Canterbury DHB

ANNUAL REPORT 2015/16

Our Mission

TĀ MĀTOU MATAKITE

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

Our Values

Ā MĀTOU UARA

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

Our Way of Working

KĀ HUARI MAHI

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

our health system

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Part I – Overview

1.1 Report from the Chair and Chief Executive

Canterbury has responded to the unique challenges as a result of the earthquakes with an internationally recognised integrated health system.

A population still under strain

The ongoing recovery from Canterbury's earthquakes has continued to have a major impact on the health of Cantabrians.

Over the past five years, demand for mental health services has significantly increased. We are particularly concerned about the children and young people in our community and the inter-generational health effects on future populations.

The demand for mental health services is not abating and we don't, based on international research on post-disaster psychosocial recovery, expect it to for another 5 to 10 years. Work is happening to ensure we can continue to meet the needs of our community and put the supports and systems in place to ensure people in need have timely access to care. Prevention is key and we are working with our communities and with other agencies to manage our psycho-social recovery as best as possible. Our School Based Mental Health Teams are supporting 107 schools (out of a total of 210) in Canterbury.

Our psychosocial recovery remains a priority. On 1 December 2015 the psychosocial wellbeing work CERA had been doing transferred to the Ministry of Health and Canterbury District Health Board (Canterbury DHB).

Canterbury DHB has been actively involved in our region's psychosocial recovery, but the transition means Canterbury DHB has picked up some additional leadership responsibilities, in partnership with local authorities and with support from the Ministry of Health. A new Governance Committee has been established to oversee the psychosocial recovery, chaired by a representative from Canterbury DHB. It also includes members from other local agencies including Christchurch City Council, Environment Canterbury, District Councils, the Police and the Ministry of Social Development.

Keeping responsibilities at a local level is fundamental to achieving expectations. Cross-agency participation is vital to Canterbury seeing improvements and positive outcomes in our community's wellbeing.

The main goal is to ensure psychosocial services respond to the needs of the most vulnerable and benefit the wellbeing of people and communities most affected by the earthquakes. We look forward to keeping the community updated on progress in promoting wellbeing for Canterbury people.

Integration and collaboration to transform our health system

The journey we started in 2007 to support people to stay well and healthy in their own homes was accelerated as a direct response to the earthquakes and continues to expand.

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

The Canterbury health system is at the forefront of successful falls prevention initiatives that are dramatically reducing the number of falls in the community. Preventing falls depends on accurate patient assessments and working with the patient and their families to develop individualised strategies to keep each patient safe - including when they leave hospital. Canterbury's community falls prevention programme brings together General Practice Teams, physiotherapists, pharmacists and other primary care providers with a falls prevention champion.

Part of our success in this area is due to the leadership of the Canterbury Clinical Network - which is the broadest health alliance in New Zealand with nine partner organisations and whole of system engagement. It plays a crucial role in developing new service delivery models, funding and contracting mechanisms that are based on principles of high trust, low

bureaucracy, openness and transparency. Putting people at the centre underpins everything we do through providing more care in community settings, investing in technology, and forming partnerships and alliances, the Canterbury health system continues to bring our three strategic goals to life:

The challenges ahead

We are immensely proud and appreciative of our people's remarkable achievements in the health system over the past five years. Despite all the difficulties since the quakes, our staff have ensured our community has continued to receive the best health care possible.

Many of our 9,634 employees have already changed their work location multiple times and are dealing with invasive quake repairs being undertaken in functioning clinical areas. We're now half way into the largest redevelopment of public health facilities New Zealand. With Burwood Hospital complete, the focus is on the Christchurch Hospital Acute Services Building and the new Outpatients facility due to be completed in 2018. Working and living in a construction zone city is tiresome. Outside the work environment, our people continue to face a range of 'secondary stressors' such as home repairs, insurance challenges and damaged infrastructure and consequent structural and organisational change. The continued wellbeing of our workforce, and ways to support our people at work remains one of the most important priorities for the organisation.

We have all been through a lot. Every day our people continue to put in an extraordinary effort to ensure we collectively respond to the needs of our community. We are concerned about the ongoing and cumulative impacts these challenges have had on our people's wellbeing.

In addition, the wellbeing of our broader social services and community workforce remains a concern and is an ongoing risk in terms of the availability and sustainability of essential health and social services across Canterbury.

We need to continue to support our people to keep looking after themselves, so they can continue to look after others effectively. We will keep looking at ways we can support our people and adapt our Wellbeing Programme to meet their needs.

Over the past 12 months we've achieved significant milestones in our facility redevelopments across the region. It's been an incredible journey and one Cantabrians should be proud of.

In November, we officially opened the new Rangiora Health Hub. The opening came after almost five years of community consultation, planning and construction, the $7 million purpose-designed facility is already making a big difference in the community.

In April this year we opened Kaikoura Health Te Hā o Te Ora, which features multi-purpose General Practice rooms, physiotherapy, community dental, ophthalmology, and space for visiting health specialists. There are a number of flexible spaces to ensure the facility will meet the needs of the community today and in the future.

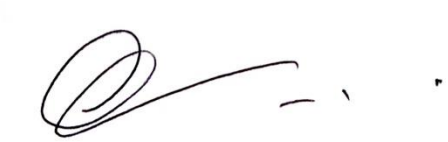
What makes Kaikoura's new health centre extra special is the fact that the community played such a big role in fundraising to ensure the project went ahead. Canterbury DHB put in $10 million and the remaining $3.4 million has come from the community.

In Ashburton we have a new acute admitting unit and theatre block underway, as well as quake repairs and refurbishing of wards. These are due to be completed in September 2016, and progress is being made planning for a new integrated health facility in Akaroa.

All this work has been in addition to the significant schedule of earthquake repairs to our existing facilities. The earthquakes have resulted in more than 14,000 rooms being damaged and to date 44 out 200 Canterbury DHB buildings have been demolished.

Over the past year, two independent PwC reviews of Canterbury DHB have reinforced we are in a stable financial position. However, the key drivers of future costs facing Canterbury DHB relate to the consequences of a large capital programme, driven as a response to the damage incurred by the earthquakes and the ongoing operational impacts of the earthquakes, including rapid changes in population.

Despite all the challenges over the past five years, Canterbury DHB has continued to be innovative in delivering quality care to our community. Our success at the 2015 Institute of Public Administration New Zealand (IPANZ) awards, where Canterbury DHB won four award categories, including the prestigious Prime Minister's award and being finalists in two categories at the awards this year, demonstrates we remain leaders in what we do.



Murray Cleverley
Chair
20 October 2016

David Meates
Chief Executive
20 October 2016

1.2 Statement of Responsibility

We are responsible for the preparation of Canterbury DHB's financial statements and Statement of Service Performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by Canterbury DHB under section 19A of the Public Finance Act 1989. We have not included the end of year performance information on all appropriations as required by this section. As stated in the Statement of Service Performance, the Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2015/16 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

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

In our opinion, these financial statements and the Statement of Service Performance fairly reflect the financial position and operations of Canterbury DHB for the year ended 30 June 2016.

For and on behalf of the Board

Murray Cleverley
Chair
20 October 2016

Steve Wakefield
Deputy Chair
20 October 2016

Part II – Service Performance

2.1 Measuring Our Progress

Like all DHBs, Canterbury DHB is expected to deliver against the national health system outcomes: '*All New Zealanders lead longer, healthier and more independent lives*' and '*the health system is cost effective and supports a productive economy*'. We are also expected to meet our objectives under the NZ Public Health and Disability Act to '*improve, promote and protect the health of people and communities*'.

As part of our accountability we need to demonstrate whether we are meeting these expectations. There is no single measure that will demonstrate the impact of the work we do. Instead, we have worked with the other four South Island DHBs to identify a core set of fifteen population health and service performance measures that will provide an insight into how well our health system is performing.

Tracking our performance against these indicators will enable us to evaluate our success in areas that are important to the Government, our Board and our community.

Six of the identified measures are outcomes indicators where success will be evident over the longer-term. As such, the aim is for a measurable change in health status over time, rather than a fixed target.

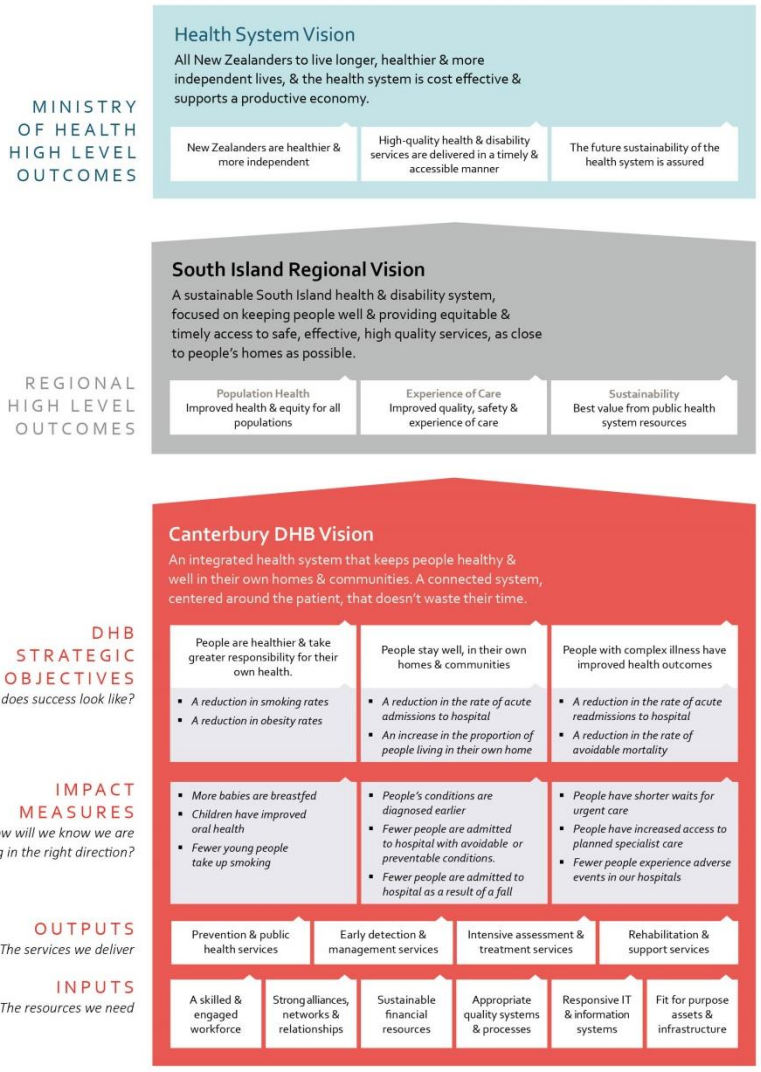
The remainder are seen as contributory measures, where our performance will have a measurable impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been identified as the main measures of performance.

We have set standards (or targets) against the contributory measures in order to evaluate our performance and determine whether we are moving in the right direction.

Results are presented in this Annual Report, alongside our Statement of Service Performance, to help evaluate the quality and effectiveness of our service delivery and determine whether we are having a positive impact on the health and wellbeing of our population.

The fifteen performance measures selected were deliberately chosen from existing national reporting frameworks and data sources to enable regular monitoring and comparison with other DHBs, and to give context to our performance.

The intervention logic is highlighted below, illustrating how the services that we fund or provide (outputs) will have an impact on the health of our population, result in the longer-term outcomes desired, and deliver the expectations and priorities of Government.



Note: In the graphs presented over the following pages, the South Island result represents the regional performance and includes all five South Island DHBs – rather than presenting Canterbury compared to the rest of the South Island. The same methodology applies to the national results.

2.2 Are We Making A Difference?

Objective 1: 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 respiratory and cardiovascular disease, cancer, diabetes and depression, all of which are major drivers of poor health and premature mortality (death) and account for significant pressure on health services. The likelihood of developing long-term conditions increases with age, and with our population ageing, the demand for health services will grow. These conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity and poor nutrition are major contributors to the most prevalent long-term conditions. These are avoidable risk factors, and can be reduced through supportive environments and improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthier choices will improve the quality of life and health status of our population and reduce avoidable demand and pressure on our health services.

OVERARCHING OUTCOME INDICATORS

Outcome: A reduction in smoking rates

Canterbury's smoking rate continues to decline and remains below the national average. The 2014 NZ Health Survey found that 15% of the Canterbury population smoke, compared to 17.7% of the New Zealand population.

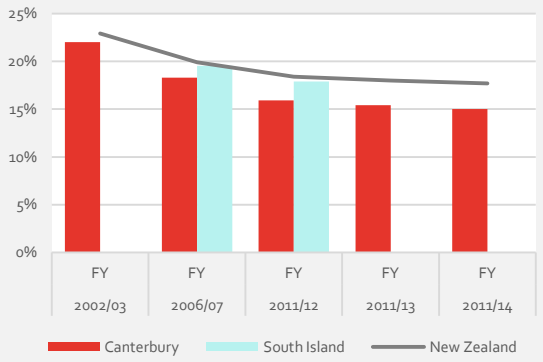
Our success can be attributed to two major factors - fewer young people taking up smoking and more current smokers being encouraged to quit.

We have continued to focus on delivering ABC to reduce smoking rates. Over the past year 85% of smokers in primary care and 97% of smokers in hospital settings have been **A**sked their smoking status, provided with **B**rief advice and offered **C**essation support.

Enrolments in our Aukati Kaipapa smoking cessation programme also remain high with over 1,200 people who smoke have enrolled in this programme in the past three years.

Data source: National NZ Health Survey [1]

Measure: Percentage of the population (15+) who smoke



Outcome: A reduction in obesity rates

Canterbury's obesity rate remains below the national average of 29.7%. However, the most recent NZ Health Survey suggests a slight increase in our rates to 27.7%.

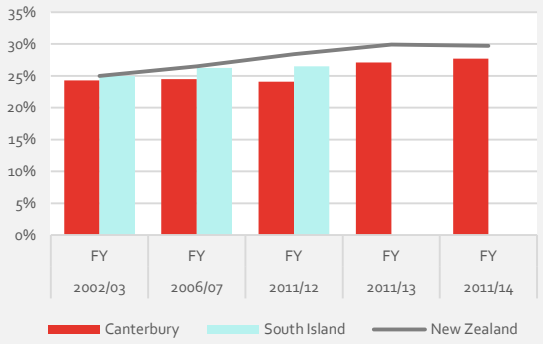
Local initiatives that encourage healthier diets and more physical activity, such as our Health Promoting Schools and Green Prescription programmes, are key to reduce obesity rates and improving health outcomes.

Green Prescription uptake is positive with 3,095 people accessing this service in the past year, and 75% of participants reporting they are more active 6-8 months later.

The DHB has also committed to achieving the new Raising Healthy Kids health target and will begin to track performance against this measure in 2016/17.[2]

Data source: National NZ Health Survey [3]

Measure: Percentage of the population (15+) who are obese



[1] *The NZ Health Survey is completed 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. The 2013 Census results for smoking (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 down from 40.2% in 2006 but higher than the total population at 14.5%.*

[2] *The new target aims to provide early intervention to support healthy eating and activity and measures whether children identified as obese at their B4 School Check are offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle advice.*

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

Impact: More babies are breastfed

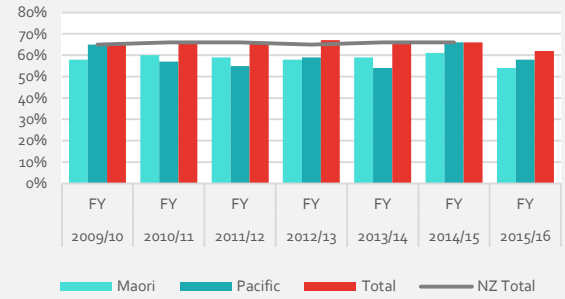
Canterbury's breastfeeding rates appear to have dropped slightly across all ethnicities, having remained relatively stable for the past several years. This is a disappointing result and a heightened focus is needed to lift these rates.

A range of services are available to encourage and support women in Canterbury to breastfeed including peer support programmes and community based lactation support. Uptake of the lactation support programme is high with over 1,000 women accessing specialist advice in the community for the third year in a row.

Breastfeeding is a key focus in our Maori Health Action Plan for 2016/17 and across our work with local Well Child Tamariki Ora providers.

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

Measure: Percentage of babies exclusively or fully breastfed at six weeks	2013/14	2014/15	2015/16 Target	2015/16 Result
	66%	66%	70%	62%



Impact: Children have improved oral health

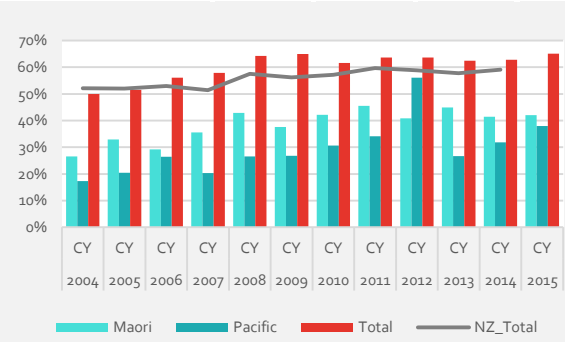
The percentage of five-year-olds caries-free (no holes or fillings) has continued to improve and we have reached the 65% target. Improved rates are also evident across all ethnicities, which is a pleasing result.

A new model of care for high-risk children was introduced in 2012, which provides more intensive preventive care in high-risk children aged 12-24 months. We may now be seeing the impact of this programme.

Oral health examination rates have also improved in the past year with 90% of enrolled children examined according to plan, compared to 86% in 2014/15.

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

Measure: Percentage of five-year-olds caries free (no holes or fillings)	2013	2014	2015 Target	2015 Result
	62%	63%	65%	65%



Impact: Fewer young people take up smoking

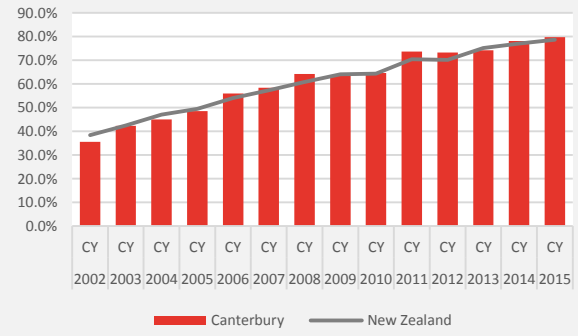
The 2014 ASH survey results continues to show a positive trend for Canterbury with 78% of Year 10 students (age 14) having never smoked.

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

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

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

Measure: Percentage of 'never smokers' among year 10 students	2013	2014	2015 Target	2015 Result
	74%	78%	>75%	80%



[4] *Provider data is not able to be combined for this measure so only performance data from the largest provider (Plunket) is presented. While this covers the majority of mothers, because the smaller local Well Child/Tamariki Ora providers primarily target Maori and Pacific mothers with their data not included results for these ethnicities may be under-stated. The standard is set nationally as part of the Well-Child Quality Framework.*

[5] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.*

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

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

WHY IS THIS OUTCOME A PRIORITY?

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

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

OVERARCHING OUTCOME INDICATORS

Outcome: A reduction in acute medical admission rates.

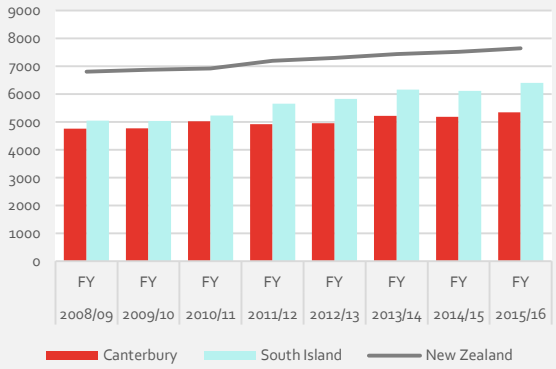
Like acute medical admission rates across the country our rates have continued to increase, but at 5,341 per 100,000 people, Canterbury DHB's rate remains one of the lowest in the country and well below the national rate (7,644).

This is a positive reflection of the system-wide focus taken in Canterbury to keep people safe and well in their own homes and communities and out of hospital.

This includes our local community-based Acute Demand Management Service which in the past year provided more than 33,000 packages of care to people in the community - preventing many unnecessary hospital admissions.

Data Source: National Minimum Data Set

Measure: Rate of acute medical admissions to hospital (age standardised, per 100,000)



Outcome: More people living in their own home

The percentage of the Canterbury population (aged 75+) living in their own homes is increasing, at 87.6%, and fewer older people are going into aged residential care.

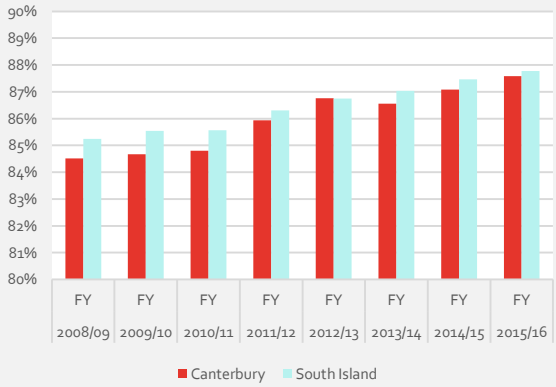
This has brought Canterbury into line with the rest of the South Island and is consistent with our strategy of supporting people to stay safe and well in their own homes.

A number of local programmes support our older population to age-in-place and are contributing to these positive results including: our restorative home-based support services, respite services and medications management services.

In the past year 1,726 people were supported by our CREST service which began as a community-based supported discharge service, facilitating earlier discharge from hospital, and has since been extended to support people, on referral from general practice, to avoid hospital admission altogether.

Data Source: SIAPO Client Claims Payment System

Measure: Percentage of the population (75+) living in their own home



Impact: People's conditions are diagnosed earlier

Demand has been exceeding reporting and machine capacity across both the public and private sectors in Canterbury and wait times have been growing.

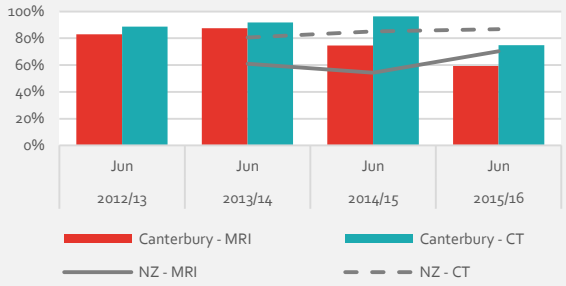
Canterbury DHB now has its CT and MRI scanners operational at Burwood Hospital and is in the process of installing a second MRI scanner at Christchurch Hospital.

This additional capacity will help to lift performance and the DHB is already running additional CT scanning sessions at Burwood to reduce delays in this area.

Data Source: Individual DHB Patient Management Systems

Measure: Percentage of people waiting less than six weeks for CT or MRI scans

	2014/15	2015/16 Target	2015/16 Result
CT	96%	95%	75%
MRI	75%	85%	59%



Impact: Fewer avoidable hospitalisations

For the 2015/16 year, Canterbury DHB's avoidable admission rate was 2,637 per 100,000. This is a slight improvement on the previous years and well below the national rate (3,717).

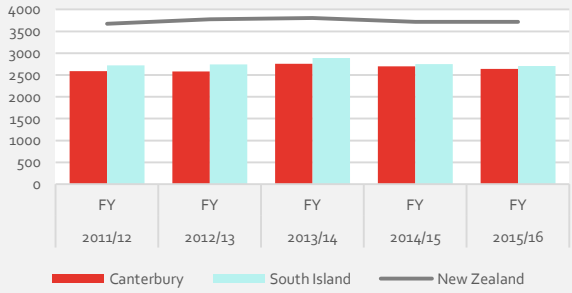
A wide range of local initiatives contribute to preventing unnecessary hospital admissions in Canterbury, including our Acute Demand Management Services, alternative ambulance pathways for people with respiratory or heart disease and a number of targeted long-term conditions programmes.

Almost 1,000 people (newly diagnosed with Type 2 diabetes or starting insulin) accessed subsidised self-management support from their general practice team in the past year. This support helps people to improve control of their diabetes and avoid complications that might lead to hospital admission.

Data Source: Ministry of Health Performance Reporting[7]

Measure: Ratio of actual vs expected avoidable hospital admissions for those aged under 75

2013/14	2014/15	2015/16 Target	2015/16 Result
2,754	2,694	-	2,637



Impact: Fewer falls-related hospitalisations

At 5.3%, the percentage of the Canterbury population (75+) admitted to hospital as a result of a fall is slightly lower than the previous year and closer to achieving the national average (5.1%).

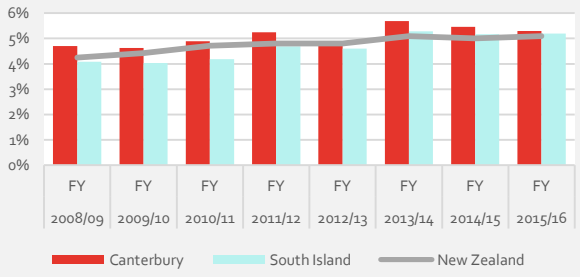
Improved awareness and falls coding is influencing increased reporting of falls admissions so rates have not dropped as fast as anticipated, however associated outcomes are positive.

We now have a system-wide Falls Prevention Strategy in place promoting clinically-led prevention across our community and in our hospitals. Over 5,000 people have accessed our community-based falls prevention programme in the past three years – 1,973 in the past year.

Data Source: National Minimum Data Set[8]

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

2013/14	2014/15	2015/16 Target	2015/16 Result
5.7%	5.5%	<5.5%	5.3%



[7] *This measure is a national DHB performance indicator (SI1) and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as a rate per 100,000 people and the target is set to maintain performance below the national rate, reflecting less people presenting to hospital. At the time of preparing the 2015/16 Plan the Ministry was working to resolve a definition issue with this measure. The definition was set in October 2015 and the Ministry provided prior year's baselines.*

[8] *The baseline results for this measure differ to those previously published due to an update of both Census population numbers and national ICD codes. These updates have had a noticeable impact on the results – although trends remain similar. The target set for 2015/16 (7.9%) was out of line with the updated trends and so was reset for the 2016/17 Annual Plan as improvement on the previous year.*

Objective 3: People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

For people who need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning system, matching capacity to demand by managing the flow of patients between services and moving the point of intervention to earlier in the path of illness.

This goal also reflects 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, readmissions and complications that have a negative impact on the health of our population, people's experience of care and their confidence in the health system. Ineffective or poor quality treatment and long waits also waste resources and add unnecessary cost into the system.

OVERARCHING OUTCOME INDICATORS

Outcome: A reduction in acute readmissions

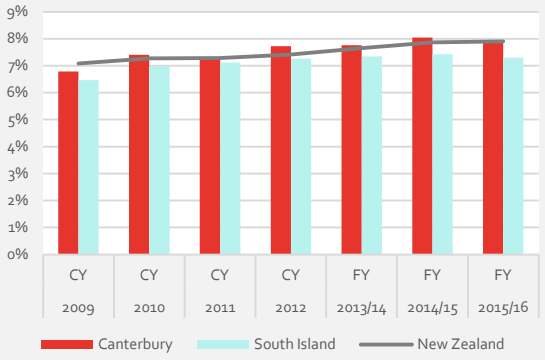
After a number of years on the rise our readmission trend has levelled off slightly this year.

We have continued to focus on providing access to treatment and procedures in community-based settings, increasing access and convenience for our population. However, having a lower acute medical admission rate than the national average means that the people we are seeing in our hospitals are likely to be frailer, have more complex conditions and be more at greater risk of readmission.

We continue to invest in rehabilitation and restorative home-based support services, particularly for patients with COPD and heart failure (which have high readmission rates), and have implemented the Enhanced Recovery After Surgery initiative to support people's recovery.

Data Source: National Minimum Data Set [9]

Measure: Rate of acute readmissions to hospital within 28 days of discharge



Outcome: A reduction in avoidable mortality

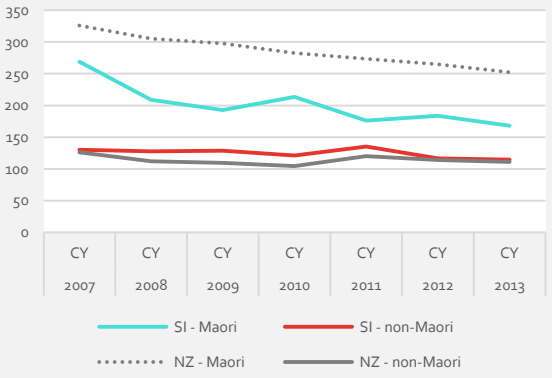
There has been a slight decrease in mortality rates across the South Island, for all ethnicities, and the overall trend continues to be positive and consistently below national rates.

Community-based acute demand and long-term condition management programmes, reduced wait times and increased access to elective surgery are making a difference by ensuring effective diagnosis and access to timely treatment.

Fewer adverse events while in our hospitals and improved rehabilitation and support on discharge are also all factors which positively influence these results.

Data Source: National Mortality Collection [10]

Measure: Rate of all-cause mortality for people under 65 (age standardised, per 100,000 people)



[9] *This measure is a national DHB performance indicator (OS8).*

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

Impact: People have shorter waits for urgent care

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

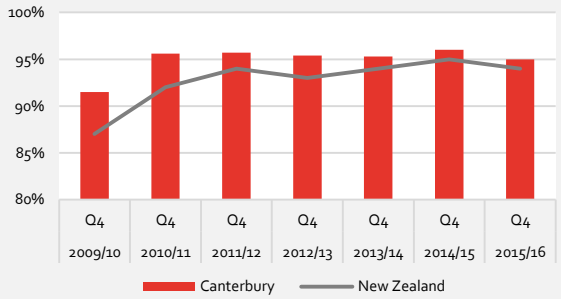
A number of community-based urgent care services support our hospitals including free after-hours care for under thirteen year olds, telephone triage and our Acute Demand Management Services – all helping to reduce avoidable ED presentations.

Strong performance results also reflect the team work within ED and across hospital departments that supports an effective flow of patients and enables the ED teams to respond to an increasing number of people within the target timeframes.

The DHBs performance in this area has been consistently high, achieving the 95% in every quarter of this year.

Data Source: DHB Patient Management Systems [11]

Measure: Percentage of people presenting in ED admitted, discharged, transferred within six hours	2013/14	2014/15	2015/16 Target	2015/16 Result
	95%	96%	95%	95%



Impact: People have shorter waits for specialist care

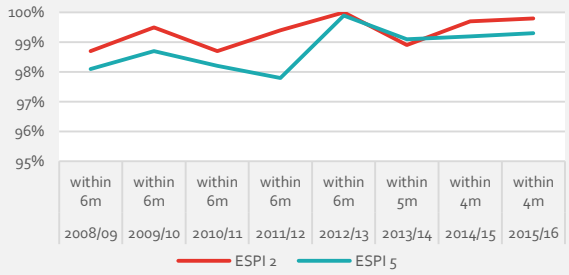
As at June 2016, 99.8% of all Canterbury residents referred for a specialist assessment were seen within four months and 99.3% of those given a commitment for treatment waited no longer than four months to receive that treatment.

Canterbury DHB also delivered 21,039 elective surgeries – more than ever before – 565 more surgeries than our national elective surgery target.

Given the continued post-quake challenges and rebuild disruptions, performance against these targets represents a major achievement for Canterbury DHB.

Data Source: Ministry of Health Quickplace Data Warehouse [12]

Measure: Percentage of people receiving specialist assessment (ESPI2) or treatment (ESPI5) within 4 months		2014/15	2015/16 Target	2015/16 Result
	ESPI2	99.7%	100%	99.8%
	ESPI5	99.2%	100%	99.3%



Impact: People experience fewer adverse events

After a slight upward trend the rate of serious falls in our hospitals has dropped back over the past year.

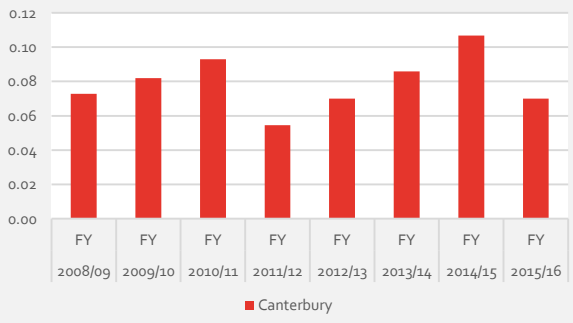
Key quality projects have focused on adoption of the national falls assessment process, standardising fall prevention visual cues and improving post-fall care.

Canterbury DHB was one of three DHBs who provided 100% of all inpatients (aged 75+) with a falls assessment in the third quarter of this year, allowing mitigation strategies and care plans to be put in place for patients at risk.[13]

Our new electronic incident management system is also helping to raise awareness around falls. All serious incidents are individually reviewed by the quality and clinical teams of each department as part of our continuous improvement approach and our commitment to zero harm.

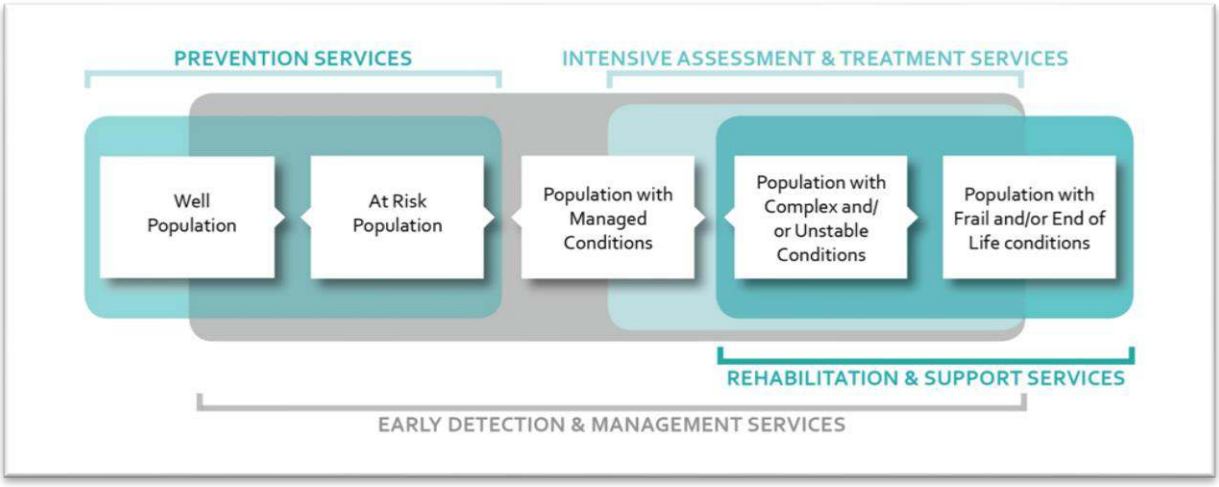
Data Source: Individual DHB Quality Systems [14]

Measure: Rate of SAC level 1 & 2 falls in hospital (per 1,000 inpatient bed days)	2013/14	2014/15	2015/16 Target	2015/16 Result
	0.09	0.11	0.06	0.07



[11] *This indicator is a national DHB health target (Shorter Stays in ED). The 2014/15 baseline results differ slightly to that previously published (95%) having been aligned to the Q4 result in line with national health target reporting rather than full year as it was previously presented.*
[12] *These indicators are two of the national Elective Services Patient Flow Indicators (ESPIs), established to track system performance. Standards are set nationally and in line with the ESPIs reporting the annual results presented are those from the final quarter of the year.*
[13] *The third quarter is the most recently published, the full year is not yet available. Canterbury's result for Q1 was 92% and Q2 98%.*
[14] *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 consequence and likelihood.*

2.3 Statement of Service Performance



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. We are strongly motivated to ensure we are delivering the most effective and efficient services possible.

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

We also evaluate our service performance by providing an annual forecast of the services we plan to deliver and the standards we expect to meet. The following service statement presents Canterbury DHB's actual performance against our 2015/16 service forecast.[15]

Services have been grouped into four service (or output) classes that are a logical fit with the continuum care. These are: prevention services; early detection and management services; intensive assessment and treatment services; and rehabilitation and support services (illustrated above).

Because it would be overwhelming to measure every service delivered, for each service class we have chosen a set of indicators which we believe are important to our community and stakeholders and that provide a fair representation of how well the DHB is performing.

In presenting our performance picture, we do not simply measure volumes of services delivered. The number of people who receive a service is often less important than whether enough of the right people received the service, or whether the service was delivered at the right time. We therefore present a mix of indicators that address four key aspects of performance: Volume (V), Timeliness (T), Coverage (C) and Quality (Q).

SETTING STANDARDS

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

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

We knew that a number of the standards would be particularly difficult to meet in our challenging post-disaster environment. However, it was felt it was important to maintain momentum and to monitor these indicators to better understand the impact of the earthquakes and make appropriate funding decisions as we move forward.

2015-2016 PERFORMANCE HIGHLIGHTS

Children are healthier

More than 34,000 children aged five and under received childhood vaccinations and 96% of all children

[15] *The 2015/16 Annual Plan, incorporating the Forecast Statement of Service Performance, is available on our website: www.cdhb.health.nz.*

in Canterbury were fully immunised at eight months. This is the first year we have achieved the eight month immunisation target in every quarter of the year. As well as being above the national average we have also achieved the target for Maori with 95% of eight month old Maori children being fully immunised.

The Before School Checks (B4SC) Service is an important opportunity to support children's health and wellbeing by identifying and addressing health needs before children start school. Coverage in Canterbury has remained high and we have achieved that national target with 91% of all children in Canterbury receiving their check and 94% of Maori children.

The percentage of five-year-olds caries-free (no holes or fillings) has continued to improve and we have reached the 65% target. Improved rates are also evident across all ethnicities, which is a pleasing result. A new model of care for high-risk children was introduced in 2012, which provides more intensive preventive care in high-risk children aged 12-24 months. We may now be seeing the positive impact of this programme.

People are taking more responsibility for their health

More than 54,000 smokers received brief advice to quit in primary care and in our hospital facilities. Our staff have delivered brief advice to 98% of all hospitalised smokers in the final quarter of this year. This is a significant achievement. Our primary care partners have achieved 88% against this national health target. More pleasing to see is the high enrolment rates in the Aukati Kaipaipa smoking cessation programme, with people actively looking to stop smoking. Smoking prevalence has dropped between the 2006 and 2014 New Zealand Health Surveys from 18.3% to 15%, demonstrating the impact of efforts in this area.

The number of people seeking additional physical activity support has also continued to rise with 3,095 people receiving a green prescription in the past year. Three quarters of those people reported being 'more active' 6-8 months later.

More of our vulnerable population are having influenza vaccinations - 74% of people aged over 65 received a free flu vaccination this year – 55,220 people, up from 54,113 last year.

Enrolments with primary care remain high, at 95%. The provision of general practice services is core to managing the health of our population and high enrolments are an indication of good engagement with general practice. An increasing proportion of our general practices provide after-hours telephone triage and 98% of children (under thirteen) now have access to free after-hours primary care in Canterbury.

We are supporting more people to stay well in their own homes and communities

For 2015/16, Canterbury DHB's avoidable hospital admission rate was 2,637 per 100,000. This is an improvement on the previous years and well below the national rate (3,717). Fewer people continue to be acutely admitted to our hospitals, with acute demand analysis showing 12,000 fewer acute admissions than expected, based on the national average.

Our Acute Demand Management Service plays a major role in easing pressure on our hospitals, with over 33,000 acute packages of care provided in the community rather than in our hospitals in the last year alone. However a wide range of local initiatives contribute to preventing unnecessary hospital admissions in Canterbury.

Increasing numbers of people access diabetes services in the community with almost 1,000 people receiving additional diabetes self-management support when newly diagnosed with type 2 diabetes or starting insulin. This service helps people to improve control of their diabetes and avoid complications that might lead to hospital admission.

Brief Intervention Counselling Services mean more than 600 young people and 5,500 adults were able to access mental health support from their general practice.

More people are accessing respiratory services in the community rather than waiting for hospital appointment and more people than ever are having skin lesions removed in general practice rather than in hospital. Over 2,800 skin lesions were removed in the community in the past year.

More people are receiving timely specialist care.

We delivered 21,039 elective surgical discharges in the past year, 565 more than the target and 3.4% higher than the previous year. More than 71,000 patients attended a first specialist assessment. We almost met national waiting time targets with 99% of people waiting no more than 4 months for their assessment or surgery.

91% of people receive their surgery on the day of admission and over half of all surgeries provided are provided as day cases meaning surgery is less disruptive for patients, who can spend the night before in their own homes.

A further 15,500 people received publicly-funded acute (unplanned or emergency) surgery in Christchurch Hospitals. That's more than 36,500 people who have had operations in the past 12 months. These people are now getting on with their lives.

There were over 94,000 attendances at our emergency departments in the past year – up from the previous year. However, we have continued to meet the waiting time health target ensuring patients are admitted, discharged or transferred within six hours.

We are ensuring that anyone waiting for chemotherapy or radiotherapy is starting their treatment within 4 weeks. This target has been consistently met for a number of years. We are working towards achieving the new national faster cancer treatment health target and 70% of people (referred with a high suspicion of cancer and a need to be seen within two weeks) received their first treatment within 62 days of being referred.

Increased demand for mental health services meant more than 3% of our population accessed specialist mental health services in the past year. Despite this demand, waiting times have improved and 93% of people now wait less than 8 weeks for non-urgent mental health and alcohol and drug service.

We are improving patient safety

Our commitment to Zero Harm and implementation of the Health Quality and Safety Commission's "Open for Better Care Campaign" resulting in 100% of inpatients over the age of 75 receiving a falls risk assessment in 2015/16. Falls assessments enable care plans and mitigations strategies to be put in place to reduce the likelihood of people falling and the rate of serious falls causing harm has dropped by a third this year.

Hand hygiene compliance had increased to 78%, up from 67% in 2013/14 and is now just 2% below the national target.

We are supporting people's recovery and rehabilitation

There has been a 15% increase in the number of people accessing community-based pulmonary rehabilitation and falls prevention services in the past year with more than 2,200 people being supported by these services to improve their health and wellbeing. At 5.3%, the percentage of the Canterbury population (aged over 75) being admitted to hospital as a result of a fall continues to drop and is now close to the national average (5.1%).

Our Community Rehabilitation Enablement and Support Team (CREST) provides a range of home-based rehabilitation packages to support people to leave hospital sooner or avoid admission altogether. In the past year CREST supported just over 1,700 older people in their own homes.

Despite increasing referrals for needs assessments, 96% of all clients receiving long term home support services have received a comprehensive InterRAI assessment to ensure they are getting the services they need. Our Aged Residential Care (ARC) facilities are engaged in InterRAI training and over 99% of people entering ARC have had an InterRAI assessment.

Consistent with our strategy of supporting our older population to age-in-place, the number of older people living in their own homes continues to increase, and at 87% is now in line with the rest of the South Island.

NOTES ON THE DATA

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

E While our aim is to improve the health of our population and reduce service demand over time, there will always be some 'demand driven' services such as: diagnostic tests and assessments, emergency, maternity, rehabilitation, dementia and palliative care services. Due to the nature of these services we do not set targets. However estimated service volumes are provided to give context in terms of the use of resources across our health system.

Δ This Statement of Service Performance incorporates services provided by the DHB but also services funded by the DHB and provided by third parties. Performance data for external parties can be affected by a delay in invoicing or reporting and results for previous years are subject to change as a result of incorporating late data.

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

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

◆ The DHB has a Māori Health Action Plan. Where the 2015/16 performance indicators aligned they had been mixed into the Statement of Performance to highlight areas of particular priority for Māori. The DHB has elected to show performance against the full set of Maori Health Action Plan indicators rather than the smaller subset initially proposed refer to page 27.

Performance Key

Rating	Criteria
Achieved	Standard reached
Partially Achieved	Standard not reached but performance improved or maintained
Not Achieved	Standard not reached and performance dropped

Prevention services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Preventive health services promote and protect the health of the population and address individual behaviours by targeting changes to physical and social environments that support people to make healthier choices. By supporting people to make healthier choices and to modify their lifestyles we can reduce the risk factors that contribute to long-term conditions and prevent or minimise the impact of these conditions.

At-risk and high-need population groups are more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore our foremost opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes. Prevention services are also often designed to disseminate consistent messages to large numbers of people and population groups so can be very cost-effective.

SERVICE PERFORMANCE- 2015/16

Health Promotion and Education Services							
These services inform people about risks and support them to make healthy choices. Success begins with awareness and engagement followed by positive behaviour choices.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Babies exclusively breastfeeding on hospital discharge	Q [16]	76%	80%	>75%	79%	-	A
Lactation support and specialist advice consultations provided in community settings	V	1,031	1,058	>600	1,033	-	A
Babies exclusive/fully breastfed at LMC discharge	Q [17]	70%	71%	75%	n.a	n.a	-
Priority schools supported by the Health Promoting Schools framework	C [18]	80%	91%	>70%	89%	-	A
'Appetite for Life' nutrition courses provided in the community	V [19]	56	59	>50	43	-	N
People accessing Green Prescriptions (GPx) for additional physical activity support	V [20]	2,879	2,797	3,000	3,095	-	A
GPx participants more active 6-8 months after referral	Q	57%	62%	>50%	75%	-	A
Smokers enrolled with a PHO receiving advice and help to quit	C ◇ [21]	75%	89%	90%	88%	88%	N
Smokers identified in hospital receiving advice and help to quit	C ◇	95%	96%	95%	98%	96%	A
Enrolments in Aukati Kaipaipa smoking cessation programmes	V	408	418	>240	385	-	A
Women smokefree at two weeks postnatal	Q [22]	89%	90%	95%	88%	-	N

[16] The percentage of babies' breastfeeding can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period. Standards are set in alignment with World Health Organisation recommendations.
[17] This measure is part of the national Well Child performance framework and standards are set nationally.
[18] The Health Promoting Schools Framework addresses health issues with an approach based on activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated and/or have a high proportion of Māori and/or Pacific children.
[19] The number of courses has dropped, with the focus going on increasing the number of people per course – the average number of registrations per course has lifted from 10.5 people to 13 people per course.
[20] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.
[21] This is a national health target measure (Better Help for Smokers to Quit). In 2014-15 the definitions changed from 'people offered advice and support within the last 12 months' to 'within the last 15 months' (being 15 months to June 2016). Baseline results are against the previous target.
[22] This measure is part of the national Well Child performance framework and standards are set nationally. The 2015/16 results reflect the 6 months to December 2015, the full year was not available at the time of printing.

Population-Based Screening Services

These services help to identify people at risk of illness and pick up conditions earlier. Success is indicated by high coverage rates.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Four-year-olds provided with a B4 School Check (B4SC)	C [23]	90%	91%	>90%	91%	92%	A
'High needs' four-year-olds provided with a B4SC	C [24]	92%	92%	>90%	88%	92%	N
Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C † [25]	100%	98%	>95%	100%	-	A
Women (25-69) having a cervical smear in the last 3 years	C [26]	76%	75%	80%	74%	77%	N
Women (50-69) having a mammography in the last 2 years	C [26]	80%	79%	>70%	77%	71%	A

Immunisation Services

These services help to reduce the transmission and impact of preventable disease. Success is indicated by high engagement and coverage rates.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Newborns enrolled on the Nat. Immunisation Register at birth	C	99%	98%	>95%	99%	-	A
Children fully immunised at eight months of age	C ◇	93%	94%	95%	96%	93%	A
Eight-month-olds 'reached' by immunisation services	Q ◇ [27]	95%	98%	95%	98%	-	A
Eligible girls completing HPV vaccinations (Dose 3)	C † [28]	35%	38%	65%	43%	65%	P
Older people (65+) receiving a free influenza ('flu') vaccination	C † [29]	75%	74%	75%	74%	67%	P

[23] *The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.*

[24] *The high needs population includes Maori, Pacific and children living in High Deprived areas. Following the 2013 Census and an update to deprivation profiles Canterbury has a much lower proportion of its population classified as quintile 5, the most highly deprived. The eligible population was set off the older deprivation series however the results relate to the updated series (9.3% prior and 12.3% after). The artificial reclassification of children between deprivation quintiles has had a material impact on results. Children identified in quintile 5 when the targets were set are now in quintiles 0-4 and have not been counted, even though they have received their B4SC. The target has been achieved for the total population and for Maori.*

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

[26] *The cervical and breast cancer screening programmes are national programmes and age bands and standards are set nationally. The 2013/14 result for breastfeeding is against the previous age bands (45-69) and is not directly comparable. Rates for cervical screening in Canterbury are below national rates and disappointingly have dropped off against previous years. Improving cervical screening rates is a focus in our Maori Health Plan for the coming year and we are re-establishing a clinical steering group to support and monitor progress in this area.*

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

[28] *The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme currently consists of three vaccinations and is free to young women under 20 years of age. Around 150 women are diagnosed with cervical cancer and 50 women die from it each year in New Zealand. The DHB made an error when realigning its age bands to the national programme in the Annual Plan - the eligible girls for the 2015/16 year are those born in 2002 not in 2003, baselines for 2013/14 were aligned to the wrong birth cohort and has been corrected in this report (previously reported as 39%). 65% of eligible girls have started the programme this year – already having received dose 1.*

[29] *While the percentage of the population (65+) being immunised has remained the same, this result is affected by our ageing population – compared to the previous year the actual number of older people having a flu vaccination has increased from 54,113 to 55,220 people.*

Early detection and management services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

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

Because these services can better support people to stay well and where they have a long-term condition, can help to reduce or avoid negative complications, acute illness or crises, they help reduce the need for a hospital appointment or hospital admission. These services therefore have a major impact on people's health and wellbeing but also on the capacity of the health system, freeing up hospital and specialist services to allow for more complex and planned interventions.

SERVICE PERFORMANCE - 2015/16

Primary Care Services							
These are services offered in community settings by general practice and allied health professionals, aimed at maintaining, improving or restoring people's health. Coverage rates or uptake of services are indicative of the accessibility and responsiveness of primary care services.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Population enrolled with a Primary Health Organisation	C	96%	95%	>95%	95%	-	A
Number of clinical HealthPathways in place across the system	V [30]	762	811	>600	915	-	A
Avoidable hospital admission rate for children (0-4)	Q [31]	6,455	6,442	-	5,927	6,789	A
Young people (0-19) accessing Brief Intervention Counselling	V Δ[32]	690	611	>500	610	-	A
Adults (20+) accessing Brief Intervention Counselling	V Δ	5,569	5,565	>3,500	5,505	-	A
Skin lesions (including cancers) removed in primary care	V Δ	2,432	2,583	>2,000	2,820	-	A

Oral Health Services							
These services help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning and efficient service.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Children (0-4) enrolled in DHB-funded oral health services	C †[33]	71%	69%	85%	61%	-	N
Enrolled children (0-12) examined according to planned recall	T †	94%	86%	>90%	90%	-	A
Adolescents (13-17) accessing DHB-funded oral health services	C †[34]	64%	62%	85%	62%	66%	N

[30] *The HealthPathways website helps general practice to navigate clinically designed pathways that guide and support patient care. This measure counts clinical pathways and supporting resources.*

[31] *Some hospital admissions are seen as avoidable through early intervention and treatment and therefore provide an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. The aim is to maintain performance below the national rate, which reflects less people presenting to hospital. At the time of preparing the 2015/16 Plan the Ministry was working to resolve a definition issue with this measure and target setting was postponed. The results presented are based off the definition set in October 2015 with the baselines having been provided by the Ministry. No targets were set for this measure in 2015/16 and the DHB has recognised its performance as an improvement on the previous year and below national rates.*

[32] *The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. Results include face-2-face and phone consultations and may undercount people accessing the service where dates of birth or NHIs have not been provided. Baselines differ due to an update of the definition around telephone consultations and removal of records with no identifier (youth -96 and -143 and adult -143 and -87).*

[33] *Enrolment rates are disappointing. In the coming year the DHB will review its enrolment processes and our School and Community Dental Service will work more closely with the Immunisation and Well Child teams to encourage families to connect with services and lift enrolment rates.*

[34] *Uptake of free oral health care by adolescents has been low for some years. The DHB is completing an evaluation of a pilot run in Aranui over the past year, to encourage uptake by adolescents and will look to roll-out the successful elements of the pilot in 2016-2017.*

Long-term Conditions Services

These services are targeted at people with high health needs and aim to improve the management of their conditions. Success is demonstrated through uptake of monitoring and management services which can reduce complications that lead to negative health outcomes and hospital admissions.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Spirometry tests provided in community rather than hospital	V Δ[35]	1,533	1,682	>1,000	1,742	-	A
Eligible population having a CVD risk assessment in the last 5 years	C ◇	66%	82%	90%	87%	91%	P
Population identified with diabetes having an HbA1c test in the last year	C Δ[36]	94%	88%	>90%	89%	-	P
Population identified with diabetes with acceptable glycaemic control (evidenced via their HbA1c test)	Q	77%	77%	>75%	75%	-	A
People receiving subsidised diabetes self-management support from their general practice team, when newly diagnosed with Type 2 diabetes or starting insulin	V Δ	799	880	>800	956	-	A

Pharmacy and Referred Services

These are services which a health professional may use to help diagnose or monitor a health condition. While largely demand driven, access to these services improves clinical decision-making and reduces unnecessary delays in treatment.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Subsidised pharmaceutical items dispensed in the community	V Δ[37]	6.2m	6.3m	E.<8m	6.5m	-	A
Laboratory tests completed for the Canterbury population	V Δ	2.4m	2.4m	E. <2.6m	2.4m	-	A
People on multiple medications receiving a Medication Management Review (MMR)	V Δ[38]	1,703	1,326	1,500	1,251	-	N
GP requested Community Referred Radiology tests completed	V Δ	43,094	44,720	E. >30k	44,404	-	A
People receiving urgent diagnostic colonoscopy within 2 weeks	T [39]	85%	96%	75%	92%	92%	A
People receiving CT scans within 6 weeks	T [40]	92%	96%	95%	75%	87%	N
People receiving MRI scans within 6 weeks	T [40]	88%	75%	>85%	59%	70%	N
People receiving elective coronary angiography within 3 months	T [39]	99%	98%	>95%	98%	96%	A

[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. Tests are delivered by GP and mobile community respiratory providers.

[36] An annual HbA1c test of patient's blood glucose levels is seen as a good means of assessing the management of people's diabetes condition - HbA1c ≤64mmol/mol reflects an acceptable blood glucose level. The 2014/15 results differ to those previous printed, having been updated to reflect the full year's results which were not available at the time of printing.

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

[38] This measure counts only MMRs. It was expected that the number would drop with the introduction of a new intensive programme of Mediation Therapy Assessments to sit alongside the MMR programme. The MTA programme began in May 2015 and between both programmes we delivered around the same number of assessment in total (104 MTAs were delivered). Assessments for both programmes will be counted in 2016/17.

[39] These diagnostic measures are national DHB performance measures. Standards are set nationally and results are for the final month of the year (June) in alignment with results published by the Ministry of Health. In 2015/16 the colonoscopy target was incorrectly transcribed as 95% and the coronary angiogram baseline was incorrectly transcribed (as 95%) both errors have been corrected.

[40] Demand for CT and MRI scanning has been exceeding reporting and machine capacity in Canterbury and wait times have been growing. The DHB now has its CT and MRI scanning has been exceeding reporting and machine capacity in Canterbury and wait times have been growing. The DHB now has its CT and MRI scanners operational at Burwood Hospital and is in the process of installing a second MRI scanner at Christchurch Hospital. This will help to lift performance and additional CT scanning sessions are running at Burwood to reduce delays.

Intensive assessment and treatment services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

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

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

SERVICE PERFORMANCE - 2015/16

Quality and Patient Safety							
These quality and patient safety measures apply across all our hospital services. High compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Rate of compliance with good hand hygiene practice	Q ◇[41]	67%	77%	80%	78%	81%	P
Hip and knee replacement patients receiving cefazolin >2g	Q ◇[42]	91%	98%	>95%	98%	96%	A
Hip and knee replacement patients who have appropriate skin preparation	Q ◇	100%	100%	100%	100%	100%	A
Proportion of time all three parts of the Surgical Safety Checklist are used	Q ◇[43]	88%	77%	90%	-	-	-
Inpatients (aged 75+) receiving a falls assessment	Q ◇[44]	93%	96%	>90%	100%	86%	A

Maternity Services							
These are services provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Service utilisation is monitored to ensure engagement with the system and capacity to respond.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Women registered with an LMC by 12 weeks of pregnancy	C †[45]	75%	77%	80%	76%	-	N
Maternity deliveries in Canterbury facilities	V [46]	5,706	5,897	E. 6,000	5,922	-	A
Proportion of deliveries made in Primary Birthing Units	V Δ[47]	10%	12%	13%	14%	-	A

[41] *The quality measures are national safety markers with definitions and standards set nationally. Baselines have been updated to the final quarters which were not available at the time of printing. The 2015/16 results are the most recent available being Q3 (January-March 2016).*
[42] *Cefazolin ≥2g is an antibiotic recommended as routine for hip and knee replacements to prevent infection complications.*
[43] *This measure was retired from the national programme at the beginning of 2015/16.*
[44] *While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and then plan accordingly.*
[45] *This measure is part of the national Well Child performance framework and standards are set nationally. The 2015/16 result reflects the latest results available - preliminary results for the 6 months to December 2015.*
[46] *The baseline for 2013/14 has been updated to reflect inclusion of deliveries at St George's Hospital (primary birthing unit), along with late coding lifting the baselines slightly from 5,654 and 5,895 and the percentage of deliveries in primary units in 2013/14 by +1%.*
[47] *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 allows for a better use of system resources and ensures capacity is available for those women who need more complex or specialist intervention.*

Acute/Urgent Services							
These are services delivered in response to illnesses that have an abrupt onset or progress rapidly. While largely demand driven, earlier intervention and shorter wait times are indicative of an effective and responsive system.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Children (0-13) with access to free primary care after hours	C	-	new	100%	98%	-	P
General practices providing telephone triage after hours	C	89%	92%	95%	93%	-	P
Acute demand packages of care provided in community settings	V Δ [48]	29,586	31,182	>28,000	33,010	-	A
Attendances at Canterbury DHB Emergency Departments	V [49]	-	91,253	E. <96k	94,251	-	A
People waiting less than 4 weeks for radiation or chemotherapy	T ◇[50]	100%	100%	100%	100%	-	A
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 ◇[51]	new	73%	85%	70%	74%	N
Acute inpatient average length of stay (standardised)	Q	2.45	2.4	<2.45	2.39	2.6	A

Elective/Arranged Services							
These are services for people who do not need immediate hospital treatment, where treatment is 'booked' or 'arranged'. Improved access is seen as indicative of an effective system.	Notes	2013/14 Base	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
First Specialist Assessments provided (medical and surgical)	V [52]	67,122	69,199	E.>60k	71,413	-	A
First Specialist Assessments that were non-contact (virtual)	Q [53]	13.5%	15.6%	>10%	16.6%	-	A
Elective surgical discharges delivered (surgeries provided)	V ◇[54]	19,489	20,353	20,474	21,039	-	A
Elective/arranged surgeries provided as day cases	Q [55]	57%	58%	57%	58%	-	A
People who receive their surgery on the day of admission	Q [55]	91%	91%	90%	91%	-	A
Elective inpatient average length of stay (standardised)	Q	1.59	1.57	<1.59	1.54	1.60	A
Outpatient attendances	V [56]	624,522	639,232	E.>600k	658,668	-	A
Outpatient 'Did not Attend' rates	Q [57]	5.8%	5.4%	<5%	4.8%	-	A
Outpatient 'Did not Attend' rates (Māori)	Q	11.8%	10.7%	<5%	9.1%	-	P

[48] *Acute demand packages of care allow people who would otherwise require a hospital admission to be treated in the community. Previous year's baselines have been updated to reflect consistent definitions to enable improved comparison between years (baselines were 28,378 and 28,944).*

[49] *This measure is based off the definitions for the national health target (Shorter Stays in ED) the national target count excludes those who do not wait and those with pre-arranged appointments. Coding allowed us to exclude these people from 2014/15 – previous baselines included people with pre-arranged appointments. The total number presenting at Christchurch Hospital ED was 94,466 and including Ashburton ED was 100,181.*

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

[51] *This measure is a national health target (Faster Cancer Treatment) introduced in Q2 of 2014/15, and presents a rolling six month result. The DHB is making progress overall with 74% of people meeting the target for the full year and 74% for the last three months of 2015/15.*

[52] *This measure counts both medical and surgical assessments but only the first assessments (where the specialist determines treatment) and not the follow-up assessments after treatment has occurred, as the first assessment is key in tracking increased access to treatment. The 2014/15 baselines have been revised (-952) as a result of ongoing quality improvement and alignment of outpatient definitions and codes as the South Island DHBs ready themselves for migration to one shared patient information care system (PICS) the same applies to non-contact FSAs (+0.2%).*

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

[54] *This measure is a national health target (Improved Access to Elective Services). The definition was updated nationally for 2015/16 to include inpatient surgical discharges from surgical and non-surgical specialities and both 'elective' and 'arranged' admissions. Baselines have been aligned.*

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

[56] *The outpatient baselines have been revised (-2.5% and -1.5%) as a result of ongoing quality improvements and alignment of outpatient definitions and codes. Outpatient DNA rates have also been affected by the revision (+1.4% and +1% total and +4.6% and +2.8% Maori).*

[57] *The DNA rate is calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not. When patients fail to turn up to scheduled appointments it is costly for the DHB, but most importantly it can negatively affect people's recovery and long-term outcomes. Maori DNA rates are significantly higher and the DHB aims to being these rates down in line with the rest of the population, because a number of factors can influence these rates, this will take time but we are pleased to already see a drop.*

Specialist Mental Health Services							
These are services for those most severely affected by mental illness or addictions. Improved access and shorter wait times are indicative of the systems positive response to demand.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Young people (0-19) accessing specialist mental health services	C Δ[58]	3.2%	3.5%	>3.1%	3.5%	3.7%	A
Adults (20-64) accessing to specialist mental health services	C Δ	3.2%	3.2%	>3.1%	3.4%	3.9%	A
People referred for non-urgent mental health and alcohol and other drug (AOD) services seen within 3 weeks	T [59]	70%	73%	80%	76%	80%	P
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	86%	90%	95%	93%	94%	P

Assessment, Treatment and Rehabilitation Services (AT&R)							
These are services that restore functional ability and enable people to live as independently as possible. Success is measures through an increase in the rate of people discharged home, rather than into residential care or hospital settings.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Admissions into all inpatient AT&R services	V [60]	3,313	3,462	E.>3,000	3,371	-	A
Admissions into Older Person's Health AT&R services made by direct community referral	Q [61]	19%	21%	20%	20%	-	A
Older Person's Health AT&R inpatients discharged to their own home rather than into aged residential care	Q Δ[62]	87%	87%	>80%	86%	-	A

[58] This measure is a national DHB performance measure (PP6) and standards are set nationally based on the expectation that 3% of the population will need access to higher-level mental health support. Results reflect specialist services reporting through to the national PRIMHD database and undercounts service provision where local providers are not reporting to the national system including some NGOs and primary care mental health services, which have been significantly ramped up in Canterbury following the earthquakes. The three year trend presented also does not reflect the extent of the increase in demand - access rates in Canterbury to December 2010 were much lower, 1.7% for youth and 2.2% for adults.

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

[60] The baselines for 2014/15 has been updated to include 12 late coded events.

[61] This is a subset of the total AT&R services and relates to aged related AT&R services provided by the Older Person's Health Division of the DHB.

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

Rehabilitation and support services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

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

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

SERVICE PERFORMANCE - 2015/16

Rehabilitation Services							
These are services restore or maximise people's health or functional ability following a health-related event such as a heart attack or stroke. Success is measured through increased referral and access to services following an acute event.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People referred to an organised stroke service (with a demonstrated stroke pathway) after an acute event	C	74%	80%	80%	80%	-	A
People accessing cardiac rehabilitation services after an acute event	C [63]	20%	15%	30%	22%	-	P
People accessing community-based pulmonary rehabilitation courses	V	230	222	>200	261	-	A
People (65+) accessing community-based falls prevention programmes	V	1,505	1,686	>1,200	1,973	-	A

Home and Community-Based Support Services							
These are services that help to restore functional independence and support people to continue living in their own homes. Largely demand driven, clinical assessment ensures appropriate and equitable access to services.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
Proportion of older people (65+) receiving long-term home and community support services, who have had a clinical assessment using InterRAI	Q [Δ64]	91%	94%	95%	96%	-	A
People supported by CREST services on hospital discharge or GP referral	V [Δ65]	1,992	1,770	>1,500	1,726	-	A
People supported by district nursing services	V [Δ]	7,645	7,765	E.>6,000	7,532	-	A
People supported by long-term home-based support services	V [Δ]	8,796	8,641	E.<8,000	8,129	-	P

[63] *This measure counts those enrolled in Phase 2 (outpatient) cardiac rehabilitation on discharge. Rehabilitation options have been extended to include evening courses and outpatient type appointments which have enabled and encourage more people to attend a positive outcome. The DHB is intending to review the definition for this measure as it currently counts all cardiac events including some minor events would not clinically necessitate a referral to a rehabilitation programme. This measure may change in the coming year.*

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

[65] *The CREST service provides a range of home-based rehabilitation services aimed at facilitating early discharge from hospital or avoiding admission to hospital entirely (via pro-active GP referral).*

Respite and Day Services							
These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Success is measured by increased access to services and effective use of capacity.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People supported by day services	V [Δ]	672	832	E.>550	804	-	A
People accessing mental health planned and crisis respite	V [Δ]	819	935	E.>750	1,006	-	A
Occupancy rate of mental health planned and crisis respite beds	C [Δ66]	84%	76%	85%	76%	-	N
Older people supported by aged care respite services	V [Δ]	1,262	1,424	E.>1,000	1,620	-	A

Palliative Care Services							
These are services that improve the quality of life for patients facing end of life and their families. Services are demand driven and access is monitored to ensure capacity is available.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People supported by hospice or home-based palliative services	V [Δ]	3,815	3,934	E.>2,500	3,617	-	A

Residential Care Services							
These services meet the needs of a person who has been assessed as requiring long-term residential care. With an ageing population, demand is expected to increase, but a reduction in demand for lower-level residential care (rest homes) is seen as indicative of more people being successfully supported to remain in their own homes.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National Average	Rating
People entering ARC having had an InterRAI assessment	Q [Δ64]	96%	99%	95%	99%	-	A
ARC residents receiving vitamin D supplements	C[67]	68%	70%	75%	69%	-	N
Subsidised ARC rest home beds provided (days)	V [Δ68]	555,950	528,795	E.<676k	501,688	-	A
Subsidised ARC hospital beds provided (days)	V [Δ]	459,658	471,724	E.<507k	494,185	-	A
Subsidised ARC dementia beds provided (days)	V [Δ]	227,345	231,066	E.>212k	239,996	-	A
Subsidised ARC psycho-geriatric beds provided (days)	V [Δ]	69,631	67,833	E.>62k	70,562	-	A

[66] *Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directed to other areas. The baseline for 2014/15 has been updated to reflect three additional beds that were contacted mid-way through that year and not included in the count - there are now 26 beds available in total.*

[67] *The data collection methodology for this programme has been reviewed and there are a number of caveats which suggest this measure may be undercounting Vitamin D prescribing in ARC. The DHB has elected not to continue reporting this measure until we are able to verify these results.*

[68] *The Baselines for the ARC bed day baseline volumes have been revised from those previous published to reflect improved data recording and calculations around start and end dates of stay. Trends are still consistent 2014/15 bed-days were: rest home 538,229, hospital 502,950, dementia 243,785, psycho-geriatric 70,362. The results for 2015/16 were run 19/08/16.*

2.4 National Health Target Performance

2015/16 was a mixed year for Canterbury DHB in terms of delivery against the national health targets. While we missed three of the seven national health targets, we improved or maintained performance on all but one and achieved our best result ever on four of the national targets. Results below show the quarterly results across the year.

National Health Targets							
Success is measured by achievement of the target but also by improved performance and comparison to other DHBs.	2015/16 Target	Q1	Q2	Q3	Q4	National Average	Rating
Children fully immunised at eight months of age	95%	95%	96%	96%	96%	93%	A
Smokers enrolled with a PHO receiving advice and help to quit	90%	83%	85%	85%	88%	88%	P
Smokers identified in hospital receiving advice and help to quit	95%	96%	98%	97%	98%	96%	A
Eligible population having had a CVD risk assessment in the last 5 years	90%	86%	85%	86%	87%	91%	P
Percentage of people presenting in ED admitted, discharged or transferred within six hours	95%	95%	95%	95%	95%	94%	A
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral	85%	72%	77%	73%	70%	74%	N
Elective surgical discharges delivered (surgeries provided)	20,474	5,375 (97%)	10,455 (98%)	15,236 (99%)	21,039 (103%)	-	A

Results against the Immunisation health target are particularly impressive reaching 96% for three quarters in row and across the full year. Canterbury DHB sits at the top of the national performance table for this target – which is a fantastic result.

Delivery against the national Shorter Stays in ED and Elective Surgery targets have also been particularly impressive this year, considering the reduced capacity and constant disruptions being experienced across our main hospitals sites as we shift services and wards to accommodate earthquakes repairs.

Performance against the new Faster Cancer Treatment target is moving in the right direction. While the fourth quarter result was lower, 74% of patients met the target across the whole year. Work being done around improving the capture and quality of the data and improving patient pathways is expected to improve our performance in 2016/17.

We achieved the Better Help for Smokers to Quit - Hospitals health target, with 98% of hospitalised smokers having received help and advice to quit in the final quarter and 97% across the full year. Improvement is also evident against the Better Help for Smokers to Quit – Primary Care health target, reaching 85% of patients who smoke across the full year and 88% in the final quarter.

The More Hearts and Diabetes Checks target, with performance sitting at 87% is an improvement on the beginning of the year but we remain low nationally against this health target. This will no longer be a national health target in 2016/17 (being replaced with the Raising Healthy Kids target) but will still be tracked as part of our service performance reporting.

2.5 Maori Health Plan Performance

Setting alongside its Annual Plan and Statement of Intent, the DHB also has a Maori Health Action Plan which sets out planned activity and standards against a set of national indicators, specifically established to support improvements in health outcomes for Maori. The 2015/16 Maori Health Action Plan is available on our website and performance against the indicators in the Action Plan are presented below.

Maori Health Action Plan Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Maori and non-Maori.	Notes	2013/14	2014/15	2015/16 Target	2015/16 Result	2015/16 National	Rating
Māori population enrolled with a PHO	C	83%	87%	95%	85%	-	N
Māori women smokefree at two week postnatal	Q [69]	66%	72%	95%	n.a	n.a	-
Māori babies exclusive/fully breastfed at LMC discharge	Q [69]	67%	68%	75%	n.a	n.a	-
Māori babies exclusive/fully breastfed at 3 months	Q	51%	54%	60%	53%	43%	N
Māori babies receiving breast milk at 6 months	Q	49%	53%	65%	51%	53%	N
Māori babies fully immunised at eight-month-olds	C	88%	96%	95%	95%	90%	A
Māori children receiving a B4 Schools Check at age four	C [70]	84%	92%	90%	94%	88%	A
Rates of avoidable hospital admissions for Māori (0-4 years)	Q [71]	5,502	5,578	-	4,946	7,631	A
Māori children (0-4) enrolled in DHB dental services	C †[72]	31%	33%	90%	29%	-	N
Māori children caries-free (no holes/fillings) at age five	Q †	45%	41%	65%	42%	-	P
Eligible Maori girls receiving Dose 3 of the HPV programme	C †[73]	28%	28%	65%	35%	71%	P
Eligible Māori men (35-44) who have had their CVD risk assessed within the past five years	C [74]	-	new	90%	61%	68%	N
Māori women (25-69) who have had a cervical smear in the last three years	C [75]	56%	55%	80%	60%	66%	P
Māori women (50-69) who have had a mammography in the last two years	C [75]	80%	74%	>70%	72%	65%	A
Older Māori (65+) having had a seasonal influenza vaccination	C †[76]	70%	71%	75%	68%	-	N
Rates of avoidable hospital admissions for Māori (45-64 years)	Q [71]	4,082	4,255	-	3,848	6,821	A
High-risk Māori receiving an angiogram ≤3 days of admission	Q	New	94%	>70%	69%	-	N
Māori presenting with Acute Coronary Syndrome undergoing angiography with completion of registry data within 30 days	Q	new	89%	>95%	100%	-	A
Rates of rheumatic fever in the South Island (per 100,000)	Q	0.4	0.4	<0.2	0.4	2.1	P
Rates of compulsory treatment orders for Māori (per 100,000)	Q [77]	206	203	-	213	294	-

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

[70] *The 2013/14 baseline has been updated from the High Need Population to Maori (which was not available at the time of printing).*

[71] *At the time of preparing the 2015/16 Plan the Ministry was working to resolve a definition issue with this measure and target setting was postponed. The definition was set in October 2015 and the Ministry provided previous years baselines as presented. No targets were set for this measure in 2015/16 and the DHB has recognised its performance as an improvement on the previous year and below national rates.*

[72] *Ethnicity results are based off that recorded at birth and the DHB is working on aligning these to the NIR and PHO dataset which are understood to be more accurate – preliminary results suggest rates are higher but still below targets.*

[73] *The DHB made an error in realigning its age bands to the national programme the eligible girls for the 2015/16 year are those born in 2002 not in 2003. The baselines for 2013/14 was aligned to the wrong birth cohort and has been corrected in this report.*

[74] *The baseline was all eligible Maori as the subset of Maori men was not available at the time – this has been updated, result is Q3 latest available.*

[75] *The cervical and breast cancer screening programmes are national programmes and age bands and standards are set nationally. The 2013/14 result for breast screening is updated for the full year but against the previous age bands (45-69) and is not directly comparable.*

[76] *This result is affected by our ageing population, the actual number of older people having a flu vaccination has increased by 52 people.*

[77] *These results are the latest available nationally to the end of Q3 - March 2016.*

Part III – Managing Our Business

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

3.1 Corporate Governance

Statutory Information

This Annual Report outlines Canterbury DHB's financial and non-financial performance for the year ended 30 June 2016 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

Board's Report & Statutory Disclosure

Principal Activities

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

Results

During the year, Canterbury DHB recorded a deficit of $0.473M against the budgeted breakeven position. (2014/15 deficit of $17.936M against the budgeted deficit of $12.550M).

Board Fees

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

	Board Fees 2016 $'000	Committee Fees 2016 $'000
Murray Cleverley	54.600	2.000
Peter Ballantyne	-	2.500
Pauline Barnett	-	1.250
Sally Buck	26.520	2.000
Anna Crighton	26.520	3.375
Elizabeth Cunningham	-	0.250
Wendy Dallas-Katoa	-	1.500
Andrew Dickerson	26.520	5.625
Hamish Doig	-	5.000
Jan Edwards	-	1.500
Baden Ewart	-	-
Rochelle Faimalo	-	1.000
Susan Foster-Cohen	-	1.250
Jo Kane	26.520	5.250
Aaron Keown	26.520	3.000
Bob Lineham	-	2.500
Sandy Lockhart	-	0.250
Ben Lucas	-	1.000
Cheryl Macaulay	-	4.000
Chris Mene	26.520	2.250
Edie Moke	26.520	3.500
David Morrell	26.520	4.000
Yvonne Palmer	-	1.250
Trevor Read	-	1.250
Ana Rolleston	-	0.250
Tony Sewell	-	3.000
William Tate	-	2.500
Susan Wallace	26.520	-
Steve Wakefield	33.150	4.375
Olive Webb	-	1.250
	326.430	**66.875**

Total fees paid for the year were $393,305 (2014/15 - $382,715).

Board and Committee Member Attendance

	Board		QFARC		HAC		CPHAC		DSAC		FAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Murray Cleverley	12	12	8	12	-	-	-	-	-	-	5	5
Peter Ballantyne	-	-	11	12	-	-	-	-	-	-	-	-
Pauline Barnett	-	-	-	-	-	-	5	6	-	-	-	-
Sally Buck	12	12	-	-	4	6	-	-	4	5	-	-
Anna Crighton	12	12	-	-	6	6	6	6	-	-	-	-
Elizabeth Cunningham	-	-	-	-	-	-	-	-	1	1	-	-
Hamish Doig	-	-	-	-	-	-	-	-	-	-	5	5
Wendy Dallas-Katoa	-	-	-	-	-	-	6	6	-	-	-	-
Andrew Dickerson	11	12	12	12	6	6	-	-	5	5	5	5
Jan Edwards	-	-	-	-	6	6	-	-	-	-	-	-
Baden Ewart	-	-	-	-	-	-	-	-	0	4	-	-
Rochelle Faimalo	-	-	-	-	-	-	4	6	-	-	-	-
Susan Foster-Cohen	-	-	-	-	-	-	-	-	5	5	-	-
Jo Kane	11	12	11	12	-	-	6	6	5	5	-	-
Aaron Keown	12	12	-	-	6	6	6	6	-	-	-	-
Bob Lineham	-	-	11	12	-	-	-	-	-	-	-	-
Sandy Lockhart	-	-	-	-	-	-	-	-	1	3	-	-
Ben Lucas	-	-	-	-	-	-	-	-	4	5	-	-
Cheryl Macaulay	-	-	-	-	-	-	-	-	-	-	4	5
Chris Mene	9	12	-	-	-	-	4	6	4	5	-	-
Edie Moke	11	12	11	12	-	-	-	-	4	5	-	-
David Morrell	10	12	12	12	6	6	-	-	-	-	-	-
Yvonne Palmer	-	-	-	-	-	-	5	6	-	-	-	-
Trevor Read	-	-	-	-	5	6	-	-	-	-	-	-
Ana Rolleston	-	-	-	-	1	6	-	-	-	-	-	-
Tony Sewell	-	-	-	-	-	-	-	-	-	-	3	5
William Tate	-	-	11	12	-	-	-	-	-	-	-	-
Susan Wallace	7	12	-	-	-	-	-	-	-	-	-	-
Steve Wakefield	11	12	11	12	5	6	-	-	-	-	5	5
Waren Warfield	-	-	-	-	-	-	-	-	-	-	3	5
Olive Webb	-	-	-	-	-	-	-	-	5	5	-	-

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

Note: DSAC Membership

Elizabeth Cunningham resigned August 2015
Baden Ewart resigned March 2016
Sandy Lockhart appointed October 2015

Director Fees

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

	2016 $'000	2015 $'000
Brian Wood	28	28
Jane Cartwright	22	18
Peter Ballantyne	6	13
Kath Fox	10	7
Paula Rose	7	0
Graeme McNally	11	11
Garth Bateup	6	6
	90	**83**

Directors' and Board Members' Loans

There were no loans made by the Board or its subsidiaries to Board Members or Directors.

Directors' and Board Members' Insurance

The Board and its subsidiaries have arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensure that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

Use of Board or Subsidiaries' Information

During the year, the Board or its subsidiaries did not receive any notices from Board Members or Directors requesting the use of Board or company information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

Payments in Respect of Termination of Employment

During the year, the Board made the following payments to employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place, for example, amounts for redundancy (based on length of service), and payment in lieu of notice etc.

The 2015/16 payments include costs relating to specific restructuring exercises including the migration of Older Persons Health services from The Princess Margaret Hospital to the Burwood Hospital campus, as well as the transition of cervical screening from an internal service to one provided by a community based service provider.

The total payments made by Canterbury DHB were $414,654 to 19 employees (2014/15 – 3 employees totalling $93,974) comprising negotiated settlements with the employees.

Requirement to Report on New Zealand Business Number Implementation

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

Remuneration of Employees

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

	2016 (including benefits) Total	2015 (including benefits) Total
100,000-109,999	198	170
110,000-119,999	129	131
120,000-129,999	98	92
130,000-139,999	91	79
140,000-149,999	59	63
150,000-159,999	46	52
160,000-169,999	55	50
170,000-179,999	36	33
180,000-189,999	30	23
190,000-199,999	25	33
200,000-209,999	25	19
210,000-219,999	22	26
220,000-229,999	28	23
230,000-239,999	33	32
240,000-249,999	23	22
250,000-259,999	18	18
260,000-269,999	22	26
270,000-279,999	27	24
280,000-289,999	23	13
290,000-299,999	14	17
300,000-309,999	16	15
310,000-319,999	14	20
320,000-329,999	8	10
330,000-339,999	14	12
340,000-349,999	8	9
350,000-359,999	8	8
360,000-369,999	10	4
370,000-379,999	5	2
380,000-389,999	4	1
390,000-399,999	1	1
400,000-409,999	2	3
410,000-419,999	1	4
420,000-429,999	3	-
430,000-439,999	1	1
440,000-449,999	1	3
450,000-459,999	1	-
460,000-469,999		2
470,000-479,999		-
480,000-489,999	1	1
500,000-509,999		-
520,000-529,999	1	-
560,000-569,999		1
590,000-599,999		1
600,000-609,999	1	
Total	1,102	1,044

Of the 1,102 (2014/15 1,044) positions identified above, 939 (2014/15 890) positions were predominantly clinical and 163 (2014/15 154) positions were management/administrative.

3.2 Our Assets

Asset management and performance

Having the right assets in the right place and managing them well is critical to the ongoing provision of high-quality and cost-effective health services. Asset management is also particularly important for Canterbury DHB as we work through the implementation of New Zealand's largest public health sector repair and redevelopment programme.

Canterbury DHB has an Asset Management Plan that helps inform our capital requirements in the short, medium, and long term. The Plan supports asset management and investment decisions by identifying the condition of those assets and any planned refurbishment, upgrades or replacements.

We have aggregated our assets into three major portfolio areas which cover the majority of those assets considered significant (critical) in regard to the delivery of core services.

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

As part of our asset management, and to improve our investment thinking, we working with the Ministry of Health, Treasury and fellow DHBs on the development of Long-Term Investment Plans. The ongoing development of these plans includes the establishment of a core set of asset performance measures which will help to ensure we are investing wisely and that the assets we have in place meet both industry standards and business needs.

In the coming year, the performance metrics for each asset portfolio will be set and agreed at clinical, management and governance levels throughout Canterbury DHB. The agreed metrics will be presented in our 2016/17 Annual Report.

3.3 Our People

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

Leadership, accountability and culture

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

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

Staff Ethnicity	Number
Americas	79
Australian	94
British	701
Chinese	153
Filipino	158
Indian	159
Irish	61
Maori	239
Middle Eastern	34
New Zealand European	4,615
New Zealander	541
Not Stated / Don't Know	1,642
Other	7
Other African	48
Other Asian	219
Other European	739
Pacific Peoples	91
South African	54
	9,634

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

Staff Mix by Average Age	Average Age
Medical	41.2
Nursing	46.5
Allied Health	44.4
Support	51.2
Management & Administration	50.1

Staff Mix by Gender	Number	Percentage
Female	7,808	81%
Male	1,826	19%
	9,634	

Integrated talent management

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

Workplace safety, health and wellbeing

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by a professional Health, Safety and Wellbeing team, which includes experts in workplace safety, occupational health and rehabilitation, as well as employee wellbeing. In addition to working with our employees this

dedicated team also provides advice and support to management and staff.

There is a health monitoring programme which includes screening and immunisation. Employees and their families are provided with free access to an Employee Assistance Programme if they are faced with work or personal issues that are negatively impacting on them. Staff also have access to onsite Work Place confidential support services through an external provider. Wellbeing programmes and activities to encourage and support employees in terms of healthier lifestyles are available throughout the organisation. An employee participation programme which includes health and safety committees and safety training encourages all employees to be responsible for building and maintaining a healthy and safe environment at work.

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

Equal opportunities and positive behaviours

Consistent with our vision and organisational values, Canterbury DHB is committed to maintaining and enhancing practices which eliminate all forms of discrimination, bullying and harassment in the workplace and barriers to the recruitment, retention, development and promotion of its employees. Canterbury DHB has a diverse, flexible and highly skilled workforce which reflects the demographics of its community and contributes significantly to the provision of quality, culturally and individually appropriate services. We are committed to identifying and dealing with all examples of bullying and harassment and have a zero tolerance policy in respect of such behaviour. All employees on joining the DHB are made familiar with both our Bullying and Harassment Policy and Equal Opportunities Policy.

Remuneration and recognition

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

Employee engagement

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

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

A key component of engagement is staff wellbeing. Canterbury DHB has just completed the latest iteration of its Staff Wellbeing Survey Staff [previous surveys in 2012 and 2014]. There were 4,042 responses to the survey which closed on 14 August 2016. Results for the survey will inform the development of a Staff Wellbeing Strategy.

Canterbury DHB's focus on engaging and empowering our workforce is evident in our

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

Employee development

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

To enable this work we have formed a tertiary alliance with the University of Otago, the University of Canterbury, and ARA (formerly CPIT), a member of the TANZ network (10 South Island and lower North Island polytechnic institutes) to make available a common curriculum of development to all employees. These programmes are additional to the extensive skills development initiatives that come through the various professional groups for both clinical and non-clinical employees.

Promoting open, user centric learning through a shared South Island e-learning platform called HealthLearn, is providing ready access to consistent and wide ranging learning. In addition, the online performance appraisal process ensures all employees are focussed on the right things and expected behaviours at an individual and team level. This process also identifies and provides input to the development needs of individuals.

Part IV – Financial Performance

4.1 Meeting Our Financial Challenges

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2016

	Notes	Group Actual 2016 $'000	Budget 2016 $'000	Actual 2015 $'000
Revenue				
Patient care revenue	2	1,558,555	1,540,961	1,512,862
Other revenue	3	35,216	35,637	27,379
Earthquake repair revenue redrawn from the Ministry of Health	16	9,882	21,000	13,150
Interest revenue		2,463	2,800	5,260
Total revenue		**1,606,116**	**1,600,398**	**1,558,651**
Expense				
Employee benefit costs	4	693,369	678,558	659,665
Treatment related costs		142,198	148,361	140,756
External service providers		606,747	597,400	586,846
Depreciation and amortisation		57,739	61,224	61,135
Finance costs		5,575	6,612	5,886
Other expenses	5	101,729	95,986	96,303
Earthquake building repair costs	16	9,882	21,000	13,150
Capital charge expense	6	5,726	7,633	12,846
Total expense		**1,622,965**	**1,616,774**	**1,576,587**
Surplus/(deficit) before Ministry of Health Revenue Deficit Funding		**(16,849)**	**(16,376)**	**(17,936)**
Ministry of Health Revenue Deficit Funding received		**16,376**	**16,376**	**-**
Surplus/(deficit) after Ministry of Health Revenue Deficit Funding		**(473)**	**-**	**(17,936)**
Other comprehensive revenue & expense				
Items that will not be reclassified to surplus/(deficit)				
Impairment of property, plant & equipment	7,14,16	**-**	**-**	**(62)**
Revaluation of property, plant & equipment	7,14	**91,753**	**-**	**-**
Total other comprehensive revenue & expense		**91,753**	**-**	**(62)**
Total comprehensive revenue & expense		**91,280**	**-**	**(17,998)**

This statement is to be read in conjunction with the Notes to the financial statements

Statement of Changes in Equity

For the year ended 30 June 2016

	Notes	Group Actual 2016 $'000	Budget 2016 $'000	Actual 2015 $'000
Total equity at beginning of the year		77,014	77,033	204,373
Total comprehensive revenue & expense for the year		91,280	-	(17,998)
Equity injections:				
Operating deficit support			-	12,500
Earthquake repair capital redrawn		33,500	62,000	-
New Burwood facilities redevelopment assets transferred from the Crown (equity value)		-	86,000	-
Equity repayments:				
Annual depreciation funding repayment		(1,861)	(1,861)	(1,861)
CDHB capital contribution towards Burwood and Christchurch facilities redevelopment		-	-	(120,000)
Total equity at end of the year	7	**199,933**	**223,172**	**77,014**

This statement is to be read in conjunction with the Notes to the financial statements

Statement of Financial Position

As at 30 June 2016

	Notes	Group Actual 2016 $'000	Budget 2016 $'000	Actual 2015 $'000
CROWN EQUITY				
Contributed capital	7	(282,151)	(167,651)	(313,790)
Revaluation reserve	7	290,849	199,158	199,096
Accumulated surpluses	7	191,235	191,665	191,708
TOTAL EQUITY		**199,933**	**223,172**	**77,014**
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8	13,546	23,133	3,640
Trade and other receivables	9	69,349	62,685	56,827
Inventories	10	9,432	8,593	8,593
Restricted assets	17	8,060	13,228	13,769
Assets held for sale		540	-	-
Investments	11	1,000	788	400
TOTAL CURRENT ASSETS		101,927	108,427	83,229
CURRENT LIABILITIES				
NZHPL sweep bank account	8	-	-	9,278
Trade and other payables	12	100,886	104,346	83,554
Employee benefits	13	154,321	161,782	160,732
Restricted funds	17	14,297	14,008	14,049
TOTAL CURRENT LIABILITIES		269,504	280,136	267,613
NET WORKING CAPITAL		(167,577)	(171,709)	(184,384)
NON-CURRENT ASSETS				
Property, plant and equipment	14	499,233	650,618	401,277
Intangible assets	15	14,386	25,580	12,284
Restricted assets	17	6,237	780	280
TOTAL NON-CURRENT ASSETS		519,856	676,978	413,841
NON-CURRENT LIABILITIES				
Employee benefits	13	6,361	7,112	6,458
Borrowings	18	145,985	274,985	145,985
TOTAL NON-CURRENT LIABILITIES		152,346	282,097	152,443
NET ASSETS		**199,933**	**223,172**	**77,014**

This statement is to be read in conjunction with the Notes to the financial statements

Statement of Cash Flows

For the year ended 30 June 2016

	Notes	Group Actual 2016 $'000	Budget 2016 $'000	Actual 2015 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Ministry of Health		1,554,809	1,510,421	1,468,333
Earthquake repair revenue redrawn from Ministry of Health		9,882	21,000	12,300
Other receipts		30,316	82,553	104,369
Interest received		2,463	2,800	5,260
		1,597,470	1,616,774	1,590,262
Cash was applied to:				
Payments to employees		699,786	678,558	657,120
Payments to suppliers		844,786	859,747	862,299
Interest paid		4,910	6,612	5,907
Capital charge		5,726	7,633	12,845
GST - net		639	-	5,137
		1,555,847	1,552,550	1,543,308
NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES	19	41,623	64,224	46,954
CASH FLOW FROM INVESTING ACTIVITIES				
Cash was provided from:				
Sale of property, plant & equipment		(22)	-	10
Earthquake insurance receipts			-	-
Receipts from restricted assets & investments		14,148	-	50,998
		14,126	-	51,008
Cash was applied to:				
Purchase of investments & restricted assets		13,775	-	14,657
Purchase of property, plant & equipment		66,929	322,490	57,126
		80,704	322,490	71,783
NET CASH INFLOW/ (OUTFLOW) FROM INVESTING ACTIVITIES		(66,578)	(322,490)	(20,775)
CASH FLOW FROM FINANCING ACTIVITIES				
Cash was provided from:				
Loans raised		-	129,000	15,000
Equity injections:				
Operating deficit support		12,500	12,500	-
New facilities redevelopment assets transferred from the Crown(equity value)		-	86,000	-
Earthquake repair capital redrawn		33,500	62,000	-
		46,000	289,500	15,000
Cash was applied to:				
Loans repaid		-	-	15,000
Equity repayments:				
Earthquake insurance remitted to the Ministry of Health		-	-	-
Annual depreciation funding repayment		1,861	1,861	1,861
CDHB capital contribution towards Burwood and Christchurch facilities redevelopment		-	-	120,000
		1,861	1,861	136,861
NET CASH INFLOW/ (OUTFLOW) FROM FINANCING ACTIVITIES		44,139	287,639	(121,861)
Net increase/ (decrease) in cash and cash equivalents		19,184	29,373	(95,682)
Cash and cash equivalents at beginning of year		(5,638)	(6,240)	90,044
CASH & CASH EQUIVALENTS AT END OF YEAR	8	**13,546**	**23,133**	**(5,638)**

This statement is to be read in conjunction with the Notes to the financial statements

4.2 Guide to Our Financial Reports

Notes to and forming part of the financial statements

1. Statement of Accounting Policies

REPORTING ENTITY AND STATUTORY BASE

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

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

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

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

The financial statements of Canterbury DHB are for the year ended 30 June 2016 and were authorised for issue by the Board on 20 October 2016.

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, 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.

Standards issued that are not yet effective and not early adopted

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 2016 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 these updated standards in preparing its 30 June 2016 financial statements, which resulted in 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.

Associates

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

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

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

Revaluations

Land, buildings and building fitout (excluding leasehold 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 sale price and the carrying amount of the asset.

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

Depreciation

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

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

Class of Asset	Years	Depreciation Rate
Freehold Buildings & Fitout	10 - 50	2 - 10%
Leasehold Buildings	3 - 20	5 - 33%
Plant, Equipment & 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 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 other comprehensive income.

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

Borrowings

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

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

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

Provisions

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

ACC Partnership Programme

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

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

Trade and other payables

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

Income tax

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

Equity

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

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

Revaluation reserve

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

Goods and services tax

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

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

Commitments and contingencies are disclosed as exclusive of GST.

Revenue

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

Ministry of Health population-based revenue

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of other services

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

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

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. Any adjustments are disclosed in note 14.

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

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

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

Retirement and long service leave

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

Leases classification

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

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised. Further information is disclosed in note 20.

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

Non-government grants

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

2. Patient Care Revenue

	Group	
	2016 $'000	**2015 $'000**
Ministry of Health population based funding	1,286,543	1,258,622
Inter-district flows	110,619	100,549
Ministry of Health other contracts	109,352	105,309
ACC revenue	26,739	25,749
Other patient related revenue	25,302	22,633
	1,558,555	**1,512,862**

3. Other Revenue

	Group	
	2016 $'000	**2015 $'000**
Gain/(loss) on sale of property, plant and equipment	(22)	(63)
Donations and bequests received	3,994	586
Insurance revenue	-	4
Pathology tests	9,162	7,155
Research & development	6,319	5,128
External rental revenue	2,044	1,439
Meals on Wheels	995	1,005
Other	12,724	12,125
	35,216	**27,379**

4. Employee Benefit Costs

	Group	
	2016 $'000	2015 $'000
Wages and salaries	680,545	639,258
Contributions to defined contribution plans	19,330	18,350
Increase/(decrease) in employee benefit provisions	(6,506)	2,057
	693,369	**659,665**

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

5. Other Expenses

	Group	
	2016 $'000	2015 $'000
Remuneration of auditor:		
Financial statement audit fees	240	231
Board members' fees	326	326
Directors' fees	90	83
Rental costs	5,988	5,671
Facilities and infrastructure costs	52,363	47,832
Other non-clinical costs	42,722	42,160
	101,729	**96,303**

6. Capital Charge

Canterbury DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the year ended June 2016 was 8%. (June 2015 8%).

7. Equity

	Group	
	2016 $'000	2015 $'000
Contributed capital		
Opening balance	(313,790)	(204,429)
Annual depreciation funding repayment	(1,861)	(1,861)
CDHB capital contribution towards Burwood and Christchurch facilities redevelopment	-	(120,000)
Operating deficit support	-	12,500
Earthquake repair capital redrawn	33,500	-
Closing balance	**(282,151)**	**(313,790)**

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

Accumulated surplus/(deficit)		
Opening balance	191,708	209,644
Operating surplus/(deficit)	(473)	(17,936)
Closing balance	191,235	191,708
Represented by:		
Accumulated surplus in parent and subsidiaries	191,157	191,630
Accumulated surplus in associates	78	78
	191,235	**191,708**
Revaluation reserve		
Opening balance	199,096	199,158
Impairment charges	-	(62)
Revaluation of land, building including fitout	91,753	-
Closing balance	290,849	199,096
Represented by:		
Revaluation of land	85,379	86,109
Revaluation of buildings including fitout	205,470	112,987
	290,849	**199,096**
Total equity	**199,933**	**77,014**

8. Cash and Cash Equivalents

	Group	
	2016 $'000	**2015 $'000**
Current assets		
Bank balances and call deposits	2,429	3,040
NZHPL sweep bank account	11,117	-
Term deposits less than 3 months	-	600
	13,546	**3,640**
Current liabilities		
NZHPL sweep bank account	-	(9,278)
	-	**(9,278)**

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

Bank facility

Canterbury DHB is a party to the "DHB Treasury Services Agreement" between **NZ Health Partnerships Limited (NZHPL) (formerly Health Benefits Ltd (HBL))** and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at a credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one-twelfth of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Canterbury DHB, that equates to $80.916M (2015: $78.862M).

9. Trade and Other Receivables

	Group	
	2016 $'000	2015 $'000
Trade receivables	11,071	11,508
Receivable from the Ministry of Health	28,262	33,557
Prepayments	4,586	3,987
Other receivables	25,430	7,775
	69,349	**56,827**

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

Trade receivables and prepayments are from exchange revenue transactions. Other receivables and receivables from the Ministry of Health are a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in other receivables and in receivables from the Ministry of Health is $17.055M ($13.513M 2015).

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

	Group	
	2016 $'000	2015 $'000
Balance at 1 July	2,748	3,067
Additional provisions made during the year	1,677	549
Receivables written-off during period	(467)	(868)
Balance at 30 June	**3,958**	**2,748**

The ageing of the impairment provisions are as follows:

	Group	
	2016 $'000	2015 $'000
Current	464	403
1-30 days	456	164
31-60 days	286	258
> 61 days	2,752	1,923
Balance at 30 June	**3,958**	**2,748**

As at 30 June 2016 and 2015, all overdue receivables have been assessed for impairment and appropriate provisions have been applied. The net ageing of receivables, excluding prepayments, are:

	Group	
	2016 $'000	2015 $'000
Current	58,951	48,525
1-30 days	3,240	2,856
31-60 days	1,054	598
> 61 days	1,518	861
Balance at 30 June	**64,763**	**52,840**

10. Inventory

	Group	
	2016 $'000	2015 $'000
Pharmaceuticals	2,093	1,846
Surgical and medical supplies	5,385	4,965
Other supplies	3,050	3,086
	10,528	9,897
Provision for obsolescence	(1,096)	(1,304)
	9,432	**8,593**

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

11. Investments

Canterbury DHB has the following investments:

	Group	
	2016 $'000	2015 $'000
Current investments are represented by:		
Term deposits	1,000	400
Total current investments	**1,000**	**400**

Maturity analysis and effective interest rates of term deposits

The maturity dates and weighted average effective interest rates for term deposits are as follows:

	Group	
	2016 $'000	2015 $'000
Term deposits with maturities of 3-12 months	1,000	400
Weighted average effective interest rates	3.12%	3.72%

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

Investment in associates

a) General information

Name of entity	Principal activities	Interest held 2016	Balance date
South Island Shared Service Agency Limited	Non Trading Company	47%	30 June

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

b) Share of associates' contingent liabilities and commitments

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

Investments in subsidiaries

At 30 June 2016 subsidiary companies comprise:

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

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

Joint ventures

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

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

12. Trade and Other Payables

	Group	
	2016 $'000	2015 $'000
Trade payables	17,799	14,998
Other payables	83,087	68,556
	100,886	**83,554**

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

Trade payables are from exchange transactions. The value of non-exchange balances in other payables is $32.443M ($8.646M 2015).

13. Employee Benefits

	Group	
	2016 $'000	2015 $'000
Current liabilities		
Annual, lieu and shift leave accruals	74,963	70,904
Unpaid days accruals	15,304	11,179
ACC accruals	4,932	8,577
Conference/sabbatical leave and expenses	24,297	24,763
Sick leave	11,617	10,647
Other	23,208	34,662
	154,321	**160,732**
Non-current liabilities		
Liability for long service leave	4,445	4,174
Liability for retirement gratuities	1,916	2,284
	6,361	**6,458**

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

14. Property, Plant and Equipment

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

15/16 financial year	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings fitout	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Cost or valuation						
Balance at 1 July 2015	131,188	301,099	197,987	409	30,964	661,647
Additions	-	31,992	21,846	-	5,537	59,375
Disposals/transfers	(540)	(188)	(21,041)	-	(5)	(21,774)
Revaluation	(730)	(47,382)	-	-	-	(48,112)
Balance at 30 June 2016	**129,918**	**285,521**	**198,792**	**409**	**36,496**	**651,136**
Depreciation & impairment losses						
Balance at 1 July 2015	-	106,482	153,520	368	-	260,370
Depreciation	-	37,100	15,362	41	-	52,503
Revaluation	-	(139,865)	-	-	-	(139,865)
Impairment	-		-	-	-	-
Disposals/transfer	-	(55)	(21,050)	-	-	(21,105)
Balance at 30 June 2016		**3,662**	**147,832**	**409**		**151,903**

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

Carrying amount	Freehold land	Freehold buildings & fitout	Plant, equipment & vehicles	Leasehold buildings fitout	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
At 1 July 2015	131,188	194,617	44,467	41	30,964	401,277
At 30 June 2016	**129,918**	**281,859**	**50,960**	-	**36,496**	**499,233**

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

Revaluation

Canterbury DHB revalued its land, buildings and building fitout (excluding leasehold building fitout) at 30 June 2016. The revaluation was carried out by an independent Registered Valuer (Chris Stanley of TelferYoung (Canterbury) Ltd), which is consistent with PBE IPSAS 17 Property Plant & Equipment. The movements in land and buildings and plant fitout were recognised in the Revaluation Reserve. See note 16 for further details.

Canterbury DHB owns land which it had allowed a third party to construct a car park on. In lieu of rental foregone, ownership of the car park building was to revert to Canterbury DHB in 2019. This was a reversionary interest that was valued as at 30 June 2010, however was impaired due to earthquake damage in 2012. Due to significant damage to the carpark, Canterbury DHB negotiated with the third party on a settlement that resulted in ownership of the car park building reverting back to Canterbury DHB in late 2014. Demolition of the carpark commenced in June 2016.

15. Intangible Assets

	Group	
	2016 $'000	2015 $'000
Software		
Cost		
Opening balance	34,798	29,340
Additions	7,554	5,568
Disposals	(1,875)	(110)
Closing balance	40,477	34,798
Amortisation and impairment losses		
Opening balance	28,450	24,208
Amortisation charge for the year	5,236	4,351
Disposals	(1,659)	(109)
Closing balance	32,027	28,450
NZ Health Partnerships Limited	5,936	5,936
Carrying amounts	**14,386**	**12,284**

There are no restrictions over the title of intangible assets and no intangible assets are pledged as security for liabilities. There is no impairment for the financial year ended 30 June 2016. There has been no change since last year.

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

- Class B Shares confer no voting rights.
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services.
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by NZHPL from the Finance, Procurement and Supply Chain Shared Service.
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company.
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation

value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.

- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

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

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

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

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

16. Impairment and the Effects of the Canterbury Earthquakes

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

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

As repair work progresses, additional damage is being discovered. As a result, the estimated cost to repair our buildings could increase.

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

Canterbury DHB continually reviews whether the carrying value of land and buildings exceeds their recoverable amount. This review has resulted in an impairment to land and buildings totalling $73.312M for the five years to 30 June 2015. As part of the 30 June 2016 revaluation process, the valuation has taken into account further revaluation decrement that we have identified. We have estimated the revaluation decrement component of the valuation to be $12.558M.

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

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

Canterbury DHB continued to incur a range of other earthquake related costs for the year to 30 June 2016, including outsourced surgery, aged residential care costs, additional community mental health services, acute demand programs, after hours care, as well as other community based costs. The Ministry of Health provided additional funding of $16.376M (2015: $12.500M) to cover a deficit that Canterbury DHB would otherwise have incurred as a direct result of these costs. This additional funding has been recorded as additional revenue, which differs from the funding received for the 2015 financial year, which was recorded as a capital contribution from the Crown.

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

From 1 July 2013 new insurance policies were placed for all of the 20 DHBs as part of their Insurance Collective, through NZ Health Partnerships Ltd. For the Material Damage and Business Interruption Policy the cover provided for Canterbury DHB has been significantly reduced for earth movement. As well as significantly higher deductibles (excesses) than was historically the case, and limited coverage for buildings assessed at less than 33% of New Building Standard (Importance level 3), Canterbury DHB does not have full replacement cover for its buildings. Under the policy cover is restricted to "actual cash value" rather than the replacement cover made available to the other DHBs, unless and until repairs have been completed. This, in the event of further earthquake damage, materially limits insurance coverage, and therefore likely recoveries.

Agreement with Ministry of Health

As part of an agreement with the Ministry of Health, $290M of insurance revenue (being the unspent portion of the earthquake insurance proceeds) was paid to the Ministry of Health in June 2014. Canterbury DHB is able to draw down funds up to $290M from the Ministry of Health over future periods to cover earthquake repair costs incurred. The first draw down of $20M was made in June 2014, with a further $13.150M drawn down in the 2015 financial year, and $43.280M drawn down in the 2016 financial year, leaving a further $213.570M that can be drawn upon in future periods to cover earthquake repair costs. The variance between the actual and budget draw down of repair revenue is due to the timing of repairs, and correlates to lower than budgeted repair costs.

17. Trust/Special Funds

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

All trust funds are held in bank accounts that are separate from Canterbury DHB's normal banking facilities.

	Group	
	2016 $'000	**2015 $'000**
Balance at beginning of year	14,049	13,760
Interest received	581	702
Donations and funds received	1,144	1,448
Funds spent	(1,477)	(1,861)
Balance at end of year	**14,297**	**14,049**

Residents' trust accounts	Group	
	2016 $'000	2015 $'000
Residents' trust account balance	**952**	**914**

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

18. Borrowings

	Group	
	2016 $'000	2015 $'000
Non-current		
Ministry of Health loans	145,985	145,985
Total non-current borrowings	**145,985**	**145,985**

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

Interest rates

Average interest rates on Canterbury DHBs' borrowings for the year are as follows:

	Group	
	2016 $'000	2015 $'000
Ministry of Health loans		
Later than one year but not more than five years	84,650	40,000
Weighted average effective interest rate	*3.80%*	*3.39%*
Later than five years	61,335	105,985
Weighted average effective interest rate	*3.88%*	*3.97%*

Security

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

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

19. Reconciliation of Net Surplus/(Deficit) for the Period with Net Cash Flows from Operating Activities

	Group	
	2016 $'000	2015 $'000
Net (deficit)/ surplus	(473)	(17,936)
Add back non-cash items:		
Depreciation and amortisation	57,739	61,135
Donated assets	-	(281)
Add back items classified as investing activities:		
Loss/(Gain) on asset sale	22	63
Prior year Equity funding	12,500	-
Movement in term portion provisions/staff entitlements	(97)	(663)
Movements in working capital:		
Decrease/(increase) in receivables & prepayments	(12,522)	30,844
Decrease/(increase) in stocks	(839)	535
Increase/(decrease) in creditors & other accruals	16,704	(29,463)
Increase/(decrease) in staff entitlements	(6,411)	2,720
Net cash inflow/(outflow) from operating activities	**41,623**	**46,954**

20. Commitments

	Group	
	2016 $'000	2015 $'000
Capital commitments		
Property	45,134	70,241
Intangible assets	26,576	30,516
Other capital commitments	15,638	14,079
Total capital commitments at balance date	**87,348**	**114,836**
Non-cancellable operating lease commitments		
Accommodation leases	39,400	39,455
Other leases	222	-
Total non-cancellable operating lease and supply commitments	**39,622**	**39,455**
For expenditure within:		
Not later than one year	5,462	5,323
Later than one year and not later than five years	15,587	14,955
Later than five years	18,573	19,177
	39,622	**39,455**

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

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

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

Operating leases as lessee

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

21. Contingencies

For the year ended 30 June 2016:

Contingent assets

Canterbury DHB has no contingent assets at year end.

Contingent liabilities

Canterbury DHB has the following contingent liabilities at year end:

- Outstanding legal proceedings
  Canterbury DHB has no material outstanding legal proceedings.
- Defined benefit contribution schemes
  Canterbury DHB is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, Canterbury DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, Canterbury DHB could be responsible for an increased share of the deficit.
- Canterbury earthquakes
  In respect of the Canterbury earthquakes there are a number of repair costs yet to be determined and incurred, both of an operational and capital nature, which will be brought to account as they become quantifiable and a liability crystallises. See note 16 for further information.
- Land and building contamination
  Canterbury DHB owns land and buildings that are or may be potentially contaminated. Canterbury DHB is continually assessing the likelihood of actual contamination when it undertakes repairs and maintenance activities. The uncertainty as to the actual contamination, and what associated costs of remediation are probable, means that the future liability cannot be reasonably estimated.

For the year ended 30 June 2015:

Contingent assets

Canterbury DHB has no contingent assets at year end.

Contingent liabilities

Canterbury DHB has the following contingent liabilities at year end:

- Outstanding legal proceedings
  Canterbury DHB has no outstanding legal proceedings.
- Defined benefit contribution schemes
  Canterbury DHB is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, Canterbury DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, Canterbury DHB could be responsible for an increased share of the deficit.

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

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

22. Categories of Financial Assets and Liabilities

	Group	
	2016 $'000	2015 $'000
Loans and receivables		
Cash and cash equivalents	13,546	3,640
Debtors and other receivables	69,349	56,827
Restricted assets	14,297	14,049
Term deposits (term>3 months)	1,000	400
Total loans and receivables	**98,192**	**74,916**
Other financial liabilities		
Overdraft	-	9,278
Creditors and other payables	100,886	83,554
Restricted liabilities	14,297	14,049
Borrowings – Ministry of Health loans (previously Crown Health Financing Agency loans)	145,985	145,985
Total other financial liabilities	**261,168**	**252,866**

23. Financial Instrument Risks

Credit risk

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

Financial instruments which potentially subject Canterbury DHB to credit risk consist mainly of cash and short-term investments, and accounts receivable. Canterbury DHB only invests funds with those entities which have a specified Standard and Poor's credit rating.

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2016, the Ministry of Health owed Canterbury DHB $28.262M (2015 $33.557M).

At the balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

Credit quality of financial assets

The table below provides the credit quality of Canterbury DHB's financial assets that are neither past due nor impaired that can be assessed by reference to Standard and Poor's credit rating (if available) or to historical information about counterparty default rates.

	Group	
	2016 $'000	2015 $'000
Counterparties with credit rating		
Cash		
AA	13,546	3,640
Term deposits		
AA	-	-
AA-	1,000	400
Total cash at bank and term deposits	**14,546**	**4,040**
Restricted assets		
A+	-	100
A-	-	200
AA	280	280
AA-	14,001	13,453
BBB+	16	-
Unrated	-	16
Total restricted assets	**14,297**	**14,049**
Counterparties without credit rating		
Balance with NZ Health Partnerships Limited		
Existing counterparty with no defaults in the past	11,117	(9,278)
Total balance with Health Benefits Limited	**11,117**	**(9,278)**
Debtors and other receivables		
Existing counterparty with no defaults in the past	69,349	56,827
Total debtors and other receivables	**69,349**	**56,827**

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. Canterbury DHB is exposed to debt securities price risk on its investments. This price risk arises due to market movements in listed debt securities. The price risk is managed by diversification of Canterbury DHB's investment portfolio in accordance with the limits set out in Canterbury DHB's investment policy.

Interest rate risk

The interest rates on Canterbury DHB's investments are disclosed in note 11 and on Canterbury DHB's borrowings in note 18.

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. Borrowings issued at fixed rate and term deposits held at fixed rates expose Canterbury DHB to fair value interest rate risk.

Canterbury DHB has adopted a policy of having a mixture of long-term fixed rate debt to fund ongoing activities.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. Canterbury DHB currently has no variable interest rate investments or borrowings.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

Canterbury DHB has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2016 (2015: nil)

Liquidity risk

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

Canterbury DHB has a maximum amount that can be drawn down against its loan facility of $145.985M (2015: $145.985M).

Contractual maturity analysis of financial liabilities

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

Contractual maturity analysis of financial liabilities for Canterbury DHB

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
	$'000	$'000	$'000	$'000	$'000	$'000
15/16 financial year						
NZHPL sweep bank account	-	-	-	-	-	-
Creditors and other payables	100,886	100,886	100,886	-	-	-
Borrowings Ministry of Health loans	145,985	176,078	5,560	5,560	98,618	66,340
Restricted liabilities	14,297	14,297	14,297	-	-	-
Total	**261,168**	**291,261**	**120,743**	**5,560**	**98,618**	**66,340**
14/15 financial year						
NZHPL sweep bank account	9,278	9,278	9,278	-	-	-
Creditors and other payables	83,554	83,554	83,554	-	-	-
Borrowings Ministry of Health loans	145,985	180,596	5,560	5,560	54,926	114,550
Restricted liabilities	14,049	14,049	14,049	-	-	-
Total	**252,866**	**287,477**	**112,441**	**5,560**	**54,926**	**114,550**

Contractual maturity analysis of financial assets

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

Contractual maturity analysis of financial assets for Canterbury DHB

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
	$'000	$'000	$'000	$'000	$'000	$'000
15/16 financial year						
Cash and cash equivalents	13,546	13,546	13,546	-	-	-
Debtors and other receivables	69,349	69,349	69,349	-	-	-
Term deposits (term > 3 months)	1,000	1,000	1,000	-	-	-
Restricted assets	14,297	14,297	8,060	6,237	-	-
Total	**98,192**	**98,192**	**91,955**	**6,237**	**-**	**-**
14/15 financial year						
Cash and cash equivalents	3,640	3,640	3,640	-	-	-
Debtors and other receivables	56,827	59,575	59,575	-	-	-
Term deposits (term > 3 months)	400	400	400	-	-	-
Restricted assets	14,049	14,049	13,769	280	-	-
Total	**74,916**	**77,664**	**77,384**	**280**	**-**	**-**

Sensitivity analysis

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

	Group			
	2016 $'000		2015 $'000	
Foreign exchange risk	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(55)	55	(49)	49
Total sensitivity	**(55)**	**55**	**(49)**	**49**

24. Capital Management

Canterbury DHB's capital is its equity, which comprises accumulated funds and other reserves. Equity is represented by net assets.

Canterbury DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

Canterbury DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure Canterbury DHB effectively achieves its objectives and purpose, whist remaining a going concern.

25. Related Parties

Canterbury DHB is a wholly owned entity of the Crown.

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

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

Canterbury DHB subsidiaries

Canterbury DHB has the following subsidiaries as of 30 June 2016:

- Canterbury Linen Services Limited
- Brackenridge Estate Limited

Key management personnel

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

Compensation of key management personnel:

	Group	
	2016 $'000	**2015 $'000**
Salaries for key personnel	3,463	3,431
Board and Committee members fees	393	383
Total key management personnel compensation	**3,856**	**3,814**

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

Key management personnel full time equivalents

	Group	
	2016	**2015**
Full time equivalent Board and Committee members	1.21	1.08
Full time equivalent Leadership Team	11.00	10.75
Total key management personnel full time equivalents	**12.21**	**11.83**

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

West Coast DHB

Canterbury DHB provides key management personnel services (including Chief Executive services) under contract to the West Coast DHB. Canterbury DHB charges the West Coast DHB for these services – 2016 $1.240M (2015: $1.240M). The amount owing by West Coast DHB relating to this agreement at balance date was $0.119M (2015: $0.119M).

26. Subsequent Events

As part of Canterbury DHB's facilities redevelopment programme, the assets and liabilities relating to the construction of the new building by the Crown on Canterbury DHB's Burwood Hospital Campus was transferred from the Crown to Canterbury DHB in August 2016. The net asset received will be offset by a corresponding increase in equity and Crown debt at 60% and 40% respectively, which differs to the originally planned financing arrangements. The impact to Canterbury DHB will be increased capital charge, debt interest, and depreciation for the 16/17 financial year onwards.

Other than this, there were no events after 30 June 2016 which could have a material impact on the information in Canterbury DHB's financial statements.

27. Major Variances to Budget

Statement of comprehensive revenue and expense

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

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

Statement of changes in equity

The significant variances in our equity are:

- revaluation of our land and buildings at 30 June 2016 resulting in a $91.753M increase to our asset revaluation reserve, and
- earthquake repair capital redrawn $28.500M less than planned due to the timing of earthquake repairs, and
- an $86M Crown equity injection in relation to the Burwood facility redevelopment originally planned for late June 2016 was deferred until August 2016.

Statement of financial position

Property, plant and equipment, and Borrowings are below plan mainly due to the handover of the Burwood facility development deferred until August 2016.

Statement of cash flows

Purchase of property, plant and equipment, Loans raised, and equity injections for new facilities are below plan due to the handover of the Burwood facility development deferred until August 2016.

Earthquake repair revenue redrawn from the Ministry of health, and Earthquake repair capital redrawn are both less than planned due to the timing of earthquake repairs.

28. Revenue Appropriation

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

The appropriation revenue received by Canterbury DHB for the 2015/16 financial year is $1,316,423,491 which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the Statement of Service Performance on pages 6-27, and page 72.

4.3 Summary of Revenues and Expenses by Output Class

Group	Actual 2016 $'000	Budget 2016 $'000
Early detection & management	324,710	322,196
Intensive assessment & treatment	1,033,686	1,029,779
Prevention	29,504	30,372
Primary health & community	449	442
Support & rehabilitation	234,143	233,985
Total revenue	**1,622,492**	**1,616,774**
Early detection & management	324,193	322,408
Intensive assessment & treatment	1,031,491	1,029,389
Prevention	32,539	30,379
Primary health & community	446	443
Support & rehabilitation	235,296	234,155
Total expenditure	**1,622,965**	**1,616,774**
Surplus/(Deficit)	**(473)**	**-**

Part V Supplementary Information

5.1 Directory

Board Members

Murray Cleverley – Chair

Steve Wakefield – Deputy Chair

Sally Buck

Anna Crighton

Andrew Dickerson

Jo Kane

Aaron Keown

Chris Mene

Edie Moke

David Morrell

Susan Wallace

Chief Executive

David Meates

Corporate Office

Level 1

32 Oxford Terrace

Christchurch

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Westpac Banking Corporation

Part VI
Independent Auditor's Report

Independent Auditor's Report

To the readers of Canterbury District Health Board Group's financial statements and performance information for the year ended 30 June 2016

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

We have audited:

- the financial statements of the Group on pages 40 to 71, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 7 to 27 and 72.

Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Group on pages 40 to 71:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

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

In respect of the 30 June 2015 comparative information only, some significant performance measures of the Group, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), relied on information from third-party health providers, such as primary health organisations. The Group's control over much of this information was limited, and there were no practicable audit procedures to determine the effect of this limited control. For example, the primary care measure that

included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of service performance for the comparative year was limited, and our audit opinion on the statement of service performance for the year ended 30 June 2015 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2016 year, however, the limitation cannot be resolved for the 30 June 2015 year, which means that the Group's performance information reported in the statement of service performance for the 30 June 2016 year, may not be directly comparable to the 30 June 2015 performance information.

In our opinion, except for the effect of the matters described above, the performance information of the Group on pages 7 to 27 and 72:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2016, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of service performance expectations for the financial year;
        - its actual revenue and output expenses as compared with the forecasts included in the statement of service performance expectations for the financial year;
    - what has been achieved with the appropriations; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 20 October 2016. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the appropriateness of the reported performance information within the Group's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

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

Responsibilities of the Board

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

- comply with generally accepted accounting practice in New Zealand and Public Benefit Entity Reporting Standards;
- present fairly the Group's financial position, financial performance and cash flows; and
- present fairly the Group's performance.

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

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