

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004.

E.80

Canterbury DHB

2017/21

STATEMENT OF INTENT

Incorporating the 2017/18
Statement of Performance Expectations &
Statement of Financial Expectations



Canterbury
District Health Board
Te Poari Hauora o Waitaha



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Statement of Joint Responsibility

The Canterbury District Health Board (DHB) is one of 20 DHBs, established under the New Zealand Public Health and Disability Act in 2011. As a DHB we are categorised as a Crown Agent under the Crown Entities Act, and are accountable to the Minister of Health for the funding and provision of public health and disability services for our resident population.

This Statement of Intent has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health.

The document sets out our goals and objectives for the coming year and describes what we intend to achieve in terms of improving the health of our population and ensuring the sustainability of our health system over the longer-term. It also contains the DHB's Statement of Performance Expectations and Statement of Financial Expectations.

The Statement of Intent is extracted from the DHB's Annual Plan and presented to Parliament, as a separate public accountability document. It is used at the end of the year to compare the planned and actual performance of the DHB. Audited results will be presented in the DHB's Annual Report for 2017/18.

In line with the New Zealand Health Strategy, the Canterbury DHB has made a strong commitment to 'whole of system' service planning. We work in partnership with other service providers and actively engage with individuals, their families and our community to design and deliver service solutions to meet the changing needs of our population.

Clinically-led alliances have been established as vehicles for implementing system change. Our alliance framework means we share a joint vision for the health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our large-scale Canterbury Clinical Network (CCN) District Alliance, with twelve local provider partners, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the West Coast DHB.

The DHB also recognises its role in actively addressing disparities in health outcomes for Māori and is committed to making a difference. We work closely with Manawhenua Ki Waitaha, both directly and through the CCN Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of the Treaty of Waitangi.

In signing this document, we are satisfied that it fairly represents our joint commitments and intentions for the coming year and is in line with Government expectations for 2017/18.



Dr John Wood
CHAIR | CANTERBURY DHB



Ta Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB



David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

October 2017

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Part I

Overview

Foreword from the Chair and Chief Executive

Meeting our challenges

Six years on from the Canterbury earthquakes, readers of health-sector annual plans might be forgiven for believing that the challenges of those times are now largely behind us. However, while much of our population has recovered, some people remain adversely affected, which is evident in higher demand and acuity for mental health services. In addition, our health system continues to experience extraordinary operational and organisational challenges as a result of the unique post-disaster environment.

These challenges include pressures of rapid population growth and increasing service demand, pressures on our workforce, and ongoing fiscal pressures.

In the past year, two further natural disasters have also been experienced in our region: the destructive Kaikoura quake in November 2016 and the Port Hills fires in February 2017.

Population challenges

We are the second-largest DHB in the country in terms of area and are responsible for the second-largest population—an estimated 558,830 people or 11.6% of the total New Zealand population. We also provide an extensive range of highly specialised services to people referred from other DHBs, where the services and capacity are not available. We provide the second largest number of elective and acute surgeries in the country and almost half of all elective surgery in the South Island.

Our population base continues to exceed statistical projections year on year. Our population has already reached the level predicted for 2022, which puts capacity pressure on our new hospital before it is even complete.

We currently have the largest total population over 75 in the country. The ageing population has more complicated health needs: this is one of the biggest challenges we face as a health system. We also have the fastest growing Māori population in the country, and the sixth largest Māori population by total number.

Demand challenges

We are experiencing a predictable increase in demand for mental health services post-quake, and attendance at our emergency departments are growing, with these trends are expected to continue into the coming year and beyond.

In spite of this increased demand, the successful integration of our health system and the capability of our general practice means our population is more likely to remain healthy and living in their own homes and communities; and we still have lower ED attendance rates per capita than other DHBs.

Unfortunately, our ability to manage with constrained capacity, by delivering a great deal of care in a

community based setting, can be misinterpreted as indicating a population with less need. On the contrary, our primary and community services have accepted the challenge to help Canterbury manage with less hospital based capacity than it needs. But they, like our hospital services, are under pressure.

Workforce pressures

Staff from across our health system have risen to the challenges of these extraordinary times, helping to make things better and putting the needs of the patient first and foremost. However, tireless commitment takes its toll, as our 2016 Staff Wellbeing Survey revealed.

Careful planning and support for our workforce will continue to be critical in the coming year. Recruitment is commencing to support the opening of the Acute Services Building and in particular the new theatres and intensive care unit.

Facilities pressures

Our significant facilities repair and redevelopment programme continues. The new Outpatients and Acute Services buildings on the Christchurch Hospital campus are both expected to be completed by the end of 2018. These facilities will increase the number of theatres and intensive care beds supporting the Canterbury population and restore in-patient bed numbers to slightly higher than pre-quake levels.

Reductions in length of stay and managing acute medical admissions at 30% lower than the national rate has compensated for the rapid increase in our population, enabling the continued delivery of services within very constrained physical capacity. Work is also underway to progress a new health facility in Akaroa, and the Health Research and Education Facility that we will co-tenant will be a valuable teaching addition for the Christchurch Health campus.

However, it will still be many years before earthquake repairs are complete, with a number of areas still to be tackled and in need of clever funding solutions as the insurance proceeds have largely been committed. These areas include mental health services, laboratory services and car parking.

Our staff also continue to run services out of inappropriate and/or widely dispersed facilities. Theatre capacity is severely under pressure to meet growing service demands and ongoing repairs place additional pressure on staff and operating budgets. It is imperative that we determine a way forward.

Fiscal pressures

Canterbury takes its obligations to be fiscally prudent seriously and is focused on reducing waste, duplication and costs across our system.

Recent analyses have shown that Canterbury has the lowest cost growth among similar sized DHBs, and our

hospitals have been benchmarked against other large hospitals internationally as the most efficient of its peers across New Zealand and Australia.

However, government health funding per capita is currently lower than much of New Zealand, largely because central measures of population and social deprivation have not anticipated post-quake fluctuations, the movement of populations within the district, and increased migration supporting the rebuild. This is a significant challenge as we look to meet the growing costs of service demand, wage expectations and repairs.

The year ahead

Post-disaster recovery – especially psychosocial recovery – is known to take many years and at times it must seem, to many Cantabrians, that the challenges we face are relentless.

We are acutely aware that our recovery journey has been uneven. Significant achievement in some areas is diminished by what is seen as a lack of progress in others, and pressures on our staff and system have been well publicised.

Despite the challenges we face, the Canterbury Health System is internationally recognised as a high-performing, well-integrated health system that puts the patient at the centre. Without this strong baseline performance, we would be unable to cope with the continued operational challenges of unexpected events and our growing population.

This document, along with the DHB's Annual Plan, sets out the ways in which we will address our challenges and deliver health services that meet the needs of our people, both across Canterbury and further afield.

Over the coming year, we will build on our high-performing, innovative and integrated history to improve outcomes for our population. We will continue to invest in strategies that reduce the need for people to make multiple hospital visits, provide increased access to care in the community and closer to people's own homes, and continue to reduce the time people waste waiting for access to the right treatment.

In looking forward to our future, we will focus on our children and the young people of Canterbury, ensuring they have the opportunity to live the best possible lives. We will look to improve the experience of people in our health system: our patients and our workforce.

We will also carefully consider where we invest our limited resources, in order to make the biggest impact for our population.



Dr John Wood
Chair, Canterbury DHB



David Meates
Chief Executive, Canterbury DHB

October 2017

Introducing the Canterbury DHB

1.1 Who are we

The Canterbury District Health Board (DHB) is one of twenty DHBs charged by the Crown with improving, promoting and protecting the health and independence of their resident populations.

Canterbury has the second largest population of all 20 DHBs. We are responsible for 558,830 people, 11.6% of the total New Zealand population.

There has been a 13.2% increase in our population over the past ten years, a faster growth rate than predicted before the earthquakes. Canterbury also has the fastest growing Māori population in the country.

We own and operate five major hospital facilities: Christchurch (including Christchurch Women's), Hillmorton, Burwood, Princess Margaret and Ashburton hospitals, and almost 30 smaller rural hospitals and community bases.

We provide the second largest number of elective surgeries in the country and deliver almost half of all the elective surgery in the South Island.

In 2015/16: there were over 94,000 presentations to our Emergency Departments; we delivered over 71,000 first specialist assessments; 189,000 consultations with community-based specialist mental health services and 650,000 outpatient appointments. We also performed 21,039 elective surgeries and 15,500 acute surgeries; delivered 5,922 babies and discharged 117,935 patients.

We are the largest employer in the South Island, employing more than 9,000 people across all of our hospital and community sites.

We also hold and monitor over 1,000 service contracts and agreements with other organisations and individuals who provide health services to our population. This includes the three Primary Health Organisations in Canterbury, as well as general practice, private hospital, laboratory, pharmacy, mental health, home based support, district nursing, residential and aged care service providers.

We are the second largest DHB in the country in terms of geographical area. Canterbury DHB covers 26,881 square kilometres and six Territorial Local Authorities.

Inclusion of the Chatham Islands

Since June 2015, Canterbury has also been responsible for the Chatham Islands population. The islands are located 840km east of Christchurch with a population of 610 people.



1.2 What we do

Like all DHBs, we receive funding from Government with which to purchase and provide the services required to meet the needs of our population, and we are expected to operate within allocated funding.

In accordance with legislation and consistent with Government objectives, we use that funding to:

Plan the strategic direction of our health system and, in collaboration with our clinical leaders and alliance partners, determine the services required to meet the needs of our population.

Purchase the health services provided to our population and through our collaborative partnerships and ongoing performance monitoring, ensure these services are responsive, coordinated and effective.

Provide a significant share of the specialist health and disability services delivered to our population, and also to people referred from other DHBs where more specialised or higher-level services are not available.

Promote and protect our population's health and wellbeing through investment in health promotion and education and delivery of evidence-based public health initiatives including earthquake recovery strategies.

1.3 Our regional role

While our responsibility is primarily for our own population, the Canterbury DHB also provides an extensive range of highly specialised, complex services to people from other DHBs where the service or treatment is not available.

In 2015/16, over 7,000 people from other DHB regions were discharged from Canterbury services and over 13,000 people had an outpatient appointment.

Much of this demand is complex in nature and demand is growing steadily. In the five years to June 2016, there was a 20% increase in inpatient admissions and a 28% increase in demand for outpatient appointments for people referred by other DHBs.

The services we provide on a regional basis include: eating disorder services, brain injury rehabilitation, child and youth inpatient mental health services, neonatal services, cardiothoracic services, neurosurgery, paediatric oncology, endocrinology, mental health forensic services and spinal services.

In addition, our laboratory service (Canterbury Health Laboratories) is one of only two tertiary level diagnostic and reference laboratories in the country. In a typical year the service completes over 4 million diagnostic tests, which inform 60-70% of the critical clinical decisions made across the health system.

We're growing

Our growth rate is 13.2% over the past 10 years—higher than predicted before the earthquakes.

**We're ageing**

Our population is older than the NZ average. By 2026, one in five people in Canterbury will be older than 65.

We're diverse

Our population is becoming more diverse. Canterbury has the fastest growing Māori population in NZ.

**1.4 Our population profile**

Despite a small dip in our population after the earthquakes, our population has returned and we are now experiencing a greater growth rate than predicted prior to the earthquakes.

In 2017/18, we will be responsible for the health and wellbeing of 558,830 people, 11.6% of the total New Zealand population – a population level we anticipated reaching in 2022 only five years ago.

There has been a steady increase in the average age of our population—one of the biggest ongoing challenges for our health system. Canterbury has the largest total population aged over 65 in the country.

The latest DHB population numbers show 15.7% of our population are aged over 65, a total of 87,560 people.

Many conditions become more common with age, including heart disease, cancer, stroke and dementia. As people age they develop more complicated health needs and are more likely to need specialist services. The ageing of our population will put significant pressure on our workforce and infrastructure.

Like age, ethnicity is also a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others.

Our Asian population is proportionately our fastest growing population group. By 2026, 12.3% of our population will be Asian. However, our Māori population is also steadily increasing. We have the fastest growing Māori population in the country and the sixth largest by total population numbers of all 20 DHBs. There are currently 51,630 Māori in Canterbury and by 2026 they will represent 10.3% of our population.

Our Māori population has a considerably different age structure than the rest of our population, with 42% of our Māori population being under 20 years of age, compared to 24% of the total Canterbury population.

1.5 Our population's health

Canterbury's total population continues to have a slightly higher life expectancy compared to the New Zealand average, with 79.8 years for males and 83.3 years for females.

Engagement with health services is positive. At the end of 2015/16, 95% of our population were enrolled with primary care, 96% of all eight months olds in Canterbury fully immunised, and fewer people were being admitted acutely to our hospitals (12,000 less people than expected, based off the national average).

However, like the rest of New Zealand, more people are living with long-term conditions such as cancer, heart disease, respiratory disease and depression leading to an increasing demand for health services.

A reduction in known risk factors, such as poor diet and lack of physical activity, smoking, and hazardous drinking could dramatically reduce the impact of these conditions for our population, and reduce the load on our health system.

All four major risk factors also have strong socio-economic gradients, so a healthier focus would contribute greatly to reducing health inequalities between population groups.

The most recent results from the 2011-2014 New Zealand Health Survey found that in Canterbury:

- 27.7% of our adult population are classified as obese, almost a third of our total population.
- 15% of our total population are current smokers and smoking rates amongst our Māori and Pacifica populations are significantly higher.
- One in every 10 adults is likely to drink in a hazardous manner.

EARTHQUAKE IMPACTS

The NZ Health Survey also reported that 20% of our population have been diagnosed with a common mental illness (such as depression or anxiety disorders) compared to just 17% of the population nationally.

While new research indicates some sections of our population are coping with the psychological impact of the earthquakes and thriving in their lives, there is increasing divergence in our community with a marked increase in demand for mental health support.

International disaster research suggests we can expect to see continued mental health service demand from some population groups for upwards of a decade. The long-term health impacts for children are particularly worrying and supporting young people's wellbeing is a major focus for our health system.

Part II

Long-Term Outlook

Our Strategic Direction

2.1 National context

Like health systems world-wide, the challenges DHBs are facing are well understood. Populations are ageing, more people are developing long-term conditions, demand is increasing, treatment costs are rising, and workforce shortages are ever-present. Increasing pressure on government funding also means we have to do more with what we have.

There is a clear understanding that these pressures mean health services cannot continue to be provided in the same way they always have.

If we are to continue to improve health outcomes within current resources, we need to integrate and connect services, not only across the health system, but across all public services.

The long-term vision for New Zealand's health service is articulated through the New Zealand (NZ) Health Strategy. The overarching intent is to support all New Zealanders to 'live well, stay well, get well'.

The Strategy identifies five key themes to give the health sector a focus for change:

- People powered
- Closer to home
- One team
- Smart system
- High value and performance.

Our direction is further guided by a range of population or condition-specific strategies, including: He Korowai Oranga (Māori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Healthy Ageing Strategy, Rising to the Challenge (Mental Health and Addiction Service Development Plan), the Disability Strategy and the United Nations convention on the Rights of People with Disabilities.

DHBs are also expected to commit to government priorities and provide 'better, sooner, more convenient health services,' and 'better public services'. The Minister of Health's letter of expectations signals annual expectations and priorities for DHBs and the DHB's Annual Plan outlines how the Canterbury DHB will meet those expectations in 2017/18.¹

In 2017/18 the focus is on:

- Delivering against the NZ Health Strategy
- Living within our means
- Working across government
- Delivering on national health targets
- Streamlining planning including developing a longer-term outlook and regional alignment.

¹ The Minister of Health's Letter of Expectations for 2017/18 is attached as Appendix 2.

2.2 Regional commitment

In delivering its commitment to better public services, and better, sooner, more convenient health services, the Government also has clear expectations of increased regional collaboration between DHBs.

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23.3%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Regional Alliance to better address our shared challenges.

Our jointly-developed Regional Health Services Plan outlines the agreed regional activity for the next three years. Canterbury has made a strong regional commitment and takes the clinical or executive lead in a number of areas including: cancer, cardiac, major trauma and stroke services. Our regional commitment is outlined in the Regional Health Services Plan.²

2.3 The Canterbury vision

Ten years ago, health professionals, providers, consumers and key stakeholders came together to rethink the future of the Canterbury health system.

We knew we needed to do things differently. Together, we developed a vision that recognised our future was not just about hospitals, but about everyone working together as one team to do the right thing for the patient and the system.

Our vision is an integrated health system that keeps people healthy and well in their own homes and communities: a connected health system, centred around the patient, that doesn't waste their time.

At the centre is our community, our whānau and our patients. In achieving our vision, we are focused on the delivery of three clear strategic objectives:

- The development of services that support people to stay well and take greater responsibility for their own health and wellbeing
- The development of primary and community-based services that support people in the community and provide a point of ongoing continuity, which for most will be general practice
- The freeing-up of hospital-based specialist resources to be responsive to episodic events, and to provide timely access to complex care and specialist advice to primary care.

² The South Island Regional Health Services Plan can be found on the Alliance website: www.sialliance.health.nz.



Our vision is illustrated in the pictogram above – with the patient at the centre and connected, integrated services radiating out from the home.

In delivering against our vision, we have been purposeful and deliberate in planning how we would meet the growing demand for services, and make the best possible use of the resources we have available right across our health system.

Across primary and community services, we are enabling system transformation through our role in the Canterbury Clinical Network District Alliance. Working as one team alongside healthcare leaders, professionals and providers from across Canterbury, we are redesigning service models to support the delivery of care closer to people's homes and realising opportunities to better integrate our health system.

Across our hospitals we are empowering our workforce to improve pathways and processes. The DHB is a founder of the national Health Innovation Hub. Our supportive innovation and research environment keep us at the forefront of best practice, harnessing innovations that add value and improve service performance and patient outcomes.

Like some of the more innovative health systems around the world, a cornerstone of our success has been the redesign of shared clinical pathways and service delivery models to address service gaps and improve access to the right services at the right time.

Sharing of data has been a key enabler of this change. Delivering a smarter system with access to real-time information is helping us to improve the quality and safety of the care we provide and save patients' time.

In 2015, the Canterbury health system won the Prime Minister's Award for Public Sector Excellence, recognising the outstanding collaboration across our health system and the considerable results being achieved for the people of Canterbury.

In 2017, the DHB, Orion and Pegasus Health won the Best Technology Solution award at the NZ Hi-Tech Awards for HealthOne our electronic health record solution making it easier for clinicians to do their job and improving safety and services for our population.

Our Challenges

2.4 Our operating environment

Meeting the health needs of a large population is complex. However, Canterbury also has a distinctly unique set of operational and organisational challenges as a result of our post-disaster environment.

POPULATION PRESSURES

Following the earthquakes, our population growth has been rapid, with a 13.2% increase over the past ten years and population levels now reaching those previously predicted for 2022.

While this population growth is a positive for our economic recovery and confidence in the region, it is a major challenge for our health system. We are working hard to find a balance between the increasing needs of our growing population, and the workforce, infrastructure, and funding resources at our disposal.

DEMAND PRESSURES

Six years on from the first major earthquakes, service demand patterns have changed. Prolonged levels of stress and anxiety are exacerbating chronic illness and negatively impacting on the health and wellbeing of our population. Increased demand is evident across our system, but particularly in mental health services.

As a major tertiary (specialist) provider, we are also dealing with an increasing level of demand for highly complex and resource-intensive services. From our own population and, increasingly, the populations of neighbouring DHBs.

We have implemented a number of intervention strategies to reduce this growing demand, but it remains a significant issue. Our health system is almost at full capacity and resources are stretched.

FACILITIES PRESSURE

The earthquake damage to our infrastructure was extensive and we are engaged in a significant repair and remediation programme across all of our hospital sites. The continued commitment from Government to the planned redevelopment of the Acute Services and Outpatient Buildings on the Christchurch Hospital site remains critical to our recovery. However, it will be at least another year before these buildings are operational and many years before our full earthquake repair programme is complete and our pre-quake capacity is restored.

In the meantime, the DHB is having to meet increasing demand with fewer hospital beds and a shortage of theatres. With our capacity significantly reduced, we are hiring theatres for our staff to work in and outsourcing some surgeries to ensure we can meet service demand and delivery expectations.

The increased service costs of this solution are not sustainable longer-term. Delays or deviations to the agreed redevelopment or repair programmes place additional pressure and stress on staff and operating budgets.

Repair strategies are not simple, with ongoing disruptions as we shift people, patients and services around to make repairs. While we wait for new buildings to be complete, many services are operating out of cramped, temporary or inadequate spaces.

Increasing population and heightening service demand are compounding this pressure. The DHB is already having to look forward to find solutions for increasing capacity beyond what will be restored once the redevelopment and repair programmes are complete.

WORKFORCE PRESSURES

The DHB is also working hard to maintain a safe environment and ensure the wellbeing of our workforce. We have implemented a number of initiatives to mitigate repair disruptions, however construction noise, service relocation and parking issues are causing increasing stress for staff and patients alike.

Along with increased service demand, the age of our population, their mental wellbeing and the increase in specialist referrals from other DHBs means the health issues people are presenting with are increasingly complex. All of these factors place additional pressure on our workforce.

Our 2016 Staff and Family Wellbeing Survey shows people are engaged and believe they are making a difference, but they are weary and staff commitment is being tested. This view is reiterated by providers from across our health system, equally concerned about the wellbeing and resilience of their workforce.

This is further complicated by national workforce shortages. Already we are experiencing difficulties recruiting to some highly specialised positions and competing with other DHBs across the country for a limited pool of people.

If we are to go to meet the growing needs of our population, and deliver on our vision, we need to support the wellbeing of our people and attract more of the right people with the right skills to Canterbury.

FISCAL PRESSURES

Meeting growing service demand, increasing treatment and infrastructure costs, and expectations around wages and salary increases is an ongoing challenge for all DHBs. This is heightened in Canterbury by the extraordinary impacts of the earthquakes, including population funding shifts, increased service demand and the operational challenges of a significant repair programme.

Our relative health funding per capita has fallen, largely because standard measures of population and deprivation have not been designed to cope with the

post-quake population fluctuations and forced migration Canterbury has experienced.

With population and deprivation levels being two of the drivers of the national population-based funding formula, the DHB is coping with a consequential and unexpected drop in revenue - despite rapid population growth and increased service demand.

It is apparent that a considerable portion of our earthquake repair work will not be covered by our insurance proceeds. The DHB's normal capital expenditure and maintenance budgets will not be enough to cover repair costs and address capacity constraints as our population continues to grow.

Significant earthquake-related operational costs are also evident in a number of areas including: increased treatment costs to meet heightened service demand; additional outsourcing costs to cover lost theatre and bed capacity; unexpected costs of supporting stranded services; and substantial depreciation and capital related charges related to repair of damaged buildings.

2.5 Critical success factors

Over the last ten years, we have been deliberate in determining the steps we will take to enable our vision: reducing the need for multiple hospital visits, increasing access to care closer to people's homes and reducing the time people waste waiting for treatment.

To ensure the long-term sustainability of our health system, further solutions need to be found to enable us to invest in the infrastructure and people needed to meet the growing demand for services and increased service delivery expectations.

The following areas represent the factors critical to our success, where we believe we need to focus in the coming year:

- Prioritising resources for the greatest impact
- Improving the flow of patients across the system
- Connecting the system electronically
- Supporting and engaging our workforce
- Collaborating on investment across sectors
- Delivering on the repair and rebuild programmes.

Our focus in 2017/18 will include supporting the North Canterbury, Kaikoura and Hurunui communities as they recover from the 2016 earthquakes.

We will also be focused on working with the Ministry of Health and key government agencies to address the challenges we face and develop a sustainable pathway forward for our health system.

OUR CHALLENGES

Population increases

Canterbury's population growth is exceeding expectations—already reaching levels predicted for 2022¹

558,830

reasons to make a difference

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



13.2%
population
growth in the
last **ten** years²

12%
of that growth
in the last **six**
years²



Fastest
growing Maori
population in NZ³

51,630 people



Largest
population aged
over 65 in NZ³

87,560 people

Demand increases

The Canterbury system has experienced unrelenting demand challenges since the earthquakes³



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 DHB⁴



74% of staff
feel their jobs
are fulfilling⁴



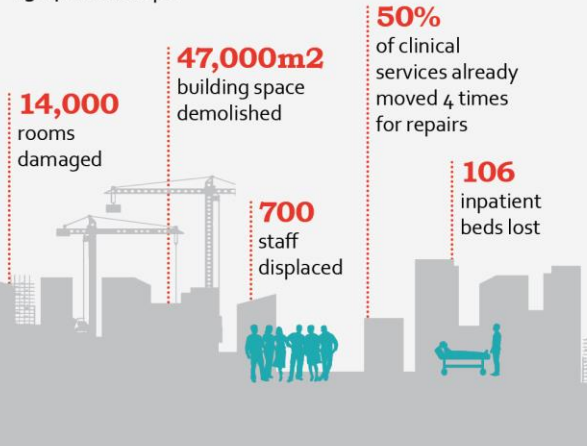
38% felt
excessive workload
is one of the top five
stressors of their job⁴



28% felt being in a
damaged environment or
surrounded by construction
work is having a negative
impact on their wellbeing⁴

Damage to health infrastructure

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



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

Managing Our Business

We aim to be a responsive organisation, respected for the quality of the service we deliver, and successfully delivering against strategic goals and national targets.

This section highlights how we organise and manage our business in order to support that aim, enable the transformation of our health system and better meet the health needs of our population.

2.6 Organisational culture

The values of our organisation, the way in which we work and the manner in which we interact with others are all key factors in our success.

ORGANISATIONAL VALUES

- Care and Respect for Others
- Integrity in All We Do
- Responsibility for Outcomes.

The DHB is committed to the development of a culture that focuses on the patient. Over the past eight years we have invested in leadership programmes that encourage staff to ask 'what is best for the patient' and empower them to redesign the way they deliver services to improve the effectiveness of our system.

We further encourage a focus on the patient through our annual Quality Improvement and Innovation Awards. These awards recognise excellence and quality improvement not only in our hospitals but across the wider Canterbury health system.

EFFECTIVE LEADERSHIP

To support good governance, we have an outcomes-based decision-making and accountability framework that enables system leaders and our community to provide direction and monitor service performance.

Clinical leadership and consumer engagement is intrinsic to our success and we ensure strategic and operational decisions are fully informed through the following formal mechanisms:

The Clinical Board: where members support and influence the DHB's vision and play an important role in raising the standard of patient care.

The Consumer Council: where members ensure a strong and viable voice for consumers in health service planning and service redesign.

Clinical leadership and consumer input into decision making is also embedded at all levels of our organisation, across primary and secondary services and across our local and regional alliance workstreams.

STRATEGIC PARTNERSHIPS

Working collaboratively has enabled us to respond to the changing needs of our population over the past six years and continues to be a critical factor in achieving our goals and objectives. The DHB's major strategic partnerships include:

The Canterbury Clinical Network (CCN): the district alliance is where the DHB and its partner organisations come together to improve the delivery of health care and realise opportunities to improve health outcomes. This includes the development of Canterbury's System Level Improvement Plan for 2017/18.

Manawhenua Ki Waitaha: under a shared Memorandum of Understanding, the DHB actively engages Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Members of Manawhenua Ki Waitaha also bring a Māori perspective to the redesign of services across a number of the CCN alliance workstreams.

Transalpine Partnership: an initial priority of connecting up the Canterbury and West Coast health systems and formalising clinical pathways is now helping to enable sustainable access to specialist services for the West Coast population. The two DHBs now share senior clinical and management expertise, corporate services teams and information systems.

2.7 Commitment to quality

Our approach to improving the quality of the services we deliver is in line with the New Zealand Triple Aim: improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health resources.

Working with the South Island Quality and Safety Alliance, we implement quality improvements through a community of practice and support each other to meet our commitments to the national Health Quality and Safety Commission (HQSC) programmes.

The national HQSC Quality and Safety markers are used by our governance groups, alongside the Australian Health Roundtable benchmarking, to monitor the effectiveness of our improvement activity and patient safety in our services. Performance is reported regularly to the DHB's Clinical Board, the Board's Quality, Finance, Audit & Risk Committee, and annually to our community through our Quality Accounts which can be found on the DHB's website.

Contracted services are also aligned with national quality standards, and auditing of contracted providers includes quality audits.

The Canterbury DHB has a focus over the coming year on improving the patient experience of care in our services which is highlighted in the DHB's Annual Plan.

2.8 Performance management

The Canterbury DHB has invested in the development of 'live data' systems where real-time information on the day-to-day operations within our hospitals enables more responsive decision making and planning.

Our service and financial performance is monitored fortnightly by the Executive Team and monthly by the DHB Board and its Quality, Finance, Audit and Risk Committee. The DHB's performance is presented in a public forum to the Board's Community and Public Health and Hospital Advisory Committees.

The DHB also reports monthly and quarterly to the Ministry of Health against key service and financial reporting indicators outlined in our Annual Plan.

On an annual basis, our performance is audited against our Statements of Performance and Financial Expectations. The results are published annually in the DHB's Annual Report.

At a broader level, we monitor our performance over the long-term against a core set of desired population outcomes, which help to evaluate the effectiveness of our strategies and investments decisions. Our goals are captured in the DHB's Outcome Framework which defines success from a whole of health system perspective and is used as a means of evaluating the success of our collective initiatives.

Further detail on the DHB's outcome goals can be found in the Monitoring our Performance section.

2.9 Asset management

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.

Since the earthquakes, our capital intentions have been updated annually to reflect known changes in asset states and intentions, in line with our earthquake repair programme and the Burwood and Christchurch Hospital redevelopments.

In line with the new Treasury requirements for monitoring investments across government, the DHB is developing an extensive ten-year Long-term Investment Plan. This Investment Plan will reflect the impact changing patterns of demand and new models of care will have on our future asset requirements and will support our investment decision going forward.

As part of the development of the Long-term Plan, the DHB is also seeking to improve investment thinking and develop and monitor performance metrics to ensure we are investing wisely.

Refer to the Meeting our Financial Challenges section of this document for the DHB's major capital investments and Appendix 3 for the DHB's high-level asset performance metrics.

2.10 Risk management

The Canterbury DHB manages and monitors risk to ensure we are meeting our obligations as a Crown Entity. Our risk management processes are aligned to the main elements of the International Standard for Risk Management AS/NZS ISO 31000:2009.

The DHB maintains Divisional Risk Registers. The top tier risks are reviewed by the Executive Management Team and the Board's Quality, Financial, Audit and Risk Committee every two months, providing assurance on the management of the most significant risks faced by the DHB. Twice a year, the full Risk Register is provided to the Board's Quality, Financial, Audit and Risk Committee for their attention.

2.11 Ownership interests

The Canterbury DHB has a number of ownership interests that support the delivery of health services including two operational subsidiaries, both of which are wholly owned by the DHB.

Canterbury Linen Services Limited: provides laundry services to DHB hospitals and external commercial clients. The Canterbury DHB owns all shares, as well as the land and buildings. The key output is the collection, laundering and delivery of laundry.

Brackenridge Estate Limited: provides residential care, respite services and day programmes for people with intellectual disability and high dependency needs. The primary source of funding is service contracts with the Ministry of Health.

The DHB also has an interest in the following partnerships which support the delivery of our vision:

The South Island Shared Service Agency Limited: (functioning as the South Island Alliance Programme Office) is jointly owned and funded by the South Island DHBs. The regional Programme Office provides audit services and drives regional service development on behalf of the five South Island DHBs.

The New Zealand Health Partnership Limited: is owned and jointly funded by all 20 DHBs, and aims to enable DHBs to collectively maximise and benefit from shared service opportunities. Canterbury is participating in the Finance, Procurement and Supply Chain programme, with the Partnership facilitating the move to a shared services model for the provision of these services.

The New Zealand Health Innovation Hub: is a joint partnership with the Counties Manukau, Waitemata and Auckland DHBs. The Innovation Hub works to engage with clinicians and industry to develop, validate and commercialise health technologies and improvement initiatives that will deliver health and economic benefits to the system.

We do not intend to acquire shares or interests in any other companies, trust or partnerships in 2017/18.

2.12 Investing in our people

To meet the needs of our population and achieve our vision we need a motivated workforce committed to doing their best for the patient and the system.

The DHB is committed to being a good employer. We promote equity, fairness and a safe and healthy workplace, and have a clear set of organisational values. These are supported by our core operational policies, including a Code of Conduct, a Wellbeing Policy and an Equality, Diversity and Inclusion policy.

As part of our commitment to our workforce we are reviewing our HR processes and systems and engaging in a number of conversations about how we continue to put people at the heart of all that we do.

Following the earthquakes, our bi-annual workforce engagement surveys show that workforce wellbeing and resilience has emerged alongside leadership capability as one of the biggest challenges for our health system. Acknowledging the links to engagement, productivity and the quality of patient care, a significant long-term commitment is being made to support wellbeing of our staff.

Continued development of our workforce and their leadership capability also remains a key strategy for enabling the transformation of our health system and meeting the increasing demand for services.

We will continue to identify available talent and expand our workforce capability through participation in national and regional initiatives, links with the education sector, sharing of training resources and support for internships and clinical placements.

The DHB will also take the South Island lead for Kia Ora Hauora, aimed at increasing the number of Māori working in health; and invest in Rural Learning Centres, to encourage people to work rurally by reducing isolation factors and providing peer support.

Our Workforce

9,745 people are employed by the Canterbury District Health Board. We are the **largest single employer** in the South Island



46 is the **average age** of our workforce

52 is the average age of our oldest workforce group: **Support Services**

107 different ethnic groups across our workforce

9% turnover rate, compared to 9.5% nationally

3.2% sick leave rate compared to 3.8% nationally

48% of our workforce work part-time

81% of our workforce are female

48% of our workforce are nurses

57% of DHB senior management roles (tier 1-3) are filled by females

2.13 Investing in information systems

Improved access to patient information enables more effective clinical decision-making, improves standards of care and reduces the time people spend waiting.

Connecting up health services is central to our vision and, by allowing us to realise opportunities to reduce waste and duplication, is a key factor in the future sustainability of our health system.

For these reasons, information management is also a national priority and DHBs are expected to implement the national Health Information Technology Plan.

The South Island DHBs have determined collective actions to deliver on the national Plan and we are committed to this approach. Canterbury is taking a lead in rolling out several of the information solutions that are streamlining the way health professionals across the South Island make requests, send referrals, and share patient information. This includes; Health Connect South, the award winning HealthOne, and the Electronic Referral Management System (ERMS).

Our transalpine partnership with the West Coast DHB also makes shared information systems increasingly important. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs, and replacing our old hospital-based patient administration system with the new single South Island Patient Information Care System (PICS).

2.14 Investing in facilities

In the same way that workforce and information technology underpin our transformation, health facilities can both support and hamper our ability to meet the needs of our population.

The \$650 million redevelopment across our Burwood and Christchurch Hospital sites will allow us to regain some of the capacity lost after the earthquakes and will support the implementation of improved models of care. It will also allow us to make efficiency savings by co-locating and consolidating services.

At the same time, the DHB is also delivering on a substantial earthquake repair programme to restore our lost capacity. Close alignment and timing of the redevelopment and repair programmes is essential to support the safe delivery of care and to avoid costly and wasteful investment in short-term solutions.

Anticipated activity for 2017- 2019 includes: ³

Christchurch Hospital Campus: Both the new Acute Services Building and the new Outpatient Building are scheduled for completion in 2018. Construction of the Energy Centre, Carpark and Tunnel is also expected during the period covered by this document.

The Christchurch Health Precinct: The development of a Health Research and Education Facility is underway in collaboration with Ara Institute and the University of Canterbury. The building is under construction by a private developer, with expected occupation in 2018.

Akaroa: The development of an IFHC is planned for the Akaroa Hospital site. The DHB is working with the community to develop an appropriate facility.

Rangiora: Phase II of the Rangiora Community Hub development involves the relocation of the temporary Outpatients Building from Christchurch Hospital. Timing is expected to be confirmed on the completion of the new Outpatients Building.

The DHB will also consider facilities solutions for a number of other sites over the coming year including: the relocation of mental health services on The Princess Margaret Hospital site and car parking solutions for the Christchurch Hospital campus.

Longer-term master-planning is underway to determine the future use of existing buildings and facilities on the Christchurch Hospital Campus. This includes Parkside and Canterbury Health Laboratories, and mental health services on the Hillmorton Campus.

2.15 Cross-sector investment

Recognising the wider influences that shape the health and wellbeing of our population, the Canterbury DHB works in partnership with other public and private organisations from outside the health sector to improve health outcomes for our population.

Earthquake recovery continues to be an important focus of our cross-sectoral work. This involves support and advice into policy processes, community resilience initiatives, and psycho-social recovery—all of which contribute to our vision of a healthier Canterbury.

We are also working closely with ACC, Corrections and the Ministries of Social Development, Education and Justice on a number of social investment initiatives aimed at improving the health and wellbeing of the most vulnerable in our community.

Major activity for 2017/2018 includes:

Canterbury Children's Team: The DHB will continue its commitment to the development of this MSD-led collaborative partnership, to better support vulnerable children and their families in the Canterbury District.

³ Note: Operational oversight and decisions on operational costs for the Christchurch Hospital Campus redevelopments have been transitioned to the Ministry of Health.

The Integrated Safety Response Pilot: The Canterbury DHB will continue to participate in this Police-led social investment strategy to pilot rapid responses from government and social agencies to meet the needs of people affected by family violence.

Step Up: The DHB is working alongside MSD and Pegasus Health to develop a new prototype primary care service to support people back into employment when they are on the jobseeker support benefit (with health condition deferred).

The All Right? Social Marketing Campaign: The DHB continues to work in partnership with the Mental Health Foundation to support and improve people's mental health and wellbeing after the earthquakes. The campaign has been well received and is informed by international evidence and local research.

Strength and Balance Programme: The DHB is working in collaboration with ACC as part of their Live Stronger for Longer Strategy, which focuses on injury prevention. This work will enhance the DHB's Falls Prevention Programme by providing increased access to community-based Strength and Balance Programmes. The approach is anticipated to minimise the risk of falls for older people by identifying and addressing key risks.

2.16 Service Configuration

SERVICE COVERAGE

All DHBs are required to deliver a minimum level of service to their population, in accordance with the national Service Coverage Schedule. This Schedule is incorporated as part of the Crown Funding Agreement between the Crown and DHBs, under Section 10 of the New Zealand Public Health and Disability (NZPHD) Act 2000, and is updated annually.

DHBs are responsible for ensuring that service coverage is maintained for their population. The Canterbury DHB works to identify service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways.

At this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2017/18. However, in our current circumstances, there are obvious service coverage risks related to resource and capacity constraints, infrastructure damage, rebuild delays, and changing service demand patterns following the earthquakes.

We are working with neighbouring DHBs and the Ministry of Health to assess and alleviate these risks, but anticipate that meeting national expectations will be a significant challenge in the coming year.

SERVICE REDESIGN

Through our CCN Alliance, we are working with our primary and community partners to redesign the way we deliver health services to better meet the needs of our population and ensure the future sustainability of our health system. We anticipate that new models of care and service delivery will continue to emerge through this collaborative work.

We also anticipate new models of service delivery will be needed as we seek to address our capacity and resource constraints. Consistent with our shared decision-making principles, we look to our clinically-led alliance and leadership groups for advice on the redesign of any service models and endeavour to keep a steady stream of information flowing across our system in regards to service change or transformation.

Listed below are the anticipated service changes for the coming year.

At times, we may wish to negotiate, enter into, or amend current service agreements or arrangements to assist in meeting our objectives and delivering against the vision and goals outlined in this document and the DHB's Annual Plan. In doing so (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000), we will seek to ensure that any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations in respect to our agreements with the Crown.

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
Location and configuration of services	Services on the Christchurch Hospital Campus	Relocation and reconfiguration of services to accommodate earthquake repairs and in line with the completion of the Acute Services and Outpatient Services Buildings.	Continued and sustainable service delivery.	Local
Location and configuration of services	Mental Health Services	Relocation and reconfiguration of services to accommodate the decanting of The Princess Margaret Hospital site.	Continued and sustainable service delivery.	Local
Provider of services	Food Services	On expiry of the current external contract, the DHB will take over the provision of Food Services by bringing the service in-house.	Increased service capacity and integration.	Local
Redesign of service model	Home and Community Based Support Services	Under the guidance of the CCN Health of Older People Workstream and Community Services Service Level Alliance, the DHB will seek to redesign the model of care for Home and Community Based Support Services.	Increased service capacity and integration, and improved patient outcomes.	Local
Redesign of service model	Mental Health Services	Under the guidance of the CCN Mental Health Workstream, the DHB will seek to further develop the model of care for mental health services in response to increasing demand and evolving need.	Increased service capacity and integration, and improved patient outcomes.	Local
Possible redesign of services models	Alcohol and Drug Services	The DHB is working with service providers and regional DHB partners to align the South Island's model of care with national changes to the Alcohol and Drug legislation.	Alignment with national service specifications and equitable access.	National
Redesign of service model and contracting arrangements	Community Pharmacy and Pharmacist Services	Under the guidance of the CCN Pharmacy Service Level Alliance, the DHB will engage with pharmacy providers to implement the national pharmacy contracting arrangements and develop local services in alignment with the national Pharmacy Action Plan.	Increased service integration, improved service quality and improved patient outcomes.	Local National
Provider and configuration of service	Maternity Services	The DHB has issued an expression of interest in the delivery of maternity services in Kaikoura to work alongside the integrated model of care.	Continued and sustainable local service delivery.	Local

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
Potential reconfiguration of services	Kaikoura Services	The DHB is working with local providers and other agencies to address emerging demand post-disaster. This may include reconfiguration of services to meet population need.	Continued and sustainable local service delivery.	Local
Potential redesign of service models	Falls and Fragility Fracture Prevention Services	The DHB is working with the Accident Compensation Corporation to further develop the service model for Falls and Fragility Fracture Service and enhance prevention strategies.	Increased service integration, and improved patient outcomes.	Local
Potential redesign of service models	Rural Services in: <ul style="list-style-type: none"> - Akaroa - Ashburton - Hurunui - Waimakariri - Oxford 	Under the guidance of the CCN Rural Health Workstream, the DHB is working to redesign models of care across rural communities, including the development of integrated family health services and sustainable after-hours' models to meet growing demand.	Increased service capacity and integration; equity of access to services.	Local
Potential redesign of service models	Elective and Acute Services	The DHB is reviewing the flow of patients and the capacity of its service, in line with increasing demand and expectations of service delivery. Solutions may result in the redesign of service models and impact on the configuration of some services. ⁴	Increased service capacity and improved patient safety, experience and outcomes.	Local Regional
Potential redesign of service models, change of provider and/or location of service	Secondary and Tertiary Care Services	The DHB is reviewing demand, capacity and operating costs across all of its service areas, in order to prioritise resources onto areas of the most immediate or greatest need. This includes aligning practice and intervention rates with national service specifications and accepted practice in other DHBs, and may impact on the configuration and scope of some services.	Reduction in operating costs, increased capacity in priority service areas, and greater patient and system returns.	Local Regional

⁴ This work is largely being driven by the DHB's Elective Services Redesign (100 Days), Frail Older Person's Pathway, Enhanced Recovery After Surgery (ERAS), Faster Cancer Treatment and Theatre Utilisation Programmes to ensure we live within our means.

Monitoring Our Performance

IMPROVING HEALTH OUTCOMES

As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

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

There is no single performance measure or indicator that can easily reflect the impact of the work we do. Instead, we have developed an outcomes framework that enables us to evaluate whether we are achieving our purpose and delivering the best possible outcomes for our population.

Together with the four other South Island DHBs, we have established three high-level outcomes goals, where we can influence change and where success will have a positive impact:

- People are healthier and take more responsibility for their own health
- People stay well in their own homes and communities
- People with complex illnesses have improved health outcomes.



Alongside each goal we identified a number of long-term population health outcome measures that are important to our stakeholders and will provide an insight into how well our health system is performing.

Tracking our performance against these measures will help us to evaluate our success. 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 identified a collective 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 if we are moving in the right direction and to evaluate our performance. These measures sit alongside our annual statement of performance expectations, outlining the service we plan to deliver and the standards we expect to meet in the coming year.

Our year-end performance results are reported to our community in our Annual Report alongside our year-end financial performance.

Performance standards (or targets) set across all these measures reflect the strategic objectives of our health system: increasing the coverage of prevention programmes; reducing acute or avoidable demand for hospital services; and maintaining access to services - while reducing waiting times and delays in treatment.

As part of our obligations under legislation DHBs must also work towards achieving equity. To promote this goal, the targets set against each of the performance indicators are the same across all population groups.

As a Crown entity and responsible for Crown assets, the DHB also provides regular financial and non-financial performance reporting to the Ministry of Health on a monthly, quarterly, and annual basis. The DHB's obligation under the Ministry's monitoring framework are highlighted in the DHB's Annual Plan.

The intervention logic diagram on the following page demonstrates the anticipated value chain by illustrating how the services the DHB funds or provides will impact on the health of our population, contribute to the goals of the wider South Island region, and deliver on the expectations of Government.

Overarching Intervention Logic

MINISTRY OF HEALTH SECTOR OUTCOMES

Health System Vision

All New Zealanders live well, stay well, get well.

New Zealanders are healthier & more independent

High-quality health & disability services are delivered in a timely & accessible manner

The future sustainability of the health system is assured

REGIONAL STRATEGIC GOALS

South Island Regional Vision

A sustainable South Island health & disability system, focused on keeping people well & providing equitable & timely access to safe, effective, high quality services, as close to people's homes as possible.

Population Health
Improved health & equity for all populations

Experience of Care
Improved quality, safety & experience of care

Sustainability
Best value from public health system resources

DHB LONG TERM OUTCOMES

What does success look like?

MEDIUM TERM IMPACTS

How will we know we are moving in the right direction?

OUTPUTS

The services we deliver

INPUTS

The resources we need

Canterbury DHB Vision

An integrated health system that keeps people healthy & well in their own homes & communities. A connected system, centered around the patient, that doesn't waste their time.

People are healthier & take greater responsibility for their own health.

- A reduction in smoking rates
- A reduction in obesity rates

People stay well, in their own homes & communities

- A reduction in the rate of acute admissions to hospital
- An increase in the proportion of people living in their own home

People with complex illness have improved health outcomes

- A reduction in the rate of acute readmissions to hospital
- A reduction in the rate of avoidable mortality

- More babies are breastfed
- Children have improved oral health
- Fewer young people take up smoking

- People's conditions are diagnosed earlier
- Fewer people are admitted to hospital with avoidable or preventable conditions.
- Fewer people are admitted to hospital as a result of a fall

- People have shorter waits for urgent care
- People have increased access to planned care
- Fewer people experience adverse events in our hospitals

Prevention & public health services

Early detection & management services

Intensive assessment & treatment services

Rehabilitation & support services

A skilled & engaged workforce

Strong alliances, networks & relationships

Sustainable financial resources

Appropriate quality systems & processes

Responsive IT & information systems

Fit for purpose assets & infrastructure

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.

Outcomes Goals

2.17 People are healthier and take greater responsibility for their own health

WHY IS THIS 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 account for significant pressure on our health services. The likelihood of developing long-term conditions increases with age, and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates more than 70% of health funding is spent on managing long-term conditions.

Tobacco smoking, inactivity and poor nutrition are major risk factors for a number of the most prevalent of these long-term conditions. These are avoidable risk factors and can be reduced through supportive environments, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthier choices will improve the quality of their lives, and by reducing the impact of these conditions reduce the burden on our health system.

Because the major risk factors also have strong socio-economic gradients, this focus will contribute greatly to reducing health inequalities between population groups. As such, we are focusing on smoking and nutrition programmes and the engagement of people, particularly children, with preventative and behavioural setting programmes.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN SMOKING RATES

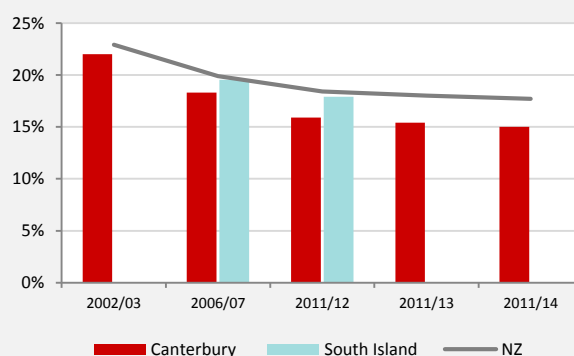
Tobacco smoking kills an estimated 5,000 people in New Zealand every year and is a major modifiable risk factor for many diseases and long-term conditions including heart disease, respiratory disease and cancer.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequalities in health status between population groups.

Data source: National NZ Health Survey⁵

Outcome measure: proportion of the population (15+) who smoke



A REDUCTION IN OBESITY RATES

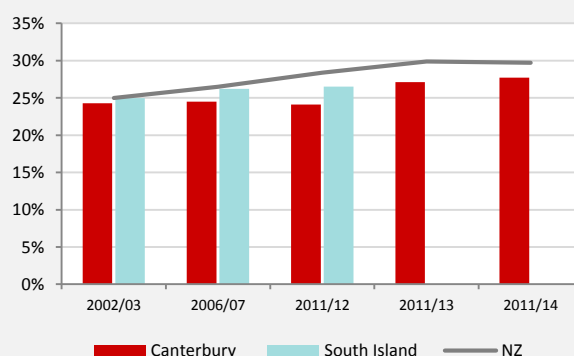
There has been a steady rise in obesity rates in New Zealand. The most recent NZ Health Survey found that 30% of adults and 10% of children are obese.

Not only does obesity impact on the quality of people's lives, but it is a significant risk factor for many of the leading long-term conditions in Canterbury including heart disease, respiratory disease, stroke, and diabetes.

Supporting our population to achieve healthier body weights is fundamental to improving people's health and wellbeing and to preventing poor health and disability at all ages.

Data source: National NZ Health Survey⁶

Outcome measure: proportion of the population (15+) who are obese



⁵ The NZ Health Survey is commissioned nationally by the Ministry of Health and since 2011 results have been combined year-on-year (hence the different time periods presented). Results are unavailable by ethnicity, however the 2013 Census (while not directly comparable) demonstrate that Māori smoking rates are improving but are still high compared to the rest of the population: 30.7% of Canterbury Māori (15+) identified as regular smokers compared to 14.5% of the total population.

⁶ The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific populations.

IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

MORE BABIES ARE BREASTFED

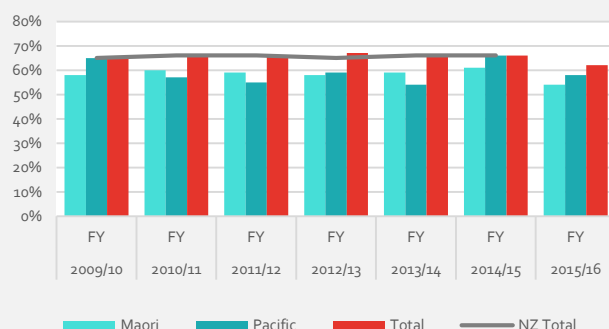
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

Breastfeeding also contributes to the wider wellbeing of mothers, and bonding between mother and baby.

Appropriate access to support services and a change in social and environmental factors influence breastfeeding behaviour and support healthier lifestyle choices. An increase in breastfeeding rates can therefore be seen as a proxy indicator of the impact of our health promotion and engagement activities.

Data source: Plunket⁷

Measure: babies exclusively or fully breastfed at six weeks	Base	Target			
	15/16	17/18	18/19	19/20	20/21
	62%	75%	>75%	>75%	>75%



CHILDREN HAVE IMPROVED ORAL HEALTH

Oral health is an integral component of lifelong health and contributes to a person's self-esteem and quality of life.

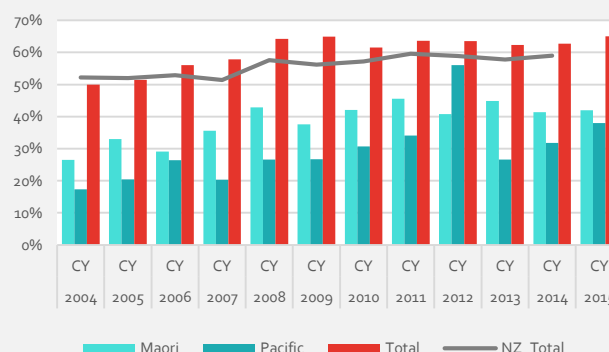
Good oral health not only reduces unnecessary hospital admission, but also signals a reduction in risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and health outcomes.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also seen as a proxy indicator of the effectiveness of services in targeting and reaching those most at risk.

The target for this measure has been set to maintain total population rates while placing particular emphasis on improving the oral health of Māori and Pacific children.

Data Source: School and Community Oral Health Services⁸

Measure: children caries free (no holes or fillings) at age five	Base	Target			
	2015	2017	2018	2019	2020
	65%	66%	67%	>67%	>67%



FEWER YOUNG PEOPLE TAKE UP SMOKING

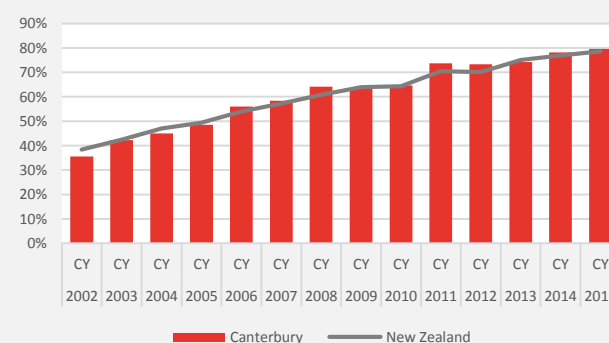
The highest prevalence of smoking is amongst younger people and preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population.

Because Māori and Pacific people have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity, and a change in the social and environmental factors that support healthier lifestyles.

Data Source: National Year 10 ASH Snapshot Survey⁹

Measure: 'never smokers' amongst Year 10 students	Base	Target			
	2015	2017	2018	2019	2020
	80%	>75%	>75%	>75%	>75%



⁷ This measure is part of the national Well Child/Tamariki Ora (WCTO) Framework and breastfeeding data is currently not able to be combined so performance data from the largest provider (Plunket) is presented. While this covers the majority of mothers, because the smaller providers primarily target Māori and Pacific mothers, results for these ethnicities are likely to be under-stated. The performance standards for the WCTO Framework measures are set nationally.

⁸ This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.

⁹ The ASH Survey is a national survey used to monitor student smoking since 1999. Run by Action on Smoking & Health it provides an annual point preference snapshot of students aged 14 or 15 years at the time of the survey – see www.ash.org.nz.

2.18 People stay well in their own homes and communities

WHY IS THIS 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 or long-stay interventions. This is not only a better in terms of health outcomes, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve these health outcomes at a lower cost, than countries with systems that focus more heavily on a specialist or hospital level response.

Health services also play an important role in supporting people to regain functionality after illness and supporting people to remain independent for longer. Even where returning to full health is not possible, access to responsive, needs-based rehabilitation, pain management and palliative care services can help to improve the quality of people's lives.

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. As such, we are investing in general practice, community-based allied health and diagnostic services with the aim of improving access to services closer to people's homes and enabling earlier detection and diagnosis and treatment.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

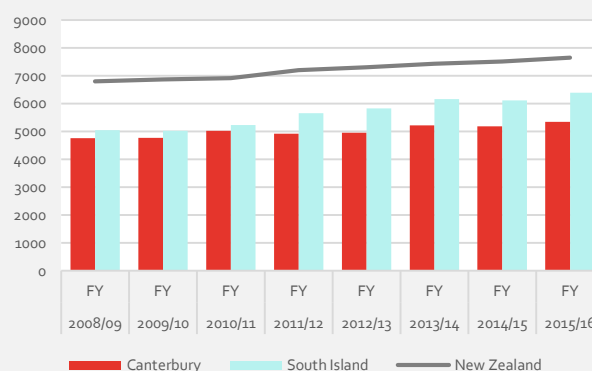
Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and even premature death.

Reducing acute hospital admissions also has a positive effect on the health system, enabling more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care.

Lower acute admission rates are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatment in the community.

Data Source: National Minimum Data Set

Outcome measure: rate of acute medical admissions to hospital (age standardised, per 100,000 people)



MORE PEOPLE LIVING IN THEIR OWN HOME

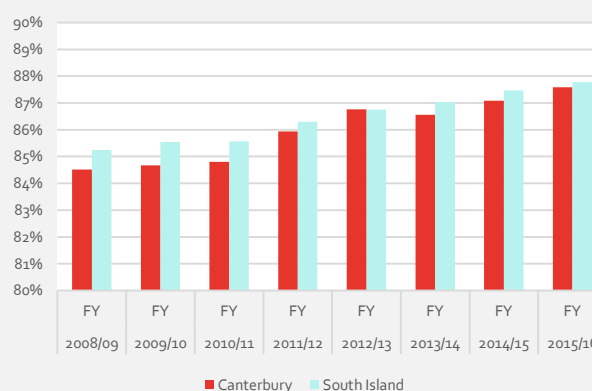
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes, when people remain in their own homes and positively connected to their local communities.

Living in residential care is also a more expensive option, and resources could be better spent providing home-based support and packages of care to help people stay well in their own homes.

An increase in the proportion of older people supported in their own homes is seen as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

Data Source: SIAPO Client Claims Payment System

Outcome measure: proportion of the population (75+) living in their own home



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

PEOPLE'S CONDITIONS ARE DIAGNOSED EARLIER

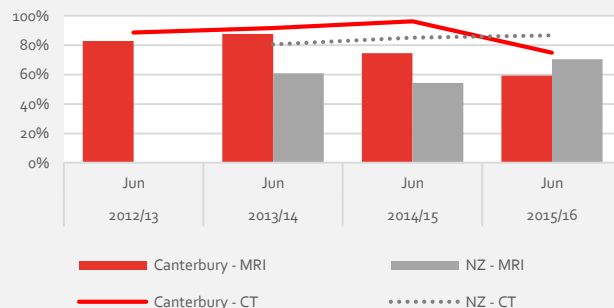
Timely access to diagnostics by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes.

People also want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

Wait times for diagnostics therefore can be seen as a proxy indicator of the effectiveness of our health system, particularly when we are seeking to minimise wait times while meeting increasing demand for services.

Data Source: DHB Patient Management System

Measure: people waiting less than 6 weeks for their non-urgent MRI/CT scans	Base	Target				
	15/16	17/18	18/19	19/20	20/21	
MRI	59%	90%	90%	90%	90%	
CT	75%	95%	95%	95%	95%	



FEWER AVOIDABLE HOSPITAL ADMISSIONS

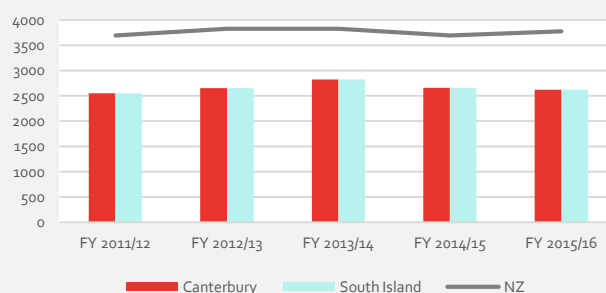
An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, early intervention and the effective management of long-term conditions - including improved coordination of care across primary and secondary services.

Not only will a reduction in avoidable admissions contribute to improved health outcomes for our population, but it will also reduce pressure on hospital and specialist services.

This indicator is seen as a proxy measure of the accessibility and quality of primary care services and a marker of a more integrated and connected health system.

Data Source: Ministry of Health Performance Reporting ¹⁰

Measure: Rate of ambulatory sensitive hospital admission for adults (45-64)	Base	Target				
	15/16	17/18	18/19	19/20	20/21	
	2,623	<2,623	<2,623	<2,623	<2,623	



FEWER FALLS-RELATED HOSPITAL ADMISSIONS

Compared to people who do not fall, those who fall experience prolonged hospital stays, loss of confidence and independence and an increased risk of institutional care.

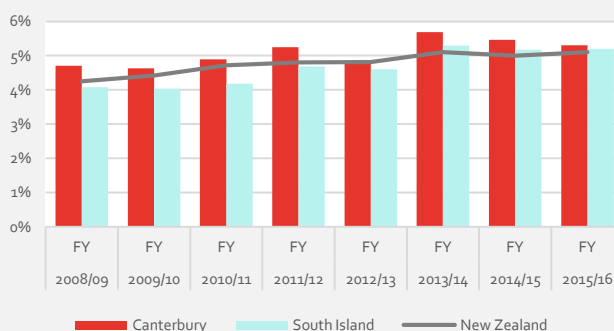
With an ageing population, our focus on reducing harm from falls will help people to stay well and independent and reduce the demand for hospital and residential services.

Solutions to preventing falls include: appropriate medications use, improved physical activity and nutrition, restorative support and a reduction in personal and environmental hazards.

This indicator is seen as a proxy measure of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the individual services being provided.

Data Source: National Minimum Data Set ¹¹

Measure: population (75+) admitted to hospital as a result of a fall	Base	Target				
	15/16	17/18	18/19	19/20	20/21	
	5.3%	<5.5%	<5.5%	<5.5%	<5.5%	



¹⁰ This measure is a national DHB performance indicator (S11) and covers hospitalisations for conditions considered preventable including: asthma, diabetes, 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. Results differ to those previously presented, being based off the national June 2017 series provided by the Ministry of Health. All baselines have been reset to reflect the current series.

¹¹ This measure was reset in 2013/14 to reflect the updated 75+ population in line with the 2013 Census. The target has been set with the aim of reducing rates to below the previous year.

2.19 People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

We are in midst of a significant facilitates redevelopment, remediation and repair programme and capacity within our hospital services is currently severely limited. In order to meet both the physical and emotional needs of our growing population, we are focusing on improving the flow of patients across our system and reducing duplication of effort in order to maintain service access while reducing waiting times for treatment.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE READMISSIONS

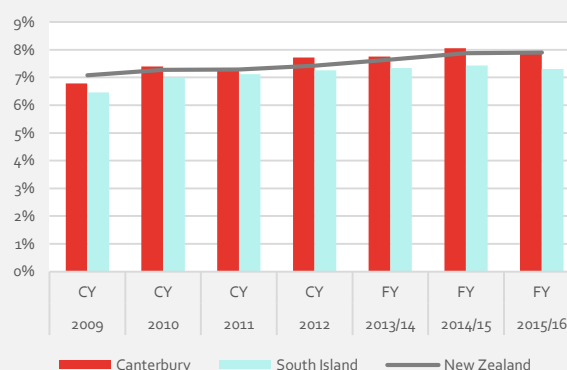
As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

Key factors in reducing acute readmissions include good patient safety and quality standards, appropriate discharge planning and transition processes, and improved care coordination at the interface between services - ensuring people receive effective (and safe) treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided and the level of integration between service providers. These rates are also a good counter-measure to productivity measures such as reductions in lengths of stay.

Data Source: Ministry of Health Performance Reporting ¹²

Outcome measure: rate of acute readmissions to hospital within 28 days of discharge (unstandardised)



A REDUCTION IN AVOIDABLE MORTALITY

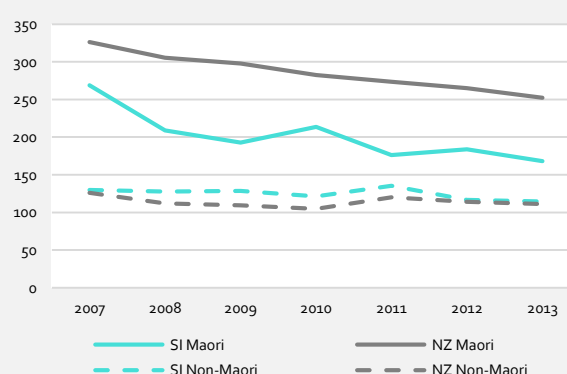
There are many upstream determinants of health, such as economic, social and environmental factors that have an influence on people's life expectancy. However, premature mortality (death before 65) is partly preventable through lifestyle change, earlier intervention and the effective management of long-term conditions.

Timely diagnosis and access to safe and effective treatment are crucial factors in improving survival rates for complex illnesses such as heart disease and cancer.

A reduction in avoidable mortality rates can therefore be used as a proxy indicator of the responsiveness of the health system to the needs of people with complex illness, and as a measure of access to timely and effective care and treatment.

Data Source: National Mortality Collection ¹³

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



¹² This measure is a national DHB performance indicator (OS8). The results differ to those previously published following a reset of the definition by the Ministry of Health in 2016. Because the definition is still undergoing review, the DHB has elected to present the 'raw' or unstandardised rate as this is easier to replicate and match against local admissions, and therefore enables closer analysis of performance. Data is three months in arrears, being the twelve months to March of each year.

¹³ The performance data presented is sourced from the national mortality collection which is three years in arrears.

IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

SHORTER WAITS FOR URGENT CARE

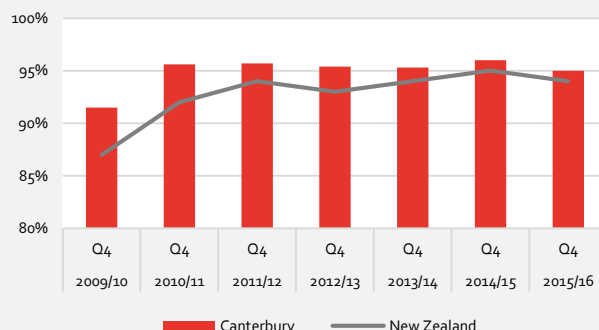
Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.

Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improved patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health services.

Solutions to reducing ED wait times address the underlying causes of delay and span not only our hospital services but the wider health system. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Data Source: DHB Patient Management System ¹⁴

Measure: people admitted, discharged or transferred from ED within 6 hours	Base	Target			
	15/16	17/18	18/19	19/20	20/21
	95%	95%	95%	95%	95%



SHORTER WAITS FOR PLANNED CARE

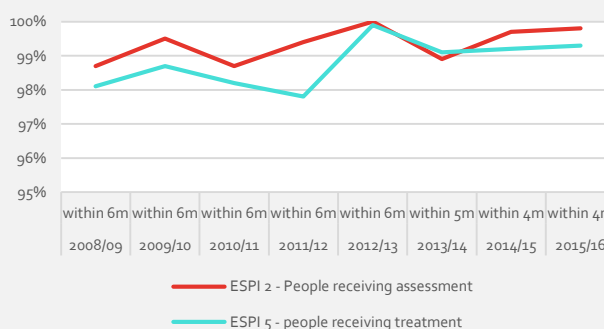
Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort and slowing the progression of disease, and contributes to restoring independence and wellbeing.

Improved performance against this measure requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our hospitals, are a proxy for how well we are managing the coordination and flow of patients across our services.

Data Source: Ministry of Health Elective Services Website ¹⁵

Measure: people receiving specialist assessment and treatment within 4 months	Base	Target			
	15/16	17/18	18/19	19/20	20/21
ESPI ²	99.8%	100%	100%	100%	100%
ESPI ⁵	99.3%	100%	100%	100%	100%



FEWER ADVERSE EVENTS IN OUR HOSPITALS

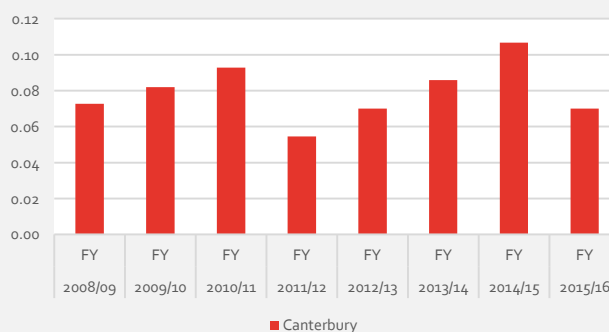
Adverse events, as well as causing avoidable harm to patients, reduce public confidence and contribute unnecessary costs into the system.

Patient falls are particularly important, as patients who experience a serious fall are more likely to have prolonged hospital stays, a loss of confidence, conditioning and independence, and an increased risk of institutional care.

Improving patient safety and quality standards in our hospitals will greatly improve outcomes for patients and achievement against this measure provides an indication of the quality of our services. This indicator is also seen as a proxy measure for the engagement of staff and clinical leaders in improving processes and patient safety.

Data Source: DHB Incident Reporting System ¹⁶

Measure: Rate of falls with a severity assessment code (SAC) of level 1 & 2	Base	Target			
	15/16	17/18	18/19	19/20	20/21
	0.07	0.06	0.06	0.06	0.06



¹⁴ This measure is the national 'Shorter Stays in ED' health target. In line with national health target expectations and reporting, the result presented refer to the final quarter of each year (01 April – 30 June).

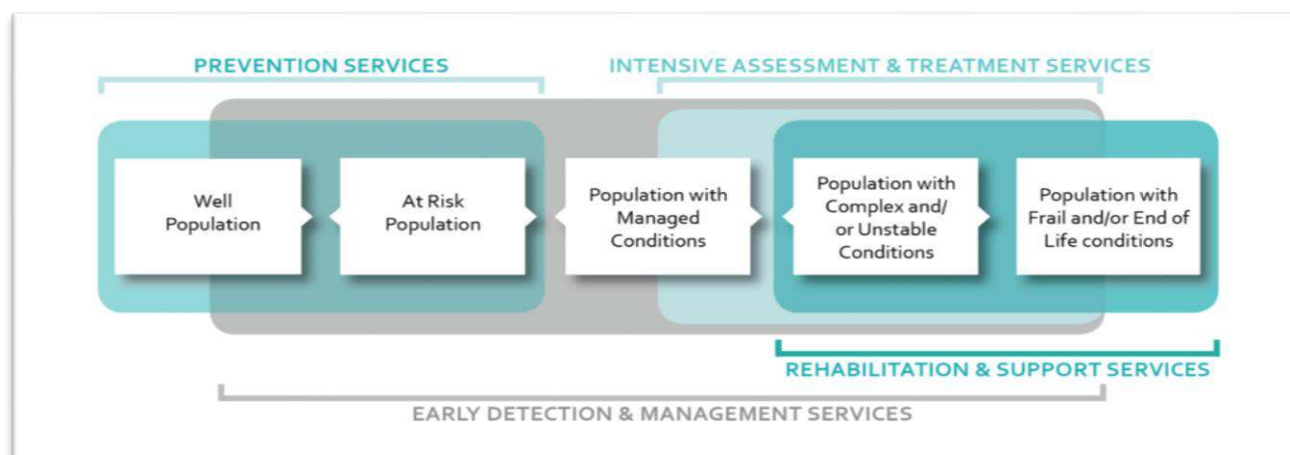
¹⁵ These measures are part of the national DHB Elective Services Patient Flow Indicators (ESPIs) set. In line with national ESPIs performance expectations and reporting the results presented refer to the final month (June) of each year.

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

Part III

Annual Operating Intentions

Statement of Performance Expectations



EVALUATING OUR PERFORMANCE

As both the major funder and provider of health services in Canterbury, the decisions we make and the way in which we deliver services have a significant impact on people's health and wellbeing.

With 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 by tracking the health of our population against a set of desired population health outcomes. These longer term health indicators are highlighted earlier in this document.

Over the shorter term, we evaluate our performance on an annual basis by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are then presented in our Annual Report.¹⁷

The following section presents the Canterbury DHB's statement of performance expectations for 2017/2018.

Because it would be overwhelming to measure every service delivered, services have been grouped into four service classes. These reflect the full health and wellbeing continuum (illustrated above): from keeping people healthy and well, through identifying and treating illness, to supporting people to age well.

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

In presenting our performance picture, the number of people who receive a service is often less important than whether enough of the right people received the service, or whether the service was delivered at the right time. We therefore presented a mix of measures that address four key aspects of performance: Access (A); Timeliness (T); Coverage (C); and Quality (Q).

SETTING STANDARDS

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

Targets reflect the strategic objectives of the DHB: increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining access to services—while reducing waiting times and delays in treatment.

Wherever possible, past years' results have been included in our forecast to give context in terms of current performance levels and what we are trying to achieve, and to support evaluation of our performance over time.

It should be noted that while targeted interventions can reduce service demand in some areas, there will always be some services demand the DHB cannot influence such as: demand for 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. Service level estimates have been provided to give context in terms of the use of resources across our health system.

¹⁷ The DHB's Annual Report is tabled in Parliament every year and is available on our website: www.cdhb.health.nz.

PERFORMANCE EXPECTATIONS

Like all DHBs, with a growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority.

All of our 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 to improve Māori health. These indicators are identified in this forecast (◆) and will be reported by ethnicity in our year-end Annual Report to highlight progress in reducing equity gaps for Māori.

Canterbury is still contending with the ongoing consequences of the earthquakes. The operational impact is being felt most markedly in an increased demand for mental health and emergency services and reduced capacity within our hospitals, due to the loss of buildings and space. The relentless disruption from repairs and construction is also having a negative impact on services and on the wellbeing of our staff.

In considering this pressure and our reduced capacity, we have retained 2016/17 standards against a number of our discretionary measures. However, many of the performance targets presented in our forecast are national expectations set for all DHBs. While we remain committed to maintaining high standards of service delivery, we note that some of these expectations will be particularly challenging in our current operating environment.

WHERE DOES THE MONEY GO?

The table below presents a summary of the budgeted financial expenditure for 2017/18, by output class.

	2017/18
Revenue	Total \$'000
Prevention	37,752
Early detection & management	349,602
Intensive assessment & treatment	1,090,819
Rehabilitation & support	268,745
Total Revenue - \$'000	1,746,918
Expenditure	Total \$'000
Prevention	38,430
Early detection & management	360,848
Intensive assessment & treatment	1,124,338
Rehabilitation & support	276,946
Total Expenditure - \$'000	1,800,562
Surplus/(Deficit) - \$'000	(53,644)

NOTES

Rather than repeating footnotes, the following symbols have been used in the performance tables:

- △ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.
- † Performance data relates to the calendar year rather than the financial year.
- ◇ National Health Targets are set to be achieved by the final quarter of any given year. In line with national performance reporting, baselines refer to the final quarter (April-June) result.
- ◆ This measure has been identified as a key priority area for Māori, and progress by ethnicity will be reported in the Annual Report.
- E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources

3.1 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. These services seek to address individual behaviours by targeting physical and social environments and norms that can influence and support people to make healthier choices and are, in this way, distinct from treatment services.

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 therefore be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Health Promotion and Education Services				
These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Mothers receiving breastfeeding support and lactation support in the community	A ¹⁸	1,058	1,033	>600
Babies exclusive/fully breastfed at LMC discharge (4-6 weeks)	Q ¹⁹ ♦	71%	na	75%
Babies exclusive/fully breastfed at 3 months	Q ¹⁹ ♦	57%	59%	60%
Priority schools supported by the Health Promoting Schools framework	C ²⁰	91%	89%	>70%
People provided with Green Prescriptions for additional physical activity support	A ²¹	2,797	3,095	>3,000
Green Prescription participants more active 6-8 months after referral	Q	62%	75%	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	C ²² ♦♦	89%	88%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	C ♦♦	96%	98%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	C ²³ ♦♦	98%	93%	90%
Women smokefree at two weeks postnatal	Q ²⁴ ♦	90%	88%	95%

¹⁸ 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.

¹⁹ These measure are part of the national WellChild/Tamariki Ora (WCTO) 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 of Health. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available at the time of printing.

²⁰ The Health Promoting Schools Framework is national approach based on addressing activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated, and/or have a high proportion of Māori and/or Pacific children.

²¹ A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a national patient survey completed by Research NZ on behalf of the Ministry of Health. In 2017 a decision was made nationally to shift to biannual surveys. The next survey will be in 2017/18.

²² These are a national performance targets based on evidence that professionals providing brief advice to smokers is shown to increase the chances of smokers making quit attempts. The ABC programme refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support. Targets are set nationally.

²³ This measure is collected via the National Maternity Dataset which covers approximately 80% of pregnancies nationally. The measure is a developmental measure nationally and results are used to indicate trends rather than absolute performance. Targets are set nationally.

²⁴ This measure is part of the national Well-Child/Tamariki Ora Quality Framework, standards are set nationally. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available to the DHB at the time of printing.

Population-Based Screening Services				
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Four-year-olds provided with a B4 School Check (B4SC)	C ²⁵ ♦	91%	91%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q ²⁶ ◇ ♦	new	new	95%
Proportion of children referred to lifestyle programmes who take up the programme	Q	new	new	>50%
Women aged 25-69 having a cervical cancer screen in the last 3 years	C ²⁷ ♦	75%	74%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	C ²⁷ ♦	79%	77%	70%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Children fully immunised at eight months of age	C ◇ ♦	94%	96%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q ²⁸ ◇	98%	98%	95%
Young women (Year 8) completing the HPV vaccination programme	C ²⁹ † ♦	38%	43%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	C ³⁰ † ♦	74%	74%	75%

²⁵ The B4 School Check is the final core WellChild/Tamariki Ora check, which children receive at age four. It is free, and includes assessment of vision, hearing, oral health, height and weight, allowing health concerns to be identified and addressed early in a child's development.

²⁶ This measure is the new national Raising Healthy Kids health target, introduced in Q1 of 2016/17.

²⁷ The cervical and breast screening measures refer to participation in national screening programmes 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.

²⁸ 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children - but have chosen to decline immunisations or opt off the NIR.

²⁹ The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV-related cancers later in life. The programme now consists of two vaccinations and is free to young women and men 9-26 years of age. The target for 2017/18 is the proportion of girls born in 2004 completing the programme. The delivery of Canterbury's HPV programme differs to that provided in other regions, being primarily a general practice based vaccination programme. A school-based programme was launched in February 2016 to complement and support the general practice programme.

³⁰ The denominator for this measure has changed, from the number of people enrolled with a PHO to the Census population, which has had a negative impact on results for the 2016/17 year and means results from previous years will not be directly comparable.

3.2 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

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 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.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Primary Care (General Practice) Services				
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	C [♦]	95%	95%	95%
Young people (0-13) enrolled with general practice where their visits are free	A	new	98%	95%
Young people (0-19) accessing brief intervention counselling in primary care	A ^{31 Δ}	611	610	>500
Adults (20+) accessing brief intervention counselling in primary care	A ^{31 Δ}	5,565	5,505	>3,500
Number of skin lesions (growths, including cancer) removed in primary care	A ^Δ	2,583	2,820	>2,000
Number of integrated HealthPathways in place across the health system	Q ³²	555	499	>500
Proportion of general practices using the primary care patient experience survey	Q ³³	-	new	>35%
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Q ^{34 ♦}	6,154	6,211	<6,476

³¹ The Brief Intervention Counselling 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 results include face-2-face and phone consultations and excludes records with no identifier.

³² The clinically designed HealthPathways support general practice teams to consistently 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. The results differ to those previous published as the count now only reflects community clinical pathways and not the supporting resource pages.

³³ The Patient Experience Survey is a national online survey to determine patients' experience in primary care and how well their overall care is managed. The survey has been piloted in a small number of DHB regions and is now being rolled-out across the country. The information will be used to improve the quality of service delivery and patient safety.

³⁴ 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. The measure is a national DHB performance indicator (SI1) and is defined as the standardised rate per 100,000 population. The DHB's aim is to maintain performance below the national rate (which reflects less people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based off the latest national series provided by the Ministry of Health – to June 2016. Baselines have been reset to reflect the current series and results are to June of each year.

Long-term Conditions Management Services				
These services are targeted at people with high health needs due to having a long-term or chronic condition. High levels of enrolment and engagement levels are indicative of a successful service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Spirometry tests provided in the community rather than in a hospital setting	A ³⁵ Δ	1,682	1,742	>1,000
Eligible population having a cardiovascular disease risk assessment in the last 5 years	C ³⁶ ◇ ◆	82%	87%	90%
People receiving subsidised diabetes self-management support from their general practice team when starting insulin	A Δ	389	392	>300
Population identified with diabetes having an HbA1c test in the last year	C ³⁷ Δ	88%	89%	90%
Population with diabetes having an HbA1c test and acceptable glycaemic control	Q ³⁷ Δ	77%	75%	>75%

Oral Health Services				
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Children (0-4) enrolled in DHB-funded oral health services	C † ◆	69%	61%	95%
Children (0-12) enrolled in DHB oral health services examined according to planned recall	T † ◆	86%	90%	90%
Adolescents (13-17) accessing DHB-funded oral health services	C †	62%	62%	85%

Pharmacy and Referred Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Number of laboratory tests completed for the Canterbury population	A Δ	2.4m	2.5m	E.<2.8m
Number of subsidised pharmaceutical items dispensed in the community	A ³⁸ Δ	6.3m	6.5m	E.<8m
People on multiple medications receiving support via the Medical Management Review programme	A ³⁹ Δ	1,326	1,355	>1,500
Number of community-referred radiology tests completed	A Δ	44,720	44,404	E.>40,000
People receiving their urgent diagnostic colonoscopy within 2 weeks	T ⁴⁰ ⁴¹ ◇	96%	92%	90%
People receiving their Magnetic Resonance Imaging (MRI) scans within 6 weeks	T ⁴⁰ ◇	75%	59%	90%
People receiving their Computed Tomography (CT) scans within 6 weeks	T ⁴⁰ ◇	96%	75%	95%

³⁵ 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. Volumes include those delivered by general practice and mobile community respiratory providers.

³⁶ Cardiovascular disease is one of the leading cause 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. Targets and eligible population is set nationally: Māori, Pacific or Indian, males 35-74, females 45-74 and all other males 45-74 and females 55-74.

³⁷ Diabetes is a leading long-term conditions 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 their condition - a level of less than 64mmol/mol reflects an acceptable blood glucose level.

³⁸ This measure covers pharmaceutical items dispensed by community pharmacies to people living in the community. Hospital dispensed items are excluded, however it may still include some non-Canterbury residents who had prescriptions filled while in Canterbury.

³⁹ The Medical Management Review programme helps to ensure the safe and appropriate use of medications. The programme now offers more intense medication therapy assessments for the most complex patients and less complex medications use reviews for others – baselines have been adjusted to reflect both aspects of the programme.

⁴⁰ These diagnostic measures are national performance measures (PP29) and baselines are as at the final month of the year (June) in line with national results published by the Ministry of Health. Targets are set to match national standards set for all DHBs. The wait times refer to non-urgent MRI and CT scans.

⁴¹ A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). A colonoscopy helps find ulcers, colon polyps, tumors, and areas of inflammation or bleeding, and to determine treatment.

3.3 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, capacity, treatment thresholds 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 result 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.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

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. ⁴²	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Rate of staff compliance with good hand hygiene practice	Q ⁴³ ◇	77%	78%	80%
Hip and knee replacement patients receiving routine antibiotics before surgery	Q ⁴⁴ ◇	98%	98%	95%
Hip and knee replacement patients receiving antiseptic skin preparation in surgery	Q ⁴⁴ ◇	100%	100%	100%
Response rate to the national inpatient patient experience survey	Q ⁴⁵	17%	37%	>30%
Proportion of patients who felt they 'received enough information from the hospital on how to manage their condition after discharge'	Q ⁴⁶	56%	54%	>64

Maternity Services				
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Women registered with a Lead Maternity Carer (LMC) by 12 weeks of pregnancy	C ⁴⁷ †◆	77%	77%	80%
Number of maternity deliveries in Canterbury DHB facilities	A	5,897	5,922	E 6,000
Proportion of maternity deliveries made in Primary Birthing Units	A ⁴⁸ Δ	12%	14%	>13%
Babies exclusively breastfeeding on hospital discharge	Q ⁴⁹	80%	79%	75%

⁴² These quality measures are national markers monitored by the NZ Health Quality & Safety Commission. Performance reporting is aligned to the HQSC reports (being the quarter to June of each year) and standards are set nationally.

⁴³ This measure is based on ward audits of medical and surgical wards conducted according to Hand Hygiene NZ standards.

⁴⁴ Cefazolin and cefuroxime are antibiotics recommended as routine for hip and knee replacements to prevent infection complications. Skin preparation with antiseptic is also recommended to prevent infection.

⁴⁵ There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. The inpatient patient experience survey runs quarterly in all district health board hospitals and covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs.

⁴⁶ This is a question in the national inpatient patient experience survey under the coordination domain and reflects patients responding yes, or definitely/yes to the question posed. The focus is on supporting people to manage at home after discharge and to reduce readmissions.

⁴⁷ This measure comes from the national Maternity Collection and updated data for 2015/16 was provided by the Ministry in line with the adoption of this measure as one of the new national Better Public Services measures. The aim is to engage mothers with the health system early in their pregnancy to promote good health and wellbeing of both mother and baby.

⁴⁸ 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 indicated. This enables the best use of resources and ensures limited secondary services are more appropriately available for those women who need more complex or specialist intervention.

⁴⁹ 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 in alignment with World Health Organisation recommendations.

Acute and Urgent Services				
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
General practices providing telephone triage outside business hours	C	92%	93%	95%
Acute demand packages of care provided in community settings	A ⁵⁰ Δ	31,182	33,010	>30,000
Presentations at Canterbury Emergency Departments (ED)	A ⁵¹	91,253	94,251	E.<96,000
Proportion of the population presenting at ED (per 1,000 people)	Q	177	177	<178
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 ◇	73%	70%	90%
Acute inpatient average length of hospital stay (standardised)	Q ⁵²	2.40	2.39	<2.35

Elective/Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
First Specialist Assessments provided	A ⁵³	72,069	71,244	E.>60,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q ⁵⁴	19%	17%	>10%
Elective/arranged surgical discharges (surgeries provided)	A ◇ ⁵⁵	20,353	21,039	21,330
Proportion of people receiving their elective coronary angiography within 3 months	T ⁵⁶	98%	98%	95%
Proportion of people receiving their surgery on the day of admission	Q ⁵⁷	91%	91%	90%
Elective inpatient average length of hospital stay (standardised)	Q ⁵²	1.57	1.54	<1.54
Outpatient consultations provided	A	651,259	671,705	E.>600k
Outpatient appointments where the patient was booked but did not attend (DNA)	Q ⁵⁸	5%	5%	<5%

⁵⁰ 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.

⁵¹ This measure is aligned to the national Shorter Stays in ED Health Target and counts presentations to both Christchurch and Ashburton Hospital EDs –this measure excludes those who do not wait and those with pre-arranged appointments.

⁵² This measure is a national DHB 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, better use of the time clinical staff spend with patients, 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.

⁵³ This measure counts both medical and surgical assessments but counts only the first specialist assessments (where the specialist determines treatment) and not follow-ups or consultations after treatment has occurred.

⁵⁴ Non-contact assessments are those where advice or assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients.

⁵⁵ This measure is aligned to the national Electives Health Target and does not include all surgery or procedures delivered by the DHB.

⁵⁶ A coronary angiogram is an x-ray test used to determine if a person's coronary arteries are blocked or narrowed, where and by how much. This is a national performance measure (PP29) and baselines are as at the final month of the year (June) in line with national results published by the Ministry of Health. An angiogram can help determine the type of treatment needed such as angioplasty or stent, coronary artery bypass surgery or medical therapy. Timely access to this treatment supports improved outcomes for patients.

⁵⁷ When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own home and indicates effective planning on behalf of services who are not delaying or cancelling surgeries.

⁵⁸ This measure is calculated as the proportion of all medical and surgical outpatient appointments where the patient was expected to attend on the day, but did not. When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes and it is costly in terms of wasted resources for the DHB.

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 a responsive and efficient service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Proportion of the population (0-19) accessing specialist mental health services	C ⁵⁹ Δ	3.5%	3.5%	>3.1%
Proportion of the population (20-64) accessing to specialist mental health services	C ⁵⁹ Δ	3.2%	3.4%	>3.1%
People referred for non-urgent mental health and alcohol and other drug services seen within 3 weeks	T ⁶⁰	73%	76%	80%
People referred for non-urgent mental health and alcohol and other drug services seen within 8 weeks	T ⁶⁰	90%	93%	95%

Specialist 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.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Admissions into inpatient AT&R services	A ^Δ	3,462	3,371	E.>3,000
Inpatients (aged 75+) who received a falls assessment	Q ⁶¹ ◇	96%	100%	90%
Admissions into Older Person's Health AT&R services by direct community referral	Q ⁶²	21%	20%	>20%
Proportion of OPH AT&R inpatients discharged to their own home rather than ARC	Q ⁶³ Δ	87%	86%	>80%

⁵⁹ These measures are national DHB performance measures (PP6), and standards are set based on the expectation that 3% of the population will need access to specialist level mental health services during their lifetime. Results are provided by the Ministry of Health and reflect only those services reporting through to the national PRIMHD database. This measure undercounts service provision where local providers are not set up to report to the national system. It should also be noted that the short timeframe presented also does not reflect the extent of the increase in demand for mental health services in Canterbury - access rates in December of 2010 (prior to the earthquakes) were 1.7% for youth and 2.2% for adults.

⁶⁰ These measures are national DHB performance measures (PP8). Performance results are provided nationally and three months in arrears.

⁶¹ While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and act accordingly. In line with national expectations, the DHB aims to assess all the falls risk of all older inpatients and develop a falls plan to reduce risk.

⁶² This is a subset of the total AT&R services: age-related AT&R services provided by the Older Person's Health Division of the DHB. The purpose of direct referral is to improve support for at risk older people by allowing an intervention to prevent an adverse event, rather than only taking referrals post an event – i.e. following an inpatient hospital stay.

⁶³ While living in ARC is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge from AT&R to home (rather than ARC) reflects the quality of services in terms of assisting that person to regain their functional independence. The measure excludes those who were ARC residents prior to AT&R admission.

3.4 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes or regain functional ability after a health related event. These services are considered to 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 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 by reducing acute demand, unnecessary ED presentations and the need for more complex interventions. These 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.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Rehabilitation Services				
These services restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
People accessing community-based pulmonary rehabilitation courses	A ⁶⁴	222	261	>200
People (65+) accessing community-based falls prevention programmes	A ⁶⁵	1,686	1,973	>1,500
People referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	Q	80%	80%	80%
People referred to cardiac rehabilitation services after an acute event	Q ⁶⁶	15%	22%	30%

Home and Community-Based Support Services				
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
People supported by CREST services, on hospital discharge or GP referral	A ⁶⁷ Δ	1,770	1,726	>1,500
People supported by district nursing services	A Δ	7,765	7,532	E.>7,000
People supported by long-term home-based support services	A Δ	8,641	8,129	E.>8,000
Older people (65+) receiving long-term home and community support services who have had a clinical assessment of need using the interRAI assessment tool	Q ⁶⁸ Δ	94%	96%	95%
People supported by hospice or home-based palliative services	A Δ	3,934	3,617	E.>3,000

⁶⁴ Respiratory or lung diseases are a key driver of a significant portion of avoidable hospital admissions in Canterbury, particularly over winter. Pulmonary Rehabilitation Programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (a type of obstructive lung disease) to manage their symptoms, which include breathlessness, coughing and wheezing. The programmes run for eight weeks and people learn breathing, diet, exercise and day-to-day living techniques to better manage their condition. This measure includes people attending community-based DHB funded pulmonary rehabilitation programmes in Ashburton and Christchurch.

⁶⁵ Falls are one 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 both 'at-risk' of a fall, or following a fall, and to support people to stay safe and well in their own homes.

⁶⁶ Cardiovascular Disease is one of the leading causes of death in Canterbury. This measure counts those accessing Phase 2 (outpatient) cardiac rehabilitation on discharge from hospital, with the aim of supporting people to modify their lifestyles following an acute event.

⁶⁷ The CREST service provides a range of home-based rehabilitation services to facilitate people's early discharge from hospital, or to avoid admission entirely, through proactive GP referral. The measure is the number of clients having received unique packages of care.

⁶⁸ The International Residential Assessment Instrument (interRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning. Evidence-based practice guidelines ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live.

Respite and Day Services				
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need 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.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Older people accessing day care services	A ^{Δ69}	832	804	E.>550
People accessing mental health crisis respite services	A ^Δ	774	886	E.>750
Occupancy rate of mental health crisis respite beds	A ⁷⁰ Δ	70%	74%	85%
People accessing aged care respite services	A ^Δ	1,424	1,620	E.>1,000

Aged Residential Care Services				
With an ageing population, demand for aged related care (ARC) is expected to increase, but 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.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Number of ARC rest home bed-days provided	A ^Δ	528,795	501,688	E.<676k
Number of ARC hospital bed-days provided	A ^Δ	471,724	494,185	E.<507k
Number of ARC dementia bed-days provided	A ^Δ	231,066	239,996	E.>220k
Number of ARC psycho-geriatric bed-days provided	A ^Δ	67,833	70,562	E.>65k
People entering ARC having had a clinical assessment of need using interRAI	Q ⁶⁸ Δ	99%	99%	95%

⁶⁹ Includes people accessing day care services in the community and in ARC.

⁷⁰ Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that services are under-utilised and resources could be better directed to other areas.

Meeting Our Financial Challenges

3.5 Canterbury's financial outlook

Government funding, via the Ministry of Health, is the main source of DHB funding. This is supplemented by revenue agreements with ACC, research grants, donations, training subsidies and patient co-payments.

While health continues to receive a large share of national funding, clear signals have been given that the health sector must rethink how it will meet the needs of our populations within a more moderate growth platform. The Minister of Health has made it clear that DHBs are expected to operate within existing resources and approved financial budgets.

Like the rest of the health sector, the Canterbury DHB is experiencing growing financial pressure from increasing demand, treatment costs, wage settlements and heightened public expectations.

However, unlike other DHBs, we are also having to manage the extraordinary impacts of the country's largest natural disaster including: population funding shifts, increased service demand and the operational challenges of a significant repair programme.

It is increasingly challenging to meet financial expectations while at the same time addressing the needs of a more vulnerable population and rebuilding almost all of our entire health infrastructure.

Earthquake related costs are evident in a number of areas: increased treatment costs to meet heightened demand; additional outsourcing costs to support service delivery while our capacity is reduced; and the unplanned costs of recovery and repair work.

A significant proportion of our repair work is not covered by our insurance proceeds. While we received the maximum \$320 million insurance pay-out under our collective sector policy, damage estimates were over \$518 million. Our repair programme will require ruthless prioritisation to remain affordable.

The Burwood Hospital redevelopment was behind schedule which impacted on the DHB's ability in achieving anticipated savings from the consolidation of services. Our DHB-wide theatre and bed capacity is reduced and until our new facilities are completed, we will have to carry significant additional costs for hiring theatres and outsourcing surgeries.

Included in the unplanned costs related to the earthquakes are the depreciation and capital charges the DHB must pay to the Crown. Because these are driven off upward movements in asset valuations the repair work (on top of planned redevelopment) results in significant annual charges. In 2017/18 Canterbury will pay an estimated \$30.3 million in capital charges to the Crown, adding additional pressure to our already tight fiscal environment.

Demand patterns continue to change. In line with other international recovery profiles, the post-disaster impacts on the health and well-being of our population are being acutely felt. This is particularly evident in the increased demand for mental health services with new presentations to children's services especially high. International evidence would suggest we could expect continued population impacts for up to a decade.

Our situation is further exacerbated by the interplay between local population fluctuations and the national population based funding mechanism. The funding formula was never designed to deal with the kind of dynamic population shifts and demand changes we have experienced. From Canterbury's perspective, the formula has the wrong inputs and is not proving to be a flexible or sensitive enough mechanism in a post-quake environment.

3.6 Planned results

In 2017/18 the Canterbury DHB will receive \$1.747 billion of total revenue with which to meet the needs of our population and manage the significant cost increases of recent Multi Employment Collective Agreement (MECA) settlements.

The Canterbury DHB is predicting a \$53.6 million deficit result for the 2017/18 year.

The \$53.6 million forecast deficit takes into account the net effect of all the known prior year's funding movements, including Canterbury's share of demographic and cost pressures and pharmaceutical investment funding provided to DHBs by the Ministry of Health and the \$5.5 million in additional mental health funding (provided in 2016 for a fixed three-year period to cover increased demand for mental health services following the earthquakes).

The additional mental health funding supported our response to changing mental health demand patterns by allowing us to invest further in a range of targeted initiatives and services where demand is highest.

While the extra funding acknowledged the sustained pressure on our mental health services, it does not address all of Canterbury's earthquake related mental health challenges, as evidenced by the ongoing demand for mental health services.

In the period ahead, the DHB will work with the Ministry to address our concerns with regards to the sustainability of funding of mental health services.

Both revenue and external provider expenditure includes the recent allocation of \$25.2 million of pay equity funding to Canterbury. While this is expected to be cost neutral for those specifically covered by the settlement, we are unable to predict the additional

costs in relation to flow-on expectations from other professional groups and providers.

OUT-YEARS' SCENARIO

The current reality in Canterbury will continue to create a high level of uncertainty with regards to both revenue and expenditure in out-years.

This uncertainty is driven by a number of interrelated factors including: revenue volatility resulting from population and deprivation shifts; changing health demands post-earthquake; costs of servicing an unenrolled rebuild population; earthquake repair costs; unforeseen delays in the redevelopment programme; and unknown costs in assuming responsibility for the Chatham Islands.

Our remaining unspent earthquake insurance proceeds are held by the Crown on behalf of the DHB. We are able to draw down these proceeds as revenue to offset earthquake-related operating repair costs and as equity to offset capitalised repair costs. However, equity drawdowns incur a capital charge in addition to the operational impact of depreciation.

Interest, depreciation and capital charge costs arising from earthquake repairs, assets revaluation and the new Burwood and Christchurch Hospital facilities will have a significant impact on our out-year financials. These costs will increase significantly on the completion of the Acute Services Building and other significant earthquake damaged replacement facilities such as Outpatients and the Energy Centre. The combined annual depreciation, interest and capital charge will increase by \$69.5 million (from \$69 million in 2015/16 to approximately \$138.5 million by 2019/20).

Whilst independent cost assessments have been received for a number of earthquake repair projects, the final interplay between the nature of repairs, new building codes and construction cost escalations is dynamic. Estimates of the anticipated costs have been included but an accurate total overall cost is still difficult to pre-determine.

Also, due to the recognition of insurance proceeds in 2012/13 (as required under current NZ accounting standards), some future costs are not able to be offset with the corresponding inflow of insurance proceeds. This creates a timing mismatch in current and out-years.

3.7 Major assumptions

Revenue and expenditure estimates for out-years have been based on current government policy settings, services delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results.

In preparing our financial forecasts, we have made the following assumptions:

- Out-years funding is assumed at the Treasury's mid-scenario forecasts for Canterbury DHB.

- The DHB will retain early payment arrangements.
- The DHB will receive deficit funding equivalent to forecast operating deficits as equity.
- Deficit funding associated with the 2016/17 deficit is not required to be recorded in Canterbury DHB closing equity as at June 2017 i.e. it will be recorded in 2017/18.
- Capital charge for out-years is based on the current rate of 6%, any rate change in the future is assumed to be financially neutral.
- Any targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement. This includes assumption of responsibility for the population of the Chatham Islands which was to be cost neutral.
- Funding for pay equity settlements will be cost neutral as they will be fully funded.
- \$290 million, (being the yet to be spent portion of Canterbury's \$320 million earthquake settlement proceeds as at 2015 and transferred to the Crown to minimise capital charge expenses), will be available to the DHB to be drawn down as required to fund the DHB's earthquake repair and reinstatement programme.
- As agreed with the Ministry of Health, the revenue and equity timing of the draw down will be flexible and based on DHB requests rather than necessarily matching the earthquake capital and operating repair spend for a particular year.
- Work will continue on the redevelopment of Canterbury facilities in accordance with the detailed business case agreed with the Ministry and Cabinet. Capital expenditure associated with the redevelopment that will take place during the term of this Plan has been included.
- Revaluations of land and buildings will continue and will impact on asset values. In addition to regular periodic revaluations, further impairment in relation to earthquakes may be necessary.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors, reasonable price charge impacts on providers, and foreseen adjustments for the impact of growth within services.
- National and regional savings initiatives and benefits will be achieved as planned.

- Transformation strategies will not be delayed or derailed due to sector or legislative changes and investment to meet increased earthquake-related demand will be prioritised and approved, in line with the Board's strategy.
- There will be no further disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no disaster.

3.8 Bridging the gap

There is no 'quick-fix' solution to ensuring the clinical and financial sustainability of our health system.

Improving the health and wellbeing of our population is the only way to truly get ahead of the demand curve. While these gains may be slow, they are already evident, and are the foundation from which we will build a more effective and sustainable health system.

Since establishing our vision in 2006, we have been purposeful and deliberate in planning how we would meet growing demand for health services and make the best use of the resources we have available.

In the past seven years, we have absorbed over \$89 million in revenue and cost impacts related to the earthquakes, over and above the \$100.4 million revenue deficit and \$12.5 million equity deficit funding received from government over the same period.

This has largely been delivered by achieving lower rates of acute demand, reducing our dependence on aged residential care, reorganising laboratory services, and removing waste and duplication from our system.

We are committed to continuing our deliberate strategy in this regard – working across the whole of our system to deliver on our vision and improve long-term health outcomes for our population.

Alongside the effective transformation of our health system, we are also focused on delivering efficiency and quality improvements to take the wait and waste out of our system. In the coming year, we will consider all options and opportunities to bridge the gap between revenue and expenditure including:

- Integrating systems, services and processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.
- Improving production planning to ensure we use our resources in the most effective way.
- Focusing expenditure on areas that are essential, and reducing the outsourcing of services.
- Prioritising investment into services that meet the most immediate demand, deliver maximum health benefits, and are sustainable longer-term.

- Aligning policies and practice with other DHBs and with national service specifications to reduce treatment and service costs.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Restraining cost growth including moderating treatment, back office, support and FTE costs.
- Supporting the South Island Alliance to implement tighter cost controls and make purchasing improvements to limit the rate of cost growth by taking a lead in the regional Procurement and Supply Chain Workstream.

Anticipated service changes for 2017/18 are outlined in the Managing our Business section of this document.

NATIONAL SUPPORT

Significant earthquake-related service planning and delivery challenges continue to be experienced. The DHB has requested the assistance of the Ministry of Health and other government agencies in addressing a number of these issues, including:

- Standard funding methodologies are unable to account for the dynamic population changes following the Canterbury earthquakes. We need a clear and stable future funding path.
- Standard measures of population deprivation are proving to be insensitive and were never designed to cope with a post-disaster environment. We need an interim fix to account for the impacts of forced migration and secondary stressors.
- Delays and choices being made in relation to the redevelopment and repair of our infrastructure are creating additional financial pressures. We need improved understanding of the operational impacts of short-term capital decisions.
- Traditional measures of demand, focused on hospital outputs, mask the true need of our population. We need to enable measures that consider the whole picture as we drive towards a more integrated system.

3.9 Capital investment

NATIONAL BUSINESS CASES

In March 2013, the detailed business case for the redevelopment of Burwood and Christchurch Hospital sites was approved by Cabinet and the Capital Investment Committee. The Burwood redevelopment has been completed and the Acute Services Building and Outpatient Building on the Christchurch Hospital campus are now scheduled for completion in 2018/19.

The business case and implementation plan for replacement of our legacy patient administration systems with one South Island Patient Information Care System (PICS) was approved by Cabinet in 2014.

Burwood was the first go-live site and we are currently progressing with the staged implementation in alignment with the new facility timeframe.

The Canterbury DHB has also submitted an indicative business case for the relocation of mental health services from the Princess Margaret Hospital site, which were originally destined to be migrated to the Christchurch Hospital campus, as part of the 2013 detailed business case.

This indicative business case, which assumed the project will be fully equity funded by the Crown, was approved by the Minister of Health in September 2017. Development of a detailed business case for this critical capital project is in progress and expected to be completed in early 2018.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, Canterbury's capital expenditure budget totals \$42 million for the 2017/18 year, and is comprised of:

- \$5 million capital expenditure portion of the strategic earthquake programme of works.⁷¹
- \$5 million Patient Information Care System.
- \$2 million Electronic Medication Management.
- \$30 million other new/replacement assets and systems.

Anticipated investment for 2017-2020 includes:

- Strategic Information Technology developments, including implementation of the Patient Information Care System, Electronic Medication Management, HealthOne, and investment in the patient portal—towards a digital hospital.
- Completion of the facilities redevelopment on the Christchurch Hospital site (Acute Services Building) in line with the approved detailed business case.
- Repair and reinstatement of the Christchurch Hospital Energy Centre, Carpark, Tunnel and Outpatient Building.
- Completion of the Rangiora and Akaroa IFHC redevelopments in line with approvals.
- Continued repair and reinstatement of assets under the DHB's earthquake repair programme.
- Relocation of mental health services currently located on the Princess Margaret Hospital site.

Any lengthy building delays, changes in building codes or cost price increases for any of our major repair or redevelopment projects are likely to have a significant impact on planned expenditure.

Out-years capital planning will also consider the future use of existing buildings and facilities, in line with our earthquakes repair programme and, in response to population growth, service capacity issues. These will include Parkside on the Christchurch Hospital campus, Canterbury Health Laboratories and buildings on the Hillmorton Hospital campus.

3.10 Debt and equity

In February 2017, all existing DHB's Crown debts were converted to equity as part of the Crown's debt/equity translation process. The pre-approved debt for the new Acute Services Building will also be translated to equity. Effective from 2016/17, DHBs will have no Crown debt. Any cost differential between increased capital charge and reduced interest expense arising from the debt/equity conversion will be adjusted for by additional funding for a two-year period (i.e. neutral impact to the operating result until mid-2018/19).

The Canterbury DHB repaid equity to the Crown of \$180 million over 2013/14 and 2014/15 as part of our contribution towards the Burwood and Christchurch Hospital redevelopments.

The extent of damage to Canterbury DHB's insured facilities and equipment is well in excess of \$518 million. However, the nature of the collective sector insurance in place at the time of the earthquake meant a total maximum loss capacity of \$320 million. While we were able to obtain the entire \$320 million, the gap between the insurance settlement and the total cost of the repairs will need to be met from our existing funds.

In June 2014, we paid \$290 million of our earthquake settlement proceeds to the Crown to minimise capital charge expenses. As agreed with the Ministry of Health, the \$290 million is being progressively drawn down to fund earthquake repair work.

For the safety of patients and staff we need to complete our repair and reinstatement programme without delay. The inherent shortfall between the insurance settlement and the full cost of repairs means we will need to access the full \$290 million earthquake settlement proceeds as agreed.

The forecast drawdown as at 30 June 2017, is \$98 million (a mix of revenue and equity), leaving a balance of \$192 million yet to be drawn, as either revenue or equity depending on the type of repairs. This is now unlikely to be sufficient in light of recent costs coming out of this settlement related to the redevelopment of the Acute Service Building, completion of the boiler house and energy centre, and costs related to the migration of stranded mental health services.

Taking into account equity movements over the next four years (such as earthquake proceeds redrawn as equity, debt to equity conversion, equity for the Acute

⁷¹ Cost for significant earthquake projects managed by the Ministry will only be charged to the DHB on completion and transfer of the assets. No transfer is expected in 2017/18.

Services Building and deficit funding), the Crown's equity in the DHB will rise from \$518 million as at June 2017 to \$1.152 billion by June 2020.

3.11 Additional considerations

DISPOSAL OF LAND

Under the NZ Public Health and Disability Act, no DHB may dispose of land without approval of the Minister of Health. Ministerial approval will only be given where the DHB has complied with its statutory clearance and public consultation obligations under the Act.

Anticipated activity for 2017-2019 includes the potential disposal of a parcel of land on St Asaph Street and two parcels of land on Tuam Street as part of a land swap with Otakaro and Land Information New Zealand (LINZ) within the Health Precinct. The DHB is also proposing disposal of two other land parcels: one on Maddison's Road in Templeton to facilitate City Council infrastructure arrangements and one on Lincoln Road in Hillmorton to accommodate the new city cycle lanes and a road widening project.

We are considering the future use of the former Christchurch Women's Hospital site in the central city and the Princess Margaret Hospital site in Cashmere. The future use of these sites will be determined following completion of the Acute Services Building and Outpatients Building and the decanting of services from the Princess Margaret Hospital.

We are considering the future use of all of our rural hospitals in line with our rural sustainability project. It is unlikely that all of the rural hospitals will continue to operate in their current form.

Due process will be undertaken with regard to the sale of any DHB land.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

No compensation is sought by the Crown in accordance with the Public Finance Act Section 41(D).

ACQUISITION OF SHARES

Before the Canterbury DHB or any of our associates or subsidiaries can subscribe for, purchase, or otherwise acquire shares in any company or other organisation, our Board will consult the responsible Minister(s) and obtain their approval.

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 4.

Statement of Financial Expectations

3.12 Group statement of comprehensive revenue and expense

For the years ending 2015/16 to 2019/20

	2015/16 Actual \$'000	2016/17 Actual \$'000	2017/18 Plan \$'000	2018/19 Plan \$'000	2019/20 Plan \$'000
REVENUE					
Ministry of Health revenue (Note 1)	1,538,949	1,573,724	1,660,767	1,707,439	1,756,663
Other government revenue	29,270	28,932	31,120	32,364	33,659
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other revenue	44,391	42,740	47,231	51,489	63,909
Total Revenue	1,622,492	1,656,108	1,746,918	1,809,792	1,878,031
EXPENSE					
Personnel	675,097	704,206	745,725	782,293	817,612
Outsourced (Note 2)	26,920	25,907	25,032	24,597	24,159
Clinical supplies	133,550	142,878	148,168	153,904	164,563
Earthquake building repair costs	9,882	10,712	7,800	18,500	23,800
Infrastructure & non clinical (excl Earthquake repairs)	101,729	105,685	99,225	102,425	105,546
Payments to non-DHB providers	606,747	643,176	684,378	698,582	685,388
Interest	5,575	3,932	200	-	-
Depreciation and amortisation	57,739	56,268	59,704	69,572	71,237
Capital charge expense	5,726	16,177	30,330	34,458	67,242
Total Expense	1,622,965	1,708,941	1,800,562	1,884,331	1,959,547
Surplus/(Deficit)	(473)	(52,833)	(53,644)	(74,539)	(81,516)
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	91,753	-	-	-	-
Impairment of property, plant & equipment	-	(1,491)	-	-	-
Total Comprehensive Income/(Deficit)	91,280	(54,324)	(53,644)	(74,539)	(81,516)

Note 1: Includes Inter-District Flow and Inter-DHB revenue

Note 2: Excludes outsourced electives payments to Non-DHB Providers

3.13 Group statement of financial position

As at 30 June for the years ending 2015/16 to 2019/20

	30/06/16 Actual \$'000	30/06/17 Actual \$'000	30/06/18 Plan \$'000	30/06/19 Plan \$'000	30/06/20 Plan \$'000
CROWN EQUITY					
Contributed capital (Note 3)	(282,151)	90,073	204,689	833,367	934,022
Revaluation reserve	290,849	289,058	289,058	289,058	289,058
Accumulated surpluses	191,235	138,702	85,058	10,519	(70,997)
Total Equity	199,933	517,833	578,805	1,132,944	1,152,083
REPRESENTED BY:					
CURRENT ASSETS					
Cash & cash equivalents	13,546	1,985	-	8,012	4,899
Trade & other receivables	69,349	72,652	126,292	147,187	154,164
Inventories	9,432	9,118	9,118	9,118	9,118
Restricted assets	8,060	11,815	11,815	11,815	11,815
Assets held for sale	540	-	-	-	-
Investments	1,000	1,350	1,350	1,350	1,350
Total Current Assets	101,927	96,920	148,575	177,482	181,346
CURRENT LIABILITIES					
NZHPL sweep bank account	-	16,505	2,250	-	-
Trade & other payables	100,886	106,936	93,936	93,936	93,936
Employee benefits	154,321	156,703	156,700	156,700	156,700
Restricted funds	14,297	12,111	12,111	12,111	12,111
Total Current Liabilities	269,504	292,255	264,997	262,747	262,747
Net Working Capital	(167,577)	(195,335)	(116,422)	(85,265)	(81,401)
NON CURRENT ASSETS					
Property, plant, & equipment	499,233	693,087	667,633	1,188,027	1,204,038
Intangible assets	14,386	25,940	33,453	36,041	35,305
Restricted assets	6,237	296	296	296	296
Total Non-Current Assets	519,856	719,323	701,382	1,224,364	1,239,639
NON CURRENT LIABILITIES					
Employee benefits	6,361	6,155	6,155	6,155	6,155
Borrowings (Note 3)	145,985	-	-	-	-
Total Non-Current Liabilities	152,346	6,155	6,155	6,155	6,155
Net Assets	199,933	517,833	578,805	1,132,944	1,152,083

Note 3: Existing borrowings from the Crown were translated to equity, effective February 2017. The pre-approved Crown debt for the Christchurch Hospital campus facility redevelopment will be transacted as equity when the completed asset is transferred to the DHB.

3.14 Group statement of movements in equity

For the years ending 2015/16 to 2019/20

	2015/16 Actual \$'000	2016/17 Actual \$'000	2017/18 Plan \$'000	2018/19 Plan \$'000	2019/20 Plan \$'000
Total equity at beginning of the year	77,014	199,933	517,833	578,805	1,132,944
Total comprehensive revenue and expense for the year	91,280	(54,324)	(53,644)	(74,539)	(81,516)
OTHER MOVEMENTS					
EQUITY REPAYMENTS					
Assets disposal net proceeds remitted to Crown	-	-	-	-	(20,000)
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
EQUITY INJECTIONS					
Earthquake repair capital redrawn	33,500	11,100	10,000	57,000	41,000
Kaikoura facility contribution	-	2,000	-	-	-
Operating deficit support (Note 4)	-	-	106,477	74,539	81,516
New facilities redevelopment assets transferred from the Crown (original equity value)	-	130,000	-	274,400	-
New facilities redevelopment assets transferred from the Crown (approved debt swapped to equity value)	-	85,000	-	224,600	-
Debt to equity swap - debt as at June 2016	-	145,985	-	-	-
Total Equity at End of the Year	199,933	517,833	578,805	1,132,944	1,152,083

Note 4: 2017/18 includes 2016/17 deficit support. Out years deficit support is accrued in the year the deficit occurs.

3.15 Group statement of cash flow

For the years ending 2015/16 to 2019/20

	2015/16 Actual \$'000	2016/17 Actual \$'000	2017/18 Plan \$'000	2018/19 Plan \$'000	2019/20 Plan \$'000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash provided from:					
<i>Receipts from Ministry of Health</i>	1,554,809	1,570,290	1,643,309	1,689,283	1,737,781
<i>Earthquake repair revenue redrawn</i>	9,882	10,712	7,800	18,500	23,800
<i>Other receipts</i>	30,316	94,967	94,230	99,042	103,517
<i>Interest received</i>	2,463	2,113	1,579	2,967	3,033
	1,597,470	1,678,082	1,746,918	1,809,792	1,868,131
Cash applied to:					
<i>Payments to employees</i>	699,786	720,349	763,497	799,887	835,030
<i>Payments to suppliers</i>	844,786	934,510	959,831	980,414	986,038
<i>Interest paid</i>	4,910	5,107	200	-	-
<i>Capital charge</i>	5,726	16,175	30,330	34,458	67,242
<i>GST - net</i>	639	(3,886)	-	-	-
	1,555,847	1,672,255	1,753,858	1,814,759	1,888,310
Net Cash Flow from Operating Activities	41,623	5,827	(6,940)	(4,967)	(20,179)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash provided from:					
<i>Sale of property, plant, & equipment</i>	(22)	728	-	-	20,000
<i>Receipt from investments and restricted assets</i>	14,148	35,345	-	-	-
	14,126	36,073	-	-	20,000
Cash applied to:					
<i>Purchase of investments & restricted assets</i>	13,775	35,928	-	-	-
<i>Purchase of property, plant, & equipment</i>	66,929	45,277	41,762	592,554	96,612
	80,704	81,205	41,762	592,554	96,612
Net Cash Flow from Investing Activities	(66,578)	(45,132)	(41,762)	(592,554)	(76,612)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash provided from:					
Equity Injections					
<i>Earthquake repair capital redrawn</i>	33,500	11,100	10,000	57,000	41,000
<i>Kaikoura facility contribution</i>	-	2,000	-	-	-
<i>Operating deficit support</i>	12,500	-	52,833	53,644	74,539
<i>Equity contribution to redeveloped ASB facilities transferred from the Crown (Note 5)</i>	-	-	-	499,000	-
	46,000	13,100	62,833	609,644	115,539
Cash applied to:					
<i>Asset disposal proceeds remitted to Crown</i>	-	-	-	-	20,000
<i>Annual depreciation funding repayment</i>	1,861	1,861	1,861	1,861	1,861
	1,861	1,861	1,861	1,861	21,861
Net Cash Flow from Financing Activities	44,139	11,239	60,972	607,783	93,678
Net increase/(decrease) in cash and cash equivalents	19,184	(28,066)	12,270	10,262	(3,113)
Cash and cash equivalents at beginning of year	(5,638)	13,546	(14,520)	(2,250)	8,012
Cash and cash equivalents at end of year (Note 6)	13,546	(14,520)	(2,250)	8,012	4,899

Note 5: Shown for transparency and completeness purpose. Historically, such transactions are accounted as 'book transactions' i.e. no actual cash exchanges.

Note 6: Includes NZHPL sweep bank account balance.

3.16 Summary of revenue and expenses by arm

Forecast Operating Statement Years ending 2015/16 to 2019/20

	2015/16 Actual \$'000	2016/17 Actual \$'000	2017/18 Plan \$'000	2018/19 Plan \$'000	2019/20 Plan \$'000
Funding Arm					
REVENUE					
Ministry of Health revenue	1,476,806	1,504,084	1,586,742	1,631,160	1,678,124
Other government revenue	1,401	2,027	1,959	2,008	2,058
Other revenue	1,417	436	-	-	-
Total Revenue	1,479,624	1,506,547	1,588,701	1,633,168	1,680,182
EXPENSE					
Personal Health	1,061,537	1,102,942	1,162,869	1,202,660	1,242,319
Mental Health	146,326	160,518	162,889	168,181	168,847
Disability Support	243,760	250,950	278,575	283,321	288,258
Public Health	3,506	4,155	4,676	4,873	3,758
Maori Health	2,210	1,864	2,061	1,941	1,961
Total Expense	1,457,339	1,520,429	1,611,070	1,660,976	1,705,143
Surplus/(Deficit)	22,285	(13,882)	(22,369)	(27,808)	(24,961)
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	22,285	(13,882)	(22,369)	(27,808)	(24,961)
Governance & Funder Admin					
REVENUE					
Ministry of Health revenue	2,749	4,197	3,841	3,893	3,946
Other government revenue	61	4	48	49	50
Other revenue	194	80	187	192	197
Total Revenue	3,004	4,281	4,076	4,134	4,193
EXPENSE					
Personnel	7,082	8,288	8,448	8,680	8,830
Outsourced	2,120	920	888	879	870
Clinical supplies	38	167	168	171	174
Infrastructure & non clinical (excl Earthquake repairs)	(5,242)	(4,674)	(5,471)	(5,639)	(5,724)
Depreciation and amortisation	42	41	43	43	43
Total Expense	4,040	4,742	4,076	4,134	4,193
Surplus/(Deficit)	(1,036)	(461)	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	(1,036)	(461)	-	-	-

3.17 Summary of revenue and expenses by arm—continued

Forecast Operating Statement Years ending 2015/16 to 2019/20

	2015/16 Actual \$'000	2016/17 Actual \$'000	2017/18 Plan \$'000	2018/19 Plan \$'000	2019/20 Plan \$'000
Provider Arm					
REVENUE					
Ministry of Health revenue	909,986	942,696	996,876	1,034,780	1,094,348
Other government revenue	27,808	26,901	29,113	30,307	31,551
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other revenue	42,780	42,224	47,044	51,297	63,712
Total Revenue	990,456	1,022,533	1,080,833	1,134,884	1,213,411
EXPENSE					
Personnel	668,015	695,918	737,277	773,613	808,782
Outsourced	24,800	24,987	24,144	23,718	23,289
Clinical supplies	133,512	142,711	148,000	153,733	164,389
Earthquake building repair costs	9,882	10,712	7,800	18,500	23,800
Infrastructure & non clinical (excl Earthquake repairs)	106,971	110,359	104,696	108,064	111,270
Interest	5,575	3,932	200	-	-
Depreciation and amortisation	57,697	56,227	59,661	69,529	71,194
Capital charge expense	5,726	16,177	30,330	34,458	67,242
Total Expense	1,012,178	1,061,023	1,112,108	1,181,615	1,269,966
Surplus/(Deficit)	(21,722)	(38,490)	(31,275)	(46,731)	(56,555)
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	91,753	-	-	-	-
Impairment of property, plant & equipment	-	(1,491)	-	-	-
Total Comprehensive Income/(Deficit)	70,031	(39,981)	(31,275)	(46,731)	(56,555)
In House Elimination					
REVENUE					
Ministry of Health revenue	(850,592)	(877,253)	(926,692)	(962,394)	(1,019,755)
Total Revenue	(850,592)	(877,253)	(926,692)	(962,394)	(1,019,755)
EXPENSE					
Payments to internal providers	(850,592)	(877,253)	(926,692)	(962,394)	(1,019,755)
Total Expense	(850,592)	(877,253)	(926,692)	(962,394)	(1,019,755)
Surplus/(Deficit)	-	-	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	-	-	-	-	-

3.18 Summary of revenue and expenses by arm—continued

Forecast Operating Statement Years ending 2015/16 to 2019/20

	2015/16 Actual \$'000	2016/17 Actual \$'000	2017/18 Plan \$'000	2018/19 Plan \$'000	2019/20 Plan \$'000
CONSOLIDATED					
REVENUE					
Ministry of Health revenue	1,538,949	1,573,724	1,660,767	1,707,439	1,756,663
Other government revenue	29,270	28,932	31,120	32,364	33,659
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other revenue	44,391	42,740	47,231	51,489	63,909
Total Revenue	1,622,492	1,656,108	1,746,918	1,809,792	1,878,031
EXPENSE					
Personnel	675,097	704,206	745,725	782,293	817,612
Outsourced	26,920	25,907	25,032	24,597	24,159
Clinical supplies	133,550	142,878	148,168	153,904	164,563
Earthquake building repair costs	9,882	10,712	7,800	18,500	23,800
Infrastructure & non clinical (excl Earthquake repairs)	101,729	105,685	99,225	102,425	105,546
Payments to non-DHB providers	606,747	643,176	684,378	698,582	685,388
Interest	5,575	3,932	200	-	-
Depreciation and amortisation	57,739	56,268	59,704	69,572	71,237
Capital charge expense	5,726	16,177	30,330	34,458	67,242
Total Expense	1,622,965	1,708,941	1,800,562	1,884,331	1,959,547
Surplus/(Deficit)	(473)	(52,833)	(53,644)	(74,539)	(81,516)
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	91,753	-	-	-	-
Impairment of property, plant & equipment	-	(1,491)	-	-	-
Total Comprehensive Income/(Deficit)	91,280	(54,324)	(53,644)	(74,539)	(81,516)

Part IV

Further Information for the Reader

Appendices

Appendix 1	Glossary of Terms
Appendix 2	Minister of Health's Letter of Expectations 2017/18
Appendix 3	Asset Performance Indicators 2017/18
Appendix 4	Statement of Accounting Policies 2017/18

Documents of interest

The following documents can be found on the Canterbury's DHB's website: www.cdhb.health.nz and read in conjunction with this document, they provide additional parts to the picture of health service delivery and transformation across the Canterbury health system.

- Canterbury DHB Annual Plan 2017/18
- Canterbury DHB Māori Health Action Plan 2017/18
- Canterbury DHB Public Health Action Plan 2017/18
- Canterbury DHB Quality Accounts 2017/18
- South Island Regional Health Services Plan 2017/18

References

Unless specifically stated, all Canterbury DHB documents referenced in this document are available on the Canterbury DHB website: www.cdhb.health.nz. All referenced Ministry of Health documents are available on the Ministry's website: www.health.govt.nz. The Crown Entities Act 2004 and the Public Finance Act 1989, referenced in this document, are available on the Treasury website: www.treasury.govt.nz.

Appendix 1 Glossary of Terms

ADMS	Acute Demand Management Service	Refers to the service whereby general practice and acute community nursing deliver packages of care that enable people who would otherwise need an ED visit or hospital admission to be treated in the community or in their own homes.
CCN	The Canterbury Clinical Network District Alliance	The Canterbury Clinical Network is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury Health System. The Alliance provides leadership to enable the transformation of the health system in collaboration with system partners and on behalf of the population.
CREST	Community Rehabilitation Enablement and Support Team	Community Rehabilitation Enablement and Support Team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. The Team is a collaboration across primary and secondary services and has been instrumental in reducing acute demand for hospital services and rates of aged residential care.
	Crown Entity	A generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the financial statements of the Government.
ERMS	Electronic Referral Management System	ERMS is available from the GP desktop, and enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including: wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in Canterbury, West Coast and South Canterbury, and rolling out across the rest of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition (e.g. a change in the health status of a population).
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them, either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Secondary Care	Specialist care that is typically provided in a hospital setting.
	Primary Care	Professional health care received in the community, usually from a general practice team, covering a broad range of health and preventative services.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations.

Appendix 2 Minister of Health's Letter of Expectations



Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

16 DEC 2016

Mr Murray Cleverley
Chairperson
Canterbury District Health Board
PO Box 1600
Christchurch 8140

murray.cleverley@cdhb.health.nz

Dear Mr Cleverley

Letter of Expectations for DHBs and Subsidiary Entities 2017/18

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2016 Vote Health received an additional \$568 million, the largest increase in seven years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy

The refreshed New Zealand Health Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to ensure that all New Zealanders live well, stay well and get well.

The DHB annual plans are the primary document for demonstrating DHB delivery of the Strategy, and your 2017/18 annual plan is expected to clearly demonstrate the linkages between the five themes of the Strategy and your DHB's performance story, activities and outcomes, while also maintaining a focus on Māori health outcomes and health equity.

In particular I want to see a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions.

Finally, I want your Board to very carefully consider how any new local initiatives fit within the context of the Strategy.

Living Within our Means

While the global economic environment continues to be challenging, DHB funding has continued to be increased year on year. DHBs need to budget and operate within allocated funding and must have clear plans to improve year-on-year financial performance. Your DHB's financial performance is currently unfavourable to your expected budget for 2016/17. I expect that you will improve this position throughout the year and will continue to make efficiency gains to ensure better performance in 2017/18. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. In particular your Board must work closely with NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services.

Working Across Government

I expect DHBs to continue supporting cross-agency work to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki once this has been established.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

All DHBs must continue to work closely with other social sector organisations to achieve cross-sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as the Prime Minister's Youth Mental Health Project, the Childhood Obesity Plan and the *Living Well with Diabetes* Plan.

Locally, I expect that Canterbury DHB will ensure systems are in place to effectively follow-up rheumatic fever cases, continue current activity to maintain high coverage rates for all immunisation milestones, and reduce child and youth waiting times for mental health and addiction services.

National Health Targets

All of the national health targets are very important for driving overall performance, and have resulted in major improvements in the health outcomes of New Zealanders. I expect DHBs to remain focussed on achieving and improving performance against all six health targets. The *faster cancer treatment* target remains a top priority for service delivery for DHBs and further progress is expected during 2017/18.

The first national result for the *raising healthy kids* health target is 49 percent. I expect results for all DHBs to improve considerably each quarter as referral processes and clinical pathways are fully implemented.

Locally, Canterbury DHB has shown good performance in relation to the *increased immunisation* and *shorter stays in emergency departments* health targets. However, performance in relation to the other health targets can be improved. Please ensure delivery of these health targets is a priority for your DHB.

Streamlining of DHB Annual Planning

In order to ensure that the Health Strategy is informing DHB planning, DHB annual plans will be streamlined in 2017/18 so that they are focussed on my key expectations for your DHB. Your DHB should also be considering longer-term strategic planning (ten-year horizon) as a way to deliver on the vision of the Health Strategy, and I expect that in the future you will be able to demonstrate this planning.

Working regionally also continues to be important, and I expect that when you are considering your long-term strategic planning you are also considering this in a regional context.

There are a number of key planning priorities for 2017/18 that DHBs will need to clearly respond to in their annual plans. These planning priorities have been selected in order to progress the key Government expectations outlined above, and also to progress other key health initiatives, such as Bowel Screening, implementation of the Healthy Ageing Strategy and continued integration of health care in order to better prevent and manage long term conditions, and provide services and care in the best ways to meet local needs. This will require ongoing engagement with your primary and community partners, including implementation of the System Level Measures.

The full list of my planning priorities for 2017/18 is attached for your information. I have asked the Ministry to provide separate advice about how each of these should be reflected in your plan.

Concluding comments

In implementing your annual plan it is important that clinicians are engaged and involved throughout; clinical leadership is fundamental in delivering high-quality health services.

Please note that I am not requiring DHBs to refresh their statements of intent (SOIs) for tabling in 2017/18. However, please ensure you review your SOI produced in 2016/17 to confirm that there are no significant changes. The statements of performance expectations will still need to be produced and tabled.

Keep in mind that the Budget 2017 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available, including information on planning priorities.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2017/18.

Yours sincerely



Hon Dr Jonathan Coleman
Minister of Health

2017/18 DHB Annual Planning Priorities

Prime Minister's Youth Mental Health Project
 Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
 Supporting Vulnerable Children Better Public Service Target
 Reducing Rheumatic Fever Better Public Service Target
 Increased Immunisation Better Public Service and Health Target
 Shorter Stays in Emergency Departments Health Target
 Improved Access to Elective Surgery Health Target
 Faster Cancer Treatment Health Target
 Better Help for Smokers to Quit Health Target
 Raising Healthy Kids Health Target
 Bowel Screening
 Mental Health
 Healthy Ageing
 Living Well with Diabetes
 Childhood Obesity Plan
 Child Health
 Disability Support Services
 Primary Care Integration
 Pharmacy Action Plan
 Improving Quality
 Living Within our Means
 Information Technology
 Workforce.

Appendix 3: Asset Performance Indicators 2017/18

To support asset performance monitoring and investment planning, the Canterbury DHB has aggregated its assets into three major portfolio areas which cover the majority of the assets considered significant (critical) in regard to the delivery of core health services.

Asset Portfolio	Asset Classes within Portfolios	Asset Purpose	2014/15 Net Book Value	2015/16 Net Book Value	2016/17 Net Book Value
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	\$326M	\$412M	\$613M
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring, or treatment	\$35M	\$41M	\$46M
Information Communication Technology	Computer hardware and computer software	To enable the delivery of core health service by aiding decision making at the point of care	\$8M	\$11M	\$26M

The performance metrics identified for each portfolio in 2017/18 are set out below, with associated standards. The DHB is adopting a tiered approach to the monitoring of asset performance and these represent the top tier – those seen as most directly related to delivery of the DHB's vision and the operational expectations set by the Ministry of Health. The metrics are being reviewed as part of our long-term planning and in conjunction with the national long-term investment planning process and are therefore seen as developmental and subject to change.

The standards presented have been set and agreed at clinical, management or governance levels throughout the DHB, as part of service level agreements, business cases and national performance expectations. All have been presented and agreed as part of annual planning for the 2017/18 year with the DHB's Executive Management Team and Board.

Property Portfolio Performance

Asset Performance Indicators	Indicator Class	2014/15	2015/16	2016/17	2017/18 Standard
Percentage of the critical property portfolio with a National Building Standard at or greater than 34% ⁷²	Condition	-	83%	84%	100%
Number of elective surgical discharges delivered ⁷³	Utilisation	20,353	21,039	21,456	21,330
Energy consumption per sqm (kWh/sqm) ⁷⁴	Functionality	442	413.8	478.8	<500

Clinical Equipment Portfolio Performance

Asset Performance Indicators	Indicator Class	2014/15	2015/16	2016/17	2017/18 Standard
Percentage of CTs and Linac Machines compliant with the requirements of the Radiation Protection Act	Condition	100%	100%	100%	100%
Percentage of CT uptime vs. operational hours	Utilisation	-	100%	99.9%	>98%
Percentage of Linac uptime vs. operational hours	Utilisation	97%	98%	98.6%	>98%
* 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. ⁷⁵	Functionality	73%	70%	85.5%	90%

⁷² All critical property, i.e. providing 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. The 2014/15 result is to April 2015 and the 2015/16 result to May 2017.

⁷⁵ 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 standards are set nationally by the Ministry of Health.

Information Communication and Technology (ICT) Portfolio Performance

Asset Performance Indicators	Indicator Class	2014/15	2015/16	2016/17	2017/18 Standard
* Condition of servers to mitigate against cyber-attacks — being the percentage of servers patched with critical and security updates at all times ⁷⁶	Condition	-	-	66%	95%
* Percentage uptime for mission critical applications (HealthConnectSouth, Éclair, MedChart and the DHB's Patient Management Systems (Homer/SAP/PICS)) ⁷⁷	Utilisation	-	99.96%	99.94%	99.5%%
Annual network security external penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational) ⁷⁸	Functionality	-	2	2.3	<2.5

⁷⁶ This is a new measure highlighting the importance of ensuring that the DHB has mitigated against cyber-attacks.

⁷⁷ This measure has been updated to include the DHB's Patient Management Systems as critical applications. Uptime of mission critical applications is captured at a point in time - 2016/17 = 1 July – 30 June 2017

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.

Appendix 4: Statement of Accounting Policies 2017/18

10.13 Statement of accounting policies

The prospective financial statements in the DHB's Annual Plan and Statement of Intent for the year ended 30 June 2018 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

(i) *Cautionary Note*

The financial information presented is prospective. Actual results are likely to vary from the information presented, and the variations may be material.

(ii) *Nature of Prospective Information*

The financial information presented consists of forecasts that have been prepared on the basis of best estimates and assumptions on future events that Canterbury DHB expects to take place.

(iii) *Assumptions*

The main assumptions underlying the forecast are noted in Section 8 of the Annual Plan.

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB is a Health Board established by the NZ Public Health and Disability Act 2000. The 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 Canterbury DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community. Canterbury DHB does not operate to make a financial return.

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

Canterbury DHB will adopt the following accounting policies consistently during the year and apply these policies for the prospective financial statements.

BASIS OF PREPARATION

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

Statement of compliance

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 and Amendment Act 2013, 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 the following assets and liabilities are stated at their fair value: land and buildings.

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

Functional and presentation currency

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

Changes in accounting policies

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

Transition to PBE accounting standards.

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

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

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

Subsidiaries

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

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

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

- Freehold land;
- Freehold buildings and fitout;
- Leased buildings;
- Plant, equipment and vehicles; and
- Work in progress.

Owned assets

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

Revaluations

Land, buildings and building fitout (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.

Additions

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

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Depreciation

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

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

Class of Asset	Years	Dep Rate
Freehold Buildings and Fitout	10 – 50	2 - 10%
Leased Buildings	3 - 20	5 - 33%
Plant, Equipment and Vehicles	3 - 12	8.3 - 33%

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

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

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

Amortisation

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

Type of asset	Estimated life	Amortisation rate
Software	2-12 years	8.3 - 50%

Investments

Bank term deposits

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

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

Trade and other receivables

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

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

Inventories

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

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

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

Cash and cash equivalents

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

Capital charge

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

Impairment

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

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

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

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

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

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

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

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

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

Impairment of property, plant, and equipment and intangible assets

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

Non-cash-generating assets

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

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

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

Borrowings

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

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

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

Provisions

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

ACC Partnership Programme

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

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

Income tax

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

Equity

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

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

Revaluation reserve

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

Goods and services tax

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

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

Revenue

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

Ministry of Health population-based revenue

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of other services

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

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

Critical accounting estimates and assumptions

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

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

Property, plant and equipment useful lives and residual value

At each balance date Canterbury DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the

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

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the surplus 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.

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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



STATEMENT OF INTENT

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