Canterbury DHB

ANNUAL REPORT 2017/18

Our Mission

Tā Mātou Matakite

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

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

Our Values

ā Mātou Uara

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

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

Responsibility for outcomes.
Te Takohanga i ngā hua.

Our Way of Working

Kā Huari Mahi

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

Demonstrate innovation.
Whakaatu te ihumanea hou.

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

our health system

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Part I
Overview

1.1 Foreword from the Chair and Chief Executive

Seven years on from the Canterbury Earthquakes we are still feeling the effects of New Zealand's largest natural disaster on our staff, our communities and our finances.

Many of our 10,500 staff are still battling with insurance, re-building, repairs to the repairs, financial loss and the on-going impact on the wellbeing of their children and other family members, not to mention their own mental health.

The demand for our specialist mental health services continues to grow. This is in line with the predictions based on international post-disaster research. Our specialist mental health services have been challenged by more people needing our help than we have physical space for – and our ageing facilities are no longer fit for purpose. This has created ongoing issues for patients, staff, and those managing the service.

In the past year 32,341 people received mental health support from our health system - either DHB specialist services, or community-based Non-Government Organisations or primary health services. Almost half of this group (16,300 people) have required specialist mental health services in the past year with 3,893 children and adolescents along with 9,899 adults and 2,419 older people being supported. With 1 in 5 Cantabrians accessing mental health support, nearly every household within Canterbury will have or know someone who has lived experience of mental health problems.

For our staff, this means they are supporting 700 more people every month in our adult general mental health service than pre-quake; 450 more people every month in our Child and Youth mental health service and in the emergency department, the number of mental health Crisis Assessments carried out in ED has increased from 700 to 1,500 assessments.

In response to the increased demand for services for Children, Mana Ake – *Stronger for tomorrow* was established in March 2018 to promote wellbeing and positive mental health for children in school years 1-8 across Canterbury. The initiative aims to provide early intervention and support for teachers, families and whanau when children are experiencing ongoing issues that impact their wellbeing. The service can support individual children and groups of children and provide advice, guidance and support for teachers and parents/whanau.

At 558,830 our population is already reaching levels predicted for 2022 and this is testing our capacity. Today we're providing care for more people than predicted in Statistics NZ population estimates for the 2017/18 year.

Our finances

Our overall financial result continues to reflect the multiple impacts of New Zealand's largest natural disaster on our:

- Facilities
- Population
- Infrastructure
- Health need e.g. significant grown mental health
- Staff

A detailed service improvement programme has been in place for over ten years which has helped mitigate some of the impacts of New Zealand's largest natural disaster and enable us to continue to provide services to our population.

As a tertiary hospital and the second largest provider of surgery – both acute and elective, it's been important to maintain our capacity both for Canterbury and the rest of New Zealand.

The variation of $10 million to our planned deficit represents 0.59% of our overall revenue and is largely resulting from three key areas:

- Unpredicted growth in Aged Residential Care
- Higher than anticipated and realised MECA [Multi-Employer Collective Agreement] wage settlements
- Increased outsourcing to compensate for lack of theatre capacity.

Facilities

Over the past year we have seen progress with the new Christchurch Outpatients building located opposite the current Christchurch Hospital Emergency Department in Oxford Terrace. It's on track to open later this year and will become home to more than 400 staff from around the Christchurch Hospital Campus and further afield in Hillmorton. The co-location of these services will promote more efficient care and improve the environment for both patients and staff.

The new Acute Services Building, located at the rear of Christchurch Women's Hospital has taken longer than anticipated to construct, which is limiting the DHB's ability to carry out more surgery in-house. We are hopeful that services will be able to move into this facility during Quarter 1 2019.

Good progress is being made on the new Akaroa Health Centre, following a sod-turning ceremony in February. It's expected to be complete in mid-2019 and will provide general practice services and Aged Residential Care for people in Akaroa and surrounding Bays.

A Detailed Business Case is in train for new facilities on the Hillmorton site to house the specialist mental health services currently located at The Princess Margaret Hospital.

A separate Business Case is also underway to help set clear direction for the remainder of the buildings on the Christchurch Hospital Campus. This includes Laboratory services, Parkside and the Riverside buildings. Once resolved this will allow the DHB to move forward with certainty and purpose.

In the absence of a parking building for patients, the DHB's Park and Ride service for patients and visitors transferred to the Council owned Lichfield Parking Building at the end June 2018. Patients and visitors pay for parking and the DHB continues to pay for a free shuttle service between the car park and Christchurch Hospital. We expect to transport our millionth passenger before the end of 2018.

Early success with shrinking our carbon footprint and achieving CEMARS certification

The environment we live in has a huge impact on our health, and we have a responsibility to future generations to look after it. In many cases actions or investments, which reduce our environmental footprint, can result in significant cost savings as well. Working more efficiently, with less wastage, is something we always aim for as a health system.

While we are in the early stages of our sustainability journey, a number of initiatives such as 'on-demand' printing, the paperlite strategy and Choosing Wisely are also helping us make the most of our resources and reducing waste.

A highlight during the past year was achieving Bronze, then Silver Energy-Mark Certification from Enviro-Mark Solutions for our energy management work. Enviro-Mark also confirmed that Canterbury DHB is now a fully CEMARS-certified organisation. CEMARS stands for Certified Emissions Measurement And Reduction Scheme. The aim of the scheme is to properly and thoroughly calculate and then manage an organisation's carbon footprint. Over the past three years, the CEMARS measurements have shown that our carbon emissions are definitely moving in the right direction.

Canterbury DHB's emissions over the past year were 33,000 tonnes of CO2 equivalent, which is 8% lower than the previous year's total of 36,000 tonnes and an impressive 20% lower than the baseline total from three years ago – when CEMARS calculated that we emitted over 41,000 tonnes of CO2 equivalent. Part of this considerable reduction can be explained by the introduction of our new environmentally-friendly biomass boilers at Burwood Hospital in 2016, which replaced old coal-fired boilers that were long past their prime.

Promoting healthy lifestyles

Over the past year our Community and Public Health team has been working on a range of programmes including Smokefree, Alcohol Harm Reduction, Health in All Policies and the highly successful AllRight? campaign continued. Active transport and waste minimisation also featured as programmes which contribute to a healthier community. Ongoing involvement with a range of education settings continued, with the All Right? Sparklers activities being very positively received within school communities across the country as well as in Canterbury. Sparklers are designed for children to help them stay calm, manage worries, be kind and feel good. All the activities are available on the Sparklers website.

The team were put to the test during a number of outbreaks including a measles outbreak which affected large numbers of people from Canterbury and throughout the South Island.

The introduction of chlorine to the Christchurch water supply was a significant issue for the team to manage alongside the council. Drinking water quality throughout the district remained high on the agenda throughout the year.

Emergency response preparedness was tested with the July 2017 floods in Canterbury which saw people evacuated from their homes and public health team provided advice to affected homeowners.

To promote Health In All Policies 16 organisational submissions were submitted for Canterbury DHB, six of these were Select Committee consultations which required significant cross-DHB consultation.

People at the heart of all we do

In our most recent wellbeing survey, more than 4,000 of our people were clear about what they needed from us to help them do their best work. One of the key themes was removing disabling bureaucracy and providing technology that made it easy to get things done. Our response has been to work with people across the organisation to re-design HR services from the ground up, and deliver many of these services using our on-line self-service HR portal - Max.

Traditional HR services such as updating your personal details, changing roster patterns, updating bank account details and applying for leave are now able to be completed online, and all employees can access their leave balances and pay-slips instantly. Almost 80% of all staff have used Max to raise 80,000 individual HR requests in the last 40 weeks alone. Our support teams have resolved nearly 60% of these requests within 24 hours. In the nine months since launch, there are 17 HR services available via Max. This includes complex cross-functional services such as on-boarding of new employees, which is saving thousands of hours of administration for hiring managers across the organisation.

We're now taking all that we've learnt about redesigning HR, and working alongside other parts of the organisation to help them make work, work better.

People also told us that leadership matters. We've responded by developing a growing body of new on-line leadership content for our line managers and beginning the implementation of the Leadership Success Profile (LSP), which is the shared approach to leadership development used across the core public sector.

We're also responding to the health and wellbeing challenges of our people almost eight years on from the earthquakes. On any given day, almost 400 staff are away from work unwell, and sick leave has increased by 30% over the last five years. We've completed a comprehensive review of our occupational health and injury management service, and we're expanding the service to provide a broader range of supports and interventions to promote wellbeing, prevent sickness and injury, and rehabilitate people more effectively when they do become unwell.

People also told us to put them at the centre of our decision-making. Our *Care Starts Here* programme has been launched as a key vehicle to promote:

- Doing the right thing, *He tika he tika.*
- Valuing everyone, *Mana tangata.*
- Being and staying well, *Oranga Tonutanga.*

We've engaged thousands of staff in a conversation about what we care about and how

we do things around here, we're strengthening our core people policies and processes – including our Code of Conduct – and we're developing tools and resources to help people live our values and how we do things around here.

Open and collaborative ways of working together

We've invested time to develop our relationships with other agencies. In a joint media statement issued in May 2018 the Ministry of Health acknowledged the exemplary response of our health system to New Zealand's natural disaster and the extreme nature of the challenges we have faced. This signalled the start of a more open and collaborative way of working together and meant a lot to our staff.

While there are still many challenges ahead, staff can be proud of their achievements over the past year. We continue to build on the proven strengths of our health system.

As we look back over this past year, we thank our staff along with our alliance partners and the many community providers who are part of the wider Canterbury health system. Your efforts to provide high-quality treatment care and support to our population are valued and appreciated.

Your efforts have made such a difference to those we support and provide services for in Canterbury and the Chatham Islands. Thank you.

Dr John Wood
CHAIR | CANTERBURY DHB

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

30 October 2018

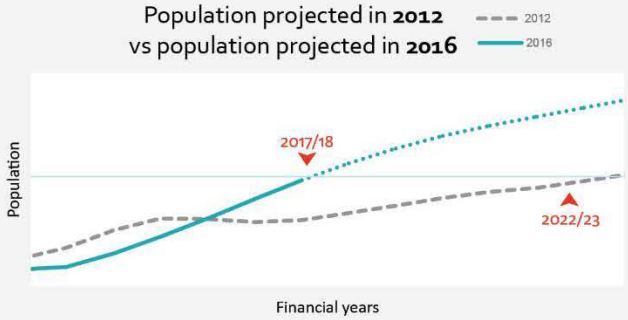
OUR CHALLENGES

Population increases

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

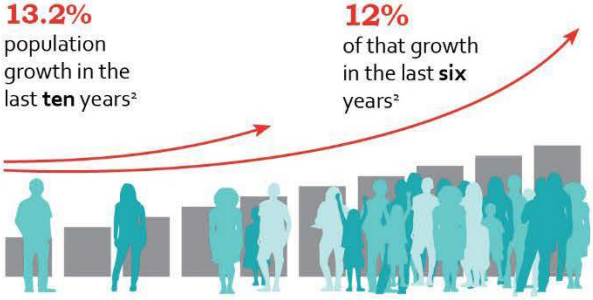
558,830
reasons to make a difference

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

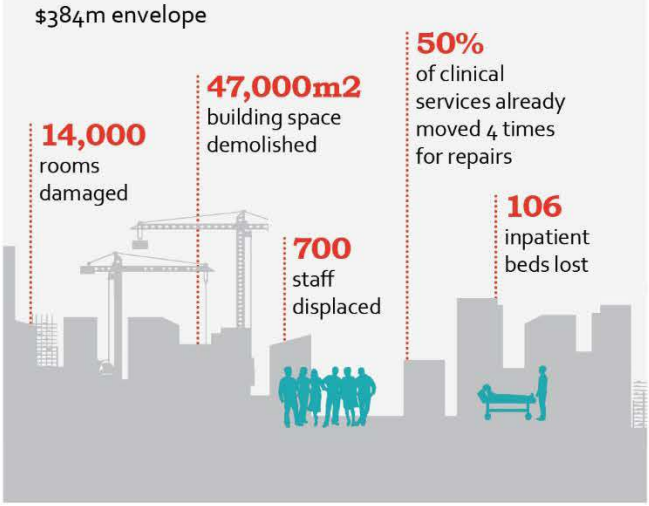
14,000 rooms damaged

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

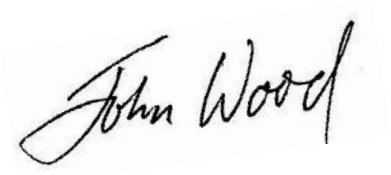
We are responsible for the preparation of Canterbury DHB's financial statements and the statement of service performance, and for the judgements made in them.

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 2018.

For and on behalf of the Board



Dr John Wood
CHAIR | CANTERBURY DHB

Ta Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB

30 October 2018

Part II
Improving Outcomes

2.1 Are We Making A Difference?

"As part of our accountability to our community and Government, we need to demonstrate whether we are achieving our goals and objectives, delivering on our commitments, and improving the health and wellbeing of our population".

DHBs have a number of different roles and associated responsibilities. There is no single performance measure or indicator that can easily reflect the impact of the work we do.

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. 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. Our overarching goal is better health for our people.

Together with the four other South Island DHBs, and in line with the vision for the future of our health system, we have developed an outcomes framework and established three high-level outcomes goals. These three goals are focused on areas where we believe we can influence change and where our success will have a positive impact on the health of our population.

Alongside each goal we have identified a number of long-term population health measures that are important to our stakeholders. Tracking our performance against these measures will help us to evaluate our success and will provide an insight into how well our health system is performing.

The nature of 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 in this space will be evident over a shorter period of time, these indicators have been selected as our main measures of performance.

We have set local standards against these contributory measures in order to determine whether we are moving in the right direction. These measures sit alongside our statement of performance expectations, outlining the services we plan to deliver and the standards we expect to meet in the coming year and form an essential part of the way in which we are held to account.

Our statement of service performance for 2017/18, in the annual performance section of this report, provides a snapshot of the services provided for our population in the past year. Many of the measures selected were deliberately chosen from national reporting frameworks, to enable comparison with other DHBs and give context to our performance.

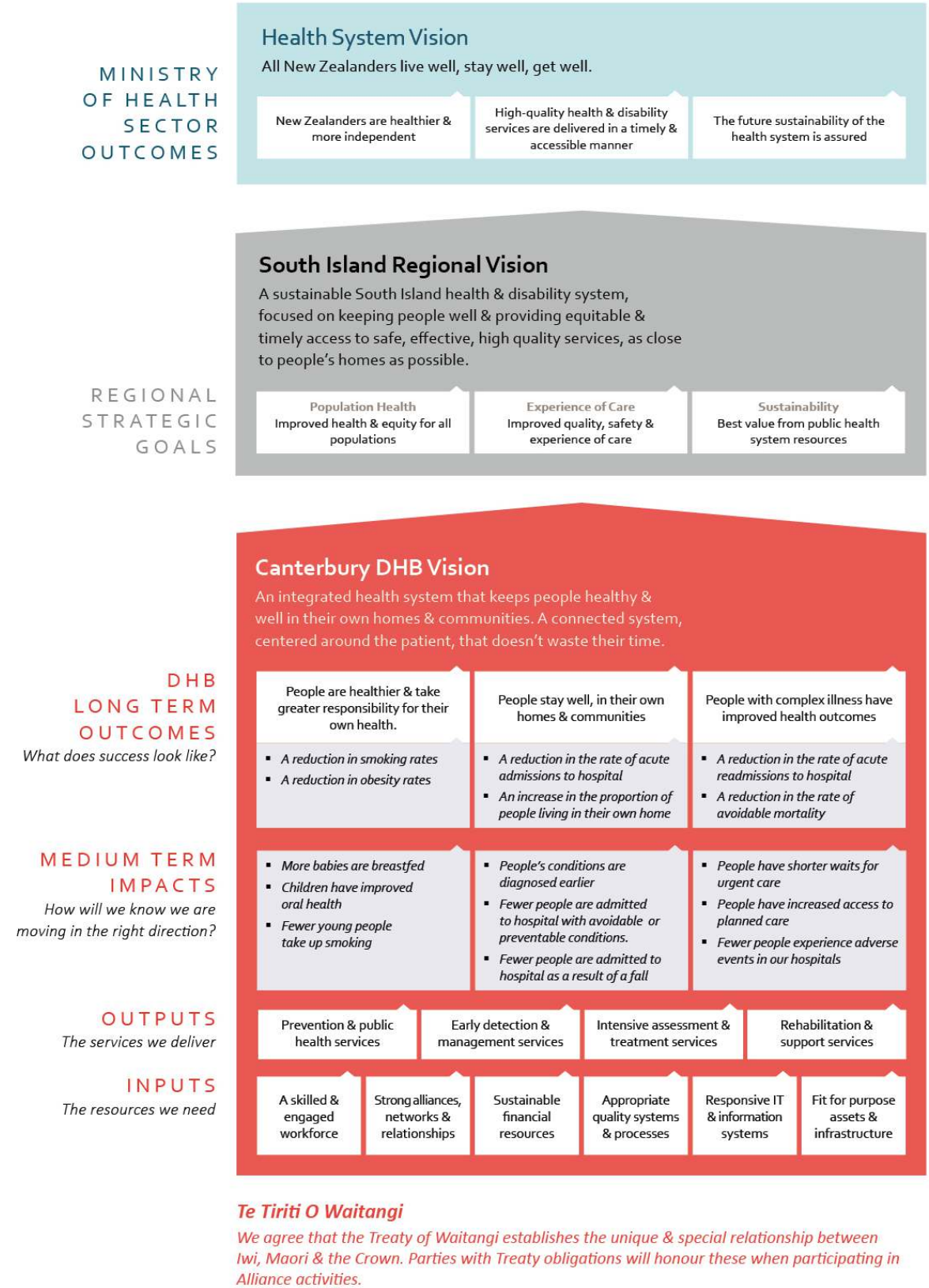
The performance expectations set across all these measures reflect the strategic objectives of our health system: increasing the engagement with prevention programmes; reducing acute or avoidable demand for hospital services; and maintaining or increasing access to services while reducing waiting times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

As part of our obligations under legislation, DHBs must work towards achieving equity across our population. To promote this goal, the standards set for each measure are the same for all population groups. As a means of evaluating whether we have made a difference for our Māori population, performance against a core set of our performance measures has been reported by ethnicity.

The DHB has also evaluated its performance against the national health targets, as these were very much in effect when the DHB set performance expectations for the year.

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



Te Tiriti O Waitangi

We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Maori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

2.2 Monitoring Our Progress

People are healthier and able to 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 cancer, heart disease, respiratory disease, diabetes and depression. These conditions are major 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 long-term conditions are more prevalent amongst Māori and Pacific Island populations. With Statistics New Zealand predicting that by 2026 one in every five people in Canterbury will be aged over 65, and our Māori population growing rapidly, meeting the health service demand associated with long-term conditions will be a major challenge for our health system.

WHERE ARE WE FOCUSED?

Tobacco smoking, inactivity, poor nutrition, alcohol consumption and obesity are significant risk factors for a number of the most prevalent long-term conditions. While tobacco consumption has decreased in New Zealand 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 strategies that improve awareness and encourage personal responsibility for health and wellbeing. Supporting people to make healthier choices will improve the quality of their lives and, by reducing the prevalence and impact of long-term conditions, will reduce the pressure on our health system. Our focus is on smoking and obesity. Because these risk factors have strong socio-economic gradients, this focus will contribute to reducing health inequalities between population groups.

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in smoking rates

After a number of years where smoking rates in Canterbury were declining, the trend appears to be shifting and is contrary to the national results. The latest NZ Health Survey reported that 17% of our population are current smokers, compared to 16% of the New Zealand population.

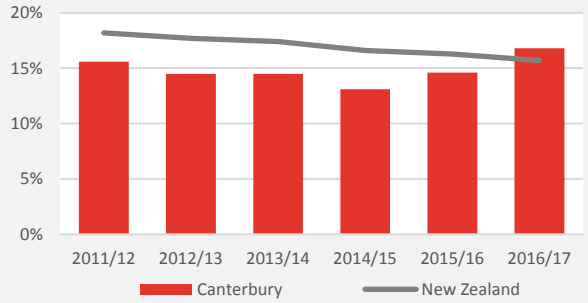
Providing smokers with brief advice to quit smoking increases their chances of making a quit attempt. The likelihood of that quit attempt being successful is increased if cessation support is also provided.

In 2017/18 we continued to focus on delivering brief smoking advice and cessation support, at all contact points across our health system. In every quarter of over the past year more than 90% of smokers identified in general practice and in our hospitals, were 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 past year 450 pregnant women received support to quit smoking through the Te Hā - Waitaha incentivised programme.

We will be watching smoking rates carefully to ascertain whether the results are a true change in trend and to understand what impact earthquake stressors have had on the smoking rates for our population.

Proportion of the population (15+) who currently smoke



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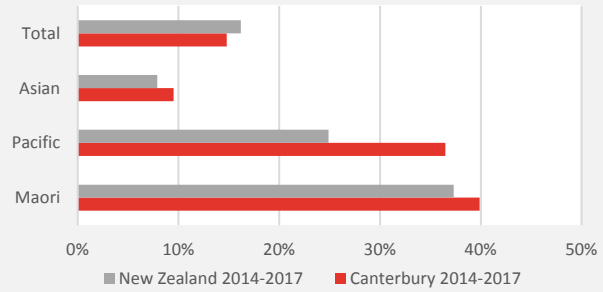


Data source: National NZ Health Survey [1]

[1] *The NZ Health Survey is an annual survey commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2016/17 Survey is the most recently released time series available and while total population results are now presented annually, ethnicity breakdowns are only presented over combined time periods (due to small survey/sample numbers). For further information refer to the Ministry of Health website for the NZ Health Survey results.*

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in obesity rates

While Canterbury's obesity rate at 31% remains just below the national rate of 32%, there has been a steady rise in obesity rates across all ages, genders and ethnicity groups. Obesity is a focus for the DHB, as it impacts on people's quality of life and is a significant risk factor for many long-term conditions.

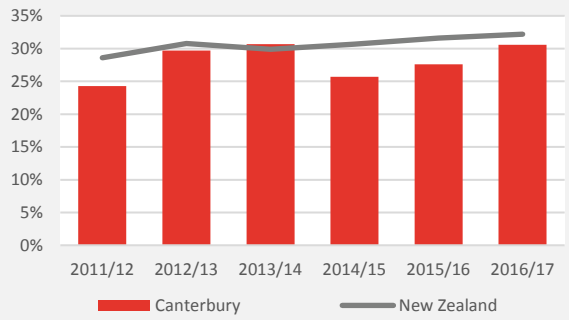
While many of the drivers of obesity sit outside of the direct control of the health system, we have a role in supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to make healthier choices.

We identify children and families who may need support at the B4 School (health) Check prior to children starting school. In the final quarter of this year, 100% of four-year-old children identified as obese were offered a referral to a health professional for assessment and family-based nutrition, activity and lifestyle advice.

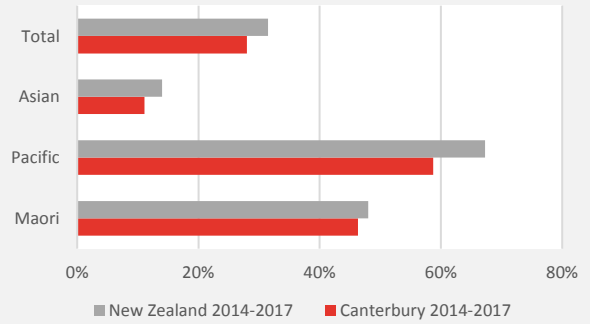
We invest in the Health Promoting Schools programme with 96% of priority schools in Canterbury having adopted the framework. Being healthy and being able to learn are closely linked. The Health Promoting Schools approach enables the whole school community to work together to address the health and wellbeing of students and staff.

We also continue to invest in lifestyle programmes that support people to increase physical activity or make healthy food choices, including the Triple P, Active Families, Appetite-for-Life, Senior Chef and Green Prescription programmes. Over 4,000 people were referred by their health professional to the Green Prescription programme in 2017/18. The latest bi-annual survey results showed 61% of participants remained more active 6-8 months after referral.

Proportion of the population (15+) who identify as obese

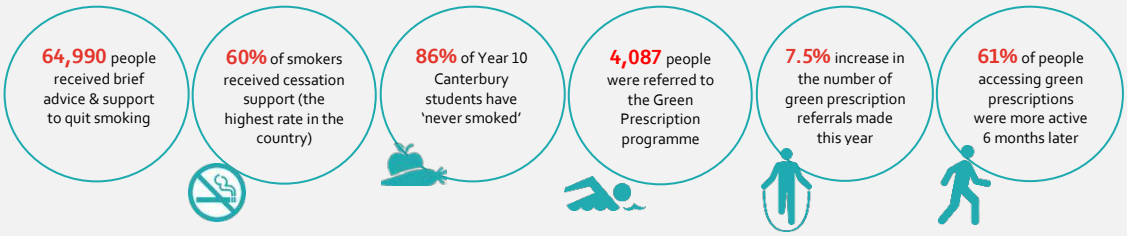


Proportion of the population (15+) who identify as obese



Data source: National NZ Health Survey [2]

FAST FACTS



[2] *The NZ Health Survey is an annual survey commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2016/17 Survey is the most recently released time series available and while total population results are now presented annually, ethnicity breakdowns are only presented over combined time periods (due to small survey/sample numbers). For further information refer to the Ministry of Health website for the NZ Health Survey results. The Survey defines 'Obese' as having a Body Mass Index (BMI) of >30, or >32 for people of Māori and Pacific ethnicity.*

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

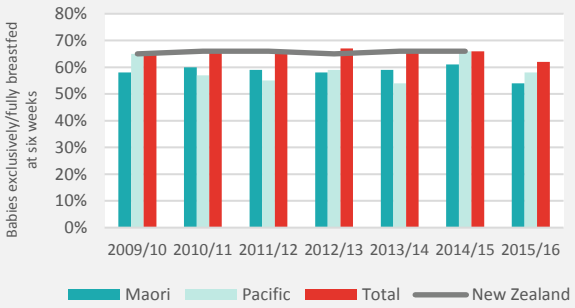
More babies are breastfed

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.

The DHB has been unable to access breastfeeding results (at six weeks of age) from the national Well Child Quality Framework reports since 2015/16. The national reports do report the percentage of babies are fully/exclusively breastfed at three months. This show Canterbury at 61%, just above the national target for this measure (of 60%) and 3% above the national average. Maori rates at three months are 4% higher than the national average, but remained static at 52%.

The DHB funds a range of services to encourage and support women to breastfeed, including peer support programmes and community-based specialist lactation support. Over 980 women were able to access specialist advice in the community to support breastfeeding in 2017/18.

	2015/16	2016/17	Target	Result
	62%	n.a	75%	n.a



Data source: Plunket via the Ministry of Health [3]

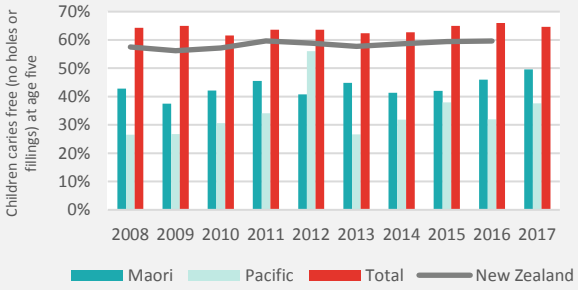
Children have improved oral health

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

The percentage of five-year-old children whose teeth are caries-free (have no holes or fillings) has plateaued for the total population (65%). However improved rates are evident for Māori (50%) and Pacific (38%) with a 4% and 6% increase in children carries free compared to the previous year. This is a positive result for our high need population groups.

Previous enrolment data suggested that our higher needs children may have been missing out and the service has been working to address equity gaps. A new multiple enrolment process and sharing of data across child services will help the service to better identify children and establish and maintain contact with families.

	2015	2016	Target	Result
	65%	66%	66%	65%



Data Source: DHB School & Community Oral Health Services [4]

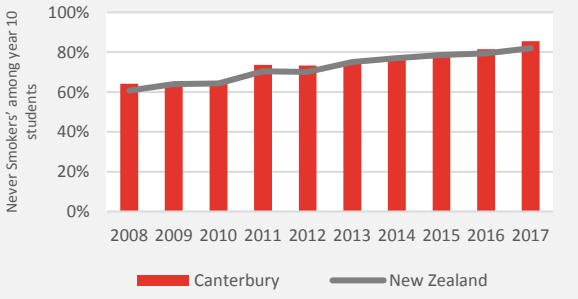
Fewer young people take up smoking

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 on their smoking behaviour and attitudes.

The 2017 survey results show a continuation of the positive trend for Canterbury students, with 86% 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.

	2015	2016	Target	Result
	80%	82%	>75%	86%



Data Source: National Year 10 ASH Snapshot Survey [5]

[3] *The data for this measure is no longer available to the DHB. The streamlined national Well-Child Tamariki Ora (WCTO) Quality Framework includes two breastfeeding measures: babies fully/exclusively breastfed at LMC discharge and babies being breastfed at three months. The DHB tracks the LMC and three month measures under its Statement of Performance Expectations.*

[4] *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 2017 year at the time of printing.*

[5] *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. Ethnicity breakdowns are not provided due to small survey numbers. For further information see www.ash.org.nz.*

People stay well in their own homes and communities

WHY IS THIS OUTCOME A PRIORITY?

When people are supported to stay well, and can access the care they need closer to home and in the community, they are less likely to need hospital-level interventions or residential care. This is not only better in terms of health outcomes, but it reduces pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke, and achieve those health outcomes at a lower cost than health systems that focus more heavily on a specialist or hospital-level response.

This is particularly important in Canterbury. We are the second fastest growing regional area in the country and have two of the three fastest growing local authority areas: Selwyn and Waimakariri. Over the last ten years our population has grown 13.6%. With a 2018/19 population of 567,870 people we have already reached a population level that we were previously not predicted to reach until 2022. Our hospital capacity is under significant pressure and it will be several years before the redevelopment, repair and remediation of our facilities are complete.

WHERE ARE WE FOCUSED?

The general practice team is a vital point of ongoing continuity, particularly in terms of improving care for people with long-term conditions and supporting people to stay well and avoid a deterioration of their condition that might lead to a hospital admission. As such, we are investing in general practice, community-based allied health, pharmacy and diagnostic services with the aim of improving access to services closer to people's homes and enabling earlier detection and diagnosis and treatment.

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in acute medical admissions

With the right intervention and support, people can avoid the deterioration of their condition or reduce the likelihood of an event that leads to hospital admission, complications, long-term illness or even premature death. We seek to reduce medical admissions that are potentially avoidable through prevention, earlier intervention or closer management in primary care.

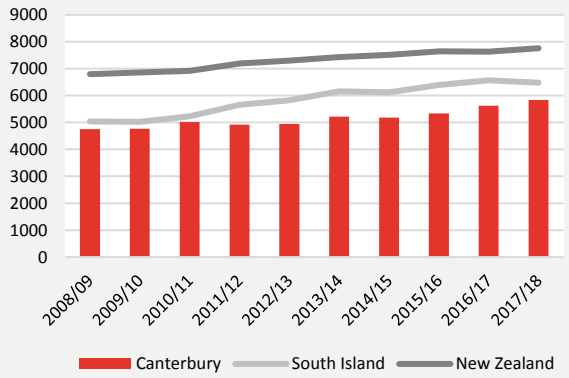
Like the rest of New Zealand, Canterbury's acute medical admission rates are slowly increasing as our population ages and more people are living with long-term conditions. However, at 5,841 per 100,000 people, our rate remains one of the lowest in the country and remains well below the national rate (7,759). This is a positive reflection of the programmes in place across our health system to make sure people get the right service, at the right time, in the right place.

The provision of organised general practice is core to keeping people well. High enrolment rates are an indication of good engagement with our health system and enrolment with general practice remains high, at 93%.

The DHB continues to subsidise access to services such as spirometry testing (for respiratory illness), diabetes (insulin) management support and a number of rehabilitation programmes to improve people's management of their long-term conditions such as our stroke, falls prevention and pulmonary rehabilitation programmes.

The DHB's continued investment also includes support for our community-based Acute Demand Management Service which provided more than 32,000 packages of care in 2017/18 - preventing many acute hospital admissions.

Acute medical admissions per 100,000 people



Data Source: National Minimum Data Set [6]

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

OUTCOME MEASURE - DEMONSTRATING PROGRESS

More people living in their own homes

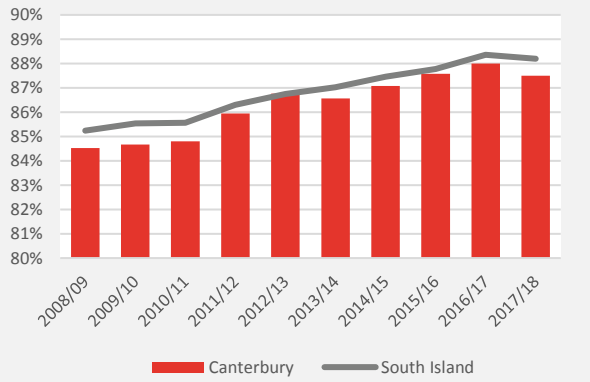
The proportion of the Canterbury population (aged 75+) living in their own homes has dropped slightly to 87.5% compared to 88% last year. This is still a positive trend when reflecting that over the last five years the over 75 year-old population has increased by 18%. Consistent with our strategy, the DHB is still focused on improving this result further.

A number of local programmes support our older population to maintain their health and wellbeing and to age-in-place for longer, including: medication management programmes, age-related harm prevention and long-term condition strategies, falls prevention programmes, restorative rehabilitation, home-based support and respite services.

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

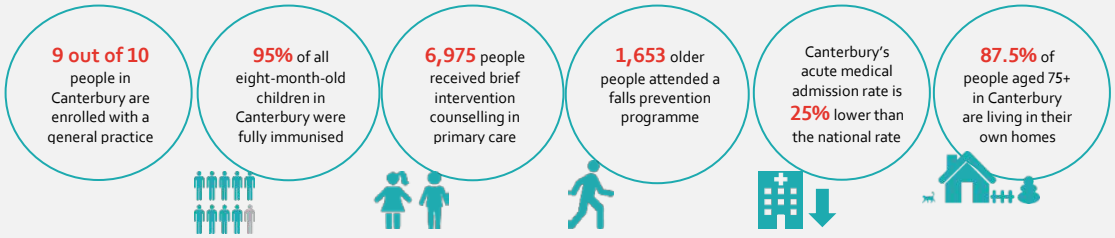
Falls in older people are very common. They frequently lead to injury and hospitalisation, a loss of confidence, and an increased risk of admittance to institutional care. Over 1,600 people accessed our community-based falls prevention programme in the last year and 97% of older inpatients received a falls assessment to help them stay safe while in our hospitals.

Proportion of the population (75+) living in their own home



Data Source: SIAPO Client Claims Payment System

FAST FACTS



IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

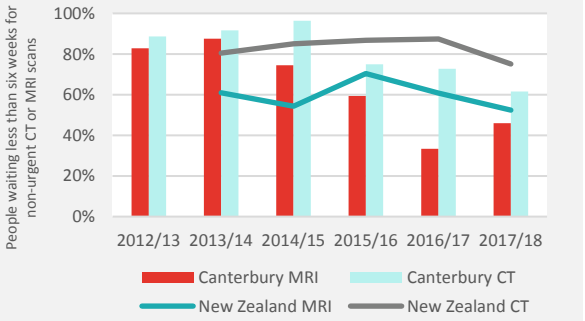
People's conditions are diagnosed earlier

Demand for CT and MRI scanning has been exceeding capacity across both the public and private sectors and wait times are increasing across the country.

A number of factors are driving this pressure including: new drugs and new treatment programmes, increased surgical volumes and population increases. Canterbury also takes the majority of tertiary referrals from other South Island DHBs, who are likewise experiencing increased demand, and this puts additional pressure on our radiology services. There have been over 590 more MRI referrals and over 2,345 more referrals for CTs than in 2016/17.

The DHB has CT and MRI scanners at Burwood Hospital and now a second MRI scanner at Christchurch Hospital, which has helped to reduce waiting times slightly. Radiologist capacity is a key constraint and the DHB is recruiting additional staff, running weekend clinics and outsourcing to private providers to meet the increasing demand.

	2015/16	2016/17	Target	Result
MRI	59%	33%	90%	46%
CT	75%	73%	95%	62%



Data Source: DHB Patient Management System

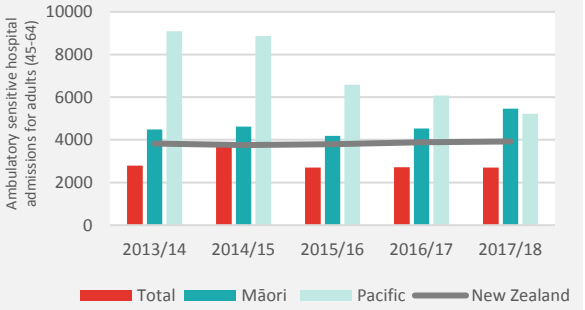
Fewer avoidable hospital admissions

In 2017/18, Canterbury's avoidable hospital admission rate for 45-64 year-olds was 2,705 per 100,000 people. While slightly above the target, it is an improvement on the previous year and well below the national rate (3,925). Our rate for our Pacific population also continues to improve, closing the equity gap and at 5,223 is considerably lower than the national rate of 9,009. Our rate for Maori (5,459) was higher than the previous year, and the total Canterbury result, but lower than the national Maori rate of 7,824.

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system, particularly in relation to long-term conditions, which if not well managed, often lead to hospital admissions.

In the past year, 93% of our population was enrolled with a primary care team, 82% of the eligible population had a cardiovascular disease risk assessment and 90% of people identified with diabetes had a management review.

	2015/16	2016/17	Target	Result
	2,694	2,710	<2,623	2,705



Data Source: Ministry of Health Performance Reporting [7]

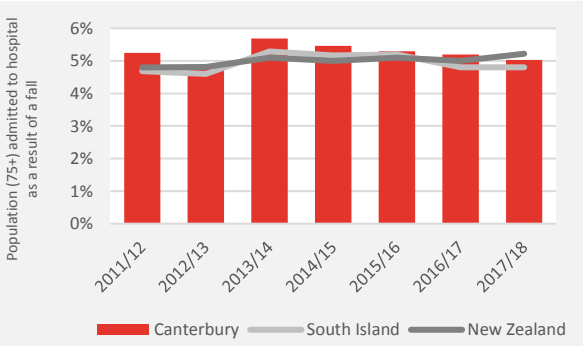
Fewer falls-related hospitalisations

At 5%, the proportion of our population (75+) admitted to hospital as a result of a fall is lower than the previous year and 0.2% lower than the national average. Importantly, those people with serious harm from a fall resulting in a fractured hip has fallen by 4.5%.

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 1,600 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.

	2015/16	2016/17	Target	Result
	5.3%	5.2%	<5.5%	5.0%



Data Source: National Minimum Data Set [8]

[7] *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 2018 series provided by the Ministry of Health in August 2018 – baselines have been reset to reflect the current series.*

[8] *This measure was reset in 2013/14 to 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 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 indicative of a well-functioning and sustainable system, able to match capacity to demand and manage the flow of patients to ensure people receive the service they need when they need it.

As the primary provider of hospital and specialist services in Canterbury, this goal also reflects the quality and effectiveness of the treatment we provide. Unnecessary waits, ineffective treatment or adverse events can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population. They can also impact on people's experience of care and their confidence in the health system and ineffective treatment or adverse events also add avoidable costs and waste valuable resources.

WHERE ARE WE FOCUSED?

Having a strong primary care foundation and managing more people in the community is better 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 more frail, have more complex conditions, and be at greater risk of complications.

We are in the midst of a significant facilitates redevelopment, repair and remediation programme and capacity within our hospital services is currently severely limited. In order to meet the increasing demand from our growing and ageing population, we are focusing on improving the coordination of care and reducing duplication of effort in order to maintain service access and reduce waiting times for treatment. This includes a focus on ensuring safe care in our hospitals and supporting people on discharge from our hospitals, to ensure they regain their independence and avoid another event that might negatively impact on their health.

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in acute readmissions to hospital

Patients who are readmitted to hospital are more likely to experience negative long-term outcomes. Readmissions also reduce public confidence in our health system and increase costs.

Canterbury's readmission trend has been relatively flat over the last couple of years and at 12.1% our readmission rate is the same as the national average, which is a positive result. We will be monitoring this trend over the next few years.

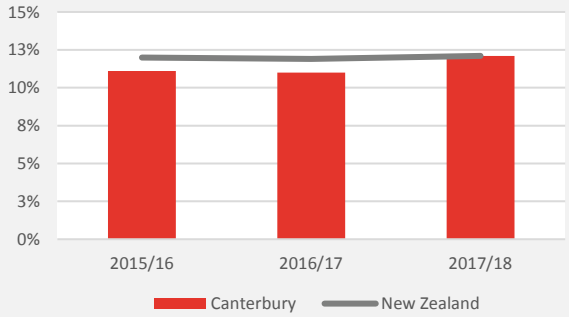
Service quality, patient safety and good discharge planning are key factors in reducing acute readmissions. The DHB has made a strong commitment to Zero Harm and the implementation of the Health Quality and Safety Commission's Open for Better Care Campaign.

We have a particular focus on the supported discharge and rehabilitation of older people and patients with heart failure and respiratory disease where readmission rates are higher. The number of older people accessing falls prevention and rehabilitation programmes remains high.

Over 1,600 people accessed our community-based falls prevention service, 270 people attended a pulmonary rehabilitation course and 78% of people having an acute stroke event were referred to a stroke rehabilitation programme.

CREST, our community-based supported discharge service, provides home-based rehabilitation packages to support older people on discharge from hospital. The service supported more than 1,800 people in 2017/18.

Proportion of people acutely readmitted to hospital within 28 days of discharge



Data Source: National Minimum Data Set [9]

[9] *This measure is a national DHB performance indicator (OS8). The results differ to those previously published following a national reset of the definition by the Ministry of Health in 2017/18. Two previous year's results have been provided by the Ministry as baselines as part of the definition change. The DHB is not able to access data prior to this definition change, hence the shorter time series presented.*

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in avoidable mortality

The overall mortality trend continues to be positive, with Maori rates dropping back down after a previous increase in 2014, and remaining well below national rates.

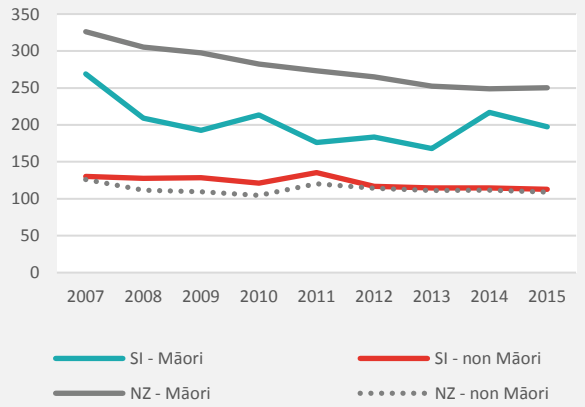
Prevention, screening and long-term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment. Rapid access to complex treatment such as radiation therapy or surgery is also an important factor in determining a positive outcome for many conditions, such as cancer, cardiovascular disease or stroke.

Cancer is one of the leading causes of mortality in Canterbury and contributes to a high proportion of premature deaths. The DHB achieved the national Faster Cancer Treatment health target in every quarter in 2017/18 with 94% of people identified with a high suspicion of cancer being seen and treated within 62 days in the final quarter of the year.

Cardiovascular disease is also a leading cause of mortality and many people require surgical intervention. For those admitted to hospital with acute coronary syndrome (sudden, reduced blood flow to the heart i.e. a heart attack), it is important to perform a coronary angiography to inform further treatment options and prevent additional cardiovascular events. In 2017/18, 666 people received an angiogram, 98% within three months, exceeding the national target of 95%.

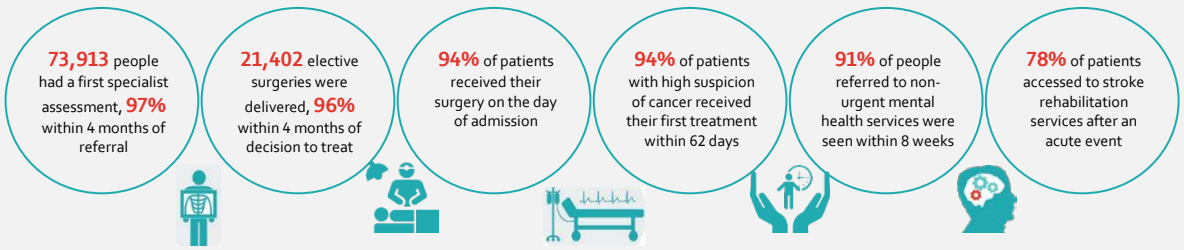
Mental illness contributes greatly to premature mortality. Unsurprisingly, after continued, unprecedented, increases in demand for mental health services, waiting times for non-urgent mental health and alcohol and drug services have risen slightly in the past year. Mental health remains a major focus for the DHB for the coming year and the DHB is working closely with community service providers to increase capacity and rolling out Mana Ake the new Mental Wellbeing Support in Schools Initiative.

All-cause mortality rate for people under 65 years of age



Data Source: National Mortality Collection [10]

Fast Facts



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

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

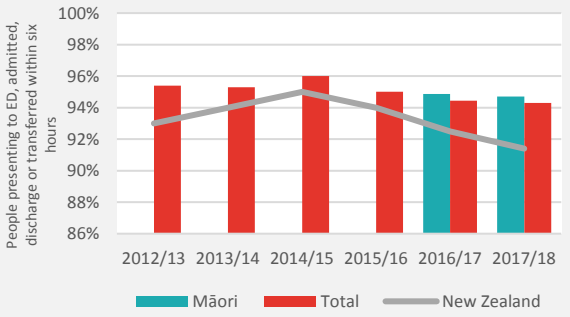
People have shorter waits for urgent care

In the five years between 2012/13 and 2017/18 there has been an 18% increase in presentations to emergency departments (ED) in Canterbury. There were over 103,000 ED presentations this year, compared to 96,000 in 2016/17.

In spite of this increasing demand the DHB's performance in this area has been consistently high. Considering the increased demand and constant construction disruptions experienced across our main hospital sites, missing the target by less than 1% is an impressive performance.

This strong performance result reflects the commitment of our ED teams and services across our hospitals to respond to an increasing number of people within the target timeframes. It also reflects the commitment of our primary care teams in supporting people in the community.

	2015/16	2016/17	Target	Result
	95%	94.4%	95%	94.3%



Data Source: DHB Patient Management Systems [11]

People have shorter waits for planned care

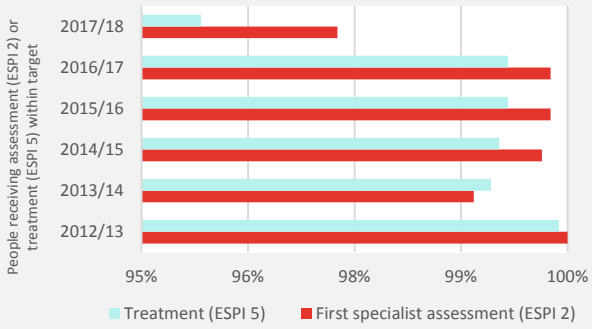
The DHB is working around significant facility constraints, ongoing construction delays and repair disruptions. Waiting times are longer than we would like, but considering the challenges for our teams, performance against these targets represents a major achievement.

More than 73,000 patients attended a first specialist assessment in Canterbury and 97.3% of all those patients were seen within four months (ESPI2).

The DHB met the elective surgery target, delivering 21,402 elective surgeries in 2017/18. Of those patients given a commitment for treatment, 95.7% were seen within four months (ESPI5).

Despite the ongoing disruptions and constraints, 94% of people received their surgery on the day of admission. This means less disruption for patients, who can spend the night before surgery in their own homes.

	2015/16	2016/17	Target	Result
ESPI2	99.8%	99.8%	100%	97.3%
ESPI5	99.3%	99.3%	100%	95.7%



Data Source: Ministry of Health Quickplace Warehouse [12]

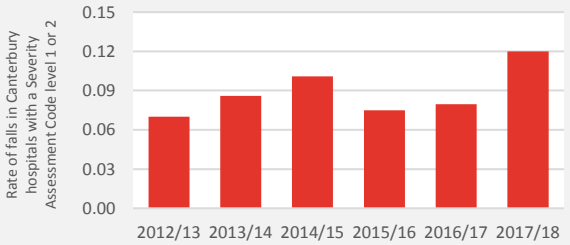
People experience fewer adverse events in hospital

The rate of serious falls in our hospitals has increased this year after a drop in the previous two years.

Key quality projects are 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 and may be improving our reporting of events.

Our hospital teams provided 97% of all inpatients aged 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 of a fall.[13]

	2015/16	2016/17	Target	Result
	0.07	0.08	0.06	0.12



Data Source: Individual DHB Quality Systems [14]

[11] *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).*

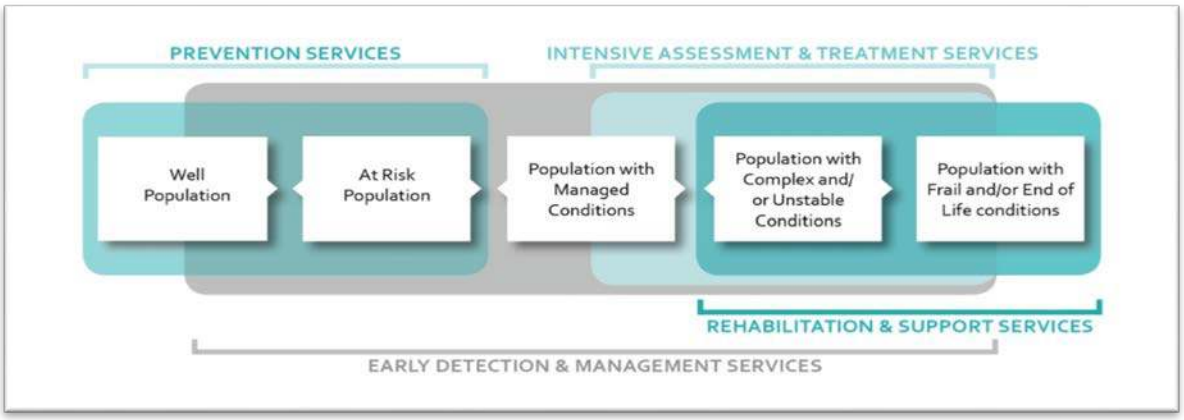
[12] *These indicators are two of the national Elective Services Patient Flow Indicators (ESPIs), established to track system performance. In line with national ESPI reporting, the annual results refer to the final month of each year (June).*

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

[14] *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 and the difference between 2016/17 and 2017/18 is 18 events. The result for 2017/18 differs from that previously published (0.04) due to the inclusion of event reports that where completed after the report was published.*

Part III
Delivering on our Plans

3.1 Statement of Service Performance



Evaluating Our Performance

Having constrained facilities, a limited pool of resources and a growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

Over the longer term, we evaluate the effectiveness of our decisions, and the quality of our services, by tracking performance against the desired population health outcomes presented on the previous pages.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The statement of service performance set out in this section presents the DHB's actual performance against the 2017/18 forecast, presented in our 2017/18 Statement of Intent.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service the DHB delivered or funded, services have been grouped into four services classes (or types). These are common to all DHBs and reflect the type of services provided across the full health and wellbeing continuum (illustrated above):

- Prevention Services
- Early Detection and Management Services
- Intensive Assessment and Treatment Services
- Rehabilitation and Support Services.

Under each service class we have identified a mix of service measures that we believe are important to our community and stakeholders, and provide a fair indication of how well the DHB is performing.

In presenting our performance picture, we have not simply presented the volume of services provided. The number of people who receive a service is often less important, for example, than whether the service was delivered at the right time.

To present a well-rounded performance picture, the mix of measures we have identified address four key aspects of service performance:

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

The DHB is responsible for improving the health and wellbeing of our population across the full continuum of care. While targeted interventions can reduce demand in some areas, there will always be some service areas where the DHB cannot influence demand, such as maternity, dementia or palliative care services.

It is not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region. We have set service level estimates for these services and report on service access to give context in terms of the use of resources across our health system.

As part of our obligations under legislation, DHBs must work towards achieving equity. To promote this goal, we have identified a core set of performance measures that are important in terms of Māori health, as a means of evaluating whether we have made a difference for our Māori population over the past year. These measures are presented by ethnicity on page 33.

Nationally, DHB performance has also been evaluated by tracking performance against six national health targets. Canterbury's performance against the health targets identified for 2017/18 is presented on page 23.

Setting Standards

In setting performance standards, we consider the changing demographic of our population, areas of increasing demand, and the assumption that resources and funding growth would be limited.

In Canterbury we are also 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 bed and theatre capacity across our hospitals, and constant disruption from repairs and construction.

Targets set in 2017/18 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

We knew that a number of the standards would be difficult to meet, considering our challenging and evolving environment. The DHB remains committed to maintaining high standards of service delivery and it is pleasing to see that, in spite of the sustained pressure over the past year, performance has been positive.

NOTES ON THE DATA

The following symbols have also been used to provide context in the performance tables:

E Services are demand driven. It is not appropriate to set targets but service volumes are provided to give context in terms of the use of resources across our health system.

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

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

◇ The measure is a national target set for DHBs to achieve by the final quarter, or final month, of the year. In line with national performance reporting, fourth quarter (April-June) or June results are reported as the annual result.

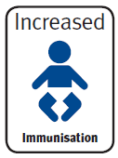
◆ The measure is a core Māori health measure. Refer to page 33 for a breakdown of results by ethnicity.

Performance Key

	Rating	Criteria
✓	**A**chieved	Standard reached
↺	**P**artially Achieved	Standard not reached but performance maintained or improved or the equity gap between population groups has reduced
✗	**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 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 2017/18 year. The national average (NZ) reflects the final quarter.



Increased Immunisation

The target is: 95% of eight-month old children are fully immunised (i.e. having had their primary course of immunisation art six weeks, three months and five months).

Target 95%		
Q1	95%	✓
Q2	95%	✓
Q3	95%	✓
Q4	**95%**	✓
NZ 91%		

Raising Healthy Kids

The target is: 95% of children, identified as obese at their B4 School Check, are offered a referral to a health professional for clinical assessment and healthy lifestyle interventions.

Target 95%		
Q1	93%	✗
Q2	96%	✓
Q3	98%	✓
Q4	**100%**	✓
NZ 98%		

Better Help For Smokers to Quit

The target is: 90% of PHO enrolled patients, who smoke, are offered advice and help to quit smoking from a health professional at least once every 15 months.

Target 90%		
Q1	91%	✓
Q2	90%	✓
Q3	91%	✓
Q4	**93%**	✓
NZ 90%		

Shorter Stays in ED

The target is: 95% of patients presenting in an Emergency Department (ED) are admitted, discharged, or transferred within six hours. Canterbury's result counts presentations to both the Christchurch and Ashburton Hospital Emergency Departments.

Target 95%		
Q1	94%	✗
Q2	95%	✓
Q3	95%	✓
Q4	**94%**	✗
NZ 91%		

Improved Access to Elective Surgery

The target is: an increase in the volume of elective surgeries by at least 4,000 discharges per year (nationally). Canterbury's target for 2017/18 was 21,330.

Target 21,330		
Q1	4,989	
Q2	10,344	
Q3	15,341	
Q4	**21,402**	✓

Faster Cancer Treatment

The target is 90% of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receive their first cancer treatment within 62 days of referral.

Target 90%		
Q1	95%	✓
Q2	94%	✓
Q3	91%	✓
Q4	**94%**	✓
NZ 91%		

3.3 2017/18 Service Performance

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Prevention services are publically funded services that promote and protect the health of the whole population or targeted sub-groups. The DHB invests in these services as a means of addressing individual behaviours and targeting physical and social environments that can 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 our population. By supporting people to make healthier choices, we can reduce 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 one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequalities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can also be a very cost-effective health intervention.

SERVICE PERFORMANCE 2017-2018

HEALTH PROMOTION AND EDUCATION SERVICES							
These services inform people about risks and support them to make healthy choices. Success is evident through increased engagement, which leads, over time, to positive behaviour choices and a healthier population.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Mothers receiving breastfeeding/lactation support in the community	A[15]	1,033	1,026	>600	980	-	✓
Babies exclusive/fully breastfed at LMC discharge (4-6 weeks)	Q[16]◆	72%	74%	75%	n.a	n.a	-
Babies exclusive/fully breastfed at three months	Q[16]◆	59%	61%	60%	61%	58%	✓
Priority schools supported by the Health Promoting Schools framework	C[17]	89%	91%	>70%	96%	-	✓
People provided with Green Prescriptions for additional physical activity	A[18]	3,095	3,800	>3,000	4,087	-	✓
Green Prescription participants more active 6-8 months after referral	Q[18]	75%	-	50%	61%	-	✓
Smokers, enrolled with a PHO, receiving advice and support to quit	C[19]◇	88%	90%	90%	93%	90%	✓
Smokers, identified in hospital, receiving advice and support to quit	C◆	98%	95%	95%	94%	94%	✗
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit	C◆[20]	93%	93%	90%	79%	89%	✗
Women smokefree at two weeks postnatal	Q[21]◆	88%	90%	95%	n.a	n.a	-

[15] 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. The percentage of babies being breastfed can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period. Standards are set nationally.

[16] These measures are part of the national Well Child/Tamariki Ora Quality 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 LMC breastfeeding results had not been published at the time of printing, the three month breastfeeding measures reflects the six months to December 2017.

[17] The Health Promoting Schools Framework is a national approach that supports a school community's capacity to create and sustain environments that improve and maintain health and wellbeing. Eligible schools have been defined as decile 1-4 and years 1-8, Priority schools are low decile, rurally isolated, and/or have a high proportion of Māori and/or Pacific children.

[18] 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 (for the quality measure) is sourced from a national patient survey competed every two years by Research NZ on behalf of the Ministry of Health. Heightened emphasis on lifestyle intervention and joint work between the DHB, PHOs and Sports Canterbury over the last couple of years has helped to raise awareness of this programme and support increased referral and uptake of green prescriptions.

[19] This is a national health target (Better Help for Smokers to Quit). Evidence shows that the majority of smokers want to quit and need help to do so. The provision of profession advice and cessation support is shown to both increase the likelihood of smokers making quit attempts and the success rate.

[20] LMC smoking rates have dropped back in the last quarter of the year. However the DHB is still getting a good number of referrals to stop smoking services and continues to identify opportunities to support LMCs to provide advice and support to pregnant women who are smoking.

[21] This measure is part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The 2016/17 results reflect the 6 months to December 2016, the full year and the 2017/18 result was not available at the time of printing.

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.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Four-year-olds provided with a B4 School Check (B4SC)	C[22]◆	91%	93%	90%	97%	93%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q[23]◆	new	95%	95%	100%	98%	✓
Children referred to lifestyle programmes who take up a programme	Q[24]	new	new	>50%	62%	-	✓
Women aged 25-69 having a cervical smear in the last three years	C[25]◆	74%	74%	80%	74%	73%	↺
Women aged 50-69 having a mammography in the last two years	C[25]◆	77%	76%	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.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Children fully immunised at eight months of age	C◇◆	96%	95%	95%	95%	91%	✓
Eight-month-olds 'reached' by immunisation services	Q[26]◇	98%	99%	95%	96%	95%	✓
Young women (Year 8) completing HPV vaccination programme	C[27]†◆	43%	59%	75%	65%	67%	↺
Older people (65+) receiving a free influenza ('flu') vaccination	C[28]†◆	74%	63%	75%	62%	54%	✗

[22] *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.*

[23] *This measure is a national health target (Raising Healthy Kids) introduced at the start of 2016/17. Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational and quality of life. A referral allows families to access support to maintain healthier lifestyles.*

[24] *This measure uses the number of children referred over the past year and the number of children taking up a programme during the year, this includes Triple P Healthy Lifestyle, Active Families, Appetite-for-Life and Green Prescription Programmes. It should be noted that some children, and their families, may take up more than one programme and some of those referred may not yet have identified a programme. The DHB is working to improve the capture of data related to these programmes.*

[25] *The cervical and breast cancer screening measures refer to participation in national screening programmes and age bands and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer by allowing for earlier intervention and treatment. Rates for cervical screening in Canterbury are below target, but slightly above national rates. Improving cervical screening rates is a health focus area for Māori and we have re-established a clinical steering group to support improved performance in this area.*

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

[27] *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 is free to young people under 26 years of age. Canterbury's HPV programme differs to that provided in other regions being primarily a general practice based programme with a school-based programme launched in February 2016 to complement and support the general practice programme. While the DHB has not yet reached the target, performance has steadily improved with a 6% increase in uptake on the previous year. We are anticipating further improvements in the coming year with 71% of eligible girls have started the programme this year (i.e. having received dose 1).*

[28] *The denominator for this measure changed from the number of people enrolled with a PHO to the Census population in 2017. Previous year's results are not directly comparable. This measure is also impacted by the increasing proportion of population aged over 65, the actual number of older people having a flu vaccination in 2018 has increased by 1,653 people, compared to 2017.*

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

The New Zealand health system is experiencing an increasing prevalence of long-term conditions, so-called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age.

Our vision of an integrated system presents a unique opportunity. For most people their general practice team is their first point of contact with health services, and is vital as a point of continuity and in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services, we are better able to support people to stay well, identify issues earlier, and reduce complications, acute illness and unnecessary hospital admissions. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support.

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PRIMARY CARE (GENERAL PRACTICE) SERVICES							
These services support people to maintain their health and wellbeing and avoid unnecessary hospital admission. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive system.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Population enrolled with a Primary Health Organisation (PHO)	C[29]◆	95%	94%	95%	93%	93%	✗
Young people (0-13) enrolled with a general practice where their visits are free	A	98%	98%	95%	99%	-	✓
Young people (0-19) accessing Brief Intervention Counselling	A[30]	610	679	>500	579	-	✓
Adults (20+) accessing Brief Intervention Counselling	A	5,505	5,861	>3,500	6,396	-	✓
Number of skin lesions (including cancers) removed in primary care	A	2,820	2,520	>2,000	2,609	-	✓
Number of integrated HealthPathways in place across the system	Q[31]	499	644	>500	691	-	✓
General practices using the primary care patient experience survey	Q[32]	new	42%	>35%	62%	-	✓
Avoidable hospital admission rate for children (0-4)	Q[33]◆	5,827	6,072	<6,476	6,033	6,748	✓

[29] Our enrolment has decreased as immigration associated with the rebuild has increased. This population may be younger and delay enrolment until they need primary care. The DHB continues to look for opportunities to enrol this group through their employers and opportunistically as they present in other parts of the system.

[30] The Brief Intervention Coordination Service aims to support people with mild to moderate mental health concerns, including depression and anxiety, to improve their health outcomes and quality of life. The service provides up to six free counselling sessions (or extended consultations) and uptake of this service is still high, and growing for adults, reflecting the ongoing need for additional mental health support across Canterbury.

[31] The clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals in Canterbury. The pathways support consistent access to treatment and care no matter where people present.

[32] The Patient Experience Survey a national online survey to determine patient's experience in primary care and their perception of how well their overall care is managed. The survey was initially piloted in a small number of DHB regions and is now being progressively rolled-out across the country with an increasing number of general practices in Canterbury now offering their patients the opportunity to provide feedback. The information collected will be used to help improve the quality of service delivery.

[33] Some admissions to hospital are seen as avoidable through early intervention and treatment and the rate of these admissions provides 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 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.

LONG-TERM CONDITIONS SERVICES

These services are targeted at people with high health needs related to long-term or chronic conditions. High enrolment and engagement levels are indicative or a successful service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Spirometry tests provided in community rather than hospital	A[34]	1,742	1,897	>1,000	2,493	-	✓
Eligible population having a cardiovascular disease (CVD) risk assessment in the last 5 years	C[35◇◆]	87%	85%	90%	82%	88%	✖
People receiving subsidised diabetes self-management support from their general practice when starting insulin	A	392	381	>300	400	-	✓
People identified with diabetes having an HbA1c test in the last year	C[36†]	89%	89%	90%	90%	-	✓
People identified with diabetes with acceptable glycaemic control (evidenced via their HbA1c test)	Q†	75%	75%	>75%	74%	-	✖

ORAL HEALTH SERVICES

These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High enrolment and timely access to treatment are indicative of an accessible and efficient service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Children (0-4) enrolled in DHB-funded oral health services	C[37†◆]	61%	62%	95%	76%	-	↺
Children (0-12) enrolled in DHB oral health services examined according to planned recall	T[37†◆]	90%	90%	90%	88%	-	✖
Adolescents (13-17) accessing DHB-funded oral health services	C[37†]	62%	61%	85%	63%	-	↺

PHARMACY AND REFERRED SERVICES

These are services health professionals use to help diagnose or monitor health conditions. Timely access to services improves clinical decision-making and reduces delays in treatment.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Laboratory tests completed for the Canterbury population	A	2.5m	2.8m	E.<2.8m	2.9m	-	✖
Subsidised pharmaceutical items dispensed in the community	A	6.5m	6.8m	E.<8m	6.8m	-	✓
People on multiple medications receiving support via the Medications Management Review programme	A[38Δ]	1,355	1,361	>1,500	1,316	-	✖
Community Referred Radiology tests completed	A	44,404	45,227	E.>40k	49,832	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T	92%	94%	>90%	89%	90%	✖
People receiving their MRI scans within six weeks	T[39]	59%	33%	90%	46%	52%	↺
People receiving their CT scans within six weeks	T[39]	75%	73%	95%	62%	75%	✖

[34] *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 and conditions can be identified earlier.*

[35] *Cardiovascular disease is one of the leading causes of death in Canterbury. By identifying those at risk of cardiovascular disease early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious event. The DHB continues to work with PHOs to lift these rates.*

[36] *Diabetes is a leading long-term condition and contributor to many other conditions. An annual HbA1c test (of a patient's blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.*

[37] *The DHB has been focusing on sharing data to enable the oral health services to contact parents and enrol children and this has lifted enrolment rates compared to the previous year, however oral health results continue to be disappointing. The DHB has reviewed the operational structure of the service and established an Oral Health Service Development Group under the Canterbury Clinical Network to focus on improving performance in this area. We are also investing in a new service (LinKIDS) to help coordinate multiple service enrolments and link parents and children with the services they need. We anticipate this work will lead to improved performance over the next few years.*

[38] *The slight decrease in the results reflects a changing balance of medication reviews from a medicines use review (MUR) to a more intensive medicines therapy assessment (MTA). Although we are able to perform fewer overall assessment we expect that the MTA will produce better outcomes for our higher need population groups.*

[39] *These diagnostic measures are national DHB performance measures (PP29). The wait times refer to non-urgent MRI and CT scans. Demand has been exceeding capacity due to a number of factors including increasing surgical volumes, the introduction of new drugs and treatment options and population increases. Canterbury also sees the majority of tertiary referrals from other South Island DHBs, who have also been experiencing growth in their areas which has increased pressure on the service. In response, the DHB now has CT and MRI scanners operational at Burwood Hospital and a second MRI scanner at Christchurch Hospital, is hiring more staff and has outsourced some aspect of the service to increase reporting capacity.*

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events, others are planned and access is determined by clinical triage, treatment thresholds, capacity and national service coverage agreements.

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 enable 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. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

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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.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Rate of staff compliance with good hand hygiene practice	Q[40] ◇	78%	83%	80%	81%	85%	✓
Hip and knee replacement patients receiving routine antibiotics before surgery	Q◇	98%	98%	95%	99%	97%	✓
Hip and knee replacement patients receiving antiseptic skin preparation in surgery	Q◇	100%	100%	100%	100%	98%	✓
Response rate to the national inpatient experience survey	Q	37%	16%	>30%	23%	26%	↺
Proportion of patients who felt they 'received enough information from the hospital on how to manage their condition after discharge'	Q	54%	59%	>64%	61%	64%	↺

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. Demand drive, service utilisation is monitored to ensure services are accessible and responsive to need.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Women registered with an LMC by 12 weeks of pregnancy	C[41]†◆	77%	78%	80%	n.a	n.a	-
Maternity deliveries in Canterbury facilities	A	5,922	6,048	E.6,000	6,056	-	✓
Maternity deliveries made in primary birthing units	A[42]	14%	14%	>13%	16%	-	✓
Babies exclusively breastfeeding on hospital discharge	Q[43]	79%	78%	75%	72%	-	✗

[40] These quality measures are national safety markers with definitions and standards set nationally. The 2017/18 results are the most recent available being: January-March 2018 for hand hygiene and October to December 2017 for the Hip and Knee measures.

[41] Early registration with a LMC is encouraged to promote the good health and wellbeing of mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report and the 2016/17 result is the most recent available being to December 2016, reported in February 2018.

[42] 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.

[43] There are many factors contributing to this result, a number of which will be fully explored as the DHB refreshes its Maternity Strategy in 2017/18.

ACUTE/URGENT SERVICES

These are services delivered in response to accidents or illnesses, which have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Early intervention can reduce the impact of the event and as such, multiple options and shorter waiting times are indicative of a responsive system.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
General practices providing telephone triage after hours	A	93%	91%	95%	91%	-	↺
Acute demand packages of care provided in community settings	A[44]	33,010	34,853	>30,000	32,701	-	✓
Attendances at Canterbury Emergency Departments (ED)	A[45]	94,251	96,854	E.<96k	103,116	-	✗
Population presenting at ED (per 1,000 people)	Q	117	173	<178	185	-	✗
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[46]◇	70%	85%	90%	94%	91%	✓
Acute inpatient average length of hospital stay (standardised)	Q[47]	2.39	2.40	<2.35	2.38	-	↺

ELECTIVE/ARRANGED SERVICES

These are medical and surgical services provided for people who do not need immediate hospital treatment, where assessment or treatment is 'booked' or 'arranged.' Maintaining access while reducing waiting times is indicative of an efficient and responsive service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
First Specialist Assessments provided	A[48]	71,244	72,049	E.>60k	73,913	-	✓
First Specialist Assessments that were non-contact (virtual)	Q[49]	17%	17%	>10%	19%	-	✓
Elective/arranged surgical discharges (surgeries provided)	A[50]◇	21,039	21,456	21,330	21,402	-	✓
People receiving their elective coronary angiography within 3 months	T	98%	97%	95%	98%	95%	✓
People who receive their surgery on the day of admission	Q	91%	91%	90%	94%	-	✓
Elective inpatient average length of hospital stay (standardised)	Q[47]	1.54	1.54	<1.54	1.57	-	✗
Outpatient consultations provided	A	671,705	672,348	E.>600k	694,629	-	✓
Outpatient appointments where the patient was booked but did not attend (DNA)	Q[51]◆	5%	4%	<5%	4%	-	✓

[44] *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.*

[45] *This measure is aligned to the national health target (Shorter Stays in ED) and counts presentations to both Christchurch and Ashburton Hospital Emergency Departments. The 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 January to March demand being higher this year than in the past. This pattern was seen across New Zealand with growth amongst younger adults of significantly higher levels.*

[46] *This is a national health target (Faster Cancer Treatment) and presents a rolling six-month result. There has been a definition change for this measure for the 2017/18 year allowing patients to delay own treatment or for treatment to be delayed due to clinical considerations (and for this not to affect the result). Previous years counted these actions as delays and results from previous years are therefore not directly comparable.*

[47] *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. There are limits to how much our acute length of stay can be decreased, given the increasing complexity of our patients. While the national target has not been achieved, the DHB continues to maintain a low length of stay particularly in comparison to other large tertiary DHBs.*

[48] *This measure counts medical and surgical assessments but only the first assessments (where the specialist determines treatment) and not follow-ups or consultations after treatment has occurred.*

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

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

[51] *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 and/or addictions, who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of an efficient and responsive service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Young people (0-19) accessing specialist mental health services	C[52]	3.5%	3.7%	>3.1%	3.6%	3.9%	✓
Adults (20-64) accessing specialist mental health services	C[52]	3.4%	3.8%	>3.1%	3.8%	3.9%	✓
People referred for non-urgent mental health and alcohol and other drug (AOD) services seen within three weeks	T[53]	76%	77%	80%	74%	79%	✗
People referred for non-urgent mental health and AOD services seen within eight weeks	T[53]	93%	94%	95%	91%	93%	✗

SPECALIST ASSESSMENT, TREATMENT AND REHABILITATION (AT&R) SERVICES

These are services provided to 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 aged residential care (ARC) reflects a successful outcome.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Admissions into all inpatient AT&R services	A	3,371	3,442	E>3,000	3,272	-	✓
Inpatients (aged 75+) who received a falls risk assessment	Q[54]	100%	97%	90%	97%	92%	✓
Admissions into Older Person's Health AT&R services made by direct community referral	Q[55]	20%	15%	>20%	25%	-	✓
Older Person's Health AT&R service inpatients discharged to their own home rather than into aged residential care	Q[56Δ]	86%	88%	>80%	86%	-	✓

[52] 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 service demand in Canterbury. Access rates in 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. Canterbury's combined (SMHS, NGO and Primary Care) access rates for the same period were 3.8% for children and youth (0-19) and 7.1% for adults (20-64).

[53] The continued demand and increased complexity of people being referred to our mental health and addiction services has reduced our capacity to respond quickly. A continued focus on earlier intervention in the community is a key strategy to reduce to number of people requiring specialist care.

[54] This measure is a national safety marker with definitions and standards set nationally by the NZ Quality and Safety Commission. The 2017/18 results are the most recent available being January-March 2018.

[55] This is a subset of 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 are dropping with a number of other options, such as CREST and the Acute Demand Programme, now available for GPs to refer patients needing additional support.

[56] A discharge from AT&R services to home, rather than into residential care, is seen as reflective of the quality and effectiveness of services in 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 ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide the assistance people need to live safely and independently in their own homes, or regain functional ability, after a health related event. These services help provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evidenced by less dependence on hospital and residential care services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness, or crisis these services have a major impact on the sustainability of our health system. Rehabilitation and support services also support patient flow by enabling people to go home from hospital earlier.

Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

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REHABILITATION SERVICES							
These services restore or maximise people's health or function following a health-related event such as a fall, heart attack or stroke. Largely demand driven, success is measured through appropriate services referral following an acute event.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
People accessing community-based pulmonary rehabilitation courses	A[57]	261	325	>200	270	-	✓
People (65+) accessing the community-based falls prevention service	A[58]	1,973	1,815	>1,500	1,653	-	✓
People referred to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q[59]	80%	80%	80%	78%		✗
People referred to cardiac rehabilitation services after an acute event	Q[60]	22%	20%	30%	25%	-	↺

HOME AND COMMUNITY-BASED SUPPORT SERVICES							
These services aim to restore or maximise people's health or functional ability, following a health related event. Largely demand driven, success is measured through appropriate service referral.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
People supported by CREST on hospital discharge or GP referral	A[61]	1,726	1,741	>1,500	1,839	-	✓
People supported by district nursing services	A	7,532	7,798	E>7,000	7,698	-	✓
People supported by long-term home-based support services	A	8,129	7,922	E>8,000	8,554	-	✓
People (65+) receiving long-term home and community support services, who have had a clinical assessment of need using the InterRAI assessment tool	Q[62]	96%	97%	95%	92%	-	✗
People supported by hospice or home-based palliative services	A	3,617	4,060	E>3,000	4,033	-	✓

[57] Pulmonary Rehabilitation is designed to help patients with Chronic Obstructive Pulmonary Disease (a type of obstructive lung disease) to manage their symptoms and learn breathing, diet, exercise and day-to-day living techniques to better manage their condition

[58] 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.

[59] This result is impacted by data collection issues in Ashburton, the results for Christchurch only is 84%. The DHB is working on resolving this issue.

[60] This measure is being reviewed to enable capture of cardiac rehabilitation options including evening courses and outpatient appointments and to eliminate people from outside the Canterbury region who go home for rehabilitation and people for whom rehabilitation is clinically appropriate.

[61] 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.

[62] 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 care to meet their needs. Efforts to enable timely reassessment using InterRAI, to better meet people's changing needs and appropriately adjust the care provision, has impacted on initial assessments. The DHB is looking at options to provide greater assessment capacity.

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. Largely demand driven, access to services are expected to increase over time as more people are supported to remain in their own homes.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
People accessing day services	A[63]	804	728	E>550	727	-	✓
People accessing mental health crisis respite services	A	886	904	E>750	1,081	-	✓
Occupancy rate of mental health crisis respite beds	A[64]	74%	73%	85%	85%	-	✓
People accessing aged care respite services	A	1,620	1,629	E>1,000	1,697	-	✓

AGED RESIDENTIAL CARE SERVICES

With an ageing population, demand for aged residential care (ARC) is expected to increase. However, a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Number of ARC rest home (level) bed-days provided	A[65]	501,688	471,627	E.<676k	485,376	-	✓
Number of ARC hospital (level) bed-days provided	A	494,185	507,028	E.<507k	531,968	-	✗
Number of ARC dementia bed-days provided	A	239,996	251,493	E.>220k	262,281	-	✓
Number of ARC psycho-geriatric bed-days provided	A	70,562	78,282	E.>65k	74,646	-	✓
People entering ARC having had a clinical assessment using InterRAI	Q[66]	99%	88%	95%	93%	-	↺

[63] *Day Support services play an important part in helping to reduce carer stress and social isolation for older people in our community. The DHB is working with clinical assessors to encourage referrals where people would benefit from support.*

[64] *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 so that resources are underutilised and could be better directed to other areas.*

[65] *After a prolonged period of decrease, rest home level bed utilisation has increase slightly. There is an excess of ARC beds in Canterbury, which may be leading to supply-induced demand. The DHB has refreshed protocols and practices to ensure only those assessed as requiring rest homes level care are being admitted into those services.*

[66] *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.*

3.4 Māori Health Performance

Like all DHBs, faced with a growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority for the Canterbury DHB. All of our performance targets are universal and have been set with the aim of bringing performance for all population groups to the same level.

Working with local stakeholders, the DHB has identified a number of key areas of focus and a set of core performance indicators. These are indicators seen as particularly important to our community in terms of improving and monitoring Māori health outcomes. These indicators were identified in our forecast Statement of Performance Expectations for 2017/18 using the symbol (◆). The results for Māori are presented below to highlight progress in reducing equity gaps. The NZ average results are the national results for Māori.

SERVICE PERFORMANCE 2017-2018

MĀORI HEALTH INDICATORS							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ Ave	
Māori babies exclusive/fully breastfed at LMC discharge	Q[67]	68%	67%	75%	n.a	n.a	-
Māori babies exclusive/fully breastfed at three months	Q[67]	52%	52%	60%	52%	48%	↺
Māori smokers, enrolled with a PHO, receiving advice and help to quit	C◇	87%	90%	90%	87%	87%	✖
Māori smokers, identified in hospital, receiving advice and help to quit	C	97%	94%	95%	95%	94%	✓
Pregnant Māori women, identified as smokers at confirmation of pregnancy with an LMC receiving advice and support to quit smoking	C	92%	100%	90%	82%	88%	✖
Māori women smokefree at two weeks postnatal	Q[67]	68%	69%	95%	n.a	n.a	-
Māori children receiving a B4 School Check at age four	C	94%	91%	90%	95%	93%	✓
Māori four year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q◇	new	93%	95%	100%	98%	✓
Māori women (25-69) having a cervical smear in the last three years	C[68]	60%	58%	80%	64%	67%	↺
Māori women (50-69) having a mammography in the last two years	C[68]	72%	71%	70%	67%	65%	✖
Māori babies fully immunised at eight months of age	C◇	95%	92%	95%	95%	86%	✓
Eligible Māori girls completing the HPV vaccination programme	C†	35%	51%	75%	51%	66%	↺
Older Māori (65+) having had a seasonal influenza vaccination	C†[69]	68%	44%	75%	42%	46%	✖
Māori population enrolled with a PHO	C	85%	82%	95%	84%	91%	↺
Rates of avoidable hospital admissions for Māori children (0-4 years)	Q[70]	5,074	5,525	<6,476	5,635	7,741	✓
Eligible Māori having their CVD risk assessed in the past five years	C[71]	80%	78%	90%	75%	86%	✖
Māori men (35-44) having their CVD risk assessed in the past five years	C[71]	new	59%	90%	57%	70%	✖
Māori children (0-4) enrolled in DHB oral health services	C†	29%	44%	95%	53%	-	↺
Māori children (0-12) examined according to planned recall	T†	87%	86%	90%	86%	-	↺
Māori women registered with a LMC by 12 weeks of pregnancy	C[67]	68%	64%	80%	n.a	n.a	-
Māori outpatient 'Did not Attend' rates	Q	9%	7%	<5%	7%	-	↺

[67] Results are published by the Ministry and the latest LMC results had not been published at the time of printing this includes smoking at two weeks post-natal. The result for three-month breastfeeding reflects the six months to December 2017.

[68] Rates for cervical and breast screening are below target and performance is mixed. Improving these screening rates is a health focus area for Māori and we have re-established a clinical steering group to support improved performance in this area.

[69] This result is affected by a change in definition, with the 2017 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 in 2018 has increased by 30 people, compared to 2017.

[70] The results presented differ to those previously presented, being based on the national March 2018 series provided by the Ministry of Health.

[71] Our primary care leaders have identified Maori men as a key target group and are working with us to design approaches to ensure this group is engaged. Recent New Zealand updates of risk algorithms have shown this group is at greater risk than previously thought.

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 2018 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 $63.959M against the budgeted $53.644M deficit (2016/17 deficit of $52.833M against the budgeted $41.987M deficit).

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
John Wood	50,050	2,000
Ta Mark Solomon	34,938	1,750
Peter Ballantyne		2,500
Barry Bragg	26,520	4,125
Roger Bridge		3,000
Sally Buck	26,520	3,500
Tom Callanan		500
Tracey Chambers	26,520	2,000
Anna Crighton	26,520	3,563
Wendy Dallas-Katoa		1,250
Andrew Dickerson	26,520	4,375
Jan Edwards		1,250
Rochelle Faimalo		750
Susan Foster-Cohen		500
Jo Kane	26,520	5,063
Aaron Keown	26,520	500
David Kerr		5,000
Chris Mene	26,520	1,750
David Morrell	26,520	3,500
Yvonne Palmer		1,000
Rochelle Phipps		1,000
Trevor Read		1,500
Ana Rolleston		500
Tony Sewell		10,000
William Tate		2,500
Steve Wakefield		12,500
Olive Webb		1,000
Hans Wouters		250
Total	323,668	77,125

Total fees paid for the year were $400,793 (2016/17 - $382,509).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	BOARD		QFARC		HAC		CPHAC		DSAC		CPH&DSAC		FAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
John Wood	10	11	8	8									10	10
Ta Mark Solomon	11	12	7	11									8	12
Peter Ballantyne			10	11										
Barry Bragg	12	12	10	11	4	6							11	12
Roger Bridge													3	6
Sally Buck	12	12			6	6	4	4	3	3	1	1		
Tom Callanan									1	1	1	1		
Tracey Chambers	7	12					3	4	3	3	1	1	5	12
Anna Crighton	11	12			6	6	4	4	2	3	1	1		
Wendy Dallas-Katoa							4	4			1	1		
Andrew Dickerson	12	12	11	11	6	6							12	12
Jan Edwards					5	6								
Rochelle Faimalo							2	4			1	1		
Susan Foster-Cohen							2	4			0	1		
Jo Kane	11	12	10	11	5	6	4	4			1	1		
Aaron Keown	12	12							2	3			9	12
David Kerr													5	8
Sandy Lockhart									0	1				
Chris Mene	9	12					4	4	2	3	1	1		
David Morrell	12	12	8	11	3	6	2	4			1	1		
Yvonne Palmer							3	4			1	1		
Rochelle Phipps					4	4								
Trevor Read					6	6								
Ana Rolleston					2	5								
Tony Sewell													10	12
William Tate			11	11										
Steve Wakefield			10	11									10	12
Olive Webb									3	3	1	1		
Hans Wouters									0	1	1	1		

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

DIRECTOR FEES

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

	2018 $'000	2017 $'000
Brian Wood	28	25
Jane Cartwright	22	22
Claire Evans	3	0-
Kath Fox	11	11
Paula Rose	11	11
Steve Wakefield	9	-
Graeme McNally	-	11
Garth Bateup	-	6
Total	84	86

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.

INFORMATION ON MINISTERIAL DIRECTIONS

WHOLE OF GOVERNMENT APPROACH

The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property.

Canterbury DHB applies the Government Rules of Sourcing for procurement.

Canterbury DHB works closely with the Government Chief Information Officer to ensure compliance with directions in relationship to ICT.

Canterbury DHB is exempt from the direction regarding Property functional leadership.

REQUIREMENT TO IMPLEMENT NEW ZEALAND BUSINESS NUMBER

The Direction requires Canterbury DHB to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018. This Direction was issued in May 2016 under s.107 of the Crown Entities Act.

Canterbury DHB has recently replaced its key finance and supply chain business system and the replacement system has taken the NZBN requirements, as provided to date, into account.

Work continues to identify other impacts and to establish the changes that need to be implemented as a result of this Direction.

AUTHENTICATION SERVICES

The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

Canterbury DHB works closely with the GCIO to ensure that our technology environment is compliant with the expected standards and applicable directions as provided, this includes authentication services.

ELIGIBILITY DIRECTION

The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.

Canterbury DHB strictly and consistently assesses patient eligibility against the Public Health and Disability Act 2000 to ensure that all eligible consumers are recognised as such.

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		
			2015/16	2016/17	2017/18
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	$412M	$613M	$576M
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	$41M	$46M	$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	$11M	$26M	$28M

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 metrics were highlighted in the DHB's 2017/18 Statement of Intent and are set out below.

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.

PROPERTY PORTFOLIO					
Asset Performance Indicators	Indicator Class	2015/16	2016/17	2017/18 Standard	2017/18 Result
Percentage of the critical property portfolio with a National Building Standard at or greater than 34% [72]	Condition	83%	84%	100%	82%
Number of elective surgical discharges delivered [73]	Utilisation	21,039	21,456	21,330	21,402
Energy consumption per m^2 (kWh/m^2) [74]	Functionality	417.3	420.7	<500	402.7

[72] *All critical property, i.e. providing or supporting the provision of critical clinical services, should have a National Building Standard at or greater than 34%. The DHB is engaged in a significant redevelopment/remediation/repair programme following the earthquakes and working to restore buildings to this standard.*

[73] *All DHBs are expected to deliver on the national Electives Health Target by delivering an increasing number of elective surgeries. The indicator provides a measure of the performance (capacity and utilisation) of the DHB's facilities as the DHB seeks to meet increasing expectations. The standards are set nationally by the Ministry of Health.*

[74] *The Energy Consumption measure is based on the Code of Practice NZS4220: 1982 Energy Conservation standard which applies to Non-Residential Buildings and specifies targets for existing buildings. Previous baselines have been refreshed to align time periods for reports to June of each year.*

CLINICAL EQUIPMENT PORTFOLIO

Asset Performance Indicators	Indicator Class	2015/16	2016/17	2017/18 Standard	2017/18 Result
Percentage of CTs and Linac machines compliant with the requirements of the Radiation Protection Act	Condition	100%	100%	100%	100%
Average CT uptime vs. operational hours [75]	Utilisation	99.0%	99.6%	>98%	99.3%
Average percentage of Linac uptime vs. operational hours	Utilisation	98.0%	98.6%	>98%	98.3%
Percentage of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first cancer treatment within 62 days of referral [76]	Functionality	70%	85.5%	90%	94%

INFORMATION COMMUNICATION AND TECHNOLOGY (ICT) PORTFOLIO

Asset Performance Indicators	Indicator Class	2015/16	2016/17	2017/18 Standard	2017/18 Result
Condition of servers to mitigate against cyber-attacks — being the percentage of servers patched with critical and security updates at all times [77]	Condition	-	66%	95%	86%
Percentage uptime for mission critical applications (HealthConnectSouth, Éclair, MedChart and the DHB's Patient Management Systems [Homer/SAP/PICS])	Utilisation	99.9%	99.9%	99.5%	99.9%
Annual network security external penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational) [78]	Functionality	2.0	2.3	<2.5	n.a

[75] Uptime means the total time that the Equipment is available for use and/or able to produce diagnostic images during the agreed operational hours of the service. The CT uptime vs. operational hours measure has been calculated as the average result across all six of the DHBs diagnostic CT machines. One CT machine (used only for treatment purposes) is excluded from calculations.

[76] All DHBs are expected to deliver on the national Faster Cancer Treatment Health Target by delivering an increasing number of cancer treatments within shorter timeframes. This indicator has been updated to reflect the current Health Target and provides a measure of the performance (capacity and utilisation) of the DHB's clinical equipment as the DHB seeks to meet increasing expectations. The Ministry of Health sets the standards nationally.

[77] This is a new measure highlighting the importance of ensuring that the DHB has mitigated against cyber-attacks. The result is reported on a monthly basis and the 2017/18 result is for June. The Information Services Team plans to work more closely with the out-of-hours teams across the DHB to increase patching activity and lift these results further.

[78] The Network Security External Penetration Test is an important measure that reflects whether the DHB's system are able to withstand external hacking attacks and whether the DHB's network is appropriately protected. Reorganisation and resourcing within the ISG team meant that the 2017/18 test was not completed within the financial year. The testing will be commenced before the end of 2018. The DHB is reviewing its approach to the penetration testing and investigating transalpine (Canterbury/West Coast) options with testing providers.

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. To that end, in late 2017 we established a programme of work, entitled "Care Starts Here" within which one of the most significant outputs includes the development and the refreshing of People and Capability policies and processes across both Canterbury DHB and West Coast DHB, including our Code of Conduct, Health and Safety Policy and Equality, Diversity and Inclusion Policy.

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	40.98
Nursing	45.87
Allied Health	44.63
Support	49.49
Management & Administration	49.93

STAFF MIX BY GENDER		
Female	8,404	81%
Male	1,925	19%
	10,329	

STAFF IDENTIFYING AS HAVING A DISABILITY[79]	
Yes	15

STAFF ETHNICITY	
Americas	73
Australian	98
British	662
Chinese	215
Filipino	201
Indian	209
Irish	50
Māori	271
Middle Eastern	32
New Zealand European	5,370
New Zealander	634
Not Stated / Don't Know	1,801
Other	8
Other African	48
Other Asian	211
Other European	298
Pacific Peoples	96
South African	52
	10,329

[79] *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 unacceptable behaviour. All individuals on joining Canterbury DHB are made familiar with both our Code of Conduct, 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.

We are also part of a tertiary alliance with the University of Otago, the University of Canterbury, and ARA (formerly CPIT), and a member of the TANZ network (7 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 2018*	Notes	Actual 2018 $'000	Budget 2018 $'000	Actual 2017 $'000
REVENUE				
Patient care revenue	2 [p51]	1,697,450	1,706,532	1,617,009
Other revenue	3 [p51]	33,856	31,007	26,274
Earthquake repair revenue redrawn from the Ministry of Health	16 [p65]	3,240	7,800	10,712
Interest revenue		1,552	1,579	2,113
Total revenue		1,736,098	1,746,918	1,656,108
EXPENSE				
Employee benefit costs	4 [p53]	774,984	763,498	722,527
Treatment related costs		149,942	151,996	150,464
External service providers		679,356	684,378	643,176
Depreciation and amortisation		58,657	59,704	56,268
Impairment in investment in NZ Health Partnerships Ltd	15 [p63]	749	-	-
Finance costs		60	200	3,932
Other expenses	5 [p53]	102,776	102,656	105,685
Earthquake building repair costs	16 [p65]	3,240	7,800	10,712
Capital charge expense	6 [p53]	30,293	30,330	16,177
Total expense		1,800,057	1,800,562	1,708,941
Surplus/(deficit)		(63,959)	(53,644)	(52,833)
OTHER COMPREHENSIVE REVENUE & EXPENSE				
Items that will not be reclassified to surplus/(deficit):				
Impairment of property, plant & equipment	7,14,16 [p53,60,65]	-	-	(1,491)
Total other comprehensive revenue & expense		-	-	(1,491)
Total comprehensive revenue & expense		(63,959)	(53,644)	(54,324)

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY *for the year ended 30 June 2018*	Notes	Actual 2018 $'000	Budget 2018 $'000	Actual 2017 $'000
Total equity at beginning of the year		517,833	517,833	199,933
Total comprehensive revenue & expense for the year		(63,959)	(53,644)	(54,324)
EQUITY INJECTIONS:				
Earthquake repair capital redrawn	7 [p53]	9,258	10,000	11,100
Operating deficit support[80]		35,000	106,477	-
Debt to Equity swap – new facilities	18 [p68]	-	-	85,000
Debt to Equity swap - debt as at June 2016	18 [p68]	-	-	145,985
Kaikoura facility contribution	7 [p53]	-	-	2,000
New Burwood facilities redevelopment assets transferred from the Crown (equity value)		-	-	130,000
EQUITY REPAYMENTS:				
Annual depreciation funding repayment		(1,861)	(1,861)	(1,861)
Total equity at end of the year	7 [p53]	496,271	578,805	517,833

The accompanying notes form part of these financial statements.

[80] *The 2018 Budget includes deficit support for both 2016/2017 and 2017/2018 years. The $35M received in 2018 related to 2016/2017.*

STATEMENT OF FINANCIAL POSITION *as at 30 June 2018*	Notes	Actual 2018 $'000	Budget 2018 $'000	Actual 2017 $'000
CROWN EQUITY				
Contributed capital	7 [p53]	132,470	204,689	90,073
Revaluation reserve	7 [p53]	289,058	289,058	289,058
Accumulated surpluses	7 [p53]	74,743	85,058	138,702
Total equity		496,271	578,805	517,833
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8 [p55]	1,678	-	1,985
Trade and other receivables	9 [ps56]	90,391	126,292	72,652
Inventories	10 [p57]	11,171	9,118	9,118
Restricted assets	17 [p67]	14,577	11,815	11,815
Investments	11 [p57]	750	1,350	1,350
Total current assets		118,567	148,575	96,920
CURRENT LIABILITIES				
NZHPL sweep account	8 [p55]	17,376	2,250	16,505
Trade and other payables	12 [p57]	111,190	93,936	106,936
Employee benefits	13 [p58]	171,361	156,700	156,703
Restricted funds	17 [p67]	14,593	12,111	12,111
Total current liabilities		314,520	264,997	292,255
Net working capital		(195,953)	(116,422)	(195,335)
NON-CURRENT ASSETS				
Property, plant and equipment	14 [p60]	670,749	667,633	693,087
Intangible assets	15 [p63]	27,635	33,453	25,940
Restricted assets	17 [p67]	16	296	296
Total non-current assets		698,400	701,382	719,323
NON-CURRENT LIABILITIES				
Employee benefits	13 [p58]	6,176	6,155	6,155
Total non-current liabilities		6,176	6,155	6,155
Net assets		496,271	578,805	517,833

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS *for the year ended 30 June 2018*	Notes	Actual 2018 $'000	Budget 2018 $'000	Actual 2017 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Receipts from Ministry of Health		1,642,515	1,643,309	1,570,290
Earthquake repair revenue redrawn from Ministry of Health		3,240	7,800	10,712
Other receipts		67,993	94,230	94,967
Interest received		1,552	1,579	2,113
		1,715,300	1,746,918	1,678,082
CASH WAS APPLIED TO:				
Payments to employees		760,305	763,497	720,349
Payments to suppliers		932,270	959,831	934,510
Interest paid		60	200	5,107
Capital charge		30,292	30,330	16,175
GST – net		(1,338)	-	(3,886)
		1,721,589	1,753,858	1,672,255
Net cash inflow/ (outflow) from operating activities	19 [p68]	(6,289)	(6,940)	5,827
CASH FLOW FROM INVESTING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Sale of property, plant & equipment		460	-	728
Receipts from restricted assets & investments		43,758	-	35,345
		44,218	-	36,073
CASH WAS APPLIED TO:				
Purchase of investments & restricted assets		43,158	-	35,928
Purchase of property, plant & equipment		38,346	41,762	45,277
		81,504	41,762	81,205
Net cash inflow/ (outflow) from investing activities		(37,286)	(41,762)	(45,132)
CASH FLOW FROM FINANCING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Earthquake repair capital redrawn	16 [p65]	9,258	10,000	11,100
Kaikoura facility contribution	7 [p53]	-	-	2,000
Operating deficit support		35,000	52,833	-
		44,258	62,833	13,100
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		42,397	60,972	11,239
Net increase/ (decrease) in cash and cash equivalents		(1,178)	12,270	(28,066)
Cash and cash equivalents at beginning of year		(14,520)	(14,520)	13,546
Cash & cash equivalents at end of year	8 [p55]	(15,698)	(2,250)	(14,520)

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 2018 and were authorised for issue by the Board on 30 October 2018.

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 year.

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 2017/18 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 equity support may be required and the Crown will provide such support where necessary to maintain viability. Canterbury DHB requires this letter of comfort in the event that actual future cashflows are significantly unfavourable to one or more of the assumptions in our cashflow projections, such as the reliance on receiving full deficit funding for the 2017/18 financial year, and full funding for the recently settled NZNO MECA. The letter of comfort therefore provides the required basis for the Board of Canterbury DHB to prepare the 2017/18 financial statements on a going concern basis. It also gives the Board comfort that financial support will be provided to maintain financial viability in the medium term if required.

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 International Public Sector Accounting Standards (IPSAS) requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue 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.

The Treasury has decided that the Financial Statements of the Government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. The DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the DHB anticipates that the standard will not have a material effect on the DHB's financial statements.

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for

annual periods beginning on or after 1 January 2019, with early application permitted. The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

Standards issued but not yet effective and early adopted

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards. Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The amendment was early adopted by Canterbury DHB in preparing its 30 June 2018 financial statements.

2. PATIENT CARE REVENUE

	2018 $'000	2017 $'000
Ministry of Health population based funding	1,394,583	1,320,870
Inter-district flows	116,683	116,566
Ministry of Health other contracts	122,156	119,904
ACC revenue	31,670	26,049
Other patient related revenue	32,358	33,620
Total patient care revenue	1,697,450	1,617,009

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 2017/18 financial year is $1,383.508M (2017: $1,353.839M) which equals the Government's actual expenses incurred in relation to the appropriation. This is the same as the budgeted appropriation figure. (Note that Canterbury DHB receives other Crown revenue additional to the appropriation.) The performance measures are set out in the statement of service performance on pages 21-33.

3. OTHER REVENUE

	2018 $'000	2017 $'000
Gain/(loss) on sale of property, plant and equipment	389	728
Donations and bequests received	1,702	2,710
Pathology tests	7,479	10,065
Research & development	6,393	6,079
External rental revenue	968	1,235
Cafeteria Sales	4,452	-
Other	12,473	5,457
Total other revenue	33,856	26,274

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

	2018 $'000	2017 $'000
Wages and salaries	737,740	699,540
Board members' fees	324	323
Directors' fees	84	86
Contributions to defined contribution plans	22,157	20,401
Increase/(decrease) in employee benefit provisions	14,679	2,177
Total employee benefit costs	774,984	722,527

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

	2018 $'000	2017 $'000
Financial statement audit fees	227	223
Rental costs including operating leases	7,479	6,746
Facilities and infrastructure costs	42,438	39,006
Other non-clinical costs	52,632	59,710
Total other expenses	102,776	105,685

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. For the year ended 30 June 2018, the rate was 6% (2017: 6%).

7. EQUITY

	2018 $'000	2017 $'000
CONTRIBUTED CAPITAL		
Opening balance	90,073	(282,151)
Annual depreciation funding repayment	(1,861)	(1,861)
Operating deficit support	35,000	-
Kaikoura facility contribution	-	2,000
Debt to equity swap	-	230,985
Contribution to redeveloped Burwood Hospital facility	-	130,000
Earthquake repair capital redrawn	9,258	11,100
Closing balance	132,470	90,073

The operating deficit for 2017 was $53M; $35M was received from the Ministry of Health in May 2018 for 2017 deficit support.

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 are 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.

ACCUMULATED SURPLUS/(DEFICIT)	2018 $'000	2017 $'000
Opening balance	138,702	191,235
Realised gain on sale transferred from revaluation reserve	-	300
Operating deficit	(63,959)	(52,833)
Closing balance	74,743	138,702
REPRESENTED BY:		
Accumulated surplus in parent and associates	71,566	135,771
Accumulated surplus in subsidiaries	3,177	2,931
Total accumulated surplus	74,743	138,702
REVALUATION RESERVE		
Opening balance	289,058	290,849
Impairment charges	-	(1,491)
Realised gain on sale transferred to retained earnings	-	(300)
Closing balance	289,058	289,058
REPRESENTED BY:		
Revaluation of land	85,079	85,079
Revaluation of buildings including fitout	203,979	203,979
Total revaluation reserve	289,058	289,058
Total equity	496,271	517,833

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	2018 $'000	2017 $'000
CURRENT ASSETS			
Bank balances and call deposits	AA-	1,678	1,985
Total cash and cash equivalents		1,678	1,985
CURRENT LIABILITIES			
NZHPL sweep account		(17,376)	(16,505)
Net cash and cash equivalents		(15,698)	(14,520)

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 $88.808M (2017: $83.618M).

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. Restricted asset cash and term investments are placed directly with high quality financial institutions.

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

	2018 $'000	2017 $'000
Trade receivables	15,696	11,296
Receivable from the Ministry of Health	34,324	27,412
Prepayments	4,554	9,412
Other receivables	35,817	24,532
Total trade and other receivables	90,391	72,652

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

Balance at 1 July	3,434	3,958
Additional provisions made during the year	958	(172)
Receivables written-off during period	(2,452)	(352)
Balance at 30 June	1,940	3,434

THE AGEING OF THE IMPAIRMENT PROVISIONS ARE AS FOLLOWS:

Current	206	426
1-30 days	106	60
31-60 days	117	152
> 61 days	1,511	2,796
Balance at 30 June	1,940	3,434

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	81,772	61,378
1-30 days	2,241	1,024
31-60 days	440	387
> 61 days	1,384	451
Balance at 30 June	85,837	63,240

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 $18.648M (2017: $12.641M).

Concentrations of credit risk from trade and other 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 2018, the Ministry of Health owed Canterbury DHB $34.324M (2017: $27.412M).

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	2018 $'000	2017 $'000
Pharmaceuticals	3,044	2,156
Surgical and medical supplies	5,624	5,083
Other supplies	3,344	2,720
	12,012	9,959
Provision for obsolescence	(841)	(841)
Total inventories	11,171	9,118

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	2018 $'000	2017 $'000
Investments are represented by:			
Term deposits with maturities of 3-12 months	AA-	750	1,350
Total investments		750	1,350
Weighted average effective interest rates		3.32%	3.36%

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 [p55].

12. TRADE AND OTHER PAYABLES	2018 $'000	2017 $'000
Trade payables	16,392	18,415
Other payables	94,798	88,521
Total trade and other payables	111,190	106,936

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 $30.201M (2017: $37.388M).

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 BENEFIT LIABILITIES	2018 $'000	2017 $'000
CURRENT LIABILITIES		
Annual, lieu and shift leave accruals	81,129	76,373
Unpaid days accruals	20,183	18,495
ACC accruals	4,408	4,382
Conference/sabbatical leave and expenses	25,723	25,533
Sick leave	9,202	9,700
Other	30,716	22,220
Total employee benefits - current	171,361	156,703
NON-CURRENT LIABILITIES		
Liability for long service leave	4,706	4,678
Liability for retirement gratuities	1,470	1,477
Total employee benefits – non-current	6,176	6,155

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:

17/18 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 2017	129,918	517,276	218,812	9,329	18,860	894,195
Additions/transfers	-	2,428	15,052	137	15,638	33,255
Disposals/transfers	-	(1,219)	(9,215)	643	-	(9,791)
Impairment	-	-	-	-	-	-
Balance at 30 June 2018	129,918	518,485	224,649	10,109	34,498	917,659
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2017	-	40,834	157,644	2,630	-	201,108
Depreciation	-	39,225	15,873	388	-	55,486
Disposals/transfer	-	(749)	(9,452)	517	-	(9,684)
Impairment	-	-	-	-	-	-
Balance at 30 June 2018	-	79,310	164,065	3,535	-	246,910
CARRYING AMOUNT						
At 30 June 2018	129,918	439,175	60,584	6,574	34,498	670,749

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/transfers	-	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

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 (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	1.7 – 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.

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 [p65].

15. INTANGIBLE ASSETS	2018 $'000	2017 $'000
SOFTWARE		
COST		
Opening balance	53,554	40,477
Additions	5,621	13,349
Disposals	(444)	(272)
Closing balance	58,731	53,554
AMORTISATION AND IMPAIRMENT LOSSES		
Opening balance	33,550	32,027
Amortisation charge for the year	3,171	1,794
Disposals	(438)	(271)
Closing balance	36,283	33,550
Total Software	22,448	20,004
INVESTMENT IN NEW ZEALAND HEALTH PARTNERSHIP LTD		
Opening balance	5,936	5,936
Impairments for the year	(749)	-
Closing balance	5,187	5,936
Carrying amounts	27,635	25,940

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)

An impairment of the NZHPL Change Management and Supply Chain as recommended by NZHPL ($0.501M), was recognised in June 2018 as well as an additional $0.248M impairment we have assessed due to budgeting, forecasting, and reporting being descoped from the National Oracle Solution (NOS) programme.

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.

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 revenue and expense.

The reversal of an impairment loss is recognised in other comprehensive revenue and expense.

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 eight years to 30 June 2018.

No impairment for land and buildings was required to be recognised for the financial year ended 30 June 2018 (2017: $1.491M).

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.

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)
Drawdown 17/18	(12.25)
Amount undrawn 30 June 2018	179.44

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

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 revenue and expense, a reversal of the impairment loss is also recognised in other comprehensive revenue and expense.

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. RESTRICTED ASSETS & RESIDENTS' TRUST ACCOUNTS

RESTRICTED ASSETS

Restricted assets are funds donated or bequeathed for a specific purpose. The use of these funds must comply with the specific terms of the sources from which the funds were derived. An amount equal to the restricted assets is reflected as a current liability.

All restricted assets 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 restricted assets 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.

	2018 $'000	2017 $'000
FUNDS HELD DIRECTLY BY CANTERBURY DHB		
Balance at beginning of year	12,111	14,297
Interest received	382	615
Donations and funds received	1,259	840
Funds transferred to Māia Health Foundation	(2,021)	(1,995)
Funds spent	(1,154)	(1,646)
Balance at end of year	10,577	12,111
FUNDS HELD WITH MĀIA HEALTH FOUNDATION		
Balance at beginning of years	-	-
Funds transferred from / (to) Canterbury DHB	4,016	-
Balance at end of year	4,016	-
Total Restricted Assets	14,593	12,111
This balance is represented by:		
Current assets	14,577	11,815
Non-current assets	16	296
Total restricted assets	14,593	12,111
Weighted average effective interest rates	3.44%	3.30%

Credit quality of restricted assets	Credit rating	2018 $'000	2017 $'000
Restricted assets:			
Bonds	AA	-	280
Term deposits with maturities of 3-12 months – Canterbury DHB	AA-	10,561	11,815
Term deposits with maturities of 3-12 months – Māia Health Foundation	AA-	4,016	-
Perpetual capital notes	BBB+	16	16
Total restricted assets		14,593	12,111

RESIDENTS' TRUST ACCOUNTS	2018 $'000	2017 $'000
Residents' trust account balance	913	889

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 Revenue and Expense, Financial Position or Cash Flow of Canterbury DHB's own financial statements.

18. BORROWINGS

The Crown made a directive in 2016 to swap Crown debt with equity. Borrowings previously from the Ministry of Health 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.

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	2018 $'000	2017 $'000
Net (deficit)/ surplus before other comprehensive revenue and expense	(63,959)	(52,833)
Add back non-cash items:		
Depreciation and amortisation	58,657	56,268
Impairment in investment in New Zealand Health Partnership Ltd	749	-
Add back items classified as investing activities:		
Loss/(gain) on asset sale	(389)	(728)
Movement in term portion provisions/staff entitlements	21	(206)
MOVEMENTS IN WORKING CAPITAL:		
Decrease/(increase) in receivables & prepayments	(17,739)	(3,303)
Decrease/(increase) in stocks	(2,053)	314
Increase/(decrease) in creditors & other accruals	3,766	3,933
Increase/(decrease) in staff entitlements	14,658	2,382
Net cash inflow/(outflow) from operating activities	(6,289)	5,827

20. COMMITMENTS	2018 $'000	2017 $'000
CAPITAL COMMITMENTS		
Property	6,226	2,898
Intangible assets	7,063	13,624
Other capital commitments	6,293	4,625
Total capital commitments at balance date	19,582	21,147

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.

NON-CANCELLABLE OPERATING LEASE COMMITMENTS		
Accommodation leases	35,237	38,891
Other leases	59	994
Total non-cancellable operating lease and supply commitments	35,296	39,885
FOR EXPENDITURE WITHIN:		
Not later than one year	6,112	6,312
Later than one year and not later than five years	13,738	15,752
Later than five years	15,446	17,821
Total non-cancellable operating lease and supply commitments	35,296	39,885

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 2018 (2017: nil).

Contingent liabilities

Canterbury DHB has the following contingent liabilities as at 30 June 2018:

Outstanding legal proceedings

Canterbury DHB has no material outstanding legal proceedings as at 30 June 2018 (2017: 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 [p65] 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

Many public and private sector entities, including Canterbury DHB, are continuing to investigate potential historic underpayment of holiday entitlements.

For employers such as Canterbury DHB that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing compliance with the Act and determining the potential underpayment is time consuming and complicated.

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that, once the baseline document is agreed, this would be used by each DHB to systematically assess their compliance with the Holidays Act and any resulting liability.

Canterbury DHB has not made an estimate and instead disclosed a contingent liability in its financial statements.

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 $'000	Contractual cash flows $'000	Less than 1 year $'000
17/18 FINANCIAL YEAR			
NZHPL sweep account	17,376	17,376	17,376
Trade and other payables	111,190	111,190	111,190
Restricted funds	14,593	14,593	14,593
Total financial liabilities	143,159	143,159	143,159
16/17 FINANCIAL YEAR			
NZHPL sweep 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

Contractual maturity analysis of financial assets	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000
17/18 FINANCIAL YEAR				
Cash and cash equivalents	1,678	1,678	1,678	-
Trade and other receivables[81]	85,837	85,837	85,837	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	14,593	14,593	14,577	16
Total financial assets	102,858	102,858	102,842	16
16/17 FINANCIAL YEAR				
Cash and cash equivalents	1,985	1,985	1,985	-
Trade and other receivables[81]	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	78,686	78,686	78,390	296

Sensitivity analysis

The table below illustrates the potential effect on the surplus or deficit for reasonable possible market movements, with all other variables held constant, based on Canterbury DHB's financial instrument exposures at balance date. Canterbury DHBs exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as investments are generally held to maturity.

[81] *Excludes prepayments*

Canterbury DHB held NZD $1,062,156 of foreign currency accounts as at 30 June 2018 (2017: NZD $355,113).

FOREIGN EXCHANGE RISK	2018 $'000 -10% Surplus	2018 $'000 +10% Surplus	2017 $'000 -10% Surplus	2017 $'000 +10% Surplus
Financial assets				
Foreign currency	(106)	97	(32)	32
Total sensitivity	(106)	97	(32)	32

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 2018	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 2018	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.

On 30 July 2018, the partners of the partnership approved the transfer of the Waitemata District Health Board's partnership shares to the remaining partners of the partnership.

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; 2018 $1.265M (2017: $1.252M). The amount owing by West Coast DHB relating to this agreement at balance date was $0.105M (2017: $0.120M).

Māia Health Foundation

Canterbury DHB provides accounting support, office space, and minor incidentals to the Māia Health Foundation at no charge, as well as assistance with seed funding of $0.250M (2017: $0.341M). Also refer note 17 [p67].

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	2018 $'000	2017 $'000
COMPENSATION OF KEY MANAGEMENT PERSONNEL		
Salaries for executive management team	3,536	3,349
Board and Committee members fees	401	383
Total key management personnel compensation	3,937	3,732

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	1.40	1.11
Full time equivalent executive management team	10.55	11.00
Total key management personnel full time equivalents	11.95	12.11

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 $645,221 to 16 employees (2017: 18 employees totalling $489,479) 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	2018	2017	SPECIFIED BANDS	2018	2017
100,000-109,999	234	237	330,000-339,999	15	13
110,000-119,999	165	165	340,000-349,999	15	13
120,000-129,999	125	117	350,000-359,999	8	6
130,000-139,999	96	107	360,000-369,999	11	5
140,000-149,999	90	69	370,000-379,999	7	5
150,000-159,999	62	60	380,000-389,999	5	5
160,000-169,999	48	51	390,000-399,999	6	2
170,000-179,999	42	28	400,000-409,999	5	3
180,000-189,999	30	33	410,000-419,999	5	3
190,000-199,999	37	28	420,000-429,999	5	3
200,000-209,999	26	25	430,000-439,999	5	2
210,000-219,999	22	29	440,000-449,999	-	-
220,000-229,999	23	23	450,000-459,999	3	2
230,000-239,999	26	23	470,000-479,999	-	2
240,000-249,999	28	27	480,000-489,999	1	-
250,000-259,999	15	22	490,000-499,999	-	-
260,000-269,999	30	20	520,000-529,999	-	-
270,000-279,999	23	28	530,000-539,999	1	-
280,000-289,999	24	16	540,000-549,999	-	1
290,000-299,999	25	19	600,000-609,999	1	-
300,000-309,999	18	18	610,000-619,999	-	1
310,000-319,999	10	21	620,000-629,999	1	1
320,000-329,999	13	9	690,000-699,000	-	1
			Total employees	1,306	1,243

Of the positions identified above, 1,101 (2017: 1,056) positions were predominantly clinical and 205 (2017: 187) positions were management/administrative.

26. STATEMENT OF PERFORMANCE EXPECTATIONS LEGISLATIVE COMPLIANCE

Canterbury DHB is required to complete its Statement of Performance Expectations by the start of the financial year under section 149C of the Crown Entities Act 2004. This requirement has not been met for the 2018/19 year. The 2018/19 Statement of Performance Expectations is yet to be signed and approved by the Board at the time of issuing the 30 June 2018 financial statements. It will be finalised and made publicly available as soon as practicable.

27. MAJOR VARIANCES TO BUDGET

Canterbury DHB budgeted for a deficit of $53.644M as published in our 2017/18 Annual Plan.

Statement of comprehensive revenue and expense

Listed below are the major factors that make up the variance between the planned deficit of $53.644M and the actual deficit of $63.959M:

Revenue:

- The following three factors are included in Patient Care revenue and whilst each is significant the combined total variance for Patient Care revenue is only $0.297M:
  - Ministry of Health devolved funding had an unfavourable variance of $2.65M due to the pay equity revenue not being fully drawn down in line with the pay equity expenditure.
  - We received $3.045M less IDF (Inter District Flow) revenue than the Ministry of Health forecast due to less referrals from DHBs outside of the Canterbury region.
  - Offsetting these unfavourable variances was a favourable price adjustment in ACC revenue plus other patient care related revenue.
- Earthquake repair revenue redrawn was $4.560M less than plan due to the timing of earthquake repairs. This amount is offset by an equal and opposite favourable variance in Earthquake building repair costs.
- The unfavourable variance in Other Revenue is partly due to a reduction in CHL revenue, and also a reclassification of revenue from other DHBs between patient care revenue and other revenue.

Expense:

- Employee benefit costs were higher than plan due to a number of factors, including:
  - Additional steps and new rates in the SMO collective agreement that was settled after our Annual Plan was submitted.
  - The Nursing MECA settlement was $4M higher than anticipated.
  - Additional RMOs have been required as part of the ongoing roster compliance process.
  - We were also running additional acute theatres on weekends, resulting in higher payroll costs.
- Additional pressures relating to increased demand in Mental Health and in ED continued to affect a number of expense categories, including employee benefit costs.
- Treatment related costs were favourable against budget due primarily to additional hospital rebates from PHARMAC.
- Earthquake building repair costs are favourable to budget due to the timing of repairs. This is offset by the unfavourable earthquake repair revenue redrawn variance above.
- External service provider costs were favourable against budget due to a number of factors, including Pay Equity payments, as mentioned in the revenue variance above, being lower than expected.
- Community Pharmacy expenditure was lower than the PHARMAC forecast.
- Offsetting these variances was an increase in the Aged Related Residential Care (ARRC) expenditure which was expected to decrease following previous year trends.

Statement of changes in equity

Budgeted deficit funding was comprised of full funding of $52.833M for the 2016/2017 year, and $53.644M for the 2017/2018 year. Actual funding received for the 2016/2017 year was $35M, and the amount of deficit funding, if any, for the 2017/2018 year is still to be confirmed with the Ministry of Health.

Statement of financial position

2017/2018 deficit funding was budgeted to be confirmed as a receivable at year end and is included in the Crown Equity. As noted above, this is still subject to confirmation.

Employee benefits include a $9M estimate for the nursing MECA settlement in July, including an associated increase in the annual leave accruals.

The NZHPL sweep bank account balance was expected to be a much smaller overdraft on the assumption we would receive full deficit funding for the 2016/2017 year.

Statement of cash flows

- The expected deficit funding for 2016/2017 in the Annual Plan cashflow was $52.833M. However we received $35M.

28. SUBSEQUENT EVENTS

There were no events after 30 June 2018, which could have a material impact on the information in Canterbury DHB's financial statements (2017: nil).

5.3 Summary of Revenues and Expenses by Output Class

	Actual 2018 $'000	Budget 2018 $'000
Early detection & management	348,660	349,602
Intensive assessment & treatment	1,085,507	1,090,819
Prevention	36,899	37,752
Rehabilitation & support	265,032	268,745
Total revenue	1,736,098	1,746,918
Early detection & management	358,156	360,848
Intensive assessment & treatment	1,125,914	1,124,338
Prevention	40,974	38,430
Rehabilitation & support	275,013	276,946
Total expenditure	1,800,057	1,800,562
Deficit	(63,959)	(53,644)

Part VI Supplementary Information

6.1 Directory

Board Members

Dr John Wood - Chair ..... appointed 3 August 2017
Ta Mark Solomon - Deputy Chair
Barry Bragg
Sally Buck
Tracey Chambers
Anna Crighton
Andrew Dickerson
Jo Kane
Aaron Keown
Chris Mene
David Morrell

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 2018

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 45 to 77, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the Group on pages 9 to 33 and page 78.

In our opinion:

- the financial statements of the Group on pages 45 to 77:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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; and
- the performance information of the Group on pages 9 to 33 and page 78:
    - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2018, 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; and

- what has been achieved with the appropriations; and

- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 October 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we draw your attention to other matters. 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.

The Health Board is reliant on financial support from the Crown

We draw your attention to the disclosures made in note 1 on page 49 that outline that the Board, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of support received from the Ministers' of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 21 on page 70. Our opinion is not modified in respect of this matter.

Failure to complete the statement of performance expectations for the reporting period beginning 1 July 2018

We draw your attention to the disclosures made in note 26 on page 75 about the failure to comply with section 149C of the Crown Entities Act 2004, which requires the Health Board to complete its statement of performance expectations before the start of the financial year. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

Basis for our 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 financial statements and 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 financial statements and 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 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.

Independent Auditor's Report (continued)

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 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 7 and 35 to 43 and page 80, 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.

Other than the audit, we have no relationship with, or interests in, the Group.

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