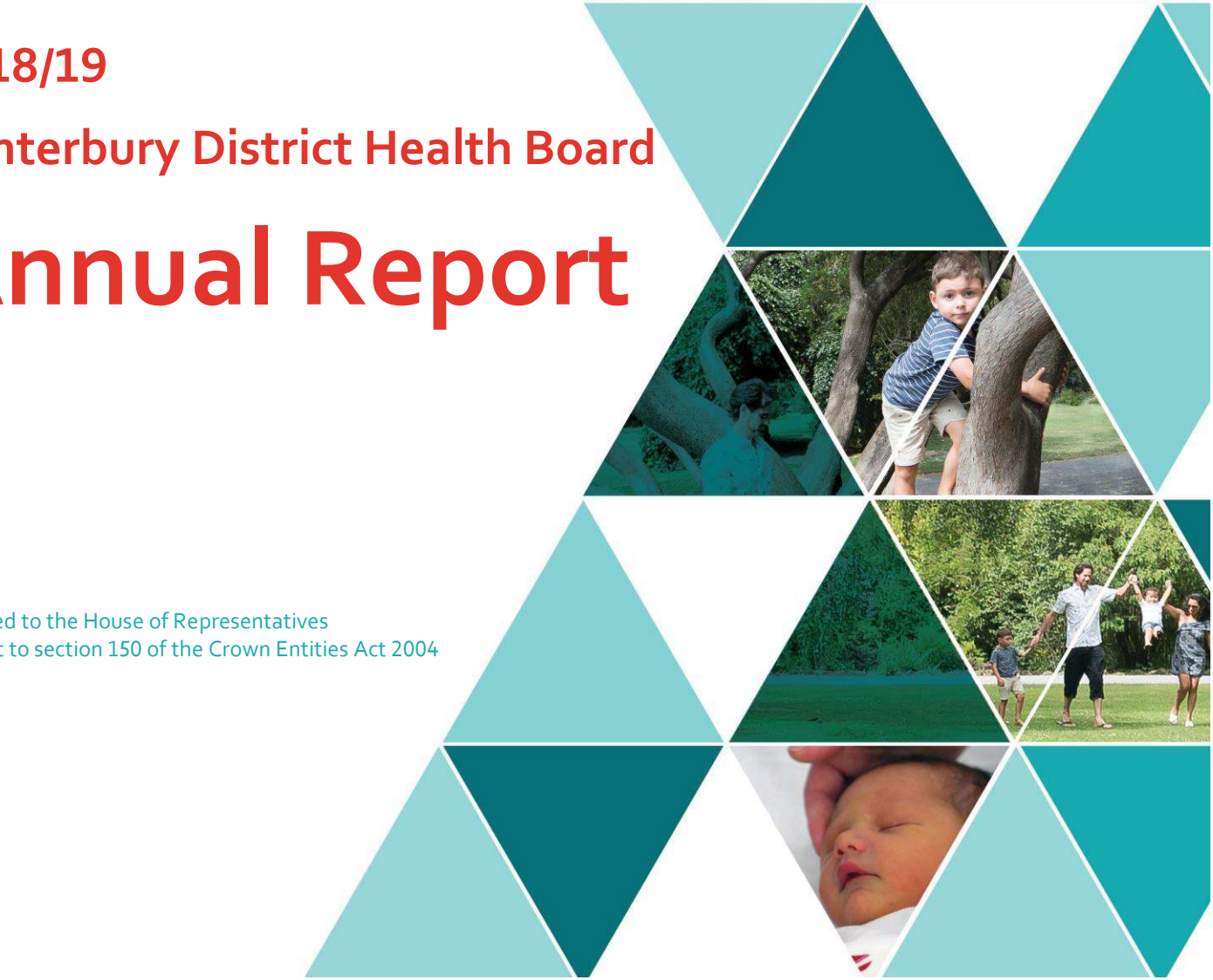
2018/19

Canterbury District Health Board

Annual Report



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

Our Mission

Tā Mātou Matakite

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

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

Our Values

ā Mātou Uara

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

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

Responsibility for outcomes.
Te Takohanga i ngā hua.

Our Way of Working

Kā Huari Mahi

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

Demonstrate innovation.
Whakaatu te ihumanea hou.

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

our health system

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Part I
Overview

1.1 Foreword from the Chair and Chief Executive

It's been yet another challenging year for our health system, but also one that helped cement our place as one of the top performing health systems in the world. During the past year we've seen the most extensive industrial action in health this country has ever seen - falling in the same year as a terrorist atrocity that shocked us all, a shock that reverberated around the globe.

Nurses, midwives and Resident Medical Officers, along with a number of other health professionals took industrial action that caused disruption to services on an unprecedented scale.

Our collective response for those affected by the mosque attacks was nothing short of extraordinary and staff from across the Canterbury health system justly received international acclaim for the skill and empathy with which they delivered care and support to our community: Of 49 people admitted with gunshot or other injuries, all but one survived with more than 100 people receiving treatment for injuries sustained in the attacks.

Together strikes and the terror attacks made the extensive flooding of one of our newest facilities, Christchurch Outpatients, feel almost minor by comparison. All three events in combination have had a major impact on our ability to meet surgical targets, and wait times are longer than they should be – we had been on track until mid-March.

Increasing demand for wellbeing support and specialist mental health services is now a well established global phenomenon, but Cantabrians have more reasons than most to be seeking help and support.

As we continue to address the long term needs of our people created in the aftermath of the 2010/11 earthquakes, we now serve a community that has been retraumatised by the Christchurch mosque attacks – which in turn requires a quite different kind of support. While recognising that the effects reach wider than any one group of people, we are working with our Muslim community on better ways of providing culturally appropriate support and care on an ongoing basis.

Our specialist mental health services continue to be stretched to meet demand that is growing as well as changing, and physical space for both inpatients and outpatients is at a premium. Although our staff continue to work under less than ideal circumstances, they continue to provide an exceptionally high standard of care.

During the past year more people than ever before received mental health support from our health system - either DHB specialist services, or community based services.

One in five Cantabrians needed to access mental health support, which means nearly every household in Canterbury will have or know someone who has lived experience of mental health or wellbeing problems.

In April, Mana Ake – *Stronger for Tomorrow* celebrated a year since its initial launch in Canterbury schools. Established in March 2018, Mana Ake promotes wellbeing and positive mental health for children in school years 1-8 across Canterbury through providing early intervention and support for teachers, families and whānau for children who are experiencing ongoing issues that affect their wellbeing, such as anxiety, social isolation, parental separation, grief and loss, and managing emotions.

In December 2018, Leading Lights – a web tool for educators, was made available to all schools in Canterbury. Leading Lights pathways are developed by professionals from across the health and education systems and help teachers and others to respond when they are concerned about the mental wellbeing of a child or young person. Eighty pathways or information pages were developed this year.

In late April 2019 Mana Ake completed the recruitment, induction and deployment of its target FTE of 80 kaimahi (workers). They have a diverse range of skills and included on the team are social workers, counsellors, teachers, youth workers and psychologists. They are led by eight team leaders/kaiarahi in supporting all primary schools from Kaikoura to Ashburton.

As of 30 June Mana Ake has supported over 1,394 children individually and 1,054 in groups since the first kaimahi commenced in schools in April 2018.

Our finances

At 578,340 our population continues to track four years ahead of Statistics NZ's population estimates.

Over the past 5 years, Canterbury has grown by 11%. Our population composition has also changed considerably, which challenges our health system to respond in different ways.

Our Māori population has increased by 31% to 53,300, our Pasifika population has increased by 31% to 14,460 and our Asian population has increased by 64% to 62,320

Our overall financial result continues to reflect the fact that population estimates for Canterbury that decide our funding, fall well short of the actual population we serve. Our cultural and demographic profile is changing.

More adults are accessing Specialist Mental Health Services for the first time. There's been a 69% increase since before the Canterbury earthquakes, which represents 3,500 more people seeking help and support on an annual basis.

For our young people, and a major reason why Mana Ake is so important, access to Child, Adolescent and Family mental health services has increased by 149% in the same period, which means an additional 2,000 rangatahi each year are struggling to cope.

In mid-June this year Dr Lester Levy was appointed by the Minister of Health as a Crown Monitor to oversee the workings of the Canterbury DHB Board and its governance structures, to help us improve our financial performance and develop a sustainable operational pathway going forward.

Facilities

Christchurch Hospital Hagley will be completed this year and at the time of writing this, plans to migrate staff, equipment and services are well advanced.

This is one of the most complex hospital builds ever undertaken in New Zealand, and a challenging project to deliver. Although there is still much to do in terms of ensuring everything is ready to receive both staff and patients, it very much feels like we are on the home straight.

Key services which will be located in the new building include sterile services and radiology, new operating theatres, an Intensive Care Unit, Emergency Department and inpatient wards. The new rooftop helipad that has been funded through donations to the Māia Health Foundation will help us save lives by drastically reducing the transfer time for critically unwell patients.

This past year has seen the opening of our new Christchurch Outpatients facility as part of the ever changing Health Precinct. Having this well designed and purpose built building enables clinicians to see around 800 people each day. We have had great feedback from staff and the public about the difference this has made to them.

Environmental sustainability initiatives in Canterbury

The environment we live in has a huge impact on our health, and sustainability and waste reduction are set to be hot topics for the foreseeable future. We have made great gains in reducing the impact we have on the environment, though we acknowledge there is much more we can and must do to cut down on waste and further reduce our carbon footprint.

I'd like to highlight two of our sustainability initiatives. The first seeks to reduce emissions from heating our buildings and providing hot water which is significant in terms of scale, while the second matters because it demonstrates we are working to change the mind-set of our staff based in the Health Precinct in particular, away from a dependence on cars as a door to door means of getting to work.

Canterbury DHB is making a major investment in measures to reduce emissions from heating sources. The largest single source of Canterbury DHB's greenhouse emissions by far is the coal-fired boilers at Christchurch Hospital. The good news is that this is set to change when the new Energy Centre/Boiler House is complete. Woody biomass will then become the heat energy source for the whole Christchurch Hospital campus. This will prevent almost 20,000 tonnes of CO_2 being released into the atmosphere every year.

The second initiative is the Healthy Commute programme, a partnership between the Greater Christchurch Partnership City Travel Planning Team, Environment Canterbury and Canterbury DHB, that encourages staff to consider alternative modes of transport for their commute. A pilot project showed a 21% reduction in car use and an increase in staff biking and bussing to work.

Thanks largely to the work of one of our Community and Public Health clinicians and that of our Energy Manager and his team, we are now a fully CEMARS (Certified Emissions Measurement And Reduction Scheme) certified organisation. This confirms we are able to properly calculate and then manage our organisation's carbon footprint. Since 2014, we've reduced our emissions by 20%, making us one of the country's top 20 reducers which has led to Canterbury DHB being listed as a finalist for the Excellence in Climate Action (large organisation) award.

Flourishing communities

Community and Public Health works closely with a number of partners capable of improving the health and wellbeing of people by ensuring health is at the forefront of local decision making.

The Health in All Policies team led a number of workshops in the Greater Christchurch Partnership 'Our space' project to keep the focus on community health and assisted Christchurch City Council and the Police in launching the Christchurch Alcohol Action Plan. We worked with our partners Christchurch City Council and Environment Canterbury on transport policy throughout the year and made multiple submissions on local, regional and national policy.

The Canterbury Wellbeing Index collates and uses data from a variety of local and national sources to describe the wellbeing of Canterbury people and informs how we can improve people's perceived quality of life and emotional wellbeing. It also identifies and assists us in focusing on the groups that need more help than others.

All Right? based on the five ways to wellbeing, continues to make a real contribution to Canterbury's psychosocial recovery following the devastating earthquakes of 2010 and 2011. 87% of people believe All Right? is valuable to the Christchurch community and those who are aware of it have higher life satisfaction and sense of purpose scores.

Broadly Speaking is a free training workshop that helps increase knowledge of the determinants of health in our communities. It draws on the experience of participants to identify opportunities to positively influence wellbeing.

Sparklers is an accessible online tool for schools and parents of school age children, comprising more than 50 activities that are proven to improve mental health and wellbeing for young people. User data for the latter part of 2018 demonstrates the ever increasing popularity of the site and feedback from education professionals is predominantly positive.

Community development health promotion is a process where communities come together to prioritise, take collective action and generate solutions to common problems. This is a strengths based approach that aims to build stronger and more resilient communities.

Several examples of Community and Public Health's involvement in community development include Buycycles (a rent to own bicycle initiative), the Food Resiliency Network (increased access to healthy, affordable and locally grown food to support healthy and active lifestyles) and the Peace Train Ride in the aftermath of the March 15 mosque attacks.

Preventing and reducing spread of communicable diseases

The processes around Communicable Disease tracing are well established in Christchurch and are an important strategy in dealing with disease outbreaks such as the recent one that began in late February in Canterbury. Subsequent to this main outbreak being declared over, a further outbreak was prevented through contact tracing which allowed quarantine arrangements to be put in place and targeted support to be provided to the affected families through local health service providers.

Smoking cessation support

Te Hā - Waitaha stop smoking service has continued to strengthen Canterbury's integrated

smokefree approach which involves a range of health and community organisations in designing, establishing and delivering stop smoking support. This approach has enabled a wide reach into the community and access to priority groups, of which, the Te Hā - Waitaha 'Pregnancy Incentive Programme' has engaged and supported many successful quit attempts.

Waka Toa Ora

Waka Toa Ora is an initiative that has spanned almost 20 years and brings together over 200 NGOs and agencies to work together to better support communities. The past 12 months has seen monthly seminars in areas of interest to inform the work and collaboration of agencies; an annual hui focusing on Whānau Ora and the Canterbury Wellbeing Index; an advisory group identifying issues such as the human impacts of climate change; and the circulation of informative material circulated to agencies.

People at the heart of all we do

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

We are currently refreshing People and Capability policies and processes across both Canterbury DHB and West Coast DHB, including our Code of Conduct, Health and Safety Policy and Diversity, Inclusion and Belonging Policy.

Leadership, accountability and culture

Health care is fundamentally about people caring for people. To enable us to deliver high quality care to the community, the Canterbury health system fosters a culture where we care for our people, as much as we care for our patients. This means we need leadership that is aligned with our vision; is responsive to their team's needs; motivates teams to meet agreed organisational goals; and is accountable for outcomes.

Dr John Wood
CHAIR | CANTERBURY DHB

29 October 2019

Recruitment, selection and induction

Canterbury DHB is committed to the shared approach to talent management including attracting, selecting and engaging people across the Canterbury health system for the needs of today and into the future. This approach supports our integrated system by having more engaged employees; and this has a positive impact on the patient journey.

Workplace safety, health and wellbeing

We are committed to providing a safe and healthy workplace, supported by a professional Wellbeing, Health and Safety team, which includes experts in workplace safety, occupational health, rehabilitation, as well as employee wellbeing.

Our people are provided with a range of support options if they are faced with work or personal issues, including tailored packages of care for individuals and teams and a toolkit of self care options.

Equal opportunities and positive behaviours

We have a diverse, flexible and highly skilled workforce that contributes significantly to the provision of quality, culturally and individually appropriate services. We are actively auditing and improving our talent management practises to ensure people, regardless of their diversity, have the opportunity to be a part of Canterbury DHB.

Thank you

Once again, our staff, our alliance partners and the many community providers who are part of the wider Canterbury health system have responded exceptionally well through all of this past year's challenges. Your continued efforts to provide world leading care and support to our population are hugely appreciated by those we support and provide services for, in Canterbury and the Chatham Islands.

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

1.2 Statement of Responsibility

We are responsible for the preparation of Canterbury DHB's financial statements and performance information, including the performance information for an appropriation required under section 19A of the Public Finance Act 1989, and for the judgements made in them.

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, except for the substantial uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003 and the uncertain impact on the financial statements as described in note 4 on page 51; and noting the DHB's inability to report results for the second and third quarters for the Emergency Department wait times performance measure as described in footnote 12 on page 17 and on page 21, these financial statements and the performance information fairly reflect the financial position and operations of Canterbury DHB for the year ended 30 June 2019.

For and on behalf of the Board

Dr John Wood
CHAIR | CANTERBURY DHB

Tā Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB

29 October 2019

Part II
Improving Outcomes

2.1 Are We Making A Difference?

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

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

There is no single performance measure or indicator that can easily reflect the impact of the work we do. In line with our vision for the future of our health system, we have developed an overarching intervention logic and system performance framework to monitor and evaluate our performance over time.

At the highest level the framework reflects three outcome goals, where we believe success will have a positive impact on the health of our population. The framework also encompasses national direction and expectations, through the inclusion of national targets and system level measures.

Under each outcome goal we have identified a number of long term population health indicators which will provide insight into how well our health system is performing over time.

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

To evaluate our performance over the shorter term, we have identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking.

Because change will be evident over a shorter period of time, these contributory measures have been selected as our main measures of performance.

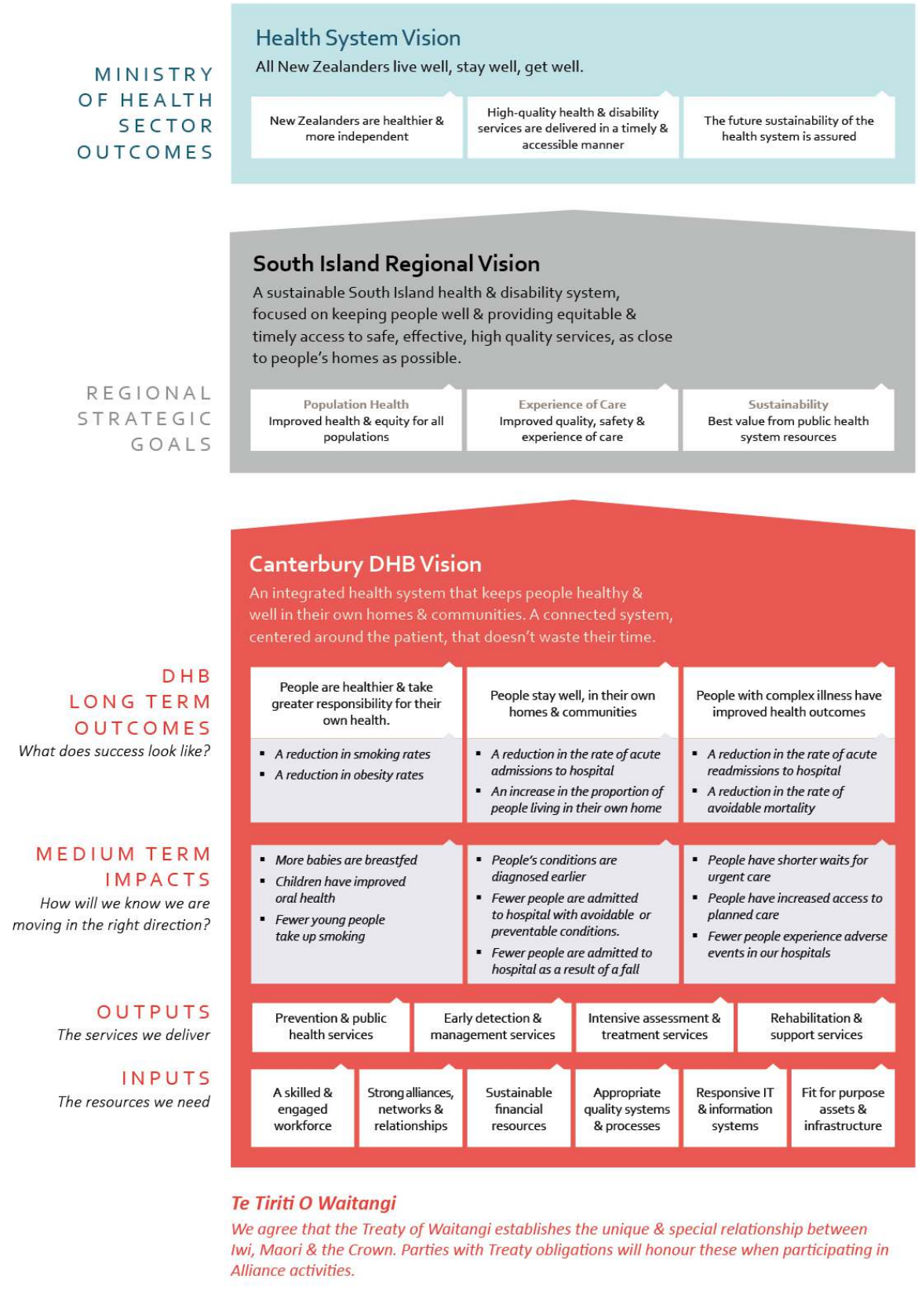
We have set performance standards for these contributory measures in order to determine whether we are moving in the right direction. Tracing our performance against these indicators helps us to evaluate our success in areas that are important to our community, our Board and Government.

These measures sit alongside our Statement of Performance Expectations (in the following section of this report), which outlines the services we planned to deliver and the standards we expected to meet in the past year, and they form an essential part of the way in which we are held to account.

Many of the measures selected were deliberately chosen from national reporting frameworks, to enable comparison with other DHBs and give context to our performance.

As part of our obligations under legislation, DHBs must work towards achieving equity for all population groups. To promote this goal, the standards set for each measure are the same for all populations. As a means of evaluating whether we have made a difference in reducing inequities, performance has been reported by ethnicity wherever breakdowns are available.
The intervention logic framework on the following page illustrates how we anticipate the services that we fund or deliver (outputs) will have an impact on the health of our population, result in the longer term outcomes desired, and deliver the expectations and priorities of Government.

Canterbury DHB – Overarching Intervention Logic Framework



Te Tiriti O Waitangi

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

2.2 Monitoring Our Progress

People are healthier and able to take greater responsibility for their own health

WHY IS THIS OUTCOME A PRIORITY?

New Zealand is experiencing a growing prevalence of long term conditions such as cancer, heart disease, respiratory disease, diabetes and depression. These conditions are major drivers of poor health and premature mortality (death) and place significant pressure on the health system in terms of demand for health services. The likelihood of developing a long term condition increases with age and long term conditions are more prevalent amongst Māori and Pacific Island populations. By 2026 one in every five people in Canterbury will be aged over 65, and 10% of our population will be Māori, meeting the health service demand associated with long term conditions will be a major challenge for our health system.

WHERE ARE WE FOCUSED?

Tobacco smoking, inactivity, poor nutrition, alcohol consumption and obesity are significant risk factors for a number of the most prevalent long term conditions. These are modifiable risk factors which can be reduced through supportive environments and strategies that enable people to change their behaviours and encourage personal responsibility for health and wellbeing. Supporting people to make healthier choices will improve the quality of their lives and, by reducing the prevalence and impact of long term conditions, will reduce the pressure on our health system. Our focus is on reducing smoking and obesity rates. Because these risk factors have strong socio-economic gradients, this focus will contribute to reducing health inequities for our Māori and Pacific populations.

OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

After a number of years where smoking rates in Canterbury were declining, the trend appears to be shifting and is contrary to the national results. The latest 2016/17 NZ Health Survey reported that 17% of our population are current smokers, compared to 16% of the New Zealand population.

Combined results from 2014-2017 show that smoking rates are highest amongst our Māori and Pacific populations.

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

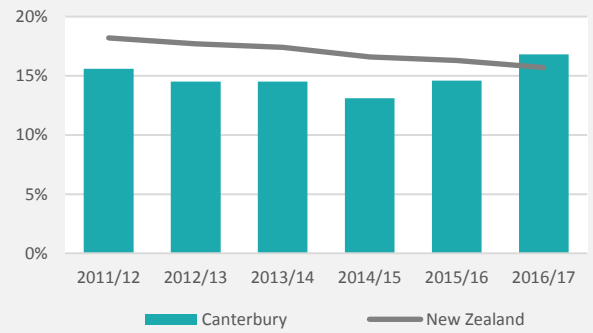
We continued to deliver brief smoking advice and cessation support at all contact points across our health system, with a particular focus on pregnant women. In 2018/19, 89% of pregnant women (identified as smokers) received advice and support to stop smoking (10% higher than at the same time the previous year).

In every quarter over the past year at least 90% of smokers identified in our hospitals were provided with brief advice and support and while the percentage of smokers receiving advice in primary care was lower (82%), 61% of those smokers received cessation support (the highest rate in the country).

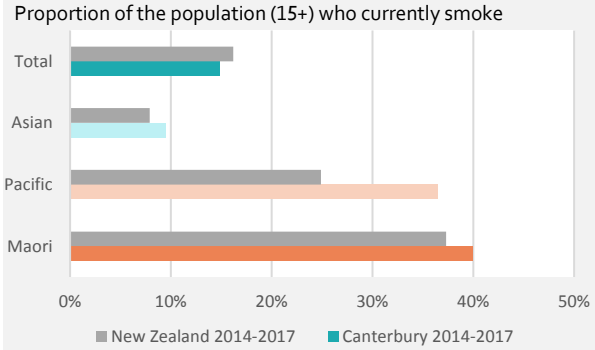
58,335 people were provided with brief advice and support to stop smoking in 2018/19 and over 1,800 people enrolled with Canterbury's cessation programme Te Hā - Waitaha.

We are watching smoking rates carefully to understand the drivers behind the latest results and what impact the earthquakes and other recent stressors have had on smoking rates for our population.

Proportion of the population (15+) who currently smoke



Proportion of the population (15+) who currently smoke



Data source: National NZ Health Survey [1]

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

OUTCOME MEASURE – A REDUCTION IN OBESITY RATES

Canterbury's obesity rate remains just below the national rate at 31% however, like the rest of the country, there has been a steady rise in obesity rates across all ages, genders and ethnicity groups.

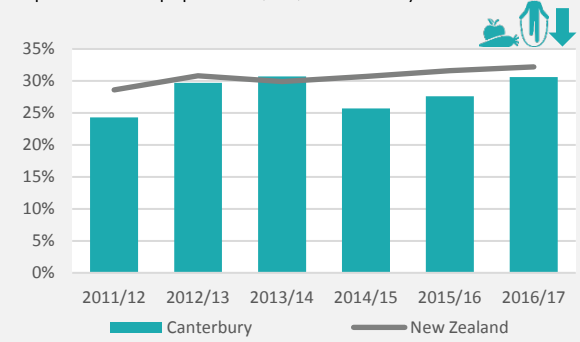
Obesity impacts on people's quality of life and is a significant risk factor for many long term conditions. While many of the drivers sit outside of the direct control of the health system, we have a role in supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to make healthier choices.

We continue to identify children and families who may need support at their B4 School (health) Check prior to starting school. In 2018/19, 96% of four-year-olds received their B4 School Check and 100% of those children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice.

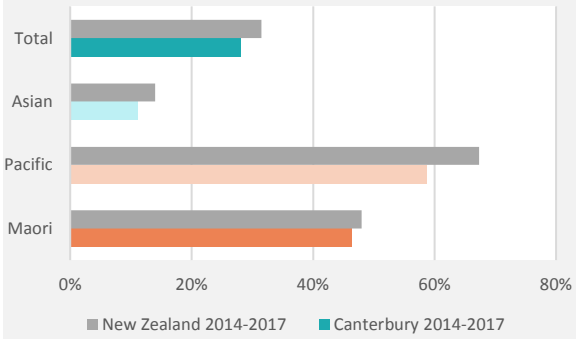
We also continue to invest in lifestyle programmes that support people to increase physical activity or make healthy food choices, including the Triple P, Active Families, Appetite-for-Life and Green Prescription programmes. In 2018/19, 4,818 people were referred by their health professional to the Green Prescription programme. This is an 18% increase in referrals compared with last year.

Signs are positive with the latest bi-annual survey results showing 61% of participants remained more active 6-8 months after taking up a green prescription referral.

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



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



Data source: National NZ Health Survey [2]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer avoidable hospital admissions

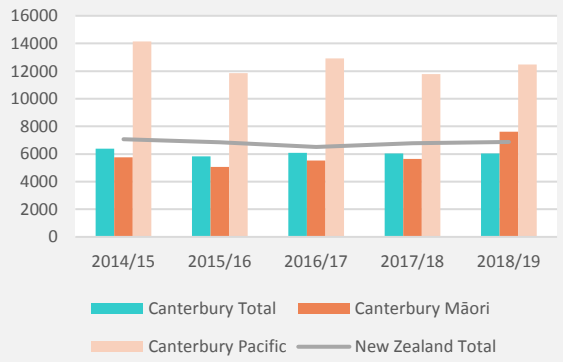
In 2018/19, Canterbury's ambulatory sensitive hospital (ASH) admission rate for children under five was 6,044 per 100,000, achieving the target set and remaining below the national average of 6,881.

The slight increase in Māori and Pacific compared to last year reflecting small numbers with 112 more events for Māori and just 11 more events for Pacific.

This measure is seen as a marker of good quality primary care and a well integrated and connected health system that engages earlier with parents and children. In the past year, 97% of new-borns were enrolled with a primary care team before three months of age and 95% of eight-month-olds were fully immunised.

Upper respiratory and ear, nose and throat infections is the largest contributor to this year's ASH rate and the DHB has committed to a number of actions in its System Level Measures Improvement Plan to reduce barriers to service access and better connect whānau with services to reduce the ethnic variation in these results.

Measure: Rate of ASH admissions for children (0-4)	2016/17	2017/18	Target	Result
	6,072	6,033	<6,416	6,044



Data Source: Ministry of Health Performance Reporting [3]

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

[3] This measure is a national DHB performance indicator and captures hospital admissions for conditions considered preventable, including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The results presented are based off the national March 2019 series provided by the Ministry of Health in August 2019. There is a difference in presentation to the 2018/19 Statement of Intent as the Ministry baselines were originally presented against calendar year and these have been reset during the 2018/19 year to financial years. The baseline results have been reset to reflect the current series.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

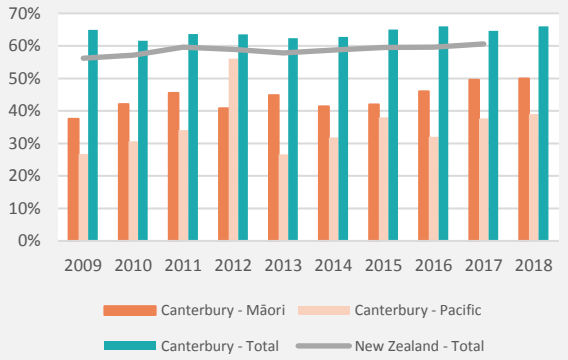
Children have improved oral health

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

The percentage of five-year-old children whose teeth are caries free (have no holes or fillings) has lifted slightly on last year reaching target for the total population (66%), and remaining on a positive trajectory for Māori (50%) and Pacific children (39%). While there is work still to be done to close the equity gap, Māori rates are the highest they have been for ten years and Pacific rates are climbing. This is a positive result for our high need population groups.

Enrolment data shows 83% of children 0-4 are enrolled with oral health services and while this suggests that we still have work to do to better engage with families, this is a 7% increase on rates for the previous year. We have established a transalpine Oral Health Alliance to address equity gaps and improved data sharing across child services is helping to better identify children and help establish contact with families.

Measure: Children caries-free at age 5	2016	2017	Target	Result
	66%	65%	66%	66%



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

Fewer young people take up smoking

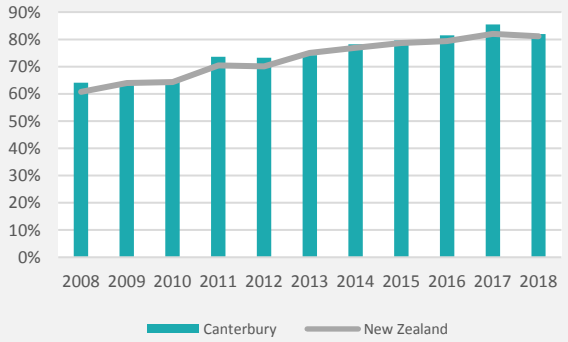
The Action on Smoking and Health (ASH) Survey is one of the largest youth smoking surveys in the world. It is a census style questionnaire that surveys around 30,000 students on their smoking behaviour and attitudes.

The 2018 survey results show a slight drop off from the high of 2017, but results are still positive for Canterbury students, with 82% of Year 10 students (age 14-15) never having smoked compared to 81% across New Zealand.

This trend reflects the impact of supportive legislation and social environments, combined with local health led initiatives such as our Health Promoting Schools, Smokefree Spaces and School Based Health Services which are now in place in all decile 1-4 schools in Canterbury.

We note the slightly higher smoking rates for our population showing up in the latest NZ Health Survey and we are watching these rates to understand whether there has been any impact due to the increased stresses in our community over the last few years.

Measure: 'Never Smokers' amongst Year 10 students	2016	2017	Target	Result
	82%	86%	>82%	82%



Data Source: National ASH Year 10 Survey [5]

[4] This measure is a national DHB performance indicator and is reported annually for the school year. National results had not been made available for the 2018 year at the time of printing.

[5] The ASH Survey is a national survey used to monitor student smoking rates since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students who are aged 14 or 15 years at the time of the survey. Ethnicity breakdowns are not provided due to small survey numbers. The 2018 results are preliminary and are subject to change. For further information see www.ash.org.nz.

People stay well in their own homes and communities

WHY IS THIS OUTCOME A PRIORITY?

When people are supported to stay well, and can access the care they need in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital level intervention or residential care. This is not only better in terms of people's health outcomes and quality of life, and it also reduces pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve those health outcomes at a lower cost than health systems that focus more heavily on a specialist or hospital level response.

This is particularly important in Canterbury. We are the second fastest growing region (outside of the Auckland region) in the country and have two of the three fastest growing local authority areas: Selwyn and Waimakariri. Over the last eight years our population has grown 15.9% and we have already reached population levels that we were previously not predicted to reach until 2025/26. Our hospital capacity is under significant pressure and it will be several years before the redevelopment, repair and remediation of our facilities are complete.

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN ACUTE MEDICAL ADMISSIONS

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

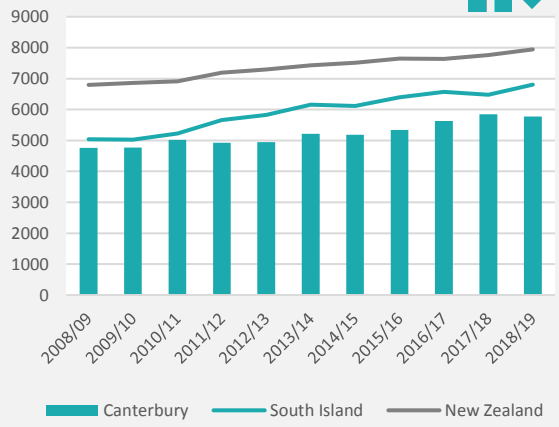
Unlike the rest of New Zealand, Canterbury's acute medical admission rates have dropped back slightly, despite our population ageing and more people living with long term conditions. At 5,771 per 100,000 people, our rate is the lowest in the country and 27% lower than the national rate. This is a positive reflection of the programmes in place across our health system to make sure people are able to get the right service, at the right time, in the right place.

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

The DHB continues to subsidise access to services such as spirometry testing (for respiratory related conditions), diabetes management support and rehabilitation programmes to support people to better manage their long term conditions, including stroke, falls prevention and pulmonary rehabilitation programmes.

The DHB also continues to invest in a community-based Acute Demand Management Service which in 2018/19 provided 35,393 packages of care to people who might otherwise have ended up in our hospitals, 2,692 more packages than 2017/18.

Acute medical admissions per 100,000 people



Data Source: National Minimum Data Set [6]

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

OUTCOME MEASURE – MORE PEOPLE LIVING IN THEIR OWN HOMES

The proportion of the Canterbury population (aged 75+) living in their own homes has come back up after a very slight drop last year 88.1% compared to 87.5% last year. This remains a positive trend particularly as our older population continues to grow, with our over 75-year-old population increasing by 16% over the last five years. Consistent with our strategy, the DHB is still focused on improving this result further.

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

Many older people are taking multiple medications and it can be tricky to manage. In the past year, 1,434 people received a medication review to reduce medication related harm.

Falls in frail older people are also very common and a leading cause of hospitalisation in Canterbury. Serious falls lead to injury and hospitalisation, a loss of confidence, and an increased risk of admission to residential care. In 2018/19, 2,127 people accessed our community based falls prevention programme (a 29% increase on the previous year) and 98% of older people in our hospitals received a falls assessment to help them stay safe during their stay.

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

Data Source: SIAPO Client Claims Payment System

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People's conditions are diagnosed earlier

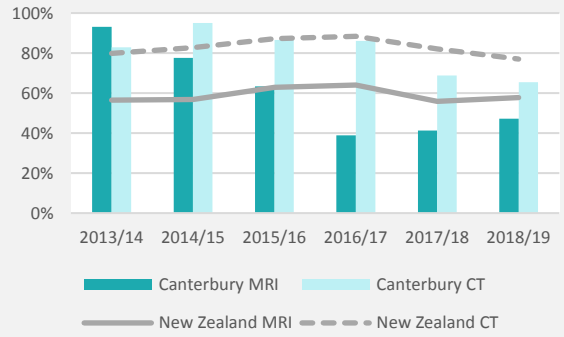
Demand for CT and MRI scans has been exceeding capacity across both the public and private sectors and wait times have increased across the country. A number of factors are driving this pressure including: new drugs and treatment programmes that require diagnostic support, increased surgical volumes and population growth.

Canterbury takes the majority of specialised tertiary referrals from other South Island DHBs, and this puts additional pressure on our radiology services. While demand is still high, additional mitigation strategies embedded in 2018/19 have begun to reduce wait times.

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

Performance by the final month of the year (June 2019) has lifted to 55% of people receiving their MRI within 6 weeks and 74% of people receiving their CT scan within 6 weeks.[7]

Measure: People receiving scans within 6 weeks		2016/17	2017/18	Target	Result
	MRI	40%	41%	90%	47%
	CT	86%	69%	95%	65%



Data Source: DHB Patient Management System

[7] The radiology measures are national DHB performance indicators, baselines presented differ to previously printed results, having been reset from year-end results (June of each year) to full year (12 month) results.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer avoidable hospital admissions

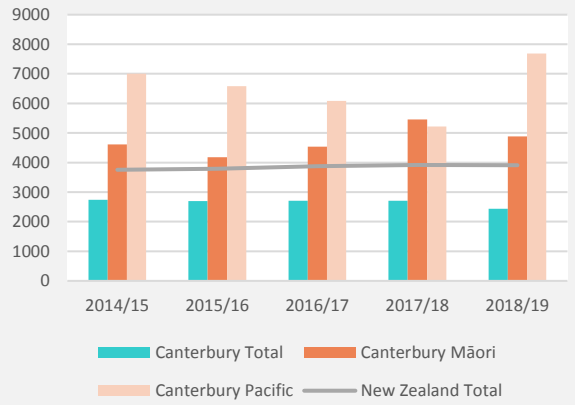
In 2018/19, Canterbury's ambulatory sensitive hospital (ASH) admission rate for adults was 2,436 per 100,000 people, achieving the target and improving on last year. Our Māori rates have also improved and both our total population and Māori rates are well below national rates.

Our ASH rate for our Pacific population stands out this year, reflecting 55 more events than the previous year, further work will be done to understand the drivers behind this increased rate. The national Pacific rate is 9,324.

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

In the past year, 93% of our population was enrolled with a primary care team and the number of people (with complex needs) who have a personalised or acute care plan in place has increased significantly over the past year. These plans support people to achieve goals that matter most to them and are accessed by the health professionals involved in their care. The plans help to reduce duplication and ensure people get quicker access to the care and support that they need.

Measure: Rate of ASH admissions for adults (45-64).	2016/17	2017/18	Target	Result
	2,710	2,708	<3,892	2,436



Data Source: Ministry of Health Performance Reporting [8]

Fewer falls related hospitalisations

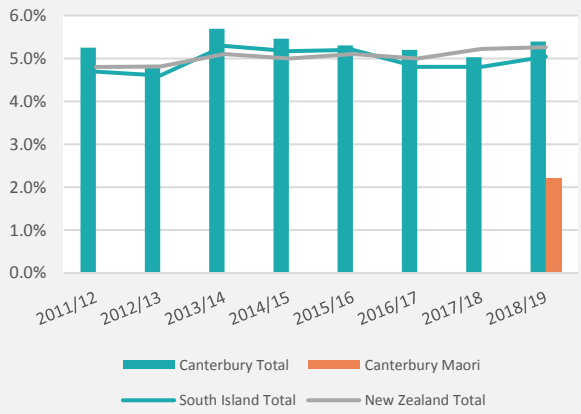
At 5.4%, the proportion of our population (75+) admitted to hospital as a result of a fall is slightly higher than the previous year and 0.4% higher than the national average.

The shifts are small but with an ageing population and stretched capacity across our hospitals, our focus on falls prevention is crucial in supporting people to stay well and independent, and reducing demand on our services.

In 2018/19, 2,127 older people accessed our community based falls prevention programme more than ever before and over 33,000 places were made available in accredited strengths and balance class in the community – almost three times higher than the target set for the year.

We have begun to track Māori fall rates and will look to investigate these in 2019/20, as they occur at a younger age. We are also working to established Māori and Pacific Strength and Balance classes in the coming year.

Measure: Population (75+) admitted to hospital as a result of a fall	2016/17	2017/18	Target	Result
	5.2%	5.0%	<5.5%	5.4%



Data Source: National Minimum Data Set

[8] This measure is a national DHB performance indicator and captures hospital admissions for conditions considered preventable, including: diabetes, asthma, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The results are based off the national March 2019 series provided by the Ministry of Health in August 2019. There is a difference in presentation to the 2018/19 Statement of Intent as the Ministry baselines were originally presented against calendar year and these have been reset during the 2018/19 year to financial years. The baseline results have been reset to reflect the current series.

People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

For people who need a higher level of intervention, timely access to specialist care and treatment is crucial in delivering a positive outcome, supporting recovery, or slowing the progression of illness. Improved access and shorter wait times are indicative of a well functioning and sustainable system, able to match capacity to demand and manage the flow of patients to ensure people receive the service they need when they need it.

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

WHERE ARE WE FOCUSED?

We are in the midst of a significant facilities redevelopment, repair and remediation programme and capacity within our hospital services is currently severely limited. In order to meet the increasing demand from our growing and ageing population, we are focusing on improving the coordination of care and reducing duplication of effort in order to continue to meet expectations around access and waiting times. We are also focused on ensuring safe care in our hospitals and better supporting people on discharge, to ensure people regain their independence and avoid another event that might negatively impact on their health.

OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

Patients who are readmitted to hospital within 28 days of discharge are more likely to experience negative long term outcomes. Readmissions also reduce public confidence in our health system and increase costs.

Canterbury's readmission trend has dropped back slightly after a higher result last year and at 11% is below the national average, which is a positive result. Māori and Pacific rates are static with Māori rates slightly above the total population rate, indicating there is more to do in this space.

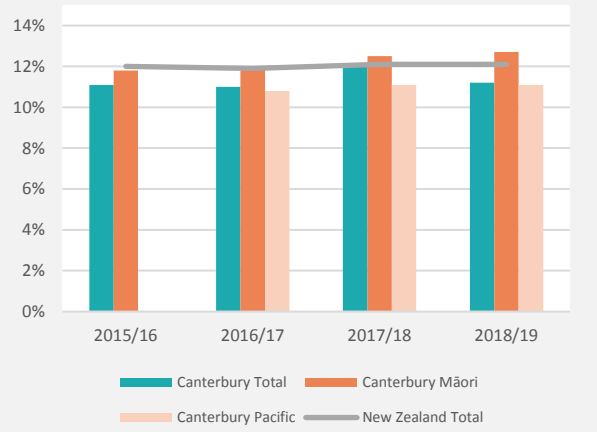
Service quality, patient safety and good discharge planning are key factors in reducing acute readmissions. The DHB has made a strong commitment to Zero Harm and the implementation of the Health Quality and Safety Commission's Open for Better Care Campaign.

We have a particular focus on the supported discharge and rehabilitation of older people and patients with heart failure and respiratory disease where readmission rates are higher.

Our community based supported discharge service (CREST), provides home based rehabilitation packages to support older people on discharge from hospital. The service supported 1,933 people in 2018/19 up from 1,839 the previous year.

The number of older people accessing rehabilitation programmes also remains high. In 2018/19, 238 people attended a pulmonary rehabilitation course and 87% of people having an acute stroke event were referred to an organised stroke service and 91% of older people accessing long term home based support had their needs clinically assessed using the internationally validated InterRAI assessment tool.[9]

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



Data Source: National Minimum Data Set [10]

[9] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning and ensure assessments are evidence based and people receive appropriate and equitable access to services.

[10] This measure is a national DHB performance indicator. The results differ to those previously published following a national reset of the definition by the Ministry of Health in 2017/18. Two previous year's results were provided by the Ministry as baselines as part of the definition change.

OUTCOME MEASURE – A REDUCTION IN AVOIDABLE MORTALITY

The overall mortality trend continues to be positive, with both total population and Māori rates dropping down, and remaining below national rates.

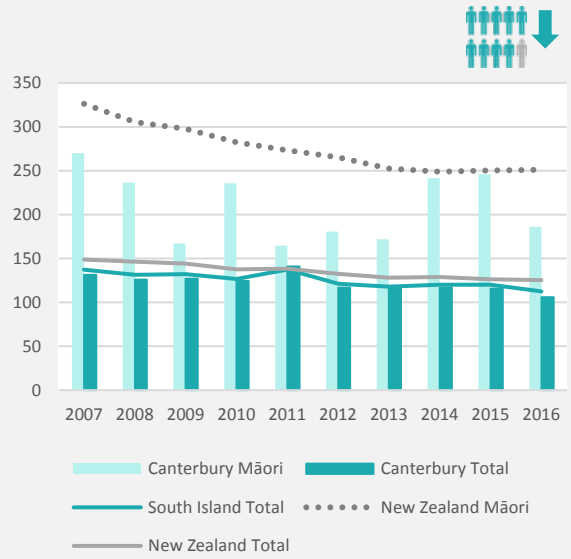
Prevention, screening and long term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment.

Shorter wait times for complex treatment such as radiation therapy or surgery is also an important factor in determining a positive outcome for many conditions, such as cancer, cardiovascular disease or stroke.

Cancer is one of the leading causes of mortality in Canterbury and contributes to a high proportion of premature deaths. The DHB continues to achieve national Faster Cancer Treatment targets with 95% of people provided with urgent cancer treatment within the target timeframe in the first half of 2018/19 and 96% in the second half of the year. In the past year 2,404 people had a skin lesion removed in primary care without the need (or wait) for a hospital appointment.

Mental illness contributes greatly to premature mortality. Access rates for mental health services in Canterbury continue to grow, demonstrating a continued demand for services. In the past year 6,905 people accessed Brief Intervention Support in primary care and 3.9% of our adult population accessed specialist mental health support in Canterbury (up 1% on the previous two years). Mental health remains a major focus for the DHB and in the coming year we are working closely with primary and community providers to increase capacity and imbedding the new national direction (aligned with the Mental Health and Addictions Inquiry, Te Ara Oranga) with additional mental health support in primary care.

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



Data Source: National Mortality Collection [11]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for urgent care

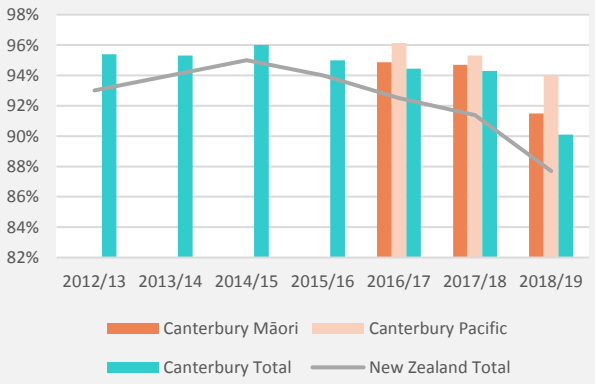
Increasing presentations are putting pressures on ED teams across the country and similar to performance across the rest of the country Canterbury's performance has dropped since last year, although it remains above the national result of 87.7%.

In the six years between 2012/13 and 2018/19 there has been a 16% increase in presentations to emergency departments in Canterbury - 101,130 presentations this year, compared to 87,221 in 2012/13.

Considering the increased demand and ongoing capacity constraints, meeting the target 90% of the time and achieving above the national average is a solid performance by our emergency department and the services across our hospitals.

It also reflects the commitment of our primary care teams in supporting an increasing number of people in the community with 35,393 of people receiving packages of care in the community (through our Acute Demand Management Service).

People are admitted, discharged or transferred from ED within 6 hours	2016/17	2017/18	Target	Result
	94.4%	94.3%	95%	90.1%



Data Source: DHB Patient Management Systems [12]

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

[12] This indicator is a national DHB performance measure and excludes those who did not wait in ED or had pre-arranged appointments. This measure was previous a national health target and in line with national reporting annual results refer to performance for the final quarter of each year (01 April - 30 June). The DHB has chosen to continue to reflect the results for 2018/19 in this way due to data collection difficulties experienced during the year as the DHB migrated from its old legacy patient management system to a new patient management system – the South Island Patient Information Care System (PICS) and an updated ED module ED at a Glance (EDAAG). The DHB has been unable to verify data from the second and third quarters of this year due to changes in data capture and coding (Canterbury achieved 93% in quarter 1). The issues have been addressed and performance for quarter four has been captured in the new systems.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for planned care

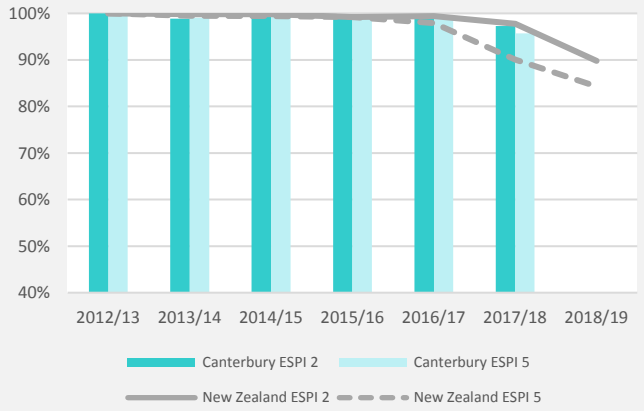
As is evident across the rest of the country, increasing service demands are putting pressure on the DHB's ability to meet waiting time expectations.

In addition to growth demand pressures, Canterbury has been working under significant facility constraints and ongoing construction delays for the last several years. In 2018/19 a series of extraordinary events including the March 15 terrorist attack, the flooding of our new outpatient's building and industrial action put further, unprecedented, pressure on our elective services.

While more than 66,982 patients attended a first specialist assessment in Canterbury and the DHB delivered 21,267 elective surgeries numbers are lower than in previous years. The unusual events of 2018/19 meant elective surgeries, first specialist assessments and outpatient appointments had to be cancelled and rescheduled several times during the year. It is anticipated that 12-15,000 first specialist assessments were impacted with a flow-on impact in terms of the number of elective surgeries delivered and the length of time people waited.

The DHB is unfortunately unable to report on the exact impact on wait times for 2018/19. During the year the DHB migrated from its old legacy patient management system to a new patient management system – the South Island Patient Information Care System (PICS). A number of issues during the migration related to data capture and coding have meant accurate wait time capture is not reported. The DHB's performance for 2018/19 is likely to have been below the national result.

Measure: People receiving specialist assessment and treatment with set timeframes.		2016/17	2017/18	Target	Result
	ESPI 2	99.8%	97.3%	100%	n.a.
	ESPI 5	99.3%	95.7%	100%	n.a.



Data Source: Ministry of Health Quickplace Warehouse [13]

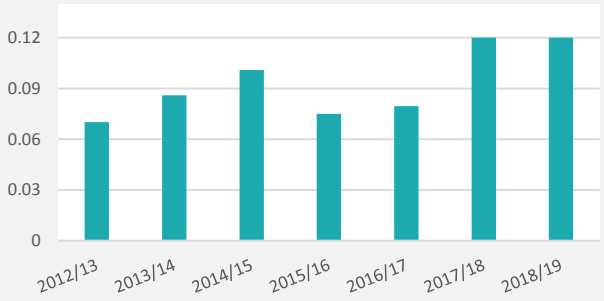
People experience fewer adverse events in hospital

The rate of serious falls in our hospitals has been held at the same rate as 2017/18, in spite of increased throughput through our hospitals. While the difference between 2018/19 and 2016/17 is just 15 events, the DHB still aims to reduce this rate with zero harm being the ultimate goal.

Key quality projects focused on adopting national falls risk assessment process and standardising prevention cues will all contribute to reducing these rates. The DHB's new electronic incident management system is also raising awareness around adverse incidents and improving our reporting of events.

Our hospital teams provided 98% of all inpatients aged 75+ with a fall's assessment in the third quarter of this year, allowing mitigation strategies and care plans to be put in place for patients at risk of a fall.

Measure: Rate of falls with a severity assessment code (SAC) of level 1&2	2016/17	2017/18	Target	Result
	0.08	0.12	<0.09	0.12



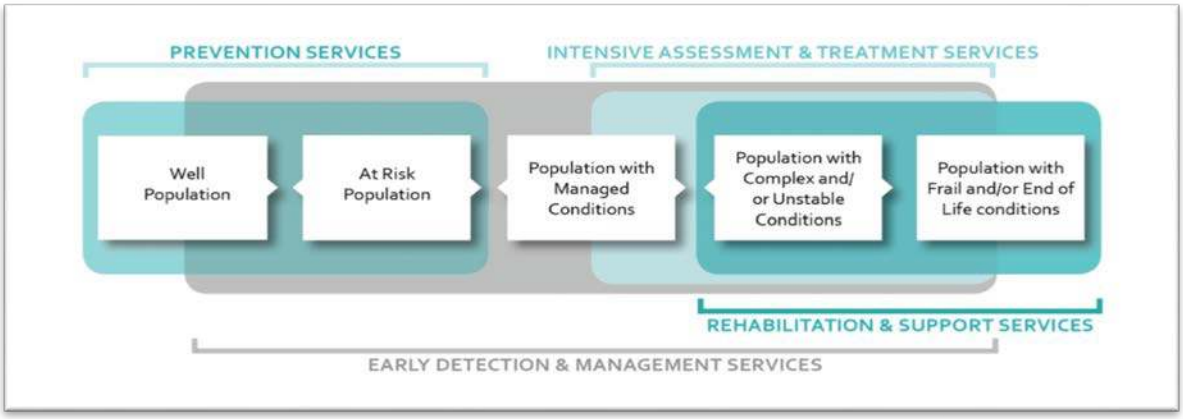
Data Source: Individual DHB Quality Systems [14]

[13] These indicators are two of the national Elective Services Patient Flow Indicators (ESPIs), established to track system performance. In line with national ESPI reporting, the annual results refer to the final month of each year (June). ESPI 2 represented those people receiving their First Specialist Assessment within four months and ESPI 5 represents those given a commitment to treatment receiving that treatment within four months.

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

Part III
Delivering on our Plans

3.1 Statement of Service Performance



Evaluating Our Performance

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

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

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The statement of service performance set out in this section presents the DHB's actual performance against the 2018/19 forecast statement of service performance presented in our 2018/19 Statement of Intent.

IDENTIFYING PERFORMANCE MEASURES

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

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

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

In health, the number of people who receive a service can be less important than whether the service was delivered at the right time. In presenting a well rounded performance picture, we have not simply presented the volume of services provided but have addressed four key aspects of service performance:

- Access (A)
- Timeliness (T)
- Quality (Q)
- Experience (E).

As part of our obligations under legislation, DHBs must also work towards achieving equity. To promote this goal and as a means of evaluating whether we have made a difference for our Māori population, we have identified a core set of performance measures that are important in terms of Māori health. These measures are presented by ethnicity on page 31.

Setting Standards

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

While targeted interventions can reduce demand in some areas, there will always be some service areas where the DHB cannot influence demand, such as maternity, dementia or palliative care services.

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

In areas where we do have more influence, targets set for 2018/19 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

In Canterbury we are still contending with the ongoing consequences of the earthquakes and in 2019 the after-effects of the March 15 terrorist event. The impact is being felt most markedly in an increased demand for mental health and emergency services, reduced bed and theatre capacity across our hospitals, and ongoing construction disruptions.

We knew that a number of the standards would be difficult to meet, considering our challenging and evolving environment. It is pleasing to see that, in spite of the sustained pressure over the past year, performance has been positive across many areas.

NOTES ON THE DATA

In 2018/19 the DHB replaced several old legacy patient information systems with a new Patient Care Information System and the associated Emergency Department system ED at a Glance (EDaaG) – the new system will be adopted as a single patient management system across the South Island.

There have been some data capture and coding issues following the change of systems. While these issues have been largely resolved, it has impacted on our ability to report against some of our usual performance measures for the 2018/19 year. Some services have also taken the opportunity to update which data is being capture for difference measures which has led to differences in what is being reported from previous years. These instances have been footnoted.

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

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

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

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

◇ The measure is reported nationally as a key DHB performance target and in line with national performance reporting, fourth quarter (April-June) results are reported as the annual result.

◆ The measure is a core Māori health measure. Refer to page 31 for a breakdown of results by ethnicity.

Performance Key

	Rating	Criteria
✓	**A**chieved	Standard reached
↺	**P**artially Achieved	Standard not reached but performance maintained or improved or the equity gap between population groups has reduced
✘	**N**ot Achieved	Standard not reached and performance dropped

3.2 2018/19 Service Performance

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Prevention services are publically funded services that promote and protect the health of the whole population or targeted sub-groups. The DHB invests in these services as a means of addressing individual behaviours and targeting physical and social environments that can influence and support people to make healthier choices.

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

SERVICE PERFORMANCE 2018-2019

Population Health Services – Healthy Environments							
These services address aspects of the physical, social, and built environment in order to protect health and improve health outcomes.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q[15]	116	78	E. 90	42	-	×
Licensed alcohol premises identified as compliant with legislation	Q[16]	79%	83%	90%	93%	-	✓
Number of exotic mosquitoes crossing the border and establishing in the region	Q	0	0	0	0	-	✓
Networked drinking water supplies compliant with Health Act	Q[17]	96%	85%	97%	n.a.	-	-

Population Based Screening Services							
These services help to identify people at risk of developing a long term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Four-year-olds provided with a B4 School Check (B4SC)	A[18]◆	93%	97%	90%	96%	91%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q[19]◆	86%	98%	95%	100%	97%	✓
Women aged 25-69 having a cervical screen in the last three years	A[20]◆	74%	74%	80%	72%	71%	×
Women aged 50-69 having a mammogram in the last two years	A◆	76%	76%	70%	75%	72%	✓

[15] The expected number of submissions in a given year varies and will be higher, for example, when Territorial Authorities are consulting on long term plans.

[16] New Zealand law prevents alcohol retailers from selling alcohol to young people aged under 18 years, with the aim of reducing alcohol related harm for this age group. Controlled Purchase Operations involve sending supervised volunteers (under 18 years) into licensed premises. Compliance is seen as a proxy measure of the success of education and training for licensed premises and reflects a culture that encourages a responsible approach to alcohol.

[17] Results are reported a year in arrears and the 2018/19 results were not available at the time of printing.

[18] 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.

[19] Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational and quality of life. A referral allows families to access support to maintain healthier lifestyles. This is a national performance measure, but no longer a national health target. Baselines differ from those previously reported having been reset to reflect a full year (12 month) result rather than the final quarter.

[20] The cervical and breast cancer screening measures refer to participation in national screening programmes and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer by allowing for earlier intervention and treatment. Rates for cervical screening in Canterbury are below target and the DHB is working closely with BreastScreen South and the PHOs to support improved uptake of cervical screening. Rates for Pacific women have been a focus and have improved to 78%, reaching target in 2018/19.

Health Promotion and Education Services							
These services inform people about risks and support them to make healthy choices. Success is evident through increased engagement, which leads to positive behaviour choices and a healthier population.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Mothers receiving breastfeeding/lactation support in the community	A[21]	1,026	980	>600	861	-	✓
Babies exclusive/fully breastfed at LMC discharge (4-6 weeks)	Q[22] ◆	74%	73%	75%	n.a.	n.a.	-
Babies exclusive/fully breastfed at three months	Q[22]◆	61%	61%	70%	n.a.	n.a.	-
Eligible schools supported by the Health Promoting Schools framework	A[23]	91%	96%	>75%	91%	-	✓
People provided with Green Prescriptions for additional physical activity	A[24]	3,800	4,087	>3,000	4,818	-	✓
Green Prescription participants more active 6-8 months after referral	Q[24]	-	61%	50%	n.a.	-	-
Smokers, enrolled with a PHO, receiving advice and support to quit	Q[25] ◆	90%	93%	90%	82%	86%	×
Smokers, identified in hospital, receiving advice and support to quit	Q[26] ◆	96%	95%	95%	92%	92%	×
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit	Q[27]◆	93%	86%	90%	86%	91%	↺

Immunisation Services							
These services help to reduce the transmission and impact of vaccine preventable diseases. High coverage rates are indicative of a well coordinated, successful service.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Children fully immunised at eight months of age	A[28]◆	94%	94%	95%	94%	90%	↺
Eight-month-olds 'reached' by immunisation services	Q[29]	98%	98%	95%	98%	96%	✓
Young women (Year 8) completing HPV vaccination programme	A[30]†◆	59%	65%	75%	n.a.	n.a.	-
Older people (65+) receiving a free influenza ('flu') vaccination	A[31]†◆	63%	62%	75%	62%	56%	↺

[21] Evidence shows that infants who are not breastfed have a higher risk of developing chronic illnesses during their lifetimes. The percentage of babies being breastfed can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period.

[22] These measures are part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. Results are published by the Ministry and breastfeeding results for 2018/19 had not been published at the time of printing.

[23] The Health Promoting Schools Framework is a national approach that supports a school community's capacity to create and sustain environments that improve and maintain health and wellbeing. Eligible schools are decile 1-4, years 1-8, those rurally isolated, and/or those that have a high proportion of Māori and/or Pacific children. An error in the 2018/19 Statement of Intent reported the 2016/17 result as 90%, the result has been corrected to 91%.

[24] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data (for the quality measure) is sourced from a national patient survey completed every two years by Research NZ on behalf of the Ministry of Health. The next survey results will be released in 2019/20. Heightened emphasis on lifestyle intervention and joint work between the DHB, PHOs and Sport Canterbury has helped to raise awareness of this programme and support increased referral and uptake of green prescriptions.

[25] The ABC programme has a cessation focus and refers to the health professional Asking about smoking status and providing Brief advice and Cessation support. The provision of professional advice and support is shown to increase both the likelihood of smokers making quit attempts and their success rate. This performance measure reflects smokers given advice and support in the last 15 months. Results have been impacted by diversion of primary care capacity to other extraordinary events over the past year including Measles and the March 15 event, Performance is expected to lift again in 2019/20.

[26] The proportion of people being offered smoking advice in our hospitals appears to have dropped. The DHB moved to an electronic discharge form which changed the way inpatient smoking data is gathered and this may have impacted on the results. Work is underway to highlight the importance of gathering this information, with performance expected to improve in the coming months. The final 2018/19 result may change slightly as additional coding is completed. The baseline results differ from those previously published having been recalculated from final quarter to full year results.

[27] The proportion of pregnant women being offered smoking advice has increased over the last year and almost reached target. A good number of referrals continued to be made to the DHB' s incentivised stop smoking programme with 281 pregnant women enrolling in the programme in 2018/19. The baseline results differ from those previously published having been recalculated from final quarter to full year results.

[28] This is a national DHB performance measure, but no longer a national health target. Baselines differ from those previously reported having been reset to reflect a full year (12 month) result rather than the final quarter of the year (April-June). The DHB achieved the 95% target in two of the four quarters in 2018/19 and reached 94% in the other two quarters.

[29] '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. This measure has been updated to reflect full year, rather than final quarter results, to align with the 8-month immunisation measure.

[30] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV related cancer later in life and is free to young people under 26 years of age. The DHB is working with the Ministry of Health to ratify results for 2018/19 with confusion arising from the change in programme from three-dose to two-dose and national systems not recognising which programme people are on and when they have completed their 'final' dose. The DHB is therefore not able to confirm a result for this measure. In the 2018/19 year, 76% of eligible young people in Canterbury started the programme (i.e. received dose 1).

[31] Almost one in four New Zealanders are infected with influenza each year and vaccinations can reduce the risk of flu associated hospitalisations. The increasing proportion of our population aged over 65 distorts performance slightly. The number of older people having a flu vaccination in 2018 has increased by 2,586 people, compared to 2017. The measure is reporting vaccinations delivered between March and September (the influenza season).

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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Primary Care (General Practice) Services These services support people to maintain their health and wellbeing and avoid unnecessary hospital admission. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive system.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Population enrolled with a Primary Health Organisation (PHO)	A[32]◆	94%	93%	95%	93%	94%	↺
New-borns enrolled with a PHO by three months of age	A[33]◆	80%	82%	85%	95%	90%	✓
Young people (0-19) accessing brief intervention counselling in primary care	A[34]	679	579	>500	552	-	✓
Adults (20+) accessing brief intervention counselling in primary care	A	5,861	6,396	>4,500	6,353	-	✓
Number of integrated HealthPathways in place across the system	Q[35]	644	691	>600	699	-	✓
General practices using the primary care patient experience survey	E[36]	42%	62%	>60%	79%	-	✓

Long term Conditions Management Services These services are targeted at people with high health needs, with the aim of reducing complications and crisis through earlier intervention and treatment and supporting people to better manage their conditions.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Spirometry tests provided in community rather than hospital	A[37]	1,897	2,493	>2,000	2,426	-	✓
Skin lesions (including cancers) removed in primary care	A	2,520	2,609	>2,000	2,404	-	✓
People receiving subsidised diabetes self-management support from their general practice when starting insulin	A	381	400	>300	379	-	✓
People identified with diabetes having an HbA1c test in the last year	A[38]Δ◆	89%	90%	90%	90%	-	✓
People with diabetes with acceptable glycaemic control (evidenced via their HbA1c test)	Q Δ◆	75%	74%	>75%	72%	-	×
Eligible population having a CVD risk assessment in the last 5 years	A[39]◆	85%	82%	90%	67%	84%	×

[32] Canterbury's enrolment rates have remained static and this appears to be younger adults not enrolling. The DHB continues to work with the PHOs and look for opportunities to enrol people new to Canterbury, through refugee services, employers and as they present in other parts of the system.
[33] A change in how this measure is calculated in 2018/19 more accurately captures enrolment figures, 2016/17 results are not directly comparable.
[34] The Brief Intervention Counselling Service aims to support people with mild to moderate mental health concerns, including depression and anxiety, to improve their health outcomes and quality of life. Service uptake remains high reflecting the ongoing need for additional support across Canterbury.
[35] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals.
[36] The Patient Experience Survey a national online survey to determine patient's experience in primary care and their perception of how well their overall care is managed. The information collected is used to help improve the quality of service delivery.
[37] Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment and conditions can be identified earlier.
[38] Diabetes is a leading long term condition and contributor to many other conditions. An annual HbA1c test (of a patient's blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.
[39] Cardiovascular disease (CVD) is one of the leading causes of death in Canterbury. By identifying those at risk of CVD early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious event. Results have been impacted by diversion of primary care capacity onto other extraordinary events over the past year include responding to Measles and the March 15 event. A CVD Improvement Plan has been developed with clinical input from the three Canterbury PHOs, outlining actions which will support implementation of new national guidelines and improve update of CVD Risk Assessments in 2019/20.

Oral Health Services

These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High enrolment and timely access to treatment are indicative of an accessible and efficient service.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Children (0-4) enrolled in DHB-funded oral health services	A[40]†◆	62%	76%	95%	83%	-	↺
Children (0-12) enrolled in DHB oral health services examined according to planned recall	T†◆	90%	88%	90%	88%	-	↺
Adolescents (13-17) accessing DHB-funded oral health services	A†	61%	63%	85%	66%	-	↺

Pharmacy and Referred Services

These are services health professionals use to help diagnose or monitor health conditions. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Laboratory tests completed for the Canterbury population	A[41]	2.8m	2.9m	E.<2.8m	2.9m	-	↺
Subsidised pharmaceutical items dispensed in the community	A	6.8m	6.8m	E.<8m	7.0m	-	✓
People on multiple medications receiving medications management support	A[42]Δ	1,361	1,316	>1,200	1,434	-	✓
People (65+) being dispensed 11 or more long term medications	Q[43]†	4.2	4.0	E. 4.6	n.a.	n.a.	-
Community Referred Radiology tests completed	A	45,227	49,832	E.>40k	55,038	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T[44]	94%	93%	90%	77%	87%	×
People receiving their MRI scans within six weeks	T[45]	39%	41%	90%	47%	58%	↺
People receiving their CT scans within six weeks	T	86%	69%	95%	65%	77%	×

[40] The DHB has continued to focus on sharing child health data to enable the oral health services to contact parents and enrol children and invested in a LinKIDS service to support multiple enrolment and this has lifted enrolment rates compared to previous years and progress is slow but evident. A transalpine Oral Health Service Development Group has been established to improve performance in this area with a particular focus on equity and lifting engagement with Maori and Pacific children. We anticipate this work will continue to improve performance over the next few years.

[41] Demand for laboratory tests is increasing as our population grows and ages. Some of this demand is also reflective of changing clinical practice and guidelines. The DHB continues to work to ensure the best use of resources in this area and use clinical HealthPathways provide general practice teams with current best practice advice.

[42] The use of multiple medications is most common in the elderly and can lead to reduce drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and higher costs for the system with little health benefits. Multiple medication use requires monitoring and review to validate whether all of the medications are complimentary and necessary. The increase in service uptake reflects the re-embedding of the service after the introduction of a more intensive medicines therapy assessment (MTA) option to complement the original medicines use reviews (MUR).

[43] This data is provided by the New Zealand Health Quality and Safety Commission. Results for 2018/19 were not available at the time of printing.

[44] A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon) to identify issues and support appropriate treatment. Baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results. Colonoscopy wait times are growing nationally due to increasing referral numbers. Between 2017/18 and 2018/19 the number of urgent colonoscopy referrals for Canterbury increased by 492. The DHB met the target times in three months this year, with the result for the final month of the year being 87%.

[45] These MRI and CT diagnostic measures are national DHB performance measures and refer to non-urgent scans, baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results.. Demand has been exceeding capacity across both the public and private sectors and wait times have increased across the country. A number of factors are driving this pressure including: new drug and treatment programmes and increased surgical volumes along with population growth and ageing. Canterbury takes the majority of specialised tertiary referrals from other South Island DHBs, and this puts additional pressure on our radiology services. While demand is still high, additional mitigation strategies embedded in 2018/19 have begun to reduce wait times. The DHB has a second MRI scanner in operation at Christchurch Hospital, is recruiting additional staff, running weekend clinics and outsourcing to private providers to meet the increasing demand. Performance by the final month of the year (June 2019) has lifted to 55% of people receiving their MRI within 6 weeks and 74% of people receiving their CT scan within 6 weeks.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

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Quality and Patient Safety							
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Rate of staff compliance with good hand hygiene practice	Q[46] ◇	83%	82%	80%	82%	86%	✓
Hip and knee replacement patients receiving routine antibiotics before surgery	Q◇	98%	100%	95%	100%	98%	✓
Inpatients (aged 75+) receiving a falls risk assessment	Q◇	97%	97%	90%	98%	89%	✓
Response rate to the national inpatient experience survey	E[47]◇	16%	24%	>30%	24%	24%	↺
Proportion of patients who felt 'hospital staff included their family, whānau or someone close to them in discussions about their care'	E[48]◇	57%	60%	65%	50%	59%	×

Maternity Services							
These are services provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand drive, service utilisation is monitored to ensure services are accessible and responsive to need.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Women registered with an LMC by 12 weeks of pregnancy	A[49]†◆	78%	80%	80%	n.a.	n.a	-
Maternity deliveries in Canterbury facilities	A	6,048	6,056	E.6,000	6,044	-	✓
Maternity deliveries made in primary birthing units	Q[50]	14%	16%	>13%	16%	-	✓

[46] These quality measures are national safety markers set to drive improvements in key patient safety areas. Standards are set nationally and in line with national reporting results refer to the final quarter of each year. The 2017/18 results have been updated to reflect the final quarter's results (April-June) which were not available at the time of printing. The 2018/19 results reflect Jan-March 2019 for hand hygiene and falls, Oct-Dec 2018 for the Hip and Knee measure and April-June for the patient experience survey results, being the most recent results available. Quarterly results for the last several years are available publically on the Quality and Safety Commissions' website www.hqsc.govt.nz as part of the Health Quality Intelligence programme.

[47] The Canterbury DHB Quality Team takes a lead in this space and working alongside the New Zealand Health Quality and Safety Commission continues to identify opportunities to improve inpatient response rates.

[48] Work to develop and implement a nominated contact person policy was delayed this year due to staff capacity issues. This is now underway and will developed over the coming year.

[49] Early registration with an LMC is encouraged to promote the good health and wellbeing of mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report and data is delayed. The 2016/17 and 2017/18 result cover the calendar year to December 2016 and December 2017. The 2018/19 results had not been released at the time of printing.

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

Acute and Urgent Services

These are services delivered in response to accidents or illnesses, which have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Early intervention can reduce the impact of the event and as such, multiple options and shorter waiting times are indicative of a responsive system.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Acute demand packages of care provided in community settings	A[51]	34,853	32,701	>30,000	35,393	-	✓
Presentations at Canterbury Emergency Departments (ED)	A	96,854	103,116	E.<105k	101,130	-	✓
Proportion of the population presenting at ED (per 1,000 people)	Q	173	185	<178	178	239	↺
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[52]	85%	95%	90%	94%	88%	×
Average acute inpatient length of stay (bed days per 1,000 people)	Q[53]	2.40	2.38	<2.35	2.44	2.49	×

Elective/Arranged Services

These are medical and surgical services provided for people who do not need immediate hospital treatment. Their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient and responsive service.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
First Specialist Assessments provided	A	72,049	73,913	E.>60k	66,982	-	✓
First Specialist Assessments that were non-contact (virtual)	Q[54]	17%	19%	>10%	21%	-	✓
Elective/arranged surgical discharges (surgeries provided)	A[55]	21,456	21,402	21,782	21,267	-	×
People receiving their elective coronary angiography within 3 months	T[56]	97%	98%	95%	97%	79%	✓
People who receive their surgery on the day of admission	E[57]	91%	94%	90%	87%	-	n/a
Average elective inpatient length of stay (bed days per 1,000 people)	Q[53]	1.54	1.57	<1.54	1.56	1.53	↺
Outpatient consultations provided	A[58]	672,348	694,629	E.>650k	653,717	-	✓
Outpatient appointments where the patient was booked but did not attend (DNA)	Q[59]◆	4%	4%	<5%	5%	-	×

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

[52] This is a national performance measure, but no longer a national health target, baselines differ to previously printed results, having been reset from final quarter (six months from Jan-June) to full year (12 month) results. There was a definition change for this measure from 2017/18, allowing patients to delay own treatment or for treatment to be delayed due to clinical considerations (without affecting the result), 2016/17 results are therefore not directly comparable. In 2018/19 the DHB reached 93% in the first quarter and achieved the target (95%) in the last three of the quarters of the year, reaching 96% in quarter four.

[53] Because factors that influence a patient's length of stay include complications and infection and lack of integration activity to support patients to return home sooner, lower rates are positive. By shortening lengths of stay the DHB also frees up beds and resources and increases productivity. Canterbury did not achieve the nationally set target this year, but given the increasing complexity of our patients there are limits to how much our lower our acute length of stay can get. Performance is carefully balanced against readmission rates to ensure earlier discharge is appropriate and service quality remains high. The DHB continues to maintain a low length of stay in comparison to national rates, particularly in comparison to other large tertiary DHBs.

[54] Non-contact First Specialist Assessments are those where specialist advice and assessment is provided without the need (or the wait) for a hospital appointment. Increasing use of telehealth technology supporting this work and reducing the travel for both patients and specialists.

[55] Several factors have impacted on elective services delivery over the past year, including ongoing delays with the completion of the Acute Services Building, industrial action, the flooding of the DHB's outpatient building and the extraordinary event of March 15th. Finishing the year just 515 elective surgeries short of target is a considerable effort under the circumstances. Production planning has been completed for 2019/20 and we anticipate achieving targets in the coming year.

[56] Changes to data capture and coding following the implementation of the new patient management system have impacted our ability to accurately report coronary angiography numbers. Internal results indicate the DHB achieved 97% in June and work to update the national result is underway.

[57] With the introduction of the DHB's new patient information system the definition for this measure has been reset and a number of plastics and gynaecology procedures previous incorporated within this measure have been more appropriate coded as day cases and are no long included in the calculations. Previous year's results and the target are not directly comparable.

[58] Changes to data capture combined with the cumulative impacts of the March 15 attack, flooding in the outpatient building and industrial action have impacted overall outpatient numbers this year. These are expected to lift again in 2019/20.

[59] The DNA rate is calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not. When patients fail to turn up to appointments, it is costly for the DHB and can negatively affect their recovery and long term outcomes. A spike in DNA rates occurred when the new patient management system was introduced and the DHB lost the ability to send text reminders. This function has been re-enabled and we expect rates more closely aligned to previous years.

Specialist Mental Health Services							
These are services for those most severely affected by mental illness and/or addictions, who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of an efficient and responsive service.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Young people (0-19) accessing specialist mental health services	C[60]	3.7%	3.6%	>3.1%	3.7%	3.9%	✓
Adults (20-64) accessing specialist mental health services	C	3.8%	3.8%	>3.1%	3.9%	4.0%	✓
People referred for non-urgent mental health and alcohol and other drug (AOD) services seen within three weeks	T[61]	77%	74%	80%	70%	78%	×
People referred for non-urgent mental health and AOD services seen within eight weeks	T[61]	94%	91%	95%	88%	92%	×
Acute inpatients accessing community services within 7 days of discharge	Q[62]	78%	81%	80%	n.a.	n.a.	-

[60] This measure is a national DHB performance measure and standards are set nationally based on the expectation that 3% of the population will need access to specialist mental health support. The three year trend presented does not reflect the extent of the increase in service demand in Canterbury. Access rates in December 2010 (prior to the earthquakes) were considerably lower (1.7% for youth and 2.2% for adults). The increasing rates demonstrate that mental health service demand is still high in Canterbury. Combined (specialist and primary care) access rates for the same period were 3.3% for children and young people (0-19) and 6.5% for adults (20-64).

[61] The continued demand and increased complexity of people accessing our specialist mental health and addiction services has reduced our capacity to respond quickly. A continued focus on earlier intervention in the community is a key strategy in reducing the number of people requiring specialist care and the wait times for treatment. Results are provided nationally and are three months in arrears.

[62] This measure is seen as an indicator of suicide prevention activity and patient safety, reflecting continued support for people who have experienced an acute psychiatric episode requiring hospitalisation. Research indicates that people have increased vulnerability immediately following discharge, including higher risk for suicide, while those leaving hospital with a formal discharge plan and links with community services and supports are less likely to experience early readmission. Data is sourced from the national NZ Mental Health and Addictions KPI Programme reports (indicator KPI 19) and standards are set nationally. The result for 2018/19 was not available at the time of printing.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

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Assessment, Treatment and Rehabilitation (AT&R) Services							
These services restore or maximise people's health or functional ability following a health related event such as a fall, heart attack or stroke. Largely demand driven, success is measured through appropriate service referral following an event.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Admissions into hospital based (inpatient) AT&R services	A	3,442	3,272	E>3,000	3,430	-	✓
AT&R inpatients discharged to their own home rather than into ARC	Q[63]	88%	86%	>80%	88%	-	✓
Inpatients referred to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q[64]	81%	80%	80%	84%	-	✓
People accessing community based pulmonary rehabilitation courses	A[65]	325	270	>200	238	-	✓
People (65+) accessing the community based falls prevention service	A[66]	1,815	1,653	>1,200	2,127	-	✓

Home Based Support Services							
These services aim to restore or maximise people's health or functional ability, following a health related event such as a fall, heart attack or stroke. Largely demand driven, success is measured through appropriate service referral following an event.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
People supported by CREST (home based rehabilitation) services	A	1,741	1,839	>1,600	1,933	-	✓
People supported by district nursing services	A[67Δ]	7,798	7,698	E.7,000	8,820	-	✓
People supported by long term home based support services	A[Δ]	7,922	8,554	E.8,000	8,466	-	✓
Proportion of the population (65+) supported by long term, home based support services	A[68Δ]	9.8%	9.7%	E.10%	9.4%	-	↺
People supported by long term home and community support services, who have had a clinical assessment of need using the InterRAI tool	Q[69Δ]	97%	92%	95%	91%	-	×
People supported by hospice or home based palliative services	A[Δ]	4,060	4,033	E.4,000	3,716	-	↺

[63] A discharge from AT&R services to home, is seen as reflective of the effectiveness of services in assisting people to regain functional independence.
[64] Baselines differ to previously printed results, being reset from final quarter to full year results, one quarter in arrears. The improved result reflects resolution of data collection issues in Ashburton where stroke patients accessing services are now being captured in results.
[65] Pulmonary Rehabilitation is designed to help patients with Chronic Obstructive Pulmonary Disease (a type of obstructive lung disease) to manage their symptoms and learn breathing, diet, exercise and day-to-day living techniques to better manage their condition
[66] Falls are one of the leading causes of hospital admission for older people. The aim of the Falls Prevention Programme is to provide better care for people 'at risk' of a fall, or who have experience a fall, and to support people to stay safe and well in their own homes.
[67] The increase in people supported by district nursing services is reflective of the ageing of our population and the increasing complexity of support needed.
[68] The drop in long term care is balanced by the increase in short term district nursing and CREST services which support people to regain their functional independence.
[69] InterRAI is a comprehensive clinical assessment tool, developed to improve the quality of life of vulnerable people, which helps to ensure they receive equitable access to the right care to meet their needs. A focus on timelier reassessment to better meet people's changing needs, and adjust the care provision, has impacted on initial assessments. The DHB is looking at options to provide greater assessment capacity.

Respite and Day Support Services

These services provide people with a break from a routine or regimented programme, so that crisis can be averted or so that a specific health need can be addressed. Largely demand driven, access to services are expected to increase over time as more people are supported to remain in their own homes.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
People accessing mental health crisis respite services	A$^{\Delta}$	904	1,081	E.>850	1,052	-	✓
Occupancy rate of mental health crisis respite beds	A$^{\Delta}$	73%	85%	85%	88%	-	✓
Older people supported by day care services	A[70]$^{\Delta}$	728	727	E.>550	578	-	✓
Older people supported by aged care respite services	A[71]$^{\Delta}$	1,715	1,697	E.>1,500	1,101	-	✓
Proportion of people supported by aged care respite services who are discharged to their own home	Q$^{\Delta}$	86%	84%	>80%	89%	-	✓

Aged Residential Care Services

With an ageing population, demand for aged residential care (ARC) is expected to increase. However, a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Portion of the population (75+) accessing rest home-level services in ARC	A[72]$^{\Delta}$	4.6%	4.7%	E.<5.0%	4.3%	-	✓
Portion of the population (75+) accessing hospital-level services in ARC	A$^{\Delta}$	6.0%	6.3%	E.<6.5%	6.1%	-	✓
Portion of the population (75+) accessing dementia services in ARC	A$^{\Delta}$	2.4%	2.7%	E. 2.5%	2.6%	-	✓
Portion of the population (75+) accessing psychogeriatric services in ARC	A$^{\Delta}$	0.8%	0.8%	E. 0.8%	0.8%	-	✓
People entering ARC having had a clinical assessment of need using InterRAI	Q[73]	88%	93%	95%	84%	88%	✗

[70] Day Support services play an important part in helping to reduce carer stress and social isolation for older people in our community. The DHB is working with clinical assessors to encourage referrals where people or their carers would benefit from support. This number is likely to increase as late invoicing is received.

[71] A decision was made this year to reduce the number of older people accessing aged care respite directly from hospital where they can suffer from deconditioning and instead provide more wraparound services that people can access in their own homes. This aligns with the Canterbury model of care to keep people in their homes longer. The drop in numbers supported by respite is therefore not unexpected and is considered a positive result.

[72] ARC measures refer to people accessing DHB funded ARC services and excludes people choosing to enter ARC and pay privately and people living independently in retirement villages. The Canterbury region has historically had higher ARC rates than national levels and by providing high quality health services to help older people to retain their health and remain in their own homes for longer, we expect to see a reduction in demand for rest home level care. After a slightly higher result in 2017/18 the DHB refreshed protocols and practices to ensure only those assessed as requiring rest homes level care were being admitted into services.

[73] InterRAI is a comprehensive clinical assessment tool, developed to improve the quality of life of vulnerable people, which helps to ensure they receive equitable access to the right support and care to meets their needs. The DHB continues to work with clinical assessors, nurse managers and aged care providers to raise awareness of the benefits of the assessments to ensure the best outcomes for our population.

3.3 Māori Health Performance 2018-2019

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

Working with local stakeholders, the DHB has identified a number of key areas of focus and a set of core performance indicators. These are indicators seen as particularly important to our community in terms of improving and monitoring Māori health outcomes. These indicators were identified in our forecast Statement of Performance Expectations for 2018/19 using the symbol (◆). The results for Māori are presented below to highlight progress in reducing equity gaps. The NZ average results are the national results for Māori.

Māori Health Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Māori babies exclusive/fully breastfed at LMC discharge	Q	67%	69%	75%	n.a.	n.a.	-
Māori babies exclusive/fully breastfed at three months	Q	52%	52%	70%	n.a.	n.a.	-
Māori smokers, enrolled with a PHO, receiving advice and help to quit	Q[74]	90%	87%	90%	79%	83%	×
Māori smokers, identified in hospital, receiving advice and help to quit	Q[74]	96%	95%	95%	92%	91%	×
Pregnant Māori women, identified as smokers at confirmation of pregnancy with an LMC receiving advice and support to quit smoking	Q[74]	92%	90%	90%	78%	92%	×
Māori children receiving a B4 School Check at age four	A	91%	95%	90%	100%	90%	✓
Māori four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q[75]	85%	97%	95%	100%	97%	✓
Māori women (25-69) having a cervical smear in the last three years	A	58%	64%	80%	68%	67%	↺
Māori women (50-69) having a mammography in the last two years	A	71%	67%	70%	68%	66%	↺
Māori babies fully immunised at eight months of age	A[75]	93%	92%	95%	91%	84%	×
Eligible Māori girls completing the HPV vaccination programme	A[76]†	51%	51%	75%	n.a.	n.a.	-
Older Māori (65+) having had a seasonal influenza vaccination	A[77]†	44%	42%	75%	40%	45%	×
Māori population enrolled with a PHO	A	82%	84%	95%	85%	90%	↺
Māori new-borns enrolled with a PHO by three months of age	A[78]	90%	85%	85%	82%	75%	×
Māori identified with diabetes having a HbA1c test in the last year	A[79]	89%	88%	90%	89%	-	↺
Māori with diabetes having an HbA1c test with acceptable glycaemic control	Q	65%	63%	>75%	63%	-	↺
Eligible Māori having their CVD risk assessed in the past five years	A[39]	78%	75%	90%	62%	82%	×
Māori men having their CVD risk assessed in the past five years	A	59%	57%	90%	46%	65%	×
Māori children (0-4) enrolled in DHB oral health services	A[80]†	44%	53%	95%	n.a.	n.a.	-

[74] The PHO ABC programme reflects smokers given advice and support from their general practice in the last 15 months. Results have been impacted by extraordinary events in 2018/19, including Measles and the March 15 event, performance is expected to lift in 2019/20. The baselines for the hospital and maternity measures differ from those previously published having been recalculated from final quarter to full year results.

[75] These measures are national DHB performance measures, but no longer national health targets. Baselines differ from those previously reported having been reset to reflect a full year (12 month) result rather than the result as at the final quarter of the year (April-June).

[76] The DHB is working with the Ministry to ratify results for 2018/19 following a change in the HPV programme from three-dose to two-dose and national systems not recognising when people have completed their 'final' dose. The result for 2018/19 is not therefore available.

[77] The actual number of older Māori having a flu vaccination in 2018 has increased by 30 people, compared to 2017.

[78] A change in how this measure is calculated more accurately captures enrolment figures, however 2018/19 results are therefore not directly comparable with previous years.

[79] The results presented are to December 2018 as June data was not available at the time of printing.

[80] The move to a new patient management system in October 2018 changed how ethnicity rates have been calculated for the oral health measures. Results are significantly different from previous years and are not accurate. Work is underway in the DHB to produce a combined ethnicity register using data from internal DHB systems and the new national enrolment system. Once complete this will allow consistent and standardised ethnicity calculations to be made.

Māori Health Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Māori children (0-12) examined according to planned recall	T†	86%	86%	90%	n.a.	n.a.	-
Māori women registered with an LMC by 12 weeks of pregnancy	A	64%	68%	80%	n.a.	n.a.	-
Māori outpatient 'Did not Attend' rates	Q[59]	7%	7%	<5%	9%	-	✖

Part IV
Managing Our Business

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

4.1 Corporate Governance

Statutory Information

This Annual Report presents Canterbury DHB's financial and non-financial performance for the year ended 30 June 2019 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

Board's Report & Statutory Disclosure

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, Canterbury DHB recorded a deficit of $177.839M against the budgeted $98.475M deficit (2017/18: deficit of $63.959M against the budgeted $53.644M deficit).

BOARD FEES

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

	Board Fees	Committee Fees
John Wood	54,600	2,500
Tā Mark Solomon	33,150	2,000
Peter Ballantyne	-	2,500
Barry Bragg	26,520	4,125
Roger Bridge	-	2,000
Sally Buck	26,520	2,250
Tom Callanan	-	1,000
Tracey Chambers	26,520	875
Anna Crighton	26,520	2,188
Wendy Dallas-Katoa	-	1,000
Andrew Dickerson	26,520	4,125
Jan Edwards	-	1,250
Rochelle Faimalo	-	750
Susan Foster-Cohen	-	750
Jo Kane	26,520	5,000
Aaron Keown	26,520	-
David Kerr	-	2,000
Chris Mene	26,520	250
David Morrell	26,520	4,000
Yvonne Palmer	-	500
Rochelle Phipps	-	1,500
Trevor Read	-	750
Hans Wouters	-	1,000
Tony Sewell	-	2,000
William Tate	-	2,250
Steve Wakefield	-	7,500
Olive Webb	-	750
Total	326,430	54,813

Total fees paid for the year were $381,243 (2017/18: $400,793).

BOARD AND COMMITTEE MEMBER ATTENDANCE

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

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

DIRECTOR FEES

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

	2019 $'000	2018 $'000
Brian Wood	29	28
Jane Cartwright	22	22
Claire Evans	11	3
Kath Fox	11	11
Paula Rose	11	11
Steve Wakefield	11	9
Erin Black	6	-
Total	101	84

Directors of subsidiaries who are also employees do not receive director fees.

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD OR SUBSIDIARIES' INFORMATION

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

INFORMATION ON MINISTERIAL DIRECTIONS

WHOLE OF GOVERNMENT APPROACH

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

Canterbury DHB applies the Government Rules of Sourcing for procurement.

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

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

REQUIREMENT TO IMPLEMENT NEW ZEALAND BUSINESS NUMBER

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

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

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

AUTHENTICATION SERVICES

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

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

ELIGIBILITY DIRECTION

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

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

4.2 Our Assets

Asset management and performance

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

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

ASSET PORTFOLIO					
			NET BOOK VALUE		
Asset Portfolio	Asset Classes Within Portfolios	Asset Purpose	2016/17	2017/18	2018/19
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	$613M	$576M	$741M
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	$46M	$46M	$44M
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of health service by aiding decision making at the point of care	$26M	$28M	$35M

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

The DHB has developed a set of developmental performance metrics, for use in internal management and decision-making processes, including relevant indicators of past and projected performance.

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

PROPERTY PORTFOLIO					
Asset Performance Indicators	Indicator Class	2016/17	2017/18	2018/19	2018/19
				Standard	Result
Percentage of the critical property portfolio with a National Building Standard at or greater than 34% [81]	Condition	84%	82%	100%	83%
Theatre Utilisation [82]	Utilisation	86.2%	87.5%	>85%	88.3%
Energy consumption per sqm (kWh/sqm) [83]	Functionality	420.7	402.7	<500	407.2

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

[82] The theatre utilisation or elective clinical occupancy measure reflects the overall efficiency of how the theatres are utilised. The utilisation is a measure of productive time over the available time. The total available time is captured as the "Total session minutes available" and the productive time is captured as the "Anaesthetic minutes (within session) used plus turnaround time".

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

4.3 Our People

People at the heart of all we do

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

We are committed to an ethos of co-design, which includes engaging our people in the development, ongoing review, and renewal of programmes and policies. To that end, we continue to engage our people via multiple channels and initiatives including our programme of work "Care Starts Here". One of the most significant outputs of this programme includes the development and the refreshing of People and Capability policies and processes across both Canterbury DHB and West Coast DHB, including our Code of Conduct, Health and Safety Policy and Diversity, Inclusion and Belonging Policy.

Leadership, accountability and culture

Healthcare is fundamentally about people caring for people. To deliver high quality care to the community, the Canterbury health system puts people – and their care – at the heart of all decisions. To achieve this requires a culture where we care for our people, as much as we care for our patients. This means we need leadership that is responsive and accountable to our people, and provides clarity of purpose based on bringing the right people together, at the right time, to provide the right service. To create a broad network of widely distributed clinical and operational leadership, the 20 DHBs have committed to implementing a shared approach to talent management and leadership development, underpinned by the State Services Commission [SSC] framework used by the core public sector. This approach allows the Canterbury DHB to support leaders to realise their potential and create a safe environment in which everyone understands their contribution and has a sense of belonging.

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

STAFF MIX BY AVERAGE AGE	
Medical	40.60
Nursing	45.44
Allied Health	44.30
Support	49.64
Management & Administration	50.15

STAFF MIX BY GENDER		
Female	8,755	81%
Male	2,034	19%
	10,789	

STAFF IDENTIFYING AS HAVING A DISABILITY[84]	
Yes	9

STAFF ETHNICITY	
Americas	75
Australian	104
British	657
Chinese	227
Filipino	246
Indian	246
Irish	55
Māori	315
Middle Eastern	33
New Zealand European	5127
New Zealander	693
Not Stated / Don't Know	1680
Other	7
Other African	49
Other Asian	285
Other European	828
Pacific Peoples	105
South African	57
	10,789

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

Recruitment, selection and induction

Canterbury DHB is committed to the shared approach to talent management including attracting, selecting and engaging people across the Canterbury health system, regionally and nationally for the needs of today and into the future. To achieve this, we are taking a talent lifecycle management approach from succession planning and strategic sourcing, to selection, candidate care and induction. The purpose of this approach is to support an integrated Canterbury health system by maximising opportunities that result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey and patient outcomes throughout the Canterbury health system.

As part of these approaches we are fully committed to enhancing our practices with respect to equity and diversity. We are also active participants in the development of consistent regional approaches to talent management and sourcing and associated support systems; as well as influencing the shape of national direction in this critical area.

Workplace safety, health and wellbeing

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

Our people, and their whānau, are provided with a range of support options if they are faced with work or personal issues that are negatively impacting on them. We enable access to meaningful support at the time it is needed, including post-incident support, wellbeing check-ins, tailored packages of care for individuals and teams, as well as providing a toolkit of self-care options.

Our Wellbeing, Health and Safety programmes, designed with our people, promote proactive safety and wellbeing through activities such as:

- Health monitoring programme which includes screening and immunisation;
- Free influenza vaccinations annually;
- Wellbeing programmes and activities to encourage and support our people in terms of healthier lifestyles;
- Workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training.

We enable our people to be and stay well at work through our injury prevention programmes as well as supporting our people to return to work following an injury, illness or other life event. Canterbury DHB continues to participate in the ACC Accredited Employer Programme to promote a safe work environment.

We do not tolerate any form of harassment, workplace bullying or discrimination. We are continually improving our policies, procedures and responses when issues of bullying, harassment or discrimination do arise. This includes a programme of work to improve our policies, code of conduct, manager capability to address issues and clearly communicating our escalation pathways to all our people.

Equal opportunities and positive behaviours

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

We have a diverse, flexible and highly skilled workforce that contributes significantly to the provision of quality, culturally and individually appropriate services. We are actively auditing and improving our talent management practises to ensure people, regardless of their diversity, have the opportunity to be a part of Canterbury DHB.

As part of our commitment to diversity and inclusion, we have implemented Project SEARCH which provides internship opportunities for young people with intellectual disabilities. We are building on the success of Project SEARCH to actively provide more opportunities for people who face barriers to employment.

We are committed to identifying and dealing with all examples of unacceptable behaviour. All individuals on joining Canterbury DHB are made familiar with our organisational values and our policies that guide how we do things at Canterbury DHB. We actively have conversations about

behaviour with our people to identify and change any behaviour that does not live up to our Care Starts Here behaviours of Valuing Everyone, Doing the Right Thing and Being and Staying Well.

Remuneration, recognition and conditions

Canterbury DHB is committed to applying fair and equitable remuneration and reward practises, taking into account our internal environment, external market relativities as well as the financial environment we operate within. Our remuneration policy is geared towards creating a rewarding workplace for our people by valuing everyone's contribution and encouraging personal development and fostering equality of opportunity. Under this framework, our structure provides clear progression paths that are aligned to the principles of individual performance development, employee competency and organisational affordability.

We regularly test our remuneration against external market and internal comparisons to ensure relativity and parity across all sectors within the Canterbury DHB.

Employee engagement

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

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

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

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

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

Employee development and promotion

We are focused on supporting and developing the health workforce at a local, regional and national level aligned to our shared approach to leadership development and talent management. Our structures and approach enable us to place the right people into the right roles at the right time.

Our people will have access to a broad range on clinical and non-clinical individual, leadership and managerial capability building. These development opportunities are structured to support effective transition between different roles and leadership contexts.

Canterbury DHB uses a blended learning approach that focuses on creating a great user experience whether online or face-to-face, supported by healthLearn - our South Island learning management platform. We recognise that learning needs to be accessible, relevant and timely, and reinventing the way people learn is one of our main missions.

We are also part of a tertiary alliance with the University of Otago, the University of Canterbury, and ARA (formerly CPIT), and a member of the TANZ network (seven South Island and lower North Island polytechnic institutes), which makes available a common curriculum of development aligned to the vision for the Canterbury health system.

Part V
Financial Performance

5.1 Meeting Our Financial Challenges

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE *for the year ended 30 June 2019*	Notes	Actual 2019 $'000	Budget 2019 $'000	Actual 2018 $'000
REVENUE				
Patient care revenue	2 [p49]	1,789,652	1,776,750	1,697,450
Other revenue	3 [p50]	39,524	37,996	33,856
Earthquake repair revenue redrawn from the Ministry of Health	16 [p63]	4,460	5,300	3,240
Interest revenue		627	1,778	1,552
Total revenue		1,834,263	1,821,824	1,736,098
EXPENSE				
Employee benefit costs	4 [p51]	915,945	830,258	774,984
Treatment related costs		140,795	149,097	149,942
External service providers		752,786	742,871	679,356
Depreciation and amortisation		54,084	57,909	58,657
Impairment of investment in NZHPL	15 [p61]	3,108	-	749
Finance costs		552	450	60
Other expenses	5 [p52]	116,131	109,420	102,776
Earthquake building repair costs	16 [p63]	4,460	5,300	3,240
Capital charge expense	6 [p52]	24,241	24,994	30,293
Total expense		2,012,102	1,920,299	1,800,057
Net Surplus/(deficit)		(177,839)	(98,475)	(63,959)
OTHER COMPREHENSIVE REVENUE & EXPENSE				
Revaluation of land and buildings	7,14,16 [pp52,58,63]	137,345	-	-
Total comprehensive revenue & expense	27[p74]	(40,494)	(98,475)	(63,959)

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY *for the year ended 30 June 2019*	Notes	Actual 2019 $'000	Budget 2019 $'000	Actual 2018 $'000
Total equity at beginning of the year		496,271	496,271	517,833
Total comprehensive revenue & expense for the year		(40,494)	(98,475)	(63,959)
EQUITY INJECTIONS:				
Equity support	7,27 [p52, 74]	81,611	63,959	35,000
Earthquake capital redrawn	7 [p52]	1,044	15,000	9,258
New Outpatients facility - earthquake capital redrawn	7 [p52]	53,607	57,000	-
New Outpatients facility – Crown contribution	7 [p52]	7,200	15,000	-
EQUITY REPAYMENTS:				
Repayment of equity – annual depreciation funding		(1,861)	(1,861)	(1,861)
Total equity at end of the year	7 [p52]	597,378	546,894	496,271

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION *as at 30 June 2019*	Notes	Actual 2019 $'000	Budget 2019 $'000	Actual 2018 $'000
CROWN EQUITY				
Contributed capital	7 [p52]	274,071	281,569	132,470
Revaluation reserve	7 [p52]	426,403	289,057	289,058
Accumulated surpluses / (deficits)	7 [p52]	(103,096)	(23,732)	74,743
Total equity		597,378	546,894	496,271
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8 [p53]	4,766	-	1,678
Trade and other receivables	9 [ps54]	96,848	90,393	90,391
Inventories	10 [p55]	13,209	11,170	11,171
Restricted assets	18 [p65]	14,743	14,577	14,577
Investments	11 [p56]	750	750	750
Total current assets		130,316	116,890	118,567
CURRENT LIABILITIES				
NZHPL sweep account	8 [p53]	36,575	48,920	17,376
Trade and other payables	12 [p56]	125,195	111,190	111,190
Employee benefits	13 [p57]	245,601	163,361	171,361
Restricted funds	18 [p65]	14,759	14,593	14,593
Total current liabilities		422,130	338,064	314,520
Net working capital		(291,814)	(221,174)	(195,953)
NON-CURRENT ASSETS				
Property, plant and equipment	14 [p58]	861,259	740,694	670,749
Intangible assets	15 [p61]	33,819	33,535	27,635
Restricted assets	17 [p65]	16	16	16
Total non-current assets		895,094	774,245	698,400
NON-CURRENT LIABILITIES				
Employee benefits	13 [p57]	5,902	6,177	6,176
Total non-current liabilities		5,902	6,177	6,176
Net assets		597,378	546,894	496,271

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS *for the year ended 30 June 2019*	Notes	Actual 2019 $'000	Budget 2019 $'000	Actual 2018 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Receipts from Ministry of Health		1,733,676	1,721,050	1,642,515
Earthquake repair revenue redrawn from Ministry of Health		4,460	5,300	3,240
Other receipts		94,154	93,696	67,993
Interest received		627	1,778	1,552
		1,832,917	1,821,824	1,715,300
CASH WAS APPLIED TO:				
Payments to employees		822,566	838,258	760,305
Payments to suppliers		1,026,260	1,006,688	932,270
Interest paid		211	450	60
Capital charge		24,241	24,994	30,292
GST – net		12,144	-	(1,338)
		1,885,422	1,870,390	1,721,589
Net cash inflow/ (outflow) from operating activities	19 [p67]	(52,505)	(48,566)	(6,289)
CASH FLOW FROM INVESTING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Sale of property, plant & equipment		123	-	460
Receipts from restricted assets & investments		17,642	-	43,758
		17,765	-	44,218
CASH WAS APPLIED TO:				
Purchase of investments & restricted assets		18,787	-	43,158
Purchase of property, plant & equipment		43,378	61,754	38,346
		62,165	61,754	81,504
Net cash inflow/ (outflow) from investing activities		(44,400)	(61,754)	(37,286)
CASH FLOW FROM FINANCING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Earthquake repair capital redrawn	16 [p63]	1,044	15,000	9,258
Equity support	7 [p52]	81,611	63,959	35,000
		82,655	78,959	44,258
CASH WAS APPLIED TO:				
Annual depreciation funding repayment		1,861	1,861	1,861
		1,861	1,861	1,861
Net cash inflow/ (outflow) from financing activities		80,794	77,098	42,397
Net increase/ (decrease) in cash and cash equivalents		(16,111)	(33,222)	(1,178)
Cash and cash equivalents at beginning of year		(15,698)	(15,698)	(14,520)
Cash & cash equivalents at end of year	8 [p53]	(31,809)	(48,920)	(15,698)

The accompanying notes form part of these financial statements.

5.2 Guide to Our Financial Reports

Notes to and forming part of the financial statements

1. STATEMENT OF ACCOUNTING POLICIES

Reporting entity and statutory base

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

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

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

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

Canterbury DHB holds a 50% interest in the Manawa building property lease by way of a jointly controlled asset. Canterbury DHB recognises its share of revenue and expenses of the jointly controlled asset. For further details of the lease, refer to note 17.

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

The financial statements of Canterbury DHB are for the year ended 30 June 2019 and were authorised for issue by the Board on 29 October 2019.

Basis of Preparation

Statement of going concern

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

Canterbury DHB's Chair received a letter of comfort from the Ministers of Health and Finance to enable the Board of Canterbury DHB to satisfy itself, for the purposes of the 2018/19 financial statements, that it is appropriate to prepare those financial statements on a going concern basis. The letter states that the Government is committed to working with Canterbury DHB over the medium term to maintain its financial viability, and also acknowledges that equity support may be required and the Crown will provide such support where necessary to maintain viability. Canterbury DHB requires this letter of comfort in the event that actual future cashflows are significantly unfavourable to one or more of the assumptions in our cashflow projections. The letter of comfort therefore provides the required basis for the Board of Canterbury DHB to prepare the 2018/19 financial statements on a going concern basis. It also gives the Board comfort that financial support will be provided to maintain financial viability in the medium term if required.

Statement of compliance

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

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

Measurement basis

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

Functional and presentation currency

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

Changes in accounting policies

With the exception of the accounting policy change in Note 9, the accounting policies set out in this report have been applied consistently to all periods presented in these consolidated financial statements.

Significant Accounting Policies

Basis for consolidation

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

Budget figures

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

Income tax

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

Goods and services tax

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

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

Commitments and contingencies are disclosed as exclusive of GST.

Critical accounting estimates and assumptions

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

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are highlighted in notes 4, 13, 14, 15.

Standards issued but not yet effective and not early adopted

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

Service Performance Reporting

In November 2017, the XRB issued PBE FRS 48 Service Performance Reporting. The new standard is effective for annual periods beginning on or after 1 January 2021 with early application permitted. The new standard establishes requirements for PBEs to select and present service performance information. Entities will need to provide users with:

- Sufficient contextual information to understand why the entity exists, what it intends to achieve in broad terms over the medium to long term, and how it goes about this; and
- Information about what the entity has done during the reporting period in working towards its broader aims and objectives.

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

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 - 38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6 - 8). The new standards are effective for annual periods beginning on or after 1 January 2019, with early application permitted. The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

2. PATIENT CARE REVENUE	2019 $'000	2018 $'000
Ministry of Health population based funding	1,463,233	1,394,583
Inter-district flows	122,670	116,683
Ministry of Health other contracts	138,563	122,156
ACC revenue	30,862	31,670
Other patient related revenue	34,324	32,358
Total patient care revenue	1,789,652	1,697,450

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

The appropriation revenue received by Canterbury DHB for the 2018/19 financial year is $1,431.953M (2017/18: $1,383.508M) which equals the Government's actual expenses incurred in relation to the appropriation.

MINISTRY OF HEALTH APPRORIATION REVENUE	Actual $'000	MOH Budget $'000
Crown funding appropriation	1,425,865	1,431,112
Terror attack funding	3,000	3,000
Earthquake funding	3,088	5,260
Total appropriation revenue	1,431,953	1,439,372

The table above shows the actual and budget Ministry of Health appropriation figures. The variance in the Crown funding appropriation relates to the 2018/19 debt equity swap capital charge funding for the new Hagley facility. This appropriation has been held in reserve within the Ministry of Health due to the delay in the rebuild, i.e. there is no additional corresponding capital charge cost to Canterbury DHB for that facility for 2018/19. The earthquake funding aligns to actual spend for the year.

(Note that Canterbury DHB receives other Crown revenue additional to the appropriation.) The performance measures are set out in the statement of service performance on pages 20-32.

ACCOUNTING POLICY

Revenue

Ministry of Health population-based funding

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

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

Inter-district flows

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

Ministry of Health other contracts

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

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are

substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the Ministry of Health to receive or retain funding.

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

ACC revenue

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

Provision of other services

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

3. OTHER REVENUE

	2019 $'000	2018 $'000
Gain/(loss) on sale of property, plant and equipment	133	389
Donations and bequests received	4,067	1,702
Pathology tests	8,811	7,479
Research & development	7,647	6,393
External rental revenue	896	968
Cafeteria Sales	4,568	4,452
Other	13,402	12,473
Total other revenue	39,524	33,856

ACCOUNTING POLICY

Revenue

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

ESTIMATES AND ASSUMPTIONS

Non-government grants

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

4. EMPLOYEE BENEFIT COSTS	2019 $'000	2018 $'000
Wages and salaries	816,130	737,740
Board members' fees	326	324
Directors' fees	101	84
Contributions to defined contribution plans	25,422	22,157
Holiday pay compliance provision	65,260	-
Increase/(decrease) in employee benefit provisions	8,706	14,679
Total employee benefit costs	915,945	774,984

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.

Holidays Act Compliance

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, the Canterbury DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

5. OTHER EXPENSES

	2019 $'000	2018 $'000
Financial statement audit fees	239	227
Rental costs including operating leases	9,025	7,479
Facilities and infrastructure costs	50,309	42,438
Other non-clinical costs	56,558	52,632
Total other expenses	116,131	102,776

ACCOUNTING POLICY

Operating lease payments

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

6. CAPITAL CHARGE

Canterbury DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December, less an allowance for donated assets. For the year ended 30 June 2019, the rate was 6% (2017/18: 6%).

The unspent portion of Canterbury DHB's earthquake insurance proceeds was paid to the Ministry of Health in June 2014 to minimise the capital charge expense. Canterbury DHB is able to draw down these funds to cover earthquake repair costs incurred. Depending upon the nature of the repair, some of these funds are drawn down as equity, when then attracts a capital charge. Canterbury DHB had discussions with the Ministry of Health in January 2019 to request the earthquake insurance proceeds, due to their nature and unique circumstances being funds not sourced from the Crown, to be exempt from the capital charge regulations, and has accounted for capital charge as if this exemption has been granted, pending confirmation from the Ministry of Health.

In July 2019, the Minister of Health announced that DHBs would be funded for capital charge on new facilities, with any deficit reducing the funding. This will benefit Canterbury DHB particularly with the new Hagley hospital redevelopment coming on stream in the 2019/20 financial year.

7. EQUITY

	2019 $'000	2018 $'000
CONTRIBUTED CAPITAL		
Opening balance	132,470	90,073
Annual depreciation funding repayment	(1,861)	(1,861)
Equity support	81,611	35,000
Earthquake repair capital redrawn	1,044	9,258
New Outpatients facility - earthquake capital redrawn	53,607	-
New Outpatients facility - Crown contribution	7,200	-
Closing balance	274,071	132,470

The operating deficit for 2018 was $63.9M. The Ministry of Health provided $30M of equity support in January 2019, and a further $51.611M was received in June 2019.

ACCUMULATED SURPLUS/(DEFICIT)	2019 $'000	2018 $'000
Opening balance	74,743	138,702
Operating deficit	(177,839)	(63,959)
Closing balance	(103,096)	74,743
REPRESENTED BY:		
Accumulated surplus in parent and associates	(106,542)	71,566
Accumulated surplus in subsidiaries	3,446	3,177
Total accumulated surplus / (deficit)	(103,096)	74,743
REVALUATION RESERVE		
Opening balance	289,058	289,058
Revaluation of Land and Buildings	137,345	-
Closing balance	426,403	289,058
REPRESENTED BY:		
Revaluation of land	94,616	85,079
Revaluation of buildings including fitout	331,787	203,979
Total revaluation reserve	426,403	289,058
Total equity	597,378	496,271

ACCOUNTING POLICY

Equity

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

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

Revaluation reserve

This reserve relates to the revaluation of land and buildings to fair value.

8. CASH AND CASH EQUIVALENTS

	Credit rating	2019 $'000	2018 $'000
CURRENT ASSETS			
Bank balances and call deposits	AA-	4,766	1,678
Total cash and cash equivalents		4,766	1,678
CURRENT LIABILITIES			
NZHPL sweep account		(36,575)	(17,376)
Net cash and cash equivalents		(31,809)	(15,698)

Bank facility

Canterbury DHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Ltd (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at a credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned

monthly Crown revenue, used in determining working capital limits, and is defined as one-twelfth of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Canterbury DHB, that equates to $88.808M (2017/18: $88.808M). There has been no change from 2018, as both the Minister of Health and the Minister of Finance advised that they have not approved the 2018/19 Annual Plan.

Credit risk

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

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

The Board places its cash and term investments with high quality financial institutions via a national DHB shared banking arrangement, facilitated by NZ Health Partnerships Ltd. Restricted asset cash and term investments are placed with high quality financial institutions.

ACCOUNTING POLICY

Bank term deposits

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

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition.

9. TRADE AND OTHER RECEIVABLES	2019 $'000	2018 $'000
Trade receivables	18,327	15,696
Receivable from the Ministry of Health	41,636	34,324
Prepayments	5,838	4,554
Other receivables	31,047	35,817
Total trade and other receivables	96,848	90,391
MOVEMENTS IN THE PROVISION FOR IMPAIRMENT OF RECEIVABLES ARE AS FOLLOWS:		
Balance at 1 July	1,940	3,434
Additional provisions made during the year	925	958
Receivables written-off during period	(803)	(2,452)
Balance at 30 June	2,062	1,940
THE AGEING OF THE IMPAIRMENT PROVISIONS ARE AS FOLLOWS:		
Current	-	206
< 6 months	975	1245
6 months – 1 year	322	266
1 – 2 years	457	70
> 2 years	308	153
Balance at 30 June	2,062	1,940

THE NET AGEING OF RECEIVABLES, EXCLUDING PREPAYMENTS, IS:

Current	86,955	81,073
< 6 months	3,815	3,480
6 months – 1 year	88	699
1 – 2 years	100	184
2 years	52	401
Balance at 30 June	91,010	85,837

Trade receivables and prepayments are from exchange revenue transactions.

The value of trade debtors that have been impaired on an individual basis total $0.183M, and the impairment on those accounts is $0.159M giving a net carrying value of $0.024M.

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 $25.400M (2017/18: $18.648M).

Concentrations of credit risk from trade and other accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2019, the Ministry of Health owed Canterbury DHB $41.636M (2017/18: $34.324M).

ACCOUNTING POLICY

Trade and other receivables

Trade and other receivables are non-interest bearing and receipt is normally within 30 day terms. Therefore, the carrying value of receivables approximates their fair value. Trade and other receivables are recorded at the amount due, less an allowance for credit losses. Canterbury DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, trade and other receivables that are individually significant have been reviewed on an individual basis, the rest are reviewed on a collective basis as they possess shared credit risk characteristics.

Trade and other receivables are written off when there is no reasonable expectation of recovery.

Previous accounting policy for impairment of receivables

In the previous year, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was recognised only when there was evidence that Canterbury DHB would not be able to collect the amount due.

10. INVENTORIES	2019 $'000	2018 $'000
Pharmaceuticals	2,824	3,044
Surgical and medical supplies	7,793	5,624
Other supplies	3,403	3,344
	14,020	12,012
Provision for obsolescence	(811)	(841)
Total inventories	13,209	11,171

ACCOUNTING POLICY

Inventories

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

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

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

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

11. INVESTMENTS	Credit rating	2019 $'000	2018 $'000
Investments are represented by:			
Term deposits with maturities of 3-12 months	AA-	750	750
Total investments		750	750
Weighted average effective interest rates		3.28%	3.32%

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

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates.

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

12. TRADE AND OTHER PAYABLES	2019 $'000	2018 $'000
Trade payables	23,613	16,392
Other payables	101,582	94,798
Total trade and other payables	125,195	111,190

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

Trade payables are from exchange transactions. The value of non-exchange balances in other payables is $33.662M (2017/18: $30.201M).

Trade and other payables are measured at fair value.

ACCOUNTING POLICY

Provisions

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

13. EMPLOYEE BENEFIT LIABILITIES	2019 $'000	2018 $'000
CURRENT LIABILITIES		
Annual, lieu and shift leave accruals	155,237	81,129
Unpaid days accruals	7,087	20,183
ACC accruals	4,816	4,408
Conference/sabbatical leave and expenses	28,619	25,723
Sick leave	5,668	9,202
Other	44,174	30,716
Total employee benefits - current	245,601	171,361
NON-CURRENT LIABILITIES		
Liability for long service leave	4,616	4,706
Liability for retirement gratuities	1,286	1,470
Total employee benefits – non-current	5,902	6,176

ACCOUNTING POLICY

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

ACC Partnership Programme

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

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

ESTIMATES AND ASSUMPTIONS

Retirement and long service leave

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

The discount rates used have been obtained from the NZ Treasury published risk-free discount rates as at 30 June 2019. The salary inflation factor has been determined after considering historical salary inflation patterns.

If the discount rate were to differ by 0.5% from that used, with all other factors held constant, the carrying value amount of the retirement and long service leave obligations would be an estimated +/- $89,000.

If the salary inflation factor were to differ by 0.5% from that used, with all other factors held constant, the carrying amount of retirement and long service leave obligations would be an estimated +/- $88,000.

14. PROPERTY, PLANT AND EQUIPMENT

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

2018/19 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2018	129,918	518,485	224,649	10,109	34,498	917,659
Additions/transfers	-	65,948	13,898	160	25,515	105,521
Disposals/transfers	-	(4,540)	(86)	(197)	-	(4,823)
Revaluation	9,537	17,313	-	-	-	26,850
Balance at 30 June 2019	139,455	597,206	238,461	10,072	60,013	1,045,207
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2018	-	79,310	164,065	3,535	-	246,910
Depreciation	-	35,786	14,765	290	-	50,841
Disposals/transfer	-	(2,514)	(608)	(186)	-	(3,308)
Revaluation	-	(110,495)	-	-	-	(110,495)
Balance at 30 June 2019	-	2,087	178,222	3,639	-	183,948
CARRYING AMOUNT						
At 30 June 2019	139,455	595,119	60,239	6,433	60,013	861,259

2017/18 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2017	129,918	517,276	218,812	9,329	18,860	894,195
Additions/transfers	-	2,428	15,052	137	15,638	33,255
Disposals/transfers	-	(1,219)	(9,215)	643	-	(9,791)
Balance at 30 June 2018	129,918	518,485	224,649	10,109	34,498	917,659
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2017	-	40,834	157,644	2,630	-	201,108
Depreciation	-	39,225	15,873	388	-	55,486
Disposals/transfer	-	(749)	(9,452)	517	-	(9,684)
Balance at 30 June 2018	-	79,310	164,065	3,535	-	246,910
CARRYING AMOUNT						
At 30 June 2018	129,918	439,175	60,584	6,574	34,498	670,749

Canterbury DHB revalued land, buildings and building fitout (excluding leased building fitout) at 30 June 2019. The revaluation was carried out by an independent registered valuer (TelferYoung (Canterbury) Ltd), which is consistent with PBE IPSAS 17 Property Plant & Equipment.

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

ACCOUNTING POLICY

Property, plant and equipment

Owned assets

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

Revaluations

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

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

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

Disposal of property, plant and equipment

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

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

Depreciation

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

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

Type of asset	Useful life (years)	Depreciation rate	*Prior year useful life (years)*
Buildings structure	35 - 80	1.3 – 2.9%	*35 - 90*
Buildings infrastructure & fitout	15 - 60	1.7 – 6.7%	*15 - 60*
Temporary buildings	2 - 20	5.0 – 50.0%	*2 - 20*
Leasehold improvements	3 - 30	3.3 – 33.3%	*3 - 20*
Plant, equipment and vehicles	3 - 20	5.0 – 33.3%	*3 - 20*

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually. During the year, a review taking into account factors such as the current operational environment, technology and medical advances, asset status and maintenance programmes in place was undertaken, resulting in minor changes to the useful life range as shown in the table above. The change to building structure is due to the 90 year upper limit being an historical outlier, and the change to leasehold improvements is to align with lease terms.

Additions

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

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

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

Subsequent costs

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

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

ESTIMATES AND ASSUMPTIONS

Useful lives and residual value

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

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

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

In light of the Canterbury earthquakes, Canterbury DHB continuously reviews the carrying value of land and buildings as further described in note 16 [p63].

15. INTANGIBLE ASSETS	2019 $'000	2018 $'000
SOFTWARE		
COST		
Opening balance	58,731	53,554
Additions	11,389	5,621
Disposals	-	(444)
Closing balance	70,120	58,731
AMORTISATION AND IMPAIRMENT LOSSES		
Opening balance	36,283	33,550
Amortisation charge for the year	3,243	3,171
Disposals	-	(438)
Closing balance	39,526	36,283
Total Software	30,594	22,448
INVESTMENT IN NZ HEALTH PARTNERSHIPS LTD		
Opening balance	5,187	5,936
Capital call – National Oracle Solution revised business case	1,146	-
Impairments for the year	(3,108)	(749)
Closing balance	3,225	5,187
Carrying amounts	33,819	27,635

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

NZ Health Partnerships Limited (NZHPL)

An impairment of the NZHPL Change Management and Supply Chain of $3.108M was recognised in June 2019, based on information and recommendations from NZHPL. The impairment was to recognise the variation between the underlying value of the Finance Procurement Information Management (FPIM) programme asset held by NZHPL, and the underlying investment carried by DHBs.

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

- Class B Shares confer no voting rights.
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services.
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by NZHPL from the Finance, Procurement and Supply Chain Shared Service.
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company.
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

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

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

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

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

ACCOUNTING POLICY

Intangible assets

Software development and acquisition

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

Amortisation

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

Type of asset	Useful life (years)	Amortisation rate	*Prior year useful life (years)*
Software	3 - 20	5% – 33.3%	2 - 15

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually. During the year, a review was undertaken, resulting in a change to the useful life range as shown in the table above. The increase to the upper range is to recognise the longer life expected from some of our specialised software such as the South Island Patient Information System.

Non-cash-generating assets

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

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

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

Estimating useful lives of software assets

Software has an infinite life, which requires Canterbury DHB to estimate the useful life of the software assets.

In assessing the useful lives of software assets, a number of factors are considered, including:

- Period of time the software is expected to be in use;
- Effects of technological change on systems and platforms; and
- Expected timeframe for the development and replacement of systems and platforms

An incorrect estimate of the useful lives of software will affect the amortisation expense recognised in the surplus or deficit, and the carrying amount of the software assets in the statement of financial position.

16. IMPAIRMENT AND THE EFFECTS OF THE CANTERBURY EARTHQUAKES

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

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

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

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

Canterbury DHB continually reviews whether the carrying value of land and buildings exceeds their recoverable amount. This review has resulted in an impairment to land and buildings totalling $87.361M for the nine years to 30 June 2019.

No further impairment for land and buildings was required to be recognised for the financial year ended 30 June 2019 (2017/18: Nil).

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

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

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

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

available to the other DHBs, unless and until repairs have been completed. This, in the event of further earthquake damage, materially limits insurance coverage, and therefore likely recoveries.

Agreement with Ministry of Health

As part of an agreement with the Ministry of Health, $290M of insurance revenue (being the unspent portion of the earthquake insurance proceeds) was paid to the Ministry of Health in June 2014. Canterbury DHB is able to draw down funds up to $290M from the Ministry of Health over future periods to cover earthquake repair costs incurred.

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

DRAWDOWN	$M
Initial payment to Ministry of Health	290.00
Drawdown 2013/14	(20.00)
Drawdown 2014/15	(13.15)
Drawdown 2015/16	(43.28)
Drawdown 2016/17	(21.88)
Drawdown 2017/18	(12.25)
Drawdown 2018/19	(6.63)
Amount undrawn 30 June 2019	172.81

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

ACCOUNTING POLICY

Impairment

The carrying amounts of Canterbury DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated. If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

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

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

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

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

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

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

Impairment losses are reversed when there is a change in the estimates to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

17. JOINTLY CONTROLLED ASSET

In 2018/19, Canterbury DHB entered into a joint property lease with Ara Institute of Canterbury for the new Health Research Educational Facility known as the Manawa building. The arrangement is by way of a jointly controlled asset.

	2019 $'000	2018 $'000
Canterbury DHB's revenue included the following as a result of the jointly controlled asset:		
Sub Tenant Revenue	286	-
Canterbury DHB's expenditure included the following as a result of the jointly controlled asset:		
Manawa lease and facility costs	1,982	-

As at 30 June 2019, Canterbury DHB owed Ara Institute $76,000. Ara Institute owed Canterbury DHB $9,000.

18. RESTRICTED ASSETS & RESIDENTS' TRUST ACCOUNTS

RESTRICTED ASSETS

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

All restricted assets are held in bank accounts that are separate from Canterbury DHB's normal banking facilities. As part of an agreement with the Māia Health Foundation, Canterbury DHB is progressively transferring some of the restricted assets to Māia to invest on behalf of Canterbury DHB. The agreement allows Canterbury DHB to draw down on these funds as and when required.

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

	2019 $'000	2018 $'000
FUNDS HELD DIRECTLY BY CANTERBURY DHB		
Balance at beginning of year	10,577	12,111
Interest received	299	382
Donations and funds received	536	1,259
Funds transferred to Māia Health Foundation	(1,798)	(2,021)
Funds spent	(669)	(1,154)
Balance at end of year	8,945	10,577
FUNDS HELD WITH MĀIA HEALTH FOUNDATION		
Balance at beginning of years	4,016	-
Funds transferred from / (to) Canterbury DHB	1,798	4,016
Balance at end of year	5,814	4,016
Total Restricted Assets	14,759	14,593
This balance is represented by:		
Current assets	14,743	14,577
Non-current assets	16	16
Total restricted assets	14,759	14,593
Weighted average effective interest rates	3.28%	3.44%

Credit quality of restricted assets	Credit rating	2019 $'000	2018 $'000
Restricted assets:			
Term deposits with maturities of up 3 months – Canterbury DHB	AA-	233	-
Term deposits with maturities of 3-12 months – Canterbury DHB	AA-	8,696	10,561
Term deposits with maturities of 3-12 months – Māia Health Foundation	AA-	5,814	4,016
Perpetual capital notes	BBB+	16	16
Total restricted assets		14,759	14,593

RESIDENTS' TRUST ACCOUNTS	2019 $'000	2018 $'000
Residents' trust account balance	1,009	913

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

19. BORROWINGS

Liquidity risk

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

ACCOUNTING POLICY

Borrowings

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

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

20. RECONCILIATION OF NET SURPLUS/(DEFICIT) FOR THE PERIOD WITH NET CASH FLOWS FROM OPERATING ACTIVITIES	2019 $'000	2018 $'000
Net (deficit)/ surplus before other comprehensive revenue and expense	(177,839)	(63,959)
Add back non-cash items:		
Depreciation and amortisation	54,084	58,657
Impairment in investment in NZ Health Partnerships Ltd	3,108	749
Add back items classified as investing activities:		
Loss/(gain) on asset sale	(123)	(389)
Movement in term portion provisions/staff entitlements	(274)	21
MOVEMENTS IN WORKING CAPITAL:		
Decrease/(increase) in receivables & prepayments	(6,457)	(17,739)
Decrease/(increase) in stocks	(2,038)	(2,053)
Increase/(decrease) in creditors & other accruals	2,794	3,766
Increase/(decrease) in staff entitlements	74,240	14,658
Net cash inflow/(outflow) from operating activities	(52,505)	(6,289)

21. COMMITMENTS	2019 $'000	2018 $'000
CAPITAL COMMITMENTS		
Property	10,404	6,226
Intangible assets	8,430	7,063
Other capital commitments	13,665	6,293
Total capital commitments at balance date	32,499	19,582

Capital commitments pertaining to the new Christchurch Hospital Hagley facility are held by the Ministry of Health until such time as these assets are handed over to Canterbury DHB.

NON-CANCELLABLE OPERATING LEASE COMMITMENTS		
Accommodation leases	77,962	35,237
Other leases	35	59
Total non-cancellable operating lease and supply commitments	77,727	35,296
FOR EXPENDITURE WITHIN:		
Not later than one year	6,739	6,112
Later than one year and not later than five years	18,296	13,738
Later than five years	52,692	15,446
Total non-cancellable operating lease and supply commitments	77,727	35,296

External service providers

Canterbury DHB contracts with a wide variety of service providers with whom there are differing contractual terms. These are renegotiated periodically reflecting the general principle that an 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. The increase in property lease commitments in the table above is due to the new health research educational facility (Manawa building). This is a jointly owned asset under a collaborative agreement with Ara Institute.

ESTIMATES AND ASSUMPTIONS

Leases classification

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

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

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

22. CONTINGENCIES

Contingent assets

Canterbury DHB has no contingent assets as at 30 June 2019 (2017/18: Nil).

Contingent liabilities

Canterbury DHB has the following contingent liabilities as at 30 June 2019:

Outstanding legal proceedings

Canterbury DHB has no material outstanding legal proceedings as at 30 June 2019 (2017/18: Nil).

Defined benefit contribution schemes

Canterbury DHB is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, Canterbury DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, Canterbury DHB could be responsible for an increased share of the deficit.

Canterbury earthquakes

In respect of the Canterbury earthquakes there are a number of repair costs yet to be determined and incurred, both of an operational and capital nature, which will be brought to account as they become quantifiable and a liability crystallises. See note 16 [p63] 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.

23. CONTRACTUAL MATURITY OF FINANCIAL ASSETS AND LIABILITIES

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

Contractual maturity analysis of financial liabilities	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000
18/19 FINANCIAL YEAR			
NZHPL sweep account	36,575	36,575	36,575
Trade and other payables	125,195	125,195	125,195
Restricted funds	14,759	14,759	14,759
Total financial liabilities	176,529	176,529	176,529
17/18 FINANCIAL YEAR			
NZHPL sweep account	17,376	17,376	17,376
Trade and other payables	111,190	111,190	111,190
Restricted funds	14,593	14,593	14,593
Total financial liabilities	143,159	143,159	143,159

Contractual maturity analysis of financial assets	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000
2018/19 FINANCIAL YEAR				
Cash and cash equivalents	4,766	4,766	4,766	-
Trade and other receivables[85]	91,009	91,009	91,009	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	14,759	14,759	14,743	16
Total financial assets	111,284	111,284	111,268	16
2017/18 FINANCIAL YEAR				
Cash and cash equivalents	1,678	1,678	1,678	-
Trade and other receivables[85]	85,837	85,837	85,837	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	14,593	14,593	14,577	16
Total financial assets	102,858	102,858	102,842	16

[85] Excludes prepayments

ACCOUNTING POLICY

Classification of financial instruments

On the date of initial application of PBE IFRS 9, being 1 July 2018, the classification of financial instruments under IPSAS 29 and PBE IFRS 9 changed as follows:

	Original PBE IPSAS 29 category	New PBE IFRS 9 category
Cash and cash equivalents	Loan and receivables	Amortised Cost
Trade and other receivables	Loan and receivables	Amortised Cost
Term deposits	Loan and receivables	Amortised Cost
Derivative financial instruments	Fair value through surplus/deficit	Fair value through surplus/deficit

The measurement categories and carrying amounts for financial liabilities have not changed between the closing 30 June 2018 and the opening 1 July 2018 dates as a result of the transition to PBE IFRS 9. All financial liabilities are measured at amortised cost.

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 exposure at balance date. Canterbury DHB's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as investments are generally held to maturity.

Canterbury DHB held NZD $990,953 of foreign currency accounts as at 30 June 2019 (2017/18: NZD $1,062,156).

	2019 $'000		2018 $'000	
FOREIGN EXCHANGE RISK	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(99)	90	(106)	97
Total sensitivity	(99)	90	(106)	97

ACCOUNTING POLICY

Foreign currency

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

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

Derivative financial instruments

Derivative financial instruments are used to manage exposure to foreign exchange risk arising from Canterbury DHB's operational activities. The Canterbury DHB does not hold or issue derivative financial instruments for trading purposes. Canterbury DHB has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently re-measured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit. Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current.

The fair values of forward foreign exchange contracts have been determined using a discounted cash flows valuation technique based on quoted market prices. The inputs into the valuation model are from independently sourced market parameters such as currency rates. Most market parameters are implied from forward foreign exchange contract prices.

Foreign exchange contracts

The notional principal amounts of outstanding forward foreign exchange contracts in NZ dollars were $4.07M (2017/18: Nil). The foreign currency principal amounts were €2.25M (2017/18: Nil)

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, whilst 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 transalpine approach to the delivery of health services. This includes both clinical, as well as non-clinical, shared staff. All other related party transactions have been entered into on an arm's length basis.

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

Significant transactions with government related entities

Canterbury DHB has received funding from the Crown, ACC, and other government entities of $1,638.484M to provide health services in Canterbury area for the year ended 30 June 2019 (2017/18: $1,553.689M).

Revenue earned from other DHBs for the care of patients domiciled outside Canterbury DHB's district as well as services provided to other DHBs amounted to $138.654M for the year ended 30 June 2019 (2017/18: $131.141M).

Expenditure to other DHBs for the care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $35.921M for the year ended 30 June 2019 (2017/18: $34.098M).

Other significant transactions with government-related entities

In conducting its activities, Canterbury DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other

than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. Canterbury DHB is exempt from paying income tax.

Canterbury DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2019 totalled $23.265M (2017/18: $21.098k). These purchases included blood products from the New Zealand Blood Service, travel through Air New Zealand and services from NZ Health Partnerships Ltd.

ACCOUNTING POLICY

Subsidiaries

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

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

Associates

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

Canterbury DHB Subsidiaries

ENTITY	Interest held 2019	Balance Date
Canterbury Linen Services Ltd	100%	30 June
Brackenridge Services Ltd	100%	30 June

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

Canterbury DHB Associates

ENTITY	Interest held 2019	Balance Date
South Island Shared Service Agency Limited	47%	30 June

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

Canterbury DHB joint ventures

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

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

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

From 1 July 2019, the partners of the partnership approved the transfer of the Counties Manukau DHB and the Auckland DHB partnership shares to Canterbury DHB.

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. 2019 charges were $1.253M (2017/18: $1.265M). The amount owing by West Coast DHB relating to this agreement at balance date was Nil (2017/18: $0.105M).

Māia Health Foundation

Canterbury DHB provides accounting support, office space, and minor incidentals to the Māia Health Foundation at no charge, as well as assistance with seed funding of $0.125M (2017/18: $0.250M). Also refer note 17 [p65].

Key management personnel

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

26. EMPLOYEE REMUNERATION

	2019 $'000	2018 $'000
COMPENSATION OF KEY MANAGEMENT PERSONNEL		
Salaries for executive management team	3,689	3,536
Board and Committee members fees	381	401
Total key management personnel compensation	4,070	3,937

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	2019 $'000	2018 $'000
Full time equivalent Board and Committee members	1.33	1.40
Full time equivalent executive management team	10.65	10.55
Total key management personnel full time equivalents	11.98	11.95

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

Payments in respect of termination of employment

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

The total payments made by Canterbury DHB were $510,218 to 16 employees (2017/18: $645,221 to 16 employees) comprising negotiated settlements with the employees.

Remuneration of Employees

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

SPECIFIED BANDS	2019	2018	SPECIFIED BANDS	2019	2018
100,000-109,999	419	234	340,000-349,999	22	15
110,000-119,999	262	165	350,000-359,999	16	8
120,000-129,999	145	125	360,000-369,999	7	11
130,000-139,999	126	96	370,000-379,999	12	7
140,000-149,999	87	90	380,000-389,999	6	5
150,000-159,999	77	62	390,000-399,999	5	6
160,000-169,999	45	48	400,000-409,999	7	5
170,000-179,999	56	42	410,000-419,999	7	5
180,000-189,999	40	30	420,000-429,999	2	5
190,000-199,999	26	37	430,000-439,999	11	5
200,000-209,999	28	26	440,000-449,999	4	-
210,000-219,999	26	22	450,000-459,999	3	3
220,000-229,999	27	23	460,000-469,999	3	-
230,000-239,999	22	26	470,000-479,999	3	
240,000-249,999	22	28	480,000-489,999	3	1
250,000-259,999	24	15	490,000-499,999	2	-
260,000-269,999	32	30	500,000-509,999	1	-
270,000-279,999	17	23	530,000-539,999	-	1
280,000-289,999	37	24	560,000-569,999	1	-
290,000-299,999	23	25	600,000-609,999	-	1
300,000-309,999	24	18	620,000-629,999	-	1
310,000-319,999	20	10	640,000-649,999	1	-
320,000-329,999	24	13	680,000-689,000	1	-
330,000-339,999	9	15			
			Total employees	1,735	1,306

Of the positions identified above, 1,502 (2017/18: 1,101) positions were predominantly clinical and 233 (2017/18: 205) positions were management/administrative.

27. MAJOR VARIANCES TO BUDGET

Canterbury DHB budgeted for a deficit of $98M as published in our 2018/19 Annual Plan.

Statement of comprehensive revenue and expense

Listed below are the major factors that make up the variance between the planned deficit of $98.M and the actual deficit of $178M:

- We received $3M additional funding to cover costs of $6M in relation to the March terrorist attack. These costs are predominantly employee benefit costs and treatment related costs.
- We received $4M less Inter District Flow (IDF) revenue than the Ministry of Health forecast due to less referrals from DHBs outside of the Canterbury region.
- Earthquake repair revenue redrawn was $1M less than plan due to the timing of earthquake repairs. This amount is offset by an equal and opposite favourable variance in earthquake building repair costs.

- Interest revenue and finance costs were unfavourable due to lower market rates achievable, as well as Ministry of Health equity support received later than planned resulting in lower cash balances and higher overdraft throughout the year.
- Employee benefit costs were higher than plan due to a number of factors, including:
  - A provision made for compliance with the Holidays Act of $65.260M.
  - Additional SMO costs of $2M incurred relating to the RDA strikes.
  - MECA settlement provision June 2018 $1M disallowed due to accounting standard criteria not met.
  - Impact on leave entitlements of $3M resulting from MECA settlements higher than anticipated.
  - The reduction in Treasury discount rates increased our leave entitlements by $1M.
  - Additional costs of $1M were incurred in relation to the South Island Patient Information Care System and the Finance & Procurement Information Management System.
  - We continued to run additional acute theatres on weekends and we increased our dependence on out-placed activity for overnight stays, resulting in higher allowance costs.
- Additional pressures relating to increased demand in Mental Health and in ED continued to affect expense categories, including employee benefit costs.
- Treatment related costs were favourable against budget due primarily to reimbursement of hospital pharmaceuticals from PHARMAC of $16M. This has an equal and opposite impact on external service providers costs. Treatment related costs also include an unfavourable adjustment of $1M in relation to a downward revision of pharmaceutical rebates from PHARMAC.
- Pharmaceutical expenditure has seen significant cost increases from new products on the pharmacy schedule, particularly immunotherapy pharmaceuticals (e.g. MABs).
- Earthquake building repair costs are favourable to budget by $0.8M due to the timing of repairs. This is offset by the unfavourable earthquake repair revenue redrawn variance above.
- External service provider costs include $2.5M of Hepatitis C (Hep C) costs. From 1 February 2019 Maviret, a Hep C medicine suitable for all genotypes, has been made available. The existing Hep C medicine Viekira Pak has been delisted and recent statistics supplied by PHARMAC show claims for Maviret exceeded the previous annual total in the first two months. The increase in claims of these highly priced medicines has contributed to an increased pharmaceutical spend in the 2018/19 financial year for Canterbury DHB. Canterbury has treated more patients proportionally than the rest of the country
- We paid $1M more IDF expenditure than the Ministry of Health forecast due to more referrals made to DHBs outside of the Canterbury region.
- Facilities expenses in relation to the March flooding incident in our new Outpatients facility are minimal, as we expect to recover most of the material damage costs through our insurance. The impact on patient care, particularly in relation to additional costs to catch up has yet to fully flow into our operational costs, and will continue to impact in the coming financial year.
- Depreciation and amortisation is favourable to plan by $3.8M due to a review of useful lives undertaken during the year.

Statement of changes in equity

The Equity support budget was comprised of full funding of $63.959M for the 2017/18 year deficit. Actual funding received was $17.652M higher to reflect our immediate cash requirements.

Earthquake capital redrawn is $13.956M less than plan due to the transfer of the tunnel delayed until the 2019/20 year.

Earthquake capital redrawn in relation to the new Outpatients facility is $3.393M less than plan due to the final costs from the Ministry of Health for the project not due until the 2019/20 year as per our handover agreement.

The new Outpatients facility cost was $7.8M less than originally planned. The Crown has reduced their contribution to the facility by the amount of this underspend.

Statement of financial position

We revalued our land and buildings as at 30 June 2019, and this has resulted in a large increase in the revaluation reserve and property, plant and equipment, due to market movements and re-assessment of useful

lives. Due to the specialised nature of revaluations and the uncertainty of the resultant values, we do not budget for revaluations.

Employee benefits include a provision made for compliance with the Holidays Act of $65.260M.

The NZHPL sweep bank account overdraft was favourable to budget, and trade and other payable unfavourable to budget mainly due to the timing of payments.

Statement of cash flows

Earthquake capital redrawn is $13.956M less than plan due to the transfer of the tunnel delayed until the 2019/20 year.

The Equity support budget was comprised of full funding of $63.959M for the 2017/18 year deficit. Actual funding received was $17.652M higher to reflect our immediate cash requirements.

Employee benefit costs were higher than plan due to a number of factors, including:

- Additional SMO costs of $2M incurred relating to the RDA strikes.
- MECA settlement provision June 2018 $1M disallowed due to accounting standard criteria not met.
- Additional costs of $1M were incurred in relation to the South Island Patient Information Care System and the Finance & Procurement Information Management System.
- We continued to run additional acute theatres on weekends and we increased our dependence on out-placed activity for over-night stays, resulting in higher allowance costs.

Treatment related costs were favourable against budget due primarily to reimbursement of hospital pharmaceuticals from PHARMAC of $16M.

28. SUBSEQUENT EVENTS

There were no events after 30 June 2019, which could have a material impact on the information in Canterbury DHB's financial statements (2017/18: Nil).

5.3 Summary of Revenues and Expenses by Output Class

	Actual 2019 $'000	Budget 2019 $'000
Early detection & management	359,050	356,194
Intensive assessment & treatment	1,149,023	1,139,717
Prevention	45,357	45,646
Rehabilitation & support	280,833	280,267
Total revenue	1,834,263	1,821,824
Early detection & management	396,421	376,047
Intensive assessment & treatment	1,258,389	1,201,928
Prevention	48,416	47,264
Rehabilitation & support	308,876	295,060
Total expenditure	2,012,102	1,920,299
Deficit	(177,839)	(98,475)

Part VI
Supplementary Information

6.1 Directory

Board Members

Dr John Wood - Chair
Tā Mark Solomon - Deputy Chair
Barry Bragg
Sally Buck
Tracey Chambers
Anna Crighton
Andrew Dickerson
Jo Kane
Aaron Keown
Chris Mene
David Morrell

Chief Executive

David Meates

Corporate Office

Level 1
32 Oxford Terrace
Christchurch

New Zealand Business Number

9429000098045

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Bank of New Zealand

Part VII
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 2019

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

We have audited:

- the financial statements of the Group on pages 43 to 76, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the Group on pages 8 to 32 and page 77.

Qualified opinion

Qualified opinion on the financial statements – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matter described in the Basis for our qualified opinion section of our report, the financial statements of the Group on pages 43 to 76:

- present fairly, in all material respects:
    - its financial position as at 30 June 2019; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information – Our work was limited because the Group has only been able to report reliably on emergency department waiting times for part of the year

In our opinion, except for the matter described in the Basis for our qualified opinion section of our report, the performance information of the Group on pages 8 to 32 and page 77:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2019, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below and we draw your attention to the matter of the Group being reliant on financial support from the Crown. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

Financial statements

As outlined in note 4 on page 51, the Group has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Group has estimated a provision as at 30 June 2019 of $65.26 million to remediate these issues. However, until further work is undertaken by the Group, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

Performance information

An important part of the Group's performance information is reporting on emergency department waiting times. As explained in footnote 12 on page 17 and on page 21 of the annual report, difficulties arose following the implementation of the new patient management system which meant that the Group has been unable to obtain accurate information on this measure for the second and third quarter of the year ended 30 June 2019. The annual report therefore only includes the performance against this measure for the first and fourth quarters. Because no reliable information was available for the second and third quarter, our work was limited and there were no practicable audit procedures we could apply to obtain assurance that the reported information fairly reflected the performance against this measure for the year.

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

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

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

The Group is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 1 on page 47 that outline that the Board, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of comfort received from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, where necessary, to maintain viability. We consider these disclosures to be adequate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Group's ability to

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 6 and 34 to 41 and page 79, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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