

Canterbury achieved the Better Help for Smokers to Quit - Primary Care health target, for the first time providing 90% of patients who identified as smokers with brief advice and support to quit smoking. Our public health and primary care partners have also supported achievement of the new Raising Healthy Kids target in the final quarter of this year. This is a great result as the national target was set to be achieved by DHBs by December 2017, we are pleased to be ahead of expectations in this area.

Performance against the new Faster Cancer Treatment target has moved in the right direction. The commitment made by service teams to improve patient pathways and data capture has improved our performance in 2016/17. Likewise, with the pressure on our hospital services, meeting the Improved Access to Elective Surgery target has required a huge commitment from many teams across the DHB and is an impressive result.

3.3 Our 2016/17 Service Performance

Prevention services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Preventive health services promote and protect the health of the population. They help to address individual behaviours by targeting changes to physical and social environments that influence and support people to make healthier choices.

The four leading long-term conditions; cancer, cardiovascular disease, diabetes and respiratory disease - make up 80% of the disease burden for the total population. These diseases are largely preventable by supporting people to make healthier choices and reducing the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high-need populations and to reduce inequalities in health status and health outcomes. Prevention services are also designed to spread consistent messages to large numbers of people, and can therefore be very cost-effective.

SERVICE PERFORMANCE- 2016/17

HEALTH PROMOTION AND EDUCATION SERVICES							
These services inform people about risks and support them to make healthy choices. Success begins with awareness and engagement followed by positive behaviour choices.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Babies exclusively breastfeeding on hospital discharge	Q [18]	80%	79%	≥75%	78%	-	✓
Babies exclusive/fully breastfed at LMC discharge	Q [19]◆	71%	n.a	75%	n.a	n.a	-
Lactation support and specialist advice consultations provided in community settings	A [20]	1,058	1,033	>600	1,026	-	✓
Priority schools supported by the Health Promoting Schools framework	C [21]	91%	89%	>70%	91%	-	✓
'Appetite for Life' nutrition courses provided in the community	A [22]	59	43	>50	42	-	➲
People provided with Green Prescriptions (GRx) for additional physical activity support	A [23]	2,797	3,095	3,000	3,800	-	✓
GRx participants more active 6-8 months after referral	Q [23]	62%	75%	>50%	n.a	n.a	-
Women smokefree at two weeks postnatal	Q [24]◆	90%	88%	95%	n.a	n.a	-
Smokers enrolled with a PHO receiving advice and help to quit	C [25]◇	89%	88%	90%	90%	89%	✓
Smokers identified in hospital receiving advice and help to quit	C ◇◆	96%	98%	95%	95%	95%	✓

[18] *The percentage of babies breastfeeding can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period. Standards are set in alignment with World Health Organization (WHO) recommendations.*

[19] *This measure is part of the national WellChild/Tamariki Ora (WCTO) performance framework and standards are set nationally. The Framework covers health promotion, education, screening and support services and checks are provided free to all New Zealand children from birth to five years. Results are published by the Ministry and the latest results had not been published at the time of printing.*

[20] *This programme aims to improve breastfeeding rates and to create a supportive breastfeeding environment. Evidence shows that infants who are not breastfed have a higher risk of developing chronic illnesses during their lifetimes. Standards are set in alignment with WHO recommendations.*

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

[22] *The number of total courses has dropped compared to previous year, with the focus going on increasing access through increasing the number of people per course – this has been achieved with the average number of registrations per course lifting from 10.5 people to 15 people per course.*

[23] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a national patient survey competed by Research NZ on behalf of the Ministry of Health. In 2017, a decision was made nationally to shift to biennial surveys. The next survey will be in 2017/18.*

[24] *This measure is part of the national Well Child performance framework and standards are set nationally. The 2015/16 results reflect the 6 months to December 2015: the full year and the 2016/17 result was not available at the time of printing.*

[25] *This is a national health target measure (Better Help for Smokers to Quit). Professionals providing brief advice to smokers is shown to increase the chances of smokers making quit attempts.*

POPULATION-BASED SCREENING SERVICES

These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake and success is indicated by high coverage rates.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Four-year-olds provided with a B4 School Check (B4SC)	C [26]	91%	91%	>90%	93%	94%	✓
% of four-year-olds (identified as obese at B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q [27]	new	new	95%	95%	91%	✓
Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C †[28]	98%	100%	>95%	100%	-	✓
Women (25-69) having a cervical smear in the last 3 years	C [29]◆	75%	74%	80%	74%	75%	➲
Women (50-69) having a mammography in the last 2 years	C [29]◆	79%	77%	>70%	76%	72%	✓

IMMUNISATION SERVICES

These services help to reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Newborns enrolled on the Nat. Immunisation Register at birth	C	98%	99%	>95%	99%	-	✓
Children fully immunised at eight months of age	C ◇◆	94%	96%	95%	95%	92%	✓
Eight-month-olds 'reached' by immunisation services	Q [30]◇	98%	98%	95%	99%	97%	✓
Eligible girls completing HPV vaccinations (Dose 3)	C [31]†◆	38%	43%	70%	59%	66%	➲
Older people (65+) receiving a free influenza ('flu') vaccination	C [32]†◆	74%	74%	75%	63%	56%	✖

[26] *The B4 School Check is the final core Well Child/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.*

[27] *This measure is the national Raising Healthy Kids health target introduced at the start of 2016/17.*

[28] *A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.*

[29] *The cervical and breast cancer screening programmes are national programmes and age bands and standards are set nationally. Rates for cervical screening in Canterbury are below target, but similar to national rates. Improving cervical screening rates is a focus in our Māori Health Plan and we have re-established a clinical steering group to support improved performance in this area.*

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

[31] *Around 150 women are diagnosed with cervical cancer and 50 women die from it each year in New Zealand. The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme currently consists of three vaccinations and is free to young people under 26 years of age. The delivery of Canterbury's HPV programme differs to that provided in other regions being primarily a general practice based programme. A school-based programme was launched in February 2016 to complement and support the general practice programme - 69% of eligible girls have already started the programme this year (having received dose 1).*

[32] *The denominator for this measure has changed, from the number of people enrolled with a PHO to the Census population, which has had a negative impact on results for the most recent year and means results from previous years are not directly comparable.*

Early detection and management services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so-called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others do, and prevalence increases with age. Early detection and management services help to maintain, improve and restore people's health by ensuring that those at risk of developing a long-term condition, or with early disease onset, are identified early and their condition is appropriately managed. These services are particularly important where people have multiple conditions requiring ongoing interventions or coordinated support.

Because these services can better support people to stay well and avoid negative complications or acute illness, they help reduce the likelihood of a hospital admission. They therefore not only have a positive impact on people's health but also reduce the pressure on the health system, freeing up limited capacity across our hospital and specialist services.

SERVICE PERFORMANCE – 2016/17

PRIMARY CARE SERVICES							
These services are offered in community settings by general practice teams and other primary healthcare professionals, to improve, maintain or restore people's health. High enrolment or access levels are indicative of a responsive system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Population enrolled with a Primary Health Organisation	C◆	95%	95%	>95%	94%	-	✖
Number of clinical HealthPathways in place across the system	Q [33]	555	499	>500	644	-	✓
Avoidable hospital admission rate for children (0-4)	Q [34]◆	6,426	5,883	<5,972	6,140	6,474	✖
Young people (0-19) accessing Brief Intervention Counselling	A [35]	611	610	>500	679	-	✓
Adults (20+) accessing Brief Intervention Counselling	A	5,565	5,505	>3,500	5,861	-	✓
Skin lesions (including cancers) removed in primary care	A	2,583	2,820	>2,000	2,520	-	✓

ORAL HEALTH SERVICES							
These services are provided by oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.	Notes	2014	2015	2016 Target	2016 Result	2016 National Average	Rating
Children (0-4) enrolled in DHB-funded oral health services	C[36]†◆	69%	61%	95%	62%	-	➲
Children (0-12), enrolled with oral health services, examined according to planned recall	T †◆	86%	90%	90%	90%	-	✓
Adolescents (13-17) accessing DHB-funded oral health services	C †[37]	62%	62%	85%	61%	67%	✖

[33] The HealthPathways website helps general practice to navigate clinically designed pathways that guide and support patient care. This measure has been updated to count only clinical pathways and not supporting resources.

[34] Some hospital admissions are seen as avoidable through early intervention and treatment and therefore provide an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. The DHB's aim is to maintain current performance below the national rate (which reflects less people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based off the national March 2017 series provided by the Ministry of Health in August 2017 – baselines have been reset to reflect the current series and are to March of each year.

[35] The Brief Intervention Coordination Service provides people with free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. Results include face-to-face and phone consultations and may undercount people accessing the service where dates of birth or NHIs have not been provided. Uptake of the service is still high, reflecting the ongoing need for additional mental health support across Canterbury.

[36] Enrolment rates are disappointing. The DHB has reviewed its enrolment processes and is adopting a multiple enrolment process where School and Community Dental Services will work more closely with Immunisation and Well Child Tamariki Ora (WCTO) teams to identify children and enrol them with services.

[37] Uptake of free oral health care by adolescents has been low for some years. The DHB has established an Oral Health Steering Group to focus on improving performance against all the oral health measures. We anticipate improved performance over the 2017/18 year.

LONG-TERM CONDITIONS SERVICES

These services are targeted at people with high health needs with the aim of reducing crises and complications through earlier identification and good management (and control) of that condition and any possible side-effects.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Spirometry tests provided in community rather than hospital	A [38]	1,682	1,742	>1,000	1,897	-	✓
Eligible population having a CVD risk assessment in the last 5 years	C [39◇◆]	82%	87%	90%	85%	90%	✗
Population identified with diabetes having an HbA1c test in the last year	C [40†]	88%	89%	>90%	89%	-	➔
Population identified with diabetes with acceptable glycaemic control (evidenced via their HbA1c test)	Q †	77%	75%	>75%	75%	-	➔
People receiving subsidised diabetes self-management support from their general practice team, when newly diagnosed with Type 2 diabetes or starting insulin	A	880	956	>800	882	-	✓

PHARMACY AND REFERRED SERVICES

These are services which a health professional may use to help diagnose or monitor a health condition. While largely demand driven, faster, direct access aids clinical decision-making, improves referral processes and reduces the wait for treatment.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Subsidised pharmaceutical items dispensed in the community	A [41]	6.3m	6.5m	E.<7m	6.8m	-	✓
Laboratory tests completed for the Canterbury population	A [42]	2.4m	2.5m	E. <2.6m	2.8m	-	✗
People on multiple medications receiving medication support	A [43Δ]	1,326	1,355	2,000	1,361	-	➔
GP requested Community Referred Radiology tests completed	A	44,720	44,404	E. >30k	45,227	-	✓
People receiving urgent diagnostic colonoscopy within 2 weeks	T [44]	96%	92%	>85%	94%	92%	✓
People receiving CT scans within 6 weeks	T [45]	96%	75%	95%	73%	87%	✗
People receiving MRI scans within 6 weeks	T [45]	75%	59%	>85%	33%	61%	✗
People receiving elective coronary angiography within 3 months	T [44]	98%	98%	>95%	97%	98%	✓

[38] *Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment. Tests are delivered by GP and mobile community respiratory providers.*

[39] *This measure refers to cardiovascular disease (CVD) risk assessments undertaken in primary care and was previously the national 'More heart and diabetes checks' health target. By identifying those at risk of CVD early, we can help them to change their lifestyle, improve their health and reduce rate of avoidable CVD-related hospitalisation for our population.*

[40] *An annual HbA1c test of patient's blood glucose levels is seen as a good means of assessing the management of people's diabetes condition - HbA1c ≤64mmol/mol reflects an acceptable blood glucose level.*

[41] *This measure excludes items dispensed in hospitals, but may include non-Canterbury residents who had prescriptions filled in Canterbury.*

[42] *Laboratory services are largely demand driven and with Canterbury's growing and ageing population, and more people living longer with long-term conditions, an increase is not surprising. However in the past year Canterbury Health Laboratories' data has been included in the national database and this is reflected in the higher number of tests being captured.*

[43] *This measure counts both Mediation Management Reviews and the new intensive Medication Therapy Assessments programme introduced in 2016. Because 2014/15 figures do not include Medication Therapy Assessments, they are not directly comparable.*

[44] *These diagnostic measures are national DHB performance measures (PP29). Standards are set nationally and results are for the final month of the year (June) in alignment with results published by the Ministry of Health.*

[45] *Demand for CT and MRI scanning has been exceeding reporting and machine capacity in Canterbury due to a number of factors including: increasing surgical volumes, the introduction of new drugs and treatments and population increases. In addition Canterbury sees the majority of tertiary referrals from other South Island DHBs, who have also been experiencing growth in their areas. In response to this increasing demand pressure, the DHB now has CT and MRI scanners operational at Burwood Hospital and a second MRI scanner at Christchurch Hospital. The DHB is also in the process of hiring more clinical staff to increase radiologist availability and reporting capacity.*

Intensive assessment and treatment services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action, and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enables people to establish more stable lives, and results in improved confidence in the health system.

As an owner of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Improved systems and processes will support patient safety, reduce the number of events causing injury or harm and improve health outcomes.

SERVICE PERFORMANCE – 2016/17

QUALITY AND PATIENT SAFETY							
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Rate of compliance with good hand hygiene practice	Q [46]◇	77%	78%	80%	83%	84%	✓
Hip and knee replacement patients receiving cefazolin >2g	Q [47]◇	98%	98%	95%	98%	97%	✓
Hip and knee replacement patients who have appropriate skin preparation	Q◇	100%	100%	100%	100%	98%	✓
Inpatients (aged 75+) receiving a falls assessment	Q [48]◇	96%	100%	90%	97%	92%	✓

MATERNITY SERVICES							
These are services provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Service utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Women registered with an LMC by 12 weeks of pregnancy	C [49]†	77%	77%	80%	n.a	n.a	-
Maternity deliveries in Canterbury facilities	A	5,897	5,922	E. 6,000	6,048	-	✓
Deliveries in primary birthing units	A [50]	12%	14%	13%	14%	-	✓

[46] *The quality measures are national safety markers with definitions and standards set nationally. Baselines have been updated to the final quarter which were not available at the time of printing. The 2016/17 results are the most recent available being (January-March 2017).*

[47] *Cefazolin ≥2g is an antibiotic recommended as routine for hip and knee replacements to prevent infection complications.*

[48] *While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and then plan accordingly.*

[49] *The data for this measure comes from the national Maternity Collection and updated data for 2014/15 and 2015/16 was provided by the Ministry in line with the adoption of this measure as one of the new national Better Public Services measures. The 2016/17 result had not yet been made available at the time of printing this report. The aim is to engage mothers early in their pregnancy to promote good health and wellbeing of both mother and baby.*

[50] *The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women birth in secondary or tertiary facilities when it is not clinically required. This allows for a better use of system resources and ensures capacity is available for those women who need more complex or specialist intervention.*

ACUTE/URGENT SERVICES

These are services delivered in response to illnesses that have an abrupt onset or progress rapidly. While largely demand driven, earlier intervention and shorter wait times are indicative of an effective and responsive system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Children (0-13) with access to free primary care after hours	A	new	98%	100%	98%	-	➲
General practices providing telephone triage after hours	A	92%	93%	95%	91%	-	✖
Acute demand packages of care provided in community settings	A [51]	31,182	33,010	>28,000	34,853	-	✓
Attendances at Canterbury DHB emergency departments	A [52]	91,253	94,251	E. <96k	96,854	-	✖
People waiting less than 4 weeks for radiation or chemotherapy	T [53]◇	100%	100%	100%	100%	-	✓
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T [54]◇	73%	70%	85%	85%	81%	✓
Acute inpatient average length of stay (standardised)	Q [55]	2.40	2.39	<2.35	2.40	2.50	✖

ELECTIVE/ARRANGED SERVICES

These are services for people who do not need immediate hospital treatment, where treatment is 'booked' or 'arranged.' Improved access is seen as indicative of an effective system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
First Specialist Assessments provided (medical and surgical)	A [56]	72,069	71,244	E.>60k	72,049	-	✓
First Specialist Assessments that were non-contact (virtual)	Q [57]	19%	17%	>10%	17%	-	✓
Elective surgical discharges delivered (surgeries provided)	A [58]◇	20,353	21,039	20,982	21,456	-	✓
Elective/arranged surgeries provided as day cases	Q [59]	58%	58%	≥57%	59%	-	✓
People who receive their surgery on the day of admission	Q [59]	91%	91%	≥90%	91%	-	✓
Elective inpatient average length of stay (standardised)	Q	1.57	1.54	<1.55	1.54	1.56	✓
Outpatient attendances	A [60]	651,259	671,705	E.>600k	672,348	-	✓
Outpatient 'Did not Attend' rates	Q [61]	5%	5%	<5%	4%	-	✓

[51] *Acute demand packages are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people to be treated in their own homes or in the community rather than having to present to hospital for treatment.*

[52] *This measure is based on the national Shorter Stays in ED Health Target and counts presentations to both Christchurch and Ashburton Hospital EDs – this measure excludes those who do not wait to be seen and those with pre-arranged appointments. There has been considerable growth in demand for ED services, with the greatest growth in the 25-29 year old age group.*

[53] *This is a national DHB performance measure (PP30) and excludes where treatment is scheduled with other treatments or part of a trial.*

[54] *This is a national health target (Faster Cancer Treatment) and presents a rolling six month result. The DHB has incorrectly reflected the 2017/18 target of 90% against this measure in the 2016/17 Plan. Elsewhere in the Plan the target was correctly reflected as 85%. DHBs are not expected to achieve the 90% target until June 2018. This has been corrected above.*

[55] *This is a national performance measure (OS3). By shortening hospital length of stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective surgery. Importantly, addressing the factors that influence a patient's length of stay includes reducing the rate of patient complications and infection, and integration activity to support patients to return home sooner. Performance is balanced against readmission rates to ensure earlier discharge is appropriate and service quality remains high.*

[56] *This measure counts medical and surgical assessments but only the first assessments (where the specialist determines treatment). Follow-up assessments are not included, as the first assessment is key in tracking increased access to treatment. The baselines have been revised as a result of ongoing quality improvements and correction of the code that assigns purchase units, enabling the count of many patient events that previously could not be classified. Baselines have been updated to ensure accurate comparison between years. Virtual FSA have also been affected by the revision.*

[57] *Non-contact FSAs are those where specialist advice and assessment is provided without the need (or the wait) for a hospital appointment.*

[58] *This is a national health target (Improved Access to Elective Services) and does not include all surgery or procedures delivered by the DHB.*

[59] *When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own home. This also frees up hospital resources.*

[60] *The baselines have been revised as a result of ongoing quality improvements and correction of the code that assigns purchase units, enabling the count of many patient events that previously could not be classified. Baselines have been updated to ensure accurate comparison between years. Outpatient DNA rates have also been affected by the revision.*

[61] *The DNA rate is calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not. When patients fail to turn up to appointments, it is costly for the DHB and can negatively affect their recovery and long-term outcomes.*

SPECIALIST MENTAL HEALTH SERVICES							
These are services for those most severely affected by mental illness or addictions. Improved access and shorter wait times are indicative of the systems positive response to demand.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Young people (0-19) accessing specialist mental health services	C [62]	3.5%	3.5%	>3.1%	3.7%	3.8%	✓
Adults (20-64) accessing specialist mental health services	C	3.2%	3.4%	>3.1%	3.8%	3.9%	✓
People referred for non-urgent mental health and alcohol and other drug (AOD) services seen within 3 weeks	T [63]	73%	76%	80%	77%	79%	➲
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	90%	93%	95%	94%	94%	✖

ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)							
These are services that restore functional ability and enable people to live as independently as possible. An increase in the proportion of older people discharged home, rather than into residential care or hospital environment reflects a successful outcome for the patient and the service.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Admissions into all inpatient AT&R services	A	3,462	3,371	E.>3,000	3,442	-	✓
Admissions into Older Person's Health AT&R services made by direct community referral	Q [64]	21%	20%	20%	15%	-	✖
Older Person's Health AT&R inpatients discharged to their own home rather than into aged residential care	Q Δ[65]	87%	86%	>80%	88%	-	✓

[62] This measure is a national DHB performance measure (PP6) and standards are set nationally based on the expectation that 3% of the population will need access to specialist mental health support. The three year trend presented does not reflect the extent of the increase in demand. Access rates in Canterbury to December 2010 (prior to the earthquakes) were considerably lower (1.7% for youth and 2.2% for adults). Results also only capture patients accessing the DHB's specialist mental health services and non-government organisations (NGOs) who report to the national PRIMHD database. This undercounts service provision where local providers are not setup to report into the national system. In Canterbury, this includes a number of NGOs and primary care mental health services that are part of the integrated approach to meeting mental health service demand, following the earthquakes. Canterbury's combined (SMHS, NGO and Primary Care) access rates for the same period were 3.9% for children and youth (0-19) and 7.5% for adults (20-64).

[63] This measure is a national DHB performance measure (PP8). Standards are set nationally and results are always three months in arrears.

[64] This is a subset of the total AT&R services and reflects age-related AT&R services provided by the Older Person's Health Division of the DHB. This service option allows a GP to refer directly to the service and the number of direct referrals have dropped by around 100 people in 2016/17. There are a number of other options, such as CREST and the Acute Demand Programme, where GPs can also refer patients directly when they need additional support and the total number of people supported by the OPH AT&R service has not dropped overall, however the DHB will be looking more closely to understand the change in behaviour as we want to be reassured that GPs feel they can refer if they need to and they are aware of the service option.

[65] A discharge from AT&R to home, rather than into residential care, is seen as reflective of the quality and effectiveness of services—in terms of assisting that person to regain their functional independence. With appropriate community supports, people who are able to remain safely in their own homes and communities and to 'age in place' report higher levels of satisfaction and quality of life.

Rehabilitation and support services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Services that support people to live safely and independently in their own homes are considered to provide a much higher quality of life, as a result of them staying active and positively connected to their communities. Even when returning to full health is not possible, timely access to assessment, advice and support enables people to maximise their function and independence.

In preventing deterioration and crisis, these services have a major impact on the sustainability of the health system by reducing acute demand, avoidable hospital admissions and the need for more complex intervention. These services also support the flow of patients, by enabling them to go home earlier, and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

SERVICE PERFORMANCE – 2016/17

REHABILITATION SERVICES							
These services restore or maximise people's health or function following a health-related event and success is often measured through increased referral to appropriate services following an acute event such as a heart attack or stroke.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
People accessing cardiac rehabilitation services after an acute event	Q [66]	15%	22%	30%	20%	-	✖
People referred to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q	80%	80%	80%	80%	-	✓
People accessing community-based pulmonary rehabilitation courses	A [67]	222	261	>200	325	-	✓
People (65+) accessing community-based falls prevention programmes	A [68]	1,686	1,973	>1,500	1,815	-	✓

HOME AND COMMUNITY-BASED SUPPORT SERVICES							
These are services that help to restore functional independence and support people to continue living in their own homes. Largely demand driven, the number of people being supported is indicative of the capacity in the system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
% of older people (65+) receiving long-term home and community support services, who have had a clinical assessment of need using the InterRAI assessment tool	Q [69]	94%	96%	95%	97%	-	✓
People supported by CREST services on hospital discharge or GP referral	A [70]	1,770	1,726	>1,500	1,741	-	✓
People supported by district nursing services	A	7,765	7,532	E.>7,000	7,798	-	✓
People supported by long-term home-based support services	A	8,641	8,129	E.<8,000	7,922	-	✓

[66] This measure counts those enrolled in Phase 2 (outpatient) cardiac rehabilitation on discharge. Rehabilitation options have been extended to include evening courses and outpatient type appointments, which have enabled and encouraged more people to have a positive outcome. Further work will be undertake to refine this measure for the coming year, as it currently captures people from outside the Canterbury region who go home for rehabilitation and people with other co-morbidities that would not make cardiac rehabilitation clinically appropriate.

[67] This measure includes people attending DHB funded pulmonary rehabilitation programmes (Ashburton and Christchurch).

[68] Falls are one of the leading causes of hospital admission for people aged over 65. The aim of the Falls Prevention Programme is to provide better care for people 'at-risk' of a fall, or who have experience a fall, and to support people to stay safe and well in their own homes.

[69] InterRAI is a comprehensive clinical assessment tool, developed to improve the quality of life of vulnerable people, that helps to ensure they receive equitable access to the right support and care to meet their needs.

[70] The CREST service provides a range of home-based rehabilitation services aimed at facilitating early discharge from hospital or avoiding admission to hospital entirely (via proactive GP referral). The measure is the number of clients having received unique packages of care.

RESPITE AND DAY SERVICES

These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Success is measured by increased access to services and effective use of capacity.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
People supported by day services	A [71]	832	804	E.>750	728	-	✗
People accessing mental health planned and crisis respite	A [72]	935	1,006	E.>850	874	-	✓
Occupancy rate of mental health planned and crisis respite beds	A [73]	76%	76%	85%	68%	-	✗
Older people supported by aged care respite services	A	1,424	1,620	E.>1,200	1,629	-	✓

PALLIATIVE CARE SERVICES

These are services that improve the quality of life for patients facing end of life and their families. Services are demand driven and access is monitored to ensure capacity is available.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
People supported by hospice or home-based palliative services	A	3,934	3,617	E.>3,000	4,060	-	✓

RESIDENTIAL CARE SERVICES

These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. A decrease in the number of bed days for aged residential care (ARC) is seen as indicative of more people being successfully supported to continue living in their own homes.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
People entering ARC having had an InterRAI assessment	Q [74]	99%	99%	95%	88%	-	✗
Subsidised ARC rest home beds provided (days)	A [75]	528,795	501,688	E.<620k	471,627	-	✓
Subsidised ARC hospital beds provided (days)	A	471,724	494,185	E.<510k	507,028	-	✓
Subsidised ARC dementia beds provided (days)	A	231,066	239,996	E.>220k	251,493	-	✓
Subsidised ARC psycho-geriatric beds provided (days)	A	67,833	70,562	E.>65k	78,282	-	✓

[71] *Day Support services play an important part in helping to reduce carer stress and social isolation for older people in our community. The 2016/17 result represents a slight drop in the number of people accessing services and the DHB is working with clinical assessors to encourage referrals where people would benefit from support.*

[72] *Some providers are reporting issues with people booking beds and not turning up or taking the beds during the day but checking out before midnight, so the bed is classed as unused as the count is taken at midnight. This is reflected in the lower occupancy rates. The DHB will be reconsidering the use of 'planned' respite beds over the coming year and will refocus this measure on crisis respite.*

[73] *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 which might imply that resources are underutilised and could be better directed to other areas. There are currently 26 beds in total.*

[74] *InterRAI is a comprehensive clinical assessment tool, developed to improve the quality of life of vulnerable people which helps to ensure they receive equitable access to the right support and care to meets their needs. The DHB continues to work with clinical assessors, nurse managers and aged care providers to raise awareness of the benefits of the assessments and increase rates of completion. In the past year, reporting changed and is now coordinated nationally rather than locally. Some people, such as palliative clients, do not require an InterRAI assessment and were excluded from reporting in the past. These clients are now being captured under this measure which is having a negative impact on results. The DHB has alerted the national InterRAI co-ordinator to this issue.*

[75] *This drop in rest home bed days is in line with the DHB's strategy of supporting people to stay well and in their own homes for longer.*

3.4 Māori Health Plan Performance

Sitting alongside the Annual Plan and Statement of Intent, the DHB also has a Māori Health Action Plan which sets out planned activity and expected standards against a set of core indicators, seen as particularly important to our community and in line with national expectations. The 2016/17 Māori Health Action Plan is available on the DHB's website and performance against the core indicators in the Action Plan is presented below.

MĀORI HEALTH ACTION PLAN INDICATORS							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Māori population enrolled with a PHO	C	87%	85%	95%	82%	-	✖
Māori smokers identified in hospital receiving advice and help to quit	C◇	95%	97%	95%	94%	95%	✖
Māori women smokefree at two weeks postnatal	Q [76]	72%	n.a	95%	n.a	n.a	-
Māori babies exclusive/fully breastfed at LMC discharge	Q [76]	68%	n.a	75%	n.a	n.a	-
Māori babies fully immunised at eight months of age	C◇	96%	95%	95%	92%	88%	✖
Māori children receiving a B4 School Check at age four	C [77]	92%	94%	90%	91%	95%	✓
Rates of avoidable hospital admissions for Māori (0-4 years)	Q [78]	5,517	4,893	<5,972	5,305	6,996	✓
Māori children (0-4) enrolled in DHB dental services	C † [79]	33%	29%	95%	44%	-	➲
Māori children (0-12) examined according to planned recall	C†	81%	87%	90%	86%	-	✖
Eligible Māori girls receiving Dose 3 of the HPV programme	C †	28%	35%	70%	51%	72%	➲
Eligible Māori who have had their CVD risk assessed within the past five years	C [80]	76%	80%	90%	78%	87%	✖
Eligible Māori men (35-44) who have had their CVD risk assessed within the past five years	C	new	new	90%	59%	69%	✖
Māori women (25-69) who have had a cervical smear in the last three years	C [81]	55%	60%	80%	58%	65%	✖
Māori women (50-69) who have had a mammography in the last two years	C [81]	74%	72%	>70%	71%	65%	✓
Older Māori (65+) having had a seasonal influenza vaccination	C † [82]	71%	68%	75%	44%	48%	✖
Māori Outpatient 'Did not Attend' rates	Q [83]	11%	9%	<5%	7%	-	➲

[76] These measures are part of the national Well Child performance framework and standards are set nationally. The 2015/16 and 2016/17 results were not available to the DHB at the time of printing.

[77] The high need grouping presented in the Annual Plan, included Māori and Pacific children and children living in high deprivation areas. The deprivation breakdowns have been significantly impacted by forced migration in Canterbury following the earthquakes and we do not believe results are directly comparable. A breakdown by Māori has been included as a better reference point for programme improvement.

[78] Some hospital admissions are seen as avoidable through early intervention and treatment and therefore provide an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. The DHB's aim is to maintain current performance below the national rate (which reflects fewer people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based on the national March 2017 series provided by the Ministry of Health in August 2017. Baselines have been reset to reflect the current series and are to March of each year.

[79] Ethnicity results are based off those recorded at birth and the DHB has worked on aligning these to the NIR and PHO dataset which are more up to date. While results are still below target this work has ensured results are more accurately presented.

[80] There has been a change in focus nationally with regards to this measure – being the higher-risk subset of Māori men, this has been included for reference. The results refer to Q3, which was the latest available at the time of printing.

[81] The cervical and breast cancer screening programmes are national programmes and age bands and standards are set nationally.

[82] This result is affected by a change in definition, with the 2016/17 year being based on Census numbers rather than PHO enrolments. Previous year's results are not directly comparable. The actual number of older Māori having a flu vaccination has increased by 100 people, compared to 2015/16.

[83] Outpatient baselines have been revised as a result of ongoing quality improvements and correction of the code that assigns purchase units enabling the count of many patient events that previously could not be classified. Outpatient DNA rates have also been affected by the revision and baselines have been updated to ensure accurate comparison between years.

Part IV
Managing Our Business

The manner in which we work, the way we interact with each other and the values of our organisation are key factors in our success. Having already identified the challenges we face and the collective vision for the Canterbury health system, this section highlights the way in which we have managed our business in order to deliver on our goals.

4.1 Corporate Governance

Statutory Information

This Annual Report presents Canterbury DHB's financial and non-financial performance for the year ended 30 June 2017 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

Canterbury DHB's 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 have 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.

Board's Report & Statutory Disclosure

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, Canterbury DHB recorded a deficit of $52.833M against the budgeted $41.987M deficit (2015/16 deficit of $0.473M against the budgeted breakeven position).

BOARD FEES

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

	Board Fees	Committee Fees
Murray Cleverley	42,618	1,312
Ta Mark Solomon	28,275	500
Peter Ballantyne		2,500
Pauline Barnett		250
Barry Bragg	15,470	1,750
Sally Buck	26,520	2,500
Tracey Chambers	15,470	1,125
Anna Crighton	26,520	3,000
Wendy Dallas-Katoa		500
Andrew Dickerson	26,520	4,375
Hamish Doig		2,000
Jan Edwards		1,500
Rochelle Faimalo		1,000
Susan Foster-Cohen		1,000
Jo Kane	26,520	4,250
Aaron Keown	26,520	1,500
Bob Lineham		2,000
Sandy Lockhart		750
Ben Lucas		250
Cheryl Macaulay		6,000
Chris Mene	26,520	312
Edie Moke	11,050	1,500
David Morrell	26,520	4,500
Yvonne Palmer		1,000
Trevor Read		1,250
Ana Rolleston		250
Tony Sewell		7,000
William Tate		2,000
Susan Wallace	11,050	
Steve Wakefield	13,812	2,500
Olive Webb		750
Total	323,385	59,124

Total fees paid for the year were $382,509 (2015/16 - $393,305).

Board elections held in October 2016 resulted in some changes to the Board as noted in section 6.1 on page 78.

BOARD AND COMMITTEE MEMBER ATTENDANCE

	BOARD		QFARC		HAC		CPHAC		DSAC		FAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Murray Cleverley	6	6	5	6							5	5
Ta Mark Solomon	6	6	2	4							3	4
Peter Ballantyne			10	10								
Pauline Barnett							1	2				
Barry Bragg	6	6	4	4	2	2					4	4
Sally Buck	10	11			6	6	1	2	3	4		
Tracey Chambers	5	6					2	2	2	2	2	4
Anna Crighton	11	11			5	6	4	4	2	2		
Hamish Doig											2	3
Wendy Dallas-Katoa							2	4				
Andrew Dickerson	11	11	10	10	6	6			2	2	9	9
Jan Edwards					6	6						
Rochelle Faimalo							4	4				
Susan Foster-Cohen									4	4		
Jo Kane	9	11	9	10	2	2	4	4	2	2		
Aaron Keown	10	11			4	4	1	2	1	2	3	4
Bob Lineham			8	10								
Sandy Lockhart									3	4		
Ben Lucas									1	4		
Cheryl Macaulay											6	7
Chris Mene	9	11					0	4	1	4		
Edie Moke	5	5	4	5					2	2		
David Morrell	11	11	10	10	6	6	2	2				
Yvonne Palmer							4	4				
Trevor Read					5	6						
Ana Rolleston					1	6						
Tony Sewell											7	9
William Tate			10	10								
Susan Wallace	2	5										
Steve Wakefield	5	5	7	7	3	3					4	4
Waren Warfield											1	6
Olive Webb									3	4		

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

DIRECTOR FEES

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

	2017	2016
Brian Wood	25,000	28,000
Jane Cartwright	22,000	22,000
Peter Ballantyne	-	6,000
Kath Fox	11,000	10,000
Paula Rose	11,000	7,000
Graeme McNally	11,000	11,000
Garth Bateup	6,000	6,000
Total	86,000	90,000

During the year Justine White (Canterbury DHB's GM Finance and Corporate Services) replaced Garth Bateup as a director at Canterbury Linen Services Limited. Directors of subsidiaries who are also employees do not receive director fees.

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.

REQUIREMENT TO REPORT ON NEW ZEALAND BUSINESS NUMBER IMPLEMENTATION

Canterbury DHB has reviewed the requirements of the Ministerial Direction (NZ Gazette, No 63 – 14 July 2016) to implement the New Zealand Business Number (NZBN) in key systems by 31 December 2018 to enable improved delivery of services. Canterbury DHB intends to replace its key finance and supply chain business system within the timeframe of the Direction, and the replacement system has taken the NZBN requirements, as provided to date, into account. Work is also ongoing to identify other impacts and to establish the changes that need to be implemented as a result of this Direction.

4.2 Our Assets

ASSET MANAGEMENT AND PERFORMANCE

Having the right assets in the right place and managing them well is critical to the ongoing provision of high-quality and cost-effective health services. Asset management is also particularly important for Canterbury DHB as we deliver on our significant redevelopment, remediation and repair programmes following the earthquakes.

The DHB has an Asset Management Plan that helps inform our capital requirements and investment decisions in the short and medium term. This identifies the condition of those assets and any planned refurbishment, upgrades or replacements. We have aggregated our assets into three major portfolio areas which cover the majority of those assets considered significant (critical) in regard to the delivery of core services.

ASSET PORTFOLIO	ASSET CLASSES WITHIN PORTFOLIOS	ASSET PURPOSE	NET BOOK VALUE		
			2014/15	2015/16	2016/17
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	$326M	$412M	$613M
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	$35M	$41M	$46M
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of health service by aiding decision making at the point of care	$8M	$11M	$26M

As part of the management of our assets, and to improve our investment thinking, we are working with the Ministry of Health, Treasury and fellow DHBs on the development of Long-Term Investment Plans. This includes the establishment of a core set of asset performance metrics for each asset portfolio which will help to ensure we are investing wisely and that the assets we have in place meet industry standards.

The DHB has developed a set of developmental performance metrics, for use in internal management and decision-making processes, including relevant indicators of past and projected performance. These were highlighted in the DHB's 2016/17 Annual Plan and have been reported to Treasury in line with national expectations.

These performance metrics are being reviewed as part of the longer-term planning and in conjunction with the national process, and we anticipate that there will be further work in this area before a final set is agreed.

4.3 Our People

People at the heart of all we do

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

We are committed to an ethos of co-design, which includes engaging our people in the development, ongoing review, and renewal of programmes and policies. This includes our good employer programmes.

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 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.

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

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

STAFF MIX BY AVERAGE AGE	
Medical	40.84
Nursing	46.17
Allied Health	44.49
Support	52.19
Management & Administration	49.78

STAFF MIX BY GENDER		
Female	7,911	81%
Male	1,849	19%
	9,760	

STAFF IDENTIFYING A DISABILITY[84]	
Yes	11

STAFF ETHNICITY	
Americas	78
Australian	98
British	687
Chinese	208
Filipino	172
Indian	172
Irish	60
Māori	237
Middle Eastern	31
New Zealand European	5,239
New Zealander	549
Not Stated / Don't Know	1,598
Other	9
Other African	43
Other Asian	187
Other European	248
Pacific Peoples	92
South African	52
	9,760

[84] *This data is voluntarily given and unlikely to reflect the true number of staff that identify as having a disability. Canterbury DHB has a 10 year Disability Action Plan which includes workforce priorities. This is available on the website www.cdhb.health.nz*

Recruitment, selection and induction

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, selection, induction, candidate care, talent management, succession planning and strategic sourcing. The purpose of this approach is to support an integrated Canterbury health system by providing proactive, targeted and agile initiatives at every level; maximising opportunities that result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey throughout the Canterbury health system.

As part of these approaches we fully embrace best practices of equity and diversity. We are also active participants in the development of consistent regional approaches to recruitment and associated support systems; as well as influencing the shape of national direction in this critical area.

Workplace safety, health and wellbeing

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by a professional Wellbeing, Health and Safety team, which includes experts in workplace safety, occupational health and rehabilitation, as well as employee wellbeing. In addition to working alongside the workforce and Health and Safety Representatives, this dedicated team provides advice and support to all levels of management.

There is a health monitoring programme which includes screening and immunisation. The entire workforce, and their families, are provided with free access to an Employee Assistance Programme if they are faced with work or personal issues that are negatively impacting on them. There is also access to onsite Work Place confidential support services through an external provider.

Wellbeing programmes and activities to encourage and support all our people in terms of healthier lifestyles are available throughout the organisation. There are many opportunities for workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training. As part of this approach, our people are supported and encouraged to be responsible for building and maintaining a healthy and safe environment at work.

Canterbury DHB continues to participate in the ACC Accredited Employer Programme to promote a safe work environment. Injury prevention programmes are developed to reduce the risk of injury and there is a focus on supporting staff to return to work following an injury or illness. We do not tolerate any form of harassment or workplace bullying and ensure all staff are aware of harassment policies and procedures to deal with such a situation. This includes discussions with individuals new to the organisation at orientation, and through information and training for managers to facilitate early intervention.

Equal opportunities and positive behaviours

Consistent with our vision and organisational values, Canterbury DHB is committed to flexibility and work design; maintaining and enhancing practices which eliminate all forms of discrimination, bullying and harassment in the workplace and barriers to the recruitment, retention, development and promotion of our employees.

We have a diverse, flexible and highly skilled workforce which reflects the demographics of our community and contributes significantly to the provision of quality, culturally and individually appropriate services.

We are committed to identifying and dealing with all examples of bullying and harassment and have a zero tolerance policy in respect of such behaviour. All individuals on joining Canterbury DHB are made familiar with both our Bullying and Harassment Policy and Equal Opportunities Policy.

Remuneration, recognition and conditions

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 Remuneration Strategy remunerates at an agreed market line which includes consideration of appropriate market data, and provides a progression path aligned to the principles of performance, employee competency development and organisational affordability.

We also monitor feedback from employee engagement, exit, and attachment surveys to ensure our practices remain relevant.

Employee engagement

Since the Canterbury earthquakes in 2010-2011, Canterbury DHB has undertaken three employee wellbeing surveys – in 2012, 2014 and 2016 – which have included measures for engagement.

The results of the 2016 Staff Wellbeing Survey (the Survey), in which over 4,042 employees (42% of all staff) participated, identified some key themes which we explored in greater depth through focus groups. In total, 12 focus groups and six individual or small group discussions were conducted with a wide range of staff from across the DHB. Over 130 volunteers participated in these sessions. This provided a rich source of information on the factors affecting staff wellbeing and engagement.

The results of the Survey and focus groups identified there are things that are working well, and that our people continue to face challenges, both in their personal and professional environments.

Despite all the challenges our people have faced since the major earthquakes of 2010 and 2011, the vast majority of survey respondents feel engaged and fulfilled. 89% feel they make a contribution to the success of the Canterbury DHB; just 1% disagree, while another 10% neither agree nor disagree. In response to a question about the extent to which their work is fulfilling, 74% feel their job is fulfilling.

What is abundantly clear is that our people are highly engaged, they find their jobs fulfilling, and they want to be part of developing solutions. This is an ideal environment for taking a broader approach to supporting staff wellbeing.

Employee development and promotion

We are focused on supporting and developing our employees. Our structures, processes and policies enable us to place the right people into the right roles at the right time.

Our people are supported by a robust process of individual and managerial capability building. Our managers and leaders have access to an array of development programmes as they move into different leadership contexts.

Information, resources and tools are provided online, supported by content on HealthLearn – our South Island e-learning platform. In addition, we provide face-to-face development opportunities for individuals and teams.

In addition, we are part of a tertiary alliance with the University of Otago, the University of Canterbury, and ARA (formerly CPIT), a member of the TANZ network (10 South Island and lower North Island polytechnic institutes), which makes available a common curriculum of development to all employees.

Part V
Financial Performance

5.1 Meeting Our Financial Challenges

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE *For the year ended 30 June 2017*	Notes	Actual 2017 $'000	Budget 2017 $'000	Actual 2016 $'000
REVENUE				
Patient care revenue	2 [p49]	1,616,199	1,585,059	1,558,555
Other revenue	3 [p49]	27,084	29,520	35,216
Earthquake repair revenue redrawn from the Ministry of Health	16 [p62]	10,712	19,100	9,882
Interest revenue		2,113	2,801	2,463
Total revenue		1,656,108	1,636,480	1,606,116
EXPENSE				
Employee benefit costs	4 [p50]	722,527	697,056	693,369
Treatment related costs		150,464	154,524	142,198
External service providers		643,176	625,000	606,747
Depreciation and amortisation		56,268	61,770	57,739
Finance costs		3,932	10,641	5,575
Other expenses	5 [p51]	105,685	98,526	101,729
Earthquake building repair costs	16 [p62]	10,712	19,100	9,882
Capital charge expense	6 [p51]	16,177	11,850	5,726
Total expense		1,708,941	1,678,467	1,622,965
Surplus/(deficit) before Ministry of Health Deficit Funding Revenue		(52,833)	(41,987)	(16,849)
Ministry of Health Deficit Funding Revenue received		-	-	16,376
Surplus/(deficit) after Ministry of Health Deficit Funding Revenue		(52,833)	(41,987)	(473)
OTHER COMPREHENSIVE REVENUE & EXPENSE				
Items that will not be reclassified to surplus/(deficit):				
Impairment of property, plant & equipment	7,14,16 [p51,58,62]	(1,491)	-	-
Revaluation of property, plant & equipment	7,14 [p51,58]	-	-	91,753
Total other comprehensive revenue & expense		(1,491)	(41,987)	91,753
Total comprehensive revenue & expense		(54,324)	(41,987)	91,280

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY *For the year ended 30 June 2017*	Notes	Actual 2017 $'000	Budget 2017 $'000	Actual 2016 $'000
Total equity at beginning of the year		199,933	108,664	77,014
Total comprehensive revenue & expense for the year		(54,324)	(41,987)	91,280
EQUITY INJECTIONS:				
Earthquake repair capital redrawn		11,100	17,000	33,500
Operating deficit support		-	41,987	-
Debt to Equity swap – new facilities	18 [p66]	85,000	-	-
Debt to Equity swap - debt as at June 2016	18 [p66]	145,985	-	-
Kaikoura facility contribution	7 [p51]	2,000	-	-
New Burwood facilities redevelopment assets transferred from the Crown (equity value)		130,000	86,000	-
EQUITY REPAYMENTS:				
Annual depreciation funding repayment		(1,861)	(1,861)	(1,861)
Total equity at end of the year	7 [p51]	517,833	209,803	199,933

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION *As at 30 June 2017*	Notes	Actual 2017 $'000	Budget 2017 $'000	Actual 2016 $'000
CROWN EQUITY				
Contributed capital	7 [p51]	90,073	(139,026)	(282,151)
Revaluation reserve	7 [p51]	289,058	199,096	290,849
Accumulated surpluses	7 [p51]	138,702	149,733	191,235
Total equity		517,833	209,803	199,933
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8 [p53]	1,985	-	13,546
Trade and other receivables	9 [p54]	72,652	96,610	69,349
Inventories	10 [p55]	9,118	9,186	9,432
Restricted assets	17 [p65]	11,815	11,510	8,060
Assets held for sale		-	-	540
Investments	11 [p55]	1,350	-	1,000
Total current assets		96,920	117,306	101,927
CURRENT LIABILITIES				
NZHPL sweep bank account	8 [p53]	16,505	4,554	-
Trade and other payables	12 [p55]	106,936	102,552	100,886
Employee benefits	13 [p56]	156,703	161,180	154,321
Restricted funds	17 [p65]	12,111	15,231	14,297
Total current liabilities		292,255	283,517	269,504
Net working capital		(195,335)	(166,211)	(167,577)
NON-CURRENT ASSETS				
Property, plant and equipment	14 [p58]	693,087	617,470	499,233
Intangible assets	15 [p61]	25,940	36,266	14,386
Restricted assets	17 [p65]	296	3,721	6,237
Total non-current assets		719,323	657,457	519,856
NON-CURRENT LIABILITIES				
Employee benefits	13 [p56]	6,155	6,458	6,361
Borrowings	18 [p66]	-	274,985	145,985
Total non-current liabilities		6,155	281,443	152,346
Net assets		517,833	209,803	199,933

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS *For the year ended 30 June 2017*	Notes	Actual 2017 $'000	Budget 2017 $'000	Actual 2016 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Receipts from Ministry of Health		1,570,290	1,528,491	1,554,809
Earthquake repair revenue redrawn from Ministry of Health		10,712	19,100	9,882
Other receipts		94,967	86,088	30,316
Interest received		2,113	2,801	2,463
		1,678,082	1,636,480	1,597,470
CASH WAS APPLIED TO:				
Payments to employees		720,349	697,056	699,786
Payments to suppliers		934,510	891,150	844,786
Interest paid		5,107	10,641	4,910
Capital charge		16,175	11,850	5,726
GST – net		(3,886)	-	639
		1,672,255	1,610,697	1,555,847
Net cash inflow/ (outflow) from operating activities	19 [p67]	5,827	25,783	41,623
CASH FLOW FROM INVESTING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Sale of property, plant & equipment		728	-	(22)
Receipts from restricted assets & investments		35,345	-	14,148
		36,073	-	14,126
CASH WAS APPLIED TO:				
Purchase of investments & restricted assets		35,928	-	13,775
Purchase of property, plant & equipment		45,277	281,020	66,929
		81,205	281,020	80,704
Net cash inflow/ (outflow) from investing activities		(45,132)	(281,020)	(66,578)
CASH FLOW FROM FINANCING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Loans raised	7 [p51]	-	129,000	-
Earthquake repair capital redrawn	16 [p62]	11,100	17,000	33,500
Kaikoura facility contribution	7 [p51]	2,000	-	-
Contribution to redeveloped Burwood facility	7 [p51]	-	86,000	-
Operating deficit support		-	-	12,500
		13,100	232,000	46,000
CASH WAS APPLIED TO:				
Annual depreciation funding repayment		1,861	1,861	1,861
		1,861	1,861	1,861
Net cash inflow/ (outflow) from financing activities		11,239	230,139	44,139
Net increase/ (decrease) in cash and cash equivalents		(28,066)	(25,098)	19,184
Cash and cash equivalents at beginning of year		13,546	20,544	(5,638)
Cash & cash equivalents at end of year	8 [p53]	(14,520)	(4,554)	13,546

The accompanying notes form part of these financial statements.

5.2 Guide to Our Financial Reports

Notes to and forming part of the financial statements

1. STATEMENT OF ACCOUNTING POLICIES

Reporting entity and statutory base

Canterbury DHB is a district health board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

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

The consolidated financial statements of Canterbury DHB consist of Canterbury DHB and its subsidiaries:

- Canterbury Linen Services Ltd (100% owned)
- Brackenridge Estate Ltd (100% owned)

Canterbury DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community. Canterbury DHB does not operate to make a financial return.

The financial statements of Canterbury DHB are for the year ended 30 June 2017 and were authorised for issue by the Board on 19 October 2017.

Basis of Preparation

Statement of going concern

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

Canterbury DHB's Chair received a letter of comfort from the Ministers of Health and Finance to enable the Board of Canterbury DHB to satisfy itself, for the purposes of the 2016/17 financial statements, that it is appropriate to prepare those financial statements on a going concern basis. The letter states that the Government is committed to working with Canterbury DHB over the medium term to maintain its financial viability, and also acknowledges that deficit support may be required and the Crown will provide such support where necessary to maintain viability. The letter of comfort therefore provides the required basis for the Board of Canterbury DHB to prepare the 2016/17 financial statements on a going concern basis.

Statement of compliance

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

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

Measurement basis

The financial statements are prepared on the historical cost basis except that land and buildings are stated at their fair values.

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.

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.

Budget figures

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

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.

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

Commitments and contingencies are disclosed as exclusive of GST.

Critical accounting estimates and assumptions

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

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are highlighted in the following notes.

Standards issued but not yet effective and not early adopted

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

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

Canterbury DHB plans to apply this standard in preparing its 30 June 2022 financial statements. Canterbury DHB has not yet assessed the effects of the new standard.

2. PATIENT CARE REVENUE	2017 $'000	2016 $'000
Ministry of Health population based funding	1,320,870	1,286,543
Inter-district flows	116,566	110,619
Ministry of Health other contracts	119,904	109,352
ACC revenue	26,049	26,739
Other patient related revenue	32,810	25,302
Total patient care revenue	1,616,199	1,558,555

Under the Public Finance Act 1989, Canterbury DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation, and the service performance measures that report against the use of that funding.

The appropriation revenue received by Canterbury DHB for the 2016/17 financial year is $1,353,839,294 (2016: $1,316,423,491) which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 20-32.

3. OTHER REVENUE	2017 $'000	2016 $'000
Gain/(loss) on sale of property, plant and equipment	728	(22)
Donations and bequests received	2,710	3,994
Pathology tests	10,065	9,162
Research & development	6,079	6,319
External rental revenue	1,235	2,044
Meals on Wheels	810	995
Other	5,457	12,724
Total other revenue	27,084	35,216

ACCOUNTING POLICY

Revenue

Ministry of Health population-based funding

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

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

Inter-district flows

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

Ministry of Health other contracts

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

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

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

ACC revenue

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

Provision of other services

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

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

Volunteer services received are not recognised as revenue or expenses by Canterbury DHB.

ESTIMATES AND ASSUMPTIONS

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.

4. EMPLOYEE BENEFIT COSTS	2017 $'000	2016 $'000
Wages and salaries	699,540	680,129
Board members' fees	323	326
Directors' fees	86	90
Contributions to defined contribution plans	20,401	19,330
Increase/(decrease) in employee benefit provisions	2,177	(6,506)
Total employee benefit costs	722,527	693,369

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

5. OTHER EXPENSES	2017 $'000	2016 $'000
Financial statement audit fees	223	215
Rental costs including operating leases	6,746	5,988
Facilities and infrastructure costs	39,006	52,363
Other non-clinical costs	59,710	43,163
Total other expenses	105,685	101,729

ACCOUNTING POLICY

Operating lease payments

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

6. CAPITAL CHARGE

Canterbury DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate has reduced twice from the rate of 8% used for the 2015/16 financial year. For the six months ended 31 December 2016, the rate was 7%. For the six months ended 30 June 2017, the rate was 6%.

7. EQUITY	2017 $'000	2016 $'000
CONTRIBUTED CAPITAL		
Opening balance	(282,151)	(313,790)
Annual depreciation funding repayment	(1,861)	(1,861)
Kaikoura facility contribution	2,000	-
Debt to equity swap	230,985	-
Contribution to redeveloped Burwood Hospital facility	130,000	-
Earthquake repair capital redrawn	11,100	33,500
Closing balance	90,073	(282,151)

As a result of the Kaikoura earthquakes, the Government gifted the Kaikoura District Council $2M to return the community's contribution for the balance of their new health centre which opened in April 2016. The sum of $2M was paid to Canterbury DHB as an equity injection, and Canterbury DHB paid the funds to the Kaikoura District Council as an operating expense.

Conversion of existing Crown loans to Crown equity (Debt to Equity swap)

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. On 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year, and increasing DHB appropriations for the increased capital charge cost to the DHB from the 2017/18 year.

Contribution to redeveloped Burwood Hospital facility

The redeveloped Burwood Hospital facility was budgeted to be a cash transaction, with both debt and equity being received in cash, with an equal payment in cash. The actual transaction was a non-cash transaction.

	2017 $'000	2016 $'000
ACCUMULATED SURPLUS/(DEFICIT)		
Opening balance	191,235	191,708
Realised gain on sale transferred from revaluation reserve	300	-
Operating deficit	(52,833)	(473)
Closing balance	138,702	191,235
REPRESENTED BY:		
Accumulated surplus in parent and associates	135,771	188,051
Accumulated surplus in subsidiaries	2,931	3,184
Total accumulated surplus	138,702	191,235
REVALUATION RESERVE		
Opening balance	290,849	199,096
Impairment charges	(1,491)	-
Realised gain on sale transferred to retained earnings	(300)	-
Revaluation of land, building including fitout	-	91,753
Closing balance	289,058	290,849
REPRESENTED BY:		
Revaluation of land	85,079	85,379
Revaluation of buildings including fitout	203,979	205,470
Total revaluation reserve	289,058	290,849
Total equity	517,833	199,933

ACCOUNTING POLICY

Equity

Equity is measured as the difference between total assets and total liabilities.

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

Revaluation reserve

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

8. CASH AND CASH EQUIVALENTS	CREDIT RATING	2017 $'000	2016 $'000
CURRENT ASSETS			
Bank balances and call deposits	AA-	1,985	2,429
NZHPL sweep bank account	AA-	-	11,117
Total cash and cash equivalents		1,985	13,546
CURRENT LIABILITIES			
NZHPL sweep bank account	AA-	(16,505)	-
Net cash and cash equivalents		(14,520)	13,546

Bank facility

Canterbury DHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at a credit interest rate received by NZHPL 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-twelfth 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 $83.618M (2016: $80.916M).

Credit risk

Financial instruments which potentially subject Canterbury DHB to credit risk consist mainly of cash and short-term investments, and accounts receivable.

The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

The Board places its cash and term investments with high quality financial institutions via a national DHB shared banking arrangement, facilitated by NZ Health Partnerships Limited

ACCOUNTING POLICY

Bank term deposits

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

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.

9. TRADE AND OTHER RECEIVABLES

	2017 $'000	2016 $'000
Trade receivables	11,296	11,071
Receivable from the Ministry of Health	27,412	28,262
Prepayments	9,412	4,586
Other receivables	24,532	25,430
Total trade and other receivables	72,652	69,349

MOVEMENTS IN THE PROVISION FOR IMPAIRMENT OF RECEIVABLES ARE AS FOLLOWS:

Balance at 1 July	3,958	2,748
Additional provisions made during the year	(172)	1,677
Receivables written-off during period	(352)	(467)
Balance at 30 June	3,434	3,958

THE AGEING OF THE IMPAIRMENT PROVISIONS ARE AS FOLLOWS:

Current	426	464
1-30 days	60	456
31-60 days	152	286
> 61 days	2,796	2,752
Balance at 30 June	3,434	3,958

As at 30 June, all overdue receivables have been assessed for impairment and appropriate provisions have been applied.

THE NET AGEING OF RECEIVABLES, EXCLUDING PREPAYMENTS, IS:

Current	61,378	58,951
1-30 days	1,024	3,240
31-60 days	387	1,054
> 61 days	451	1,518
Balance at 30 June	63,240	64,763

Trade receivables and prepayments are from exchange revenue transactions. Other receivables and receivables from the Ministry of Health are a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in other receivables and in receivables from the Ministry of Health is $12.641M (2016: $17.055M).

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 2017, the Ministry of Health owed Canterbury DHB $28.412M (2016: $28.262M).

ACCOUNTING POLICY

Trade and other receivables

Trade and other receivables are non-interest bearing and receipt is normally within 30-day terms. Therefore, the carrying value of receivables approximates their fair value. Trade and other receivables are subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified. A receivable is considered impaired when there is evidence that Canterbury DHB will not be able to collect the amount due. The amount of the impairment is the difference

between the carrying amount of the receivable and the present value of the amounts expected to be collected.

10. INVENTORIES	2017 $'000	2016 $'000
Pharmaceuticals	2,156	2,093
Surgical and medical supplies	5,083	5,385
Other supplies	2,720	3,050
	9,959	10,528
Provision for obsolescence	(841)	(1,096)
Total inventories	9,118	9,432

ACCOUNTING POLICY

Inventories

No inventories are pledged as security for liabilities; however some inventories are subject to retention of title clauses.

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

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

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

11. INVESTMENTS	CREDIT RATING	2017 $'000	2016 $'000
Investments are represented by:			
Term deposits with maturities of 3-12 months	AA-	1,350	1,000
Total investments		1,350	1,000
Weighted average effective interest rates		3.36%	3.12%

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

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.

Information relevant to Canterbury DHB credit risk can be found in note 8 [p53].

12. TRADE AND OTHER PAYABLES	2017 $'000	2016 $'000
Trade payables	18,415	17,799
Other payables	88,521	83,087
Total trade and other payables	106,936	100,886

Trade and other payables are non-interest bearing and are normally settled within 50 days, therefore the carrying value of trade and other payables approximates their fair value.

Trade payables are from exchange transactions. The value of non-exchange balances in other payables is $37.388M (2016: $32.443M).

Trade and other payables are measured at fair value.

ACCOUNTING POLICY

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.

13. EMPLOYEE BENEFITS

	2017 $'000	2016 $'000
CURRENT LIABILITIES		
Annual, lieu and shift leave accruals	76,373	74,963
Unpaid days accruals	18,495	15,304
ACC accruals	4,382	4,932
Conference/sabbatical leave and expenses	25,533	24,297
Sick leave	9,700	11,617
Other	22,220	23,208
Total employee benefits - current	156,703	154,321
NON-CURRENT LIABILITIES		
Liability for long service leave	4,678	4,445
Liability for retirement gratuities	1,477	1,916
Total employee benefits – non-current	6,155	6,361

ACCOUNTING POLICY

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method including a salary inflation factor 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. The salary inflation factor has been determined after considering historical salary inflation patterns and future movements. Canterbury DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. The sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent Canterbury DHB anticipates it will be used by staff to cover those future absences.

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

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.

ESTIMATES AND ASSUMPTIONS

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.

14. PROPERTY, PLANT AND EQUIPMENT

Movements for each class of property, plant and equipment for Canterbury DHB:

16/17 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2016	129,918	285,521	198,792	409	36,496	651,136
Additions	-	236,429	25,208	5,914		267,551
Disposals/transfers	-	(3,006)	(5,188)	3,006	(17,636)	(22,824)
Impairment	-	(1,668)	-	-	-	(1,668)
Balance at 30 June 2017	129,918	517,276	218,812	9,329	18,860	894,195
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2016	-	3,662	147,832	409	-	151,903
Depreciation	-	39,124	14,904	446	-	54,474
Disposals/transfer	-	(1,775)	(5,092)	1,775	-	(5,092)
Impairment	-	(177)	-	-	-	(177)
Balance at 30 June 2017	-	40,834	157,644	2,630	-	201,108
CARRYING AMOUNT						
At 30 June 2017	129,918	476,442	61,168	6,699	18,860	693,087

15/16 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2015	131,188	301,099	197,987	409	30,964	661,647
Additions	-	31,992	21,846	-	5,537	59,375
Disposals/transfers	(540)	(188)	(21,041)	-	(5)	(21,774)
Revaluation	(730)	(47,382)	-	-	-	(48,112)
Balance at 30 June 2016	129,918	285,521	198,792	409	36,496	651,136
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2015	-	106,482	153,520	368	-	260,370
Depreciation	-	37,100	15,362	41	-	52,503
Disposals/transfer	-	(55)	(21,050)	-	-	(21,105)
Revaluation	-	(139,865)	-	-	-	(139,865)
Balance at 30 June 2016	-	3,662	147,832	409	-	151,903
CARRYING AMOUNT						
At 30 June 2016	129,918	281,859	50,960	-	36,496	499,233

Canterbury DHB last revalued its land, buildings and building fitout (excluding leased building fitout) at 30 June 2016. The revaluation was carried out by an independent registered valuer (Chris Stanley of TelferYoung (Canterbury) Ltd), which is consistent with PBE IPSAS 17 Property Plant & Equipment.

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.

ACCOUNTING POLICY

Property, plant and equipment

Owned assets

Except for land and buildings, and the assets vested from the Crown items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Revaluations

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

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

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

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 sale price and the carrying amount of the asset.

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

Depreciation

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

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

TYPE OF ASSET	USEFUL LIFE	DEPRECIATION RATE
Buildings structure	35 - 90	1.1 – 2.9%
Buildings infrastructure & fitout	15 - 60	3.3 – 6.7%
Temporary buildings	2 - 20	5.0 – 50.0%
Leasehold improvements	3 - 20	5.0 – 33.3%
Plant, equipment and vehicles	3 - 20	5.0 – 33.3%

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually. Buildings structure, infrastructure & fitout, and temporary buildings have been shown separately this year, and the useful life is shown as the total useful life (the remaining useful life had been shown in prior years). The

depreciation rates of these assets have not been changed, so there is no impact on the depreciation expense.

The useful life of certain plant and IT equipment has been adjusted during the year, resulting in a minor reduction in depreciation expense shown.

Additions

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

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

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

Subsequent costs

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

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

ESTIMATES AND ASSUMPTIONS

Useful lives and residual value

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

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

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

In light of the Canterbury earthquakes, Canterbury DHB continuously reviews the carrying value of land and buildings as further described in note 16 [p62].

15. INTANGIBLE ASSETS	2017 $'000	2016 $'000
SOFTWARE		
COST		
Opening balance	40,477	34,798
Additions	13,349	7,554
Disposals	(272)	(1,875)
Closing balance	53,554	40,477
AMORTISATION AND IMPAIRMENT LOSSES		
Opening balance	32,027	28,450
Amortisation charge for the year	1,794	5,236
Disposals	(271)	(1,659)
Closing balance	33,550	32,027
Total Software	20,004	8,450
NZ Health Partnerships Limited	5,936	5,936
Carrying amounts	25,940	14,386

There are no restrictions over the title of intangible assets and no intangible assets are pledged as security for liabilities.

New Zealand Health Partnership Limited (NZHPL)

NZHPL 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 NZHPL 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 NZHPL will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

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

NZHPL have also issued 100 A class shares to be held by DHBs equally. Canterbury DHB has 5 shares.

ACCOUNTING POLICY

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Staff training and other costs associated with maintaining computer software are recognised as an expense when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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	2-15 years	6.7 – 50.0%

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually. The useful life of certain software has been adjusted during the year, resulting in a minor reduction in amortisation expense shown.

Non-cash-generating assets

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

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

The reversal of an impairment loss is recognised in other comprehensive income.

16. IMPAIRMENT AND THE EFFECTS OF THE CANTERBURY EARTHQUAKES

A 7.1 magnitude earthquake occurred in the Canterbury region on 4 September 2010, with subsequent large aftershocks, including a 6.3 magnitude earthquake on 22 February 2011, and a further 6.3 magnitude earthquake on 13 June 2011. These events caused significant damage to many of Canterbury DHB's buildings and assets. Damage was sustained to more than 200 buildings, and over 14,000 rooms required some level of

repair. Additionally, Canterbury DHB needed to install a number of temporary infrastructure facilities to ensure continued operations, such as emergency boilers, and water supplies for fire sprinkler systems.

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

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. This review has resulted in an impairment to land and buildings totalling $87.361M for the seven years to 30 June 2017.

An impairment of $1.491M was recognised for the financial year ended 30 June 2017 (2016: nil). The 2017 impairment relates, in the main, to land at Burwood that has been identified as more seriously damaged than previously indicated meaning that a rebuild will be required where previously it was expected that repairs would be done.

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.

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 NZ Health Partnerships Ltd. 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.

There was another significant earthquake in the North Canterbury (Culverden / Kaikoura) region in November 2016. Canterbury DHB incurred further earthquake related costs due to this disaster. The Ministry of Health contributed additional revenue of $0.995M; the estimated costs associated with the Kaikoura earthquake as at 30 June 2017 were $2M. A further $2M equity funding was received from the Ministry of Health to enable Canterbury DHB to return to the Kaikoura District Council a $2M donation received from the Kaikoura community last financial year to partly fund the new Kaikoura health facility. The donation received was recorded as revenue in 2015/16, and the refund as an expense in 2016/17.

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 following table shows the drawdown of insurance proceeds from June 2014, both revenue and equity:

DRAWDOWN	$'000
Initial payment to Ministry of Health	290.00
Drawdown 13/14	(20.00)
Drawdown 14/15	(13.15)
Drawdown 15/16	(43.28)
Drawdown 16/17	(21.88)
Amount undrawn 30 June 2017	191.69

The balance can be drawn upon in future periods to cover earthquake repair costs. The variance between the actual and budget draw down of repair revenue is due to the timing of repairs, and offsets against the lower than budgeted repair costs.

ACCOUNTING POLICY

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 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.

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.

As part of an agreement with the Māia Health Foundation, Canterbury DHB is progressively transferring some of the trust funds to Māia to invest on behalf of Canterbury DHB. The agreement allows Canterbury DHB to draw down on these funds as and when required.

Māia is a registered charitable organisation set up to support and assist providers of healthcare services to undertake those services to the highest possible standard. Canterbury DHB has three appointees as Trustees of Māia.

	2017 $'000	2016 $'000
Balance at beginning of year	14,297	14,049
Interest received	615	581
Donations and funds received	840	1,144
Funds transferred to Māia Health Foundation	(1,995)	-
Funds spent	(1,646)	(1,477)
Balance at end of year	12,111	14,297
This balance is represented by:		
Current assets	11,815	8,060
Non-current assets	296	6,237
Total restricted assets	12,111	14,297
Weighted average effective interest rates	3.30%	3.62%

RESIDENTS' TRUST ACCOUNTS

Residents' trust account balance	889	952

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.

Credit quality of restricted assets	Credit rating	2017 $'000	2016 $'000
Restricted assets:			
Bonds	AA	280	280
Term deposits with maturities of 3-12 months	AA-	11,815	14,001
Perpetual capital notes	BBB+	16	16
Total restricted assets		12,111	14,297

18. BORROWINGS

	2017 $'000	2016 $'000
NON-CURRENT		
Ministry of Health loans	-	145,985
Total borrowings	-	145,985

Average interest rates on Canterbury DHB Borrowings for the year are as follows

Less than one year	-	-
Weighted average effective interest rate	2.01%	
Later than one year but not more than five years	-	84,650
Weighted average effective interest rate	3.80%	3.80%
Later than five years	-	61,335
Weighted average effective interest rate	3.88%	3.88%

The decrease in the Ministry of Health loans is a result of the Crown's directive to swap Crown debt with equity. As at 30 June 2016, Canterbury DHB had $146M of long term debt. A further $85M of debt was added as part of the handover of the redeveloped Burwood facility from the Ministry of Health in August 2016. The Ministry of Health loans were swapped from debt to equity in February 2017.

Liquidity risk

Liquidity risk is the risk that Canterbury DHB 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 had a maximum amount that was able to be drawn down against its loan facility of $145.985M at June 2016. This facility was withdrawn in February 2017 when loans were swapped from debt to equity.

ACCOUNTING POLICY

Borrowings

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

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

19. RECONCILIATION OF NET SURPLUS/(DEFICIT) FOR THE PERIOD WITH NET CASH FLOWS FROM OPERATING ACTIVITIES	2017 $'000	2016 $'000
Net (deficit)/ surplus before other comprehensive revenue and expense	(52,833)	(473)
Add back non-cash items:		
Depreciation and amortisation	56,268	57,739
Add back items classified as investing activities:		
Loss/(gain) on asset sale	(728)	22
Movement in term portion provisions/staff entitlements	(206)	(97)
Movements in working capital:		
Decrease/(increase) in receivables & prepayments	(3,303)	(25,022)
Decrease/(increase) in stocks	314	(839)
Increase/(decrease) in creditors & other accruals	3,933	16,704
Increase/(decrease) in staff entitlements	2,382	(6,411)
Net cash inflow/(outflow) from operating activities	5,827	41,623

20. COMMITMENTS	2017 $'000	2016 $'000
CAPITAL COMMITMENTS		
Property	2,898	45,134
Intangible assets	13,624	26,576
Other capital commitments	4,625	15,638
Total capital commitments at balance date	21,147	87,348

Capital commitments pertaining to the new buildings (Acute Services Building and Outpatients) are held by the Ministry of Health until such time as these assets are handed over to Canterbury DHB. We have reviewed our process for defining capital commitments to ensure that they are in line with accounting standards. We have not restated the 2016 comparatives.

NON-CANCELLABLE OPERATING LEASE COMMITMENTS		
Accommodation leases	38,891	39,400
Other leases	994	222
Total non-cancellable operating lease and supply commitments	39,885	39,622
FOR EXPENDITURE WITHIN:		
Not later than one year	6,312	5,462
Later than one year and not later than five years	15,752	15,587
Later than five years	17,821	18,573
Total non-cancellable operating lease and supply commitments	39,885	39,622

External service providers

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 on-going 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 Canterbury DHB'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.

ESTIMATES AND ASSUMPTIONS

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.

21. CONTINGENCIES

Contingent assets

Canterbury DHB has no contingent assets as at 30 June 2017 (2016: nil).

Contingent liabilities

Canterbury DHB has the following contingent liabilities as at 30 June 2017:

Outstanding legal proceedings

Canterbury DHB has no material outstanding legal proceedings as at 30 June 2017 (2016: nil).

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 [p62] for further information.

Land and building contamination

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

Holidays Act Compliance

Canterbury DHB is part of a national DHB group reviewing and setting a Holidays Act Compliance baseline. This baseline will be agreed with the Ministry of Business, Innovation & Employment (MBIE), and the NZ Council of Trade Unions (NZCTU), and the intent is to work through an audit of DHB compliance against these baselines. Until these baselines are agreed and approved by DHBs nationally, MBIE and the NZCTU, there is

uncertainty over any actual costs which may arrive from this audit, so any future liability cannot be reasonably estimated.

22. CONTRACTUAL MATURITY OF FINANCIAL ASSETS AND LIABILITIES

The tables below analyse Canterbury DHB's financial liabilities and assets into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date, based on undiscounted cash flows:

Contractual maturity analysis of financial liabilities	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
	$'000	$'000	$'000	$'000	$'000	$'000
16/17 FINANCIAL YEAR						
NZHPL sweep bank account	16,505	16,505	16,505			
Trade and other payables	106,936	106,936	106,936			
Restricted funds	12,111	12,111	12,111			
Total financial liabilities	135,552	135,552	135,552			
15/16 FINANCIAL YEAR						
Trade and other payables	100,886	100,886	100,886	-	-	-
Ministry of Health loans	145,985	176,078	5,560	5,560	98,618	66,340
Restricted funds	14,297	14,297	14,297	-	-	-
Total financial liabilities	261,168	291,261	120,743	5,560	98,618	66,340

Contractual maturity analysis of financial assets	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	More than 2 years
	$'000	$'000	$'000	$'000	
16/17 FINANCIAL YEAR					
Cash and cash equivalents	1,985	1,985	1,985		
Trade and other receivables[85]	63,240	63,240	63,240		
Term deposits (term > 3 months)	1,350	1,350	1,350		
Restricted assets	12,111	12,111	11,815	296	
Total financial assets	76,686	76,686	78,390	296	
15/16 FINANCIAL YEAR					
Cash and cash equivalents	13,546	13,546	13,546	-	-
Trade and other receivables[85]	64,763	64,763	64,763	-	-
Term deposits (term > 3 months)	1,000	1,000	1,000	-	-
Restricted assets	14,297	14,297	8,060	6,237	-
Total financial assets	93,606	93,606	87,369	6,237	-

Sensitivity analysis

The table below illustrates the potential effect on the surplus or deficit for reasonable possible market movements, with all other variables held constant, based on Canterbury DHB's financial instrument exposures

[85] *Excludes prepayments*

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.

Canterbury DHB held NZD $355,113 of foreign currency accounts as at 30 June 2017 (2016: NZD $609,146).

FOREIGN EXCHANGE RISK	2017 $'000 -10% Surplus	2017 $'000 +10% Surplus	2016 $'000 -10% Surplus	2016 $'000 +10% Surplus
Financial assets				
Foreign currency	(32)	32	(55)	55
Total sensitivity	(32)	32	(55)	55

ACCOUNTING POLICY

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.

23. 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, whilst remaining a going concern.

24. RELATED PARTIES

Canterbury DHB is a wholly owned entity of the Crown.

Canterbury DHB and West Coast DHB collectively continue to maintain a trans-alpine approach to the delivery of health services. This includes both clinical, as well as non-clinical, shared staff. All other related party transactions have been entered into on an arm's length basis.

Related party disclosures have not been made for transactions with related parties, including associates, that are within a normal supplier or client / recipient relationship on terms and conditions no more or less favourable than those that are reasonable to expect that Canterbury DHB would have adopted in dealing with the party at an arm's length in the same circumstances. Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms for such transactions.

ACCOUNTING POLICY

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.

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.

Associates

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

Canterbury DHB Subsidiaries

ENTITY	Interest held 2017	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 on-going care for intellectually disabled persons.

Canterbury DHB Associates

ENTITY	Interest held 2017	Balance Date
South Island Shared Service Agency Limited	47%	30 June

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

Canterbury DHB joint ventures

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

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

West Coast DHB

Canterbury DHB provides key management personnel services (including Chief Executive services) under contract to the West Coast DHB.

Canterbury DHB charges the West Coast DHB for these services; 2017 $1.252M (2016: $1.240M). The amount owing by West Coast DHB relating to this agreement at balance date was $0.120M (2016: $0.119M).

Māia Health Foundation

Refer note 17 [p65].

Key management personnel

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

25. EMPLOYEE REMUNERATION	2017 $'000	2016 $'000
COMPENSATION OF KEY MANAGEMENT PERSONNEL		
Salaries for executive management team	3,349	3,463
Board and Committee members fees	383	393
Total key management personnel compensation	3,732	3,856

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

KEY MANAGEMENT PERSONNEL FULL TIME EQUIVALENTS		
Full time equivalent Board and Committee members	1.11	1.21
Full time equivalent executive management team	11.00	11.00
Total key management personnel full time equivalents	12.11	12.21

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

Payments in Respect of Termination of Employment

During the year, the Board made the following payments to employees in respect of the termination of their employment with the Board.

The total payments made by Canterbury DHB were $489,479 to 18 employees (2016: 19 employees totalling $414,654) comprising negotiated settlements with the employees.

Remuneration of Employees

The number of employees of Canterbury DHB whose income inclusive of benefits within the specified bands is as follows:

SPECIFIED BANDS	2017	2016	SPECIFIED BANDS	2017	2016
100,000-109,999	237	198	320,000-329,999	9	8
110,000-119,999	165	131	330,000-339,999	13	14
120,000-129,999	117	98	340,000-349,999	13	8
130,000-139,999	107	91	350,000-359,999	6	8
140,000-149,999	69	59	360,000-369,999	5	10
150,000-159,999	60	46	370,000-379,999	5	5
160,000-169,999	51	55	380,000-389,999	5	4
170,000-179,999	28	37	390,000-399,999	2	1
180,000-189,999	33	30	400,000-409,999	3	2
190,000-199,999	28	25	410,000-419,999	3	1
200,000-209,999	25	25	420,000-429,999	3	3
210,000-219,999	29	22	430,000-439,999	2	1
220,000-229,999	23	28	440,000-449,999	-	1
230,000-239,999	23	33	450,000-459,999	2	1
240,000-249,999	27	23	470,000-479,999	2	-
250,000-259,999	22	18	480,000-489,999	-	1
260,000-269,999	20	22	520,000-529,999	-	1
270,000-279,999	28	27	540,000-549,999	1	-
280,000-289,999	16	23	600,000-609,999	-	1
290,000-299,999	19	14	610,000-619,999	1	-
300,000-309,999	18	16	620,000-629,999	1	-
310,000-319,999	21	14	690,000-699,000	1	-
			Total employees	1,243	1,105

Of the positions identified above, 1,056 (2016: 939) positions were predominantly clinical and 187 (2016: 166) positions were management / administrative.

26. SUBSEQUENT EVENTS

There were no events after 30 June 2017, which could have a material impact on the information in Canterbury DHB's financial statements (2016: nil).

27. MAJOR VARIANCES TO BUDGET

The budget figures reported in this Annual Report are those that are approved by the Board of Canterbury DHB in its Statement of Performance Expectations tabled in Parliament – a deficit of $41.987M. The final budget was a deficit of $38.496M as approved by Ministers in March 2017 as published in our 2016/17 Annual Plan.

Statement of comprehensive revenue and expense

The major factors that make up the variance between our planned deficit of $41.987M and our actual deficit of $52.833M are:

Revenue:

- Our budget excluded additional funding advised in the Government's May 2016 budget, such as additional demographic funding, pharmaceutical investment funding, and funding to support health services in Canterbury.
- We received more IDF (Inter District Flow) revenue, as a result of treating more patients domiciled out of the Canterbury region than expected.
- We received a $1.1M donation from the Ashburton community to assist with funding the new Ashburton theatres.
- Offsetting these, earthquake repair revenue redrawn was $8.4M less than plan due to the timing of earthquake repairs. This amount is offset by an equal and opposite variance in Earthquake building repair costs.

Expense:

- Employee benefit costs were higher than plan due to a number of factors, including costs associated with providing services for additional funding received, as well as the impact of the RDA (Resident Doctors Association) strikes, and costs associated with the North Canterbury earthquakes.
- Additional costs relating to increased demand in Mental Health continue to affect a number of expense categories, including employee benefit costs.
- External service providers were above budget due to a number of factors, including costs associated with providing services for additional funding received, as well as additional surgical outsourcing to meet elective targets, additional investment in IBT (In Between Travel), palliative care, residential care, and primary care.
- Depreciation and amortisation are below budget due to a revision of asset depreciation rates to ensure they approximate the respective assets useful lives.
- Finance costs are favourable to budget mainly due to the debt to equity swap.
- The unfavourable Other expenses variance includes the return of the Kaikoura community donation of $2M to the Kaikoura District Council, as part of a Government arrangement to assist with the impacts of the North Canterbury earthquakes.
- Earthquake building repair costs is favourable to budget due to the timing of repairs, and the categorisation of these repair costs as either operating or capital expenditure.

Other comprehensive revenue & expense:

- The impairment expense is the result of our annual review, and relates mainly to further earthquake related damage identified.

Statement of changes in equity

The significant variances in our movements in equity are:

- Earthquake repair capital redrawn was $5.9M less than plan due to the timing of earthquake repairs.
- There was an expectation that we would receive deficit funding of $41.987M.
- The debt to equity swap was not confirmed when the budget was set.
- There was an expectation that the Burwood facility would be initially funded 40% equity and 60% debt. The actual funding received was 60% equity and 40% debt.
- The donation from the Kaikoura community that was returned to the Kaikoura District Council was reimbursed to Canterbury DHB as equity.

Statement of financial position

- Operating deficit support was budgeted to be confirmed as a receivable at year end.

- Property, plant and equipment and Intangible assets variances relate to timing of expenditure.
- Borrowings are nil due to the debt to equity swap.

Statement of cash flows

- The redeveloped Burwood Hospital facility was budgeted to be a cash transaction, with both debt and equity being received in cash, with an equal payment in cash. The actual transaction was done without the need for a physical cash transaction.

5.3 Summary of Revenues and Expenses by Output Class

	Actual 2017 $'000	Budget 2017 $'000
Early detection & management	345,779	328,209
Intensive assessment & treatment	1,035,283	1,028,581
Prevention	37,919	35,886
Rehabilitation & support	237,127	243,804
Total revenue	1,656,108	1,636,480
Early detection & management	355,907	337,195
Intensive assessment & treatment	1,063,319	1,054,715
Prevention	42,581	36,450
Rehabilitation & support	247,134	250,107
Total expenditure	1,708,941	1,678,467
Deficit	(52,833)	(41,987)

Part VI Supplementary Information

6.1 Directory

Board Members

Murray Cleverley – Chair ..... resigned 11 Apr 2017

Ta Mark Solomon-Deputy Chair ..... term commenced 5 Dec 2016

Steve Wakefield – Deputy Chair ..... term ended 4 Dec 2016

Barry Bragg ..... term commenced 5 Dec 2016

Sally Buck

Tracey Chambers ..... term commenced 5 Dec 2016

Anna Crighton

Andrew Dickerson

Jo Kane

Aaron Keown

Chris Mene

Edie Moke ..... term ended 4 Dec 2016

David Morrell

Susan Wallace ..... term ended 4 Dec 2016

Chief Executive

David Meates

Corporate Office

Level 1

32 Oxford Terrace

Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Westpac Banking Corporation

Part VII
Independent Auditor's Report

7.1 Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Canterbury District Health Board Group's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of Canterbury District Health Board Group (the Group). The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for appropriations, of the Group on his behalf.

Opinion

We have audited:

- the financial statements of the Group on pages 43 to 75, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, 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 the statement of accounting policies and other explanatory information; and
- the performance information of the Group on pages 8 to 32 and page 76.

In our opinion:

- the financial statements of the Group on pages 43 to 75:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.
- the performance information of the Group on pages 8 to 32 and page 76:
    - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2017, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
- what has been achieved with the appropriations; and
- the actual expenses or capital expenditure incurred as compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 19 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Group for preparing the financial statements and the performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Group or there is no realistic alternative but to do so.

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

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but it is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the Group's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 6 and pages 34 to 41, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

Other than the audit and the audit of a group subsidiary on request, we have no relationship with, or interests in, the Group.

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