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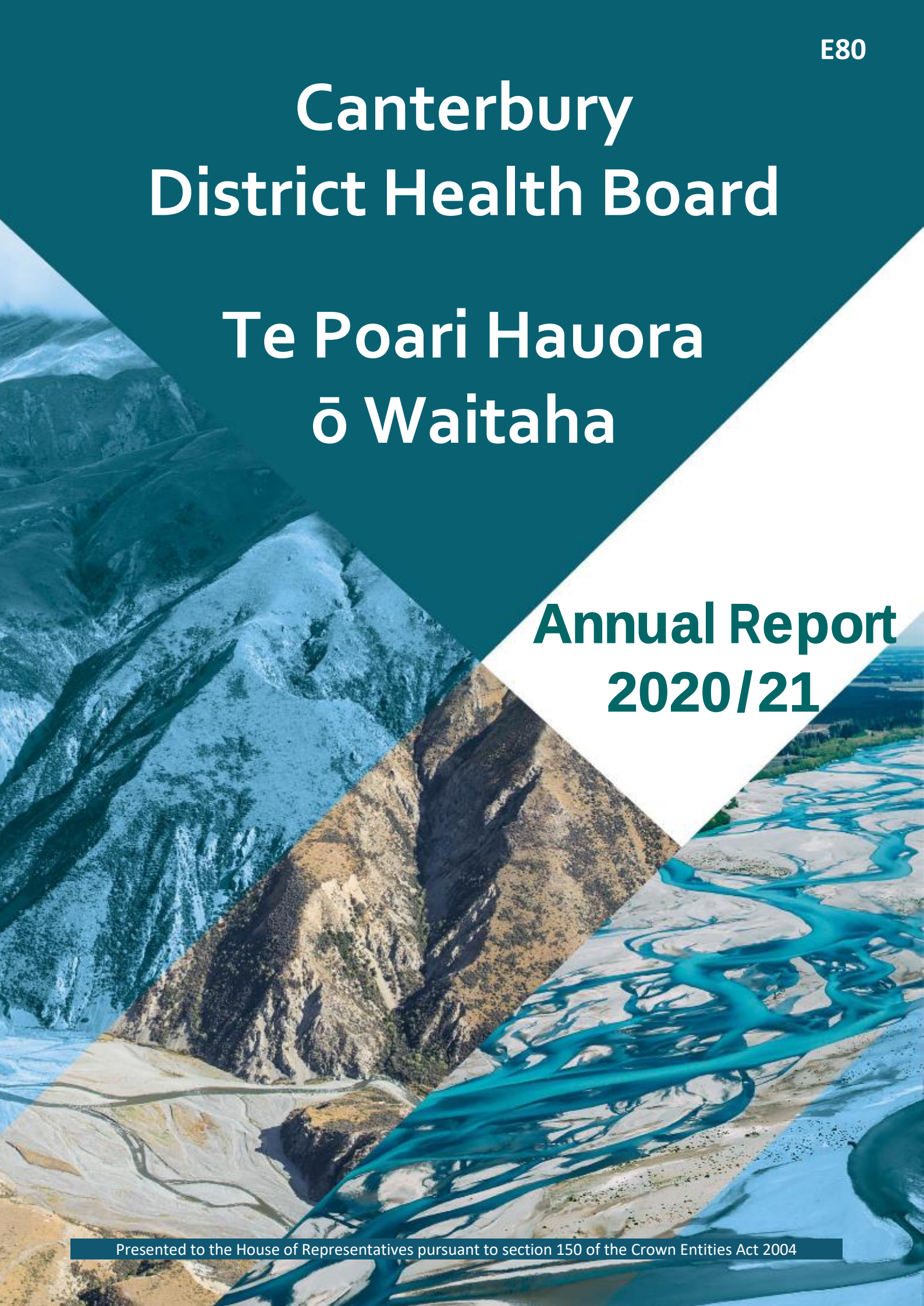
Canterbury District Health Board

Te Poari Hauora ō Waitaha

Annual Report 2020/21



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

TĀ MĀTOU MATAKITE | OUR MISSION

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

Ā MĀTOU UARA | OUR VALUES

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

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

Te Takohanga i ngā hua.
Responsibility for outcomes.

KĀ HUARI MAHI | OUR WAY OF WORKING

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

Whakaatu te ihumanea hou.
Demonstrate innovation

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

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1. TIRO WHĀNUI | OVERVIEW

1.1 Kupu Whakataki nā te Heamana rāua ko te Kaiwhakahaere Matua | Foreword from the Chair and Chief Executive

We are pleased to share our Annual Report for the 2020/21 financial year. It was a successful year of delivering quality care, despite continuing challenges fuelled by uncertainty.

To do our mahi effectively, we need to ensure Canterbury DHB staff are well supported to do their jobs well and provide exceptional service to the community. To provide the leadership our people and community need, rebuilding the executive team has been a priority. We have appointed key executive directors to lead the DHB through the transition to enactment of the health reforms announced in April 2021.

The Government announced that all DHBs will be replaced by new health entities: Health New Zealand, a new Māori Health Authority and a new Public Health Agency. It's been signalled that there will be a 'locality model' developed which will see a series of nationally-coordinated and locally-driven agencies as part of the new health system. Finer details on how the new system will look are still to be determined.

This time of transition is unsettling for many of our people, but our mandate has not changed – to meet the health needs of our community, and we will continue to provide services to improve the health and wellbeing of Cantabrians and those on the Chatham Islands.

We continue to see successes such as:

- 94% of children fully immunised at eight months
- 94% of newborns enrolled with a PHO at three months - up 1% from last year
- 38,775 acute demand packages of care provided in community settings – a year on year increase of over 3,000
- 42,886 planned care interventions delivered – 37% above target
- 95% of patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral
- 95% of inpatients aged 75+ received a falls risk assessment - up 3% from last year
- 68% of patients felt 'hospital staff included their family/whānau or someone close to them in discussions about their care' - up 3%.

Another year meeting the challenges of COVID-19

We have all played our part in preventing COVID-19 from getting a permanent foothold in Aotearoa New Zealand to date, and it has stretched our healthcare system and our people. We are grateful to everyone who has stepped up to the challenge.

We thank everyone who has been working and supporting the Managed Isolation and Quarantine Facilities (MIQF), our contact tracers, community public health colleagues, those conducting COVID-19 testing and the health laboratories that process them. Staff have worked long hours, coped with ever changing conditions, and sometimes weathered unfair and poorly informed criticism while continuing to innovate and focus on what we are all working to achieve.

Our COVID-19 vaccination programme kicked off early in 2021 and we have been scaling up at pace, as part of our fight against the virus. We have only been able to achieve our successes through working in close partnership with mana whenua, primary health organisations, NGO providers, general practices, pharmacies, rural health, aged residential care providers and other disability and health service providers as well as community leaders – with a strong health equity focus. Thanks to this cross-system effort we are on track to deliver on our targets for 2021 which will at its peak see more than 100 vaccination clinics up and running across Canterbury.

Accelerating our Future

Accelerating our Future is a programme of work set up to identify strategies to support efficiencies and smarter ways of working and to bring the DHB back on track towards financial sustainability. Since launching the programme in July 2020, and thanks to suggestions and contributions from across the system, we realised savings of $28 million during this financial year. At the heart of this programme is our desire to continue to innovate and to focus resources where they are needed most, while maintaining or improving the health and wellbeing of our population.

The focus of Accelerating our Future has been on improving services and improving the return on our investment in health, targeting those who are most in need of support, reducing duplication and delivering services more efficiently. People, services and teams from across our system have considered how they may help, and whether changes can be made that improve equity of access to services, work smarter together, and work altogether more effectively. The programme is tracking well and we continue to improve our financial sustainability and performance.

Some of the efficiencies we have implemented include:

- Implementing digital GP letters, phasing out fax machines, and modernising clerical, administrative and non-clinical systems
- Using data and insight to inform resourcing, purchasing, and decision-making
- Identifying key drivers for increased demand and taking advantage of opportunities for teams to improve the flow of patients across the system
- Making use of technology to advance and expand services such as:
    - implementing virtual appointments for people in aged residential care to reduce ED presentations
    - securing funding to enable telehealth models to reach rural communities
    - using AVL technology to connect Corrections staff with clinical reviews to enable greater input.
- Reviewing external provider contracts to better target our most vulnerable populations and reduce access inequity
- Recognising and reducing service duplication
- Optimising internal service capacity to bring some outsourced services back in-house and so reduce outsourcing costs
- Automating aspects of service delivery such as how we manage referrals and notifications.

National Bowel Screening Programme

The National Bowel Screening Programme was expanded to include Canterbury in late 2020. By the end of June 2021, more than 31,000 people between the ages of 60 and 74 had been invited to participate and just under 62% had competed and returned their test kit, exceeding the national target of 60%.

From the tests that came back positive and needed further investigation, our gastroenterology team had completed close to 500 diagnostic tests. Cancer had been detected in 45 people during this financial year, the vast majority of whom will now have a much greater chance of a better outcome because screening has found their cancer early enough to be treated successfully.

At this rate, we look set to find around 100 cancers during the first full year of the programme here, saving many lives and improving quality of life for others through early diagnosis and treatment.

Engaging with our people – Tāngata Ora | Our People survey

We are always interested to hear what our staff have to say so we can do our best to address their needs. We ran the Tāngata Ora | Our People Survey in May 2021 and received more than 5,000 responses. The survey gave our executive team and leaders a clearer understanding of how we can better support our people to do their best work.

Some of the key themes that shone through as already working well included: staff feeling positive about their working relationship with their team and leaders, people finding their work meaningful, and being confident about their understanding of the health and safety processes in their work area.

We acknowledge that there is always room for improvement and have started working with leaders to address feedback on some of those themes: on the better use of data and insight to plan and resource workloads based on current and future demand for example, and managing reports of bullying and harassment better and addressing poor performance more effectively.

We thank everyone who took the time to provide their valuable input, enabling us to work towards supporting wellness at work, with the benefits of that work contributing to improving our care of both staff and the public.

Investing in Facilities and the Future of Care

Opening and moving some of our services into Waipapa has been a key and hugely anticipated highlight. With a building footprint of 10,450m^2, the new Christchurch Hospital building is the South Island's largest hospital building. It has been built to IL4 (Importance Level 4) standards, or 180% of 'code' – the highest level for a building designated as an essential facility that needs to be up and running, both through and after a disaster. The building has 129 base-isolators designed to keep users of the facility safer and significantly reduce the damaging effects of a major earthquake.

Thanks to the generosity of various foundations and public donations, we now have a bigger and better rooftop helipad than had been originally planned – it can take larger aircraft and allows two to land at a time as well as having a dedicated facility to stabilise patients before transfer to theatre or other care destination.

During this coming year the redevelopment of the Hillmorton Hospital campus, Te Huarahi Hou, will be a key focus for us and its phased progress will be instrumental in our ability to deliver contemporary models of care to consumers of mental health services. We are looking forward to continuing the development and enhancement of other facilities including the Selwyn Health Hub and Rangiora's new integrated primary care facility to be co-located next to the Rangiora Health Hub. These investments are designed to support the needs of our communities now and into the future.

Ko te pae tawhiti, whāia kia tata; ko te pae tata, whakamaua kia tīna

Seek out distant horizons and cherish those you attain.

Hon Sir John Hansen KNZM
CHAIR

Dr Peter Bramley
CHIEF EXECUTIVE

22 December 2021

1.2 Tohu Tūrangatanga | Statement of Responsibility

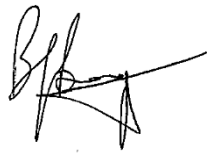
We are responsible for the preparation of Canterbury DHB's financial statements and performance information, including the performance information for an appropriation required under section 19A of the Public Finance Act 1989, and for the judgements made in them.

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 47, these financial statements and the performance information fairly reflect the financial position and operations of Canterbury DHB for the year ended 30 June 2021.

For and on behalf of the Board

Hon Sir John Hansen KNZM
CHAIR



Barry Bragg
CHAIR, QUALITY, FINANCE, AUDIT & RISK COMMITTEE

22 December 2021

2. WHAKATAUNGA | IMPROVING OUTCOMES

2.1 Ka rerekē, ka aha? | Are We Making A Difference?

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

DHBs have a number of different roles and associated responsibilities. In our governance role, we are striving to improve health outcomes for our population. As a funder, we are concerned with the effectiveness of the health system and the return on 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.

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 small number of long-term population health indicators which will help to 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 these outcome measures. Our focus is to develop and maintain positive trends over time, rather than to achieve 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 (or impact) 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. Tracking our performance against these indicators helps us to evaluate our success in areas that are important to our community, our Board and Government.

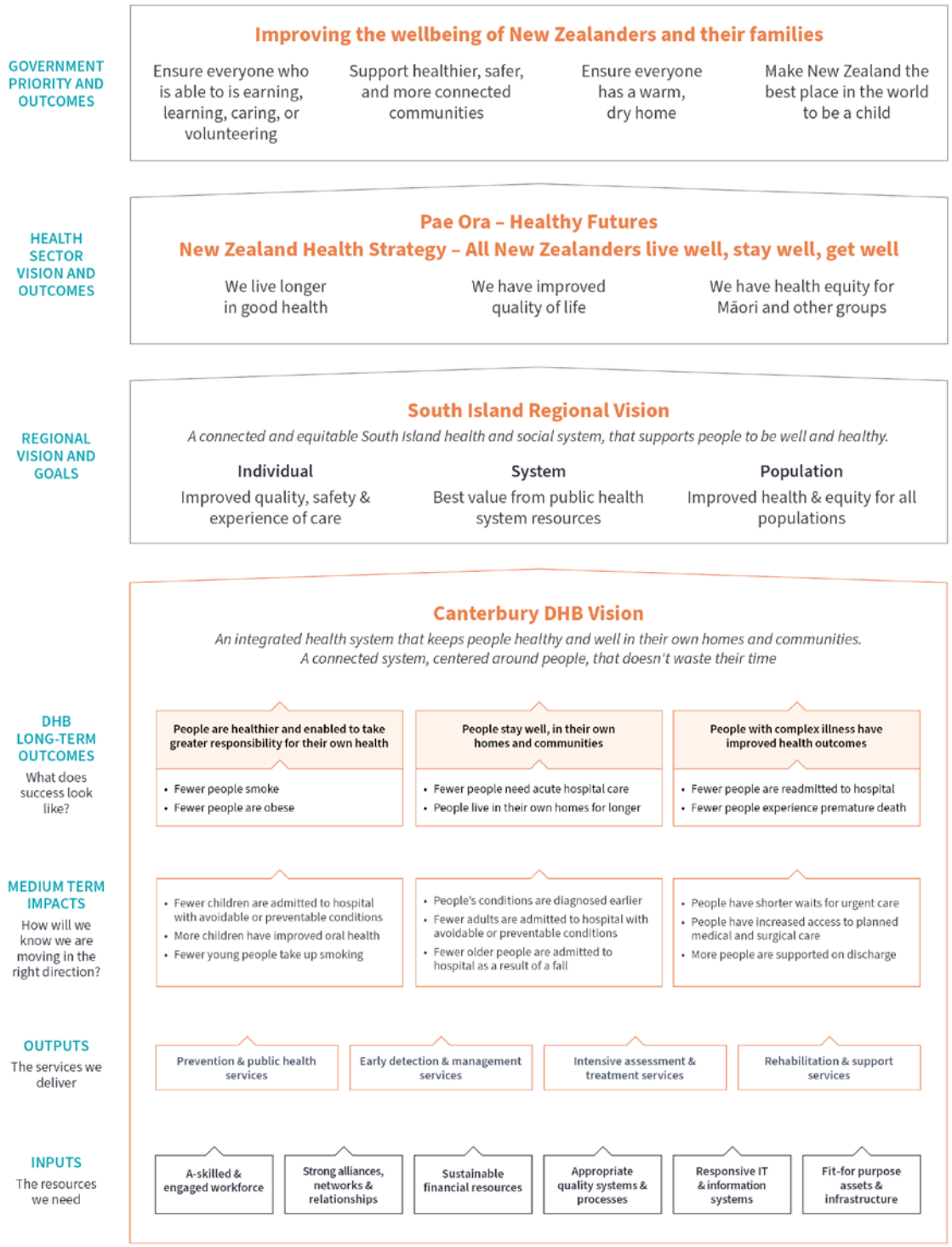
These outcomes measures sit alongside our Statement of Performance Expectations (the following section of this report), which outlines the services we planned to deliver and the standards we expected to meet in 2020/21. Collectively these measures form an essential part of the way in which we are held 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 population groups. As a means of evaluating whether we have made a difference in reducing inequities, performance has been reported by ethnicity wherever information is 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, contribute to the longer-term population health outcomes desired, and deliver on 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, Māori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

Wellbeing Outcomes

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

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions. Cancers, heart disease, musculoskeletal conditions, respiratory disease, diabetes and mental illness are major drivers of poor health and premature mortality and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates that long-term conditions make up 87.3% of all health loss in New Zealand, up from 82.5% in 1990.[1]

WHERE ARE WE FOCUSED?

Tobacco smoking, inactivity, poor nutrition and hazardous drinking and substance abuse are major risk factors for a number of the most common long-term conditions. These are modifiable risk factors and can be reduced through supportive environments and improved awareness, which enable people to take personal responsibility for health and wellbeing. Public health promotion and education services, by supporting people to make healthier lifestyle choices, will improve health outcomes for our population. Because these major risk factors also have strong socio-economic gradients, a change in behaviours will contribute to reducing inequities in health outcomes between population groups

OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

After a number of years where smoking rates in Canterbury were declining, the trend appeared to be shifting, contrary to national results. However, the 2017-20 NZ Health Survey (the latest available with DHB breakdowns) reports that 12% of our population were current smokers, compared to 14% of the New Zealand population. A positive trend is now more clear smoking rates falling from 16% in 2011/12 to 12% in 2019/20.

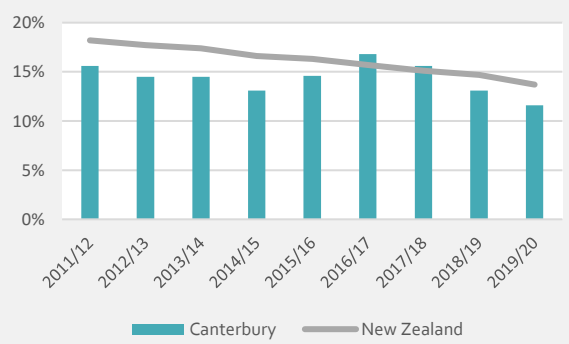
Combined results from 2017-2020 show that smoking rates continue to be highest amongst our Māori and Pacific populations. However, positively our Māori and Pacific rates dropped the most over this time period reflecting our equity focus.

Provision of brief smoking advice and cessation support was lower than we would have liked last year and an increased focus from our teams has resulted in a lift in performance. In 2020/21, 78% of smokers identified in primary care received advice and support to stop smoking (5% higher than the previous year) and 93% of smokers identified in our hospitals were provided with brief advice and support. Pregnant smokers are a key focus and 90% of pregnant women (identified as smokers) received advice and support to stop smoking in the past year.

This equates to just over 48,600 people being provided with brief advice and support in the past 12 months, with 1,591 people enrolling in Te Hā Waitaha, our local Smoking Cessation Programme.

An evaluation of engagement in Te Hā Waitaha by pregnant women in 2021/22, will help us to identify barriers and strategies to increased engagement with young Māori women who have the highest smoking rates.

Proportion of the population (15+) who currently smoke



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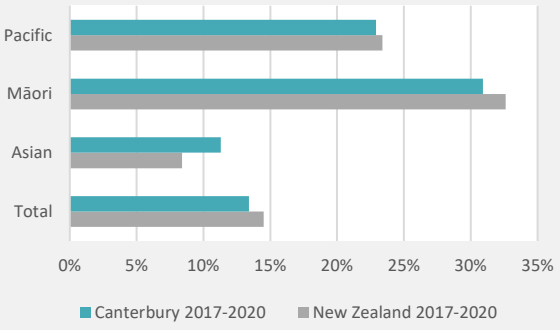


Data source: NZ Health Survey [2]

[1] Ministry of Health, Health and Independence Report 2017.

[2] The NZ Health Survey is an annual survey commissioned by the Ministry of Health which collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2019/20 Survey is the most recently released time series with regional (DHB) breakdowns available and while total population results are presented annually, ethnicity breakdowns for DHBs 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

Like smoking, obesity impacts on the quality of people's lives and is a significant risk factor for several long-term conditions. 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.

The 2019/20 NZ Health Survey reported that Canterbury's obesity rate was 7% below the national rate at 24%. Unlike the rest of the country, a steady drop in obesity rates was evident for our population across all ethnicity groups.

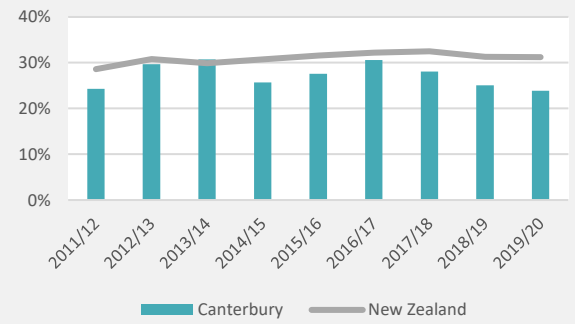
According to the Health Survey, national results have remained relatively stable with 31% of the population currently identified as obese.

We continue to identify children who may need support as part of their B4 School Check, prior to starting school. In 2020/21, 99% of children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice.

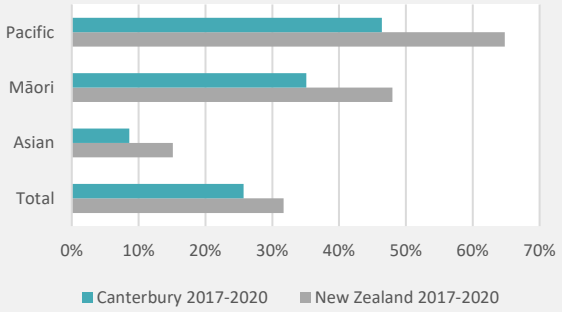
We also continue to invest in lifestyle programmes that support adults to increase their physical activity levels and make heathier choices. In 2020/21, 3,542 people were referred to the Green Prescription programme by their health professional.

A review and re design of our investment in lifestyle programmes in 2021/22 is expected to increase the focus on people at greater risk from obesity-related conditions.

Proportion of the population (15+) who were identified as obese



Proportion of the population (15+) who were identified as obese



Data source: NZ Health Survey [3]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer avoidable hospital admissions

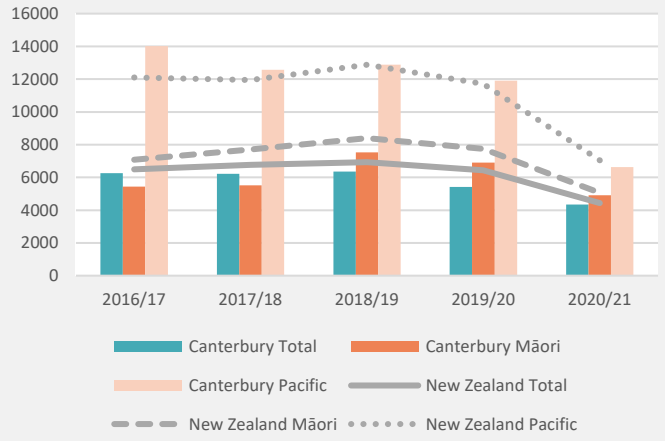
Canterbury's ambulatory sensitive hospital (ASH) admission rate for children under five reduced to 4,336 per 100,000, achieving the target and remaining below the national average of 4,432. Māori and Pacific rates both also fell between 2019/20 and 2020/21.

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system that engages earlier with children and their parents and care givers.

In the past year, 94% of all newborns were enrolled with a primary care team before three months of age, 94% of babies were fully immunised at eight months of age and 92% of all four-year-old children received their B4 School Check.

Upper respiratory and ear, nose and throat infections continue to be the driver of ASH rates in Canterbury, particularly for Pacific children. The DHB is working with Pacific providers to develop a Pacific focused Pregnancy & Parenting Education programme in 2021/22, to raise awareness and support earlier engagement with services.

Measure: Rate of Ambulatory sensitive hospitalisations for children (0-4)	2018/19	2019/20	Target	Result
	6,363	5,427	<6,871	4,336



Data Source: Ministry of Health Performance Reporting [4]

[3] The NZ Health Survey is an annual survey commissioned by the Ministry of Health which collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2019/20 Survey is the most recently released time series with regional (DHB) breakdowns available and while total population results are presented annually, ethnicity breakdowns for DHBs 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.

[4] This 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 ASH results are published three months in arrears and the results reflect the 12 months to March 2021.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Children have improved oral health

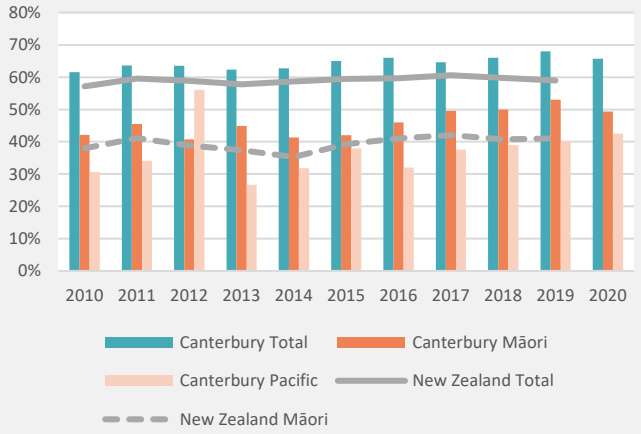
The DHB provides free oral health care for children from birth to 17 years, with a key focus on ensuring all eligible children are enrolled and examined on time.

The percentage of five-year-old children whose teeth are caries free (have no holes or fillings) fell slightly for the total and Māori populations but increased slightly (by 3%) for Pacific children. This is the fourth year that performance has improved for Pacific children in Canterbury and while the national result for 2020 is yet to be released we are confident that we continue to perform above national rates.

The DHB has been focused on improved data sharing across child services to help establish contact with families and address equity gaps. Over the past year the proportion of children aged 0-4 enrolled with our oral health services has increased by 4% to 91%.

A number of other lifestyle factors influence good oral health for young children and the DHB's focus on our maternity action plan, breastfeeding and pregnancy and parenting programmes will continue to help improve these rates in the future.

Measure: Children caries-free at age 5	2018	2019	Target	Result
	66%	68%	67%	66%



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

Fewer young people take up smoking

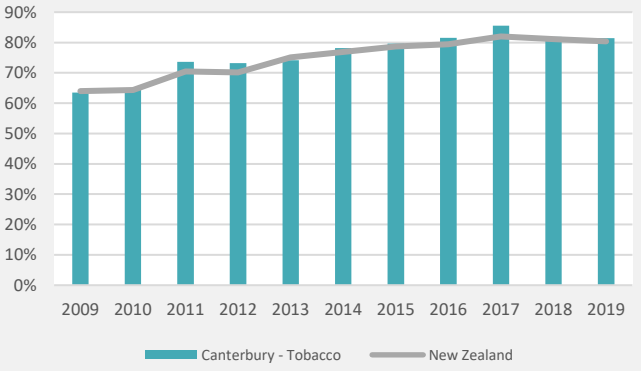
The Action on Smoking and Health (ASH) Survey is one of the largest youth smoking surveys in the world. It is a census style questionnaire that surveys 30,000 students on their smoking behaviour and attitudes.

The 2019 survey results show a slight drop from 2018, but results are relatively static, with 81% of year 10 students (age 14-15) never having smoked compared to 80% across New Zealand.

We note that a growing number of year 10 students are trying or vaping regularly. We will continue to monitor this to establish what impact vaping may have on tobacco use among young people.

Our public health team also continues to undertake controlled purchase operations to ensure that licenced premises are not selling tobacco to young people under the legal age of 18. Over the period July 2020 to June 2021, 81% of premises tested were compliant with the legislation.

Measure: 'Never Smokers' amongst Year 10 students	2018	2019	Target	Result
	82%	81%	>82%	n.a



Data Source: National ASH Year 10 Survey [6]

[5] This performance measure is a national DHB performance indicator and is reported annually for the school year. National results for 2019 were released in 2020. Results for 2020 were not available at the time of printing.

[6] The ASH Survey is a national survey used to monitor student smoking rates since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students who are aged 14 or 15 years at the time of the survey. Ethnicity breakdowns are not provided due to small survey numbers. The ASH Survey was not completed in 2020 due to COVID. Results for 2021 are expected early in 2022. For further information see www.ash.org.nz.

People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

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

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, diagnosis and treatment.

OUTCOME MEASURE – A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand. In 2020/21, 58% of admissions to Christchurch Hospital were acute.

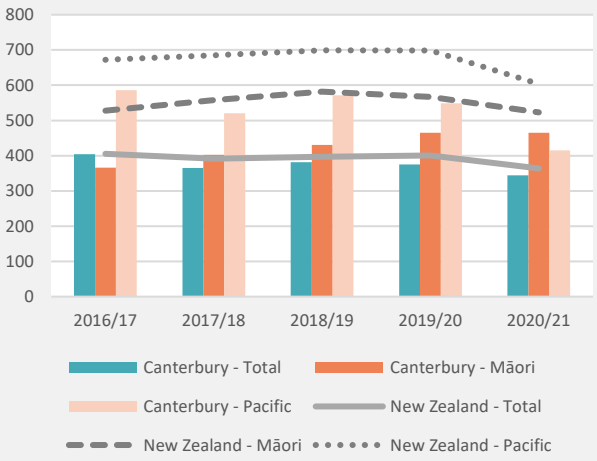
Acute hospital bed-day rates are used as a proxy indicator of improved long-term conditions management and timely access to treatment, that reduces the type of crisis and deterioration that leads to an acute hospital admission.

Canterbury's rates have dropped over the past year and remain below the national average. Pleasingly acute bed days for our Pacific population have also dropped and are now well below national rates.

Canterbury's community-based Acute Demand Management Programme continues to contribute to lower acute hospital admissions, and more than 38,000 packages of care were provided through the programme in 2020/21.

Enrolment with general practice is a key focus for the coming year and we are working with the three Canterbury PHOs and our Māori and Pacific providers to connect people into general practice and ensure they get the support they need earlier and avoid acute presentations to our hospitals.

Rate of acute hospital bed-days



Data Source: National Minimum Data Set[7]

OUTCOME MEASURE – MORE PEOPLE LIVING IN THEIR OWN HOME

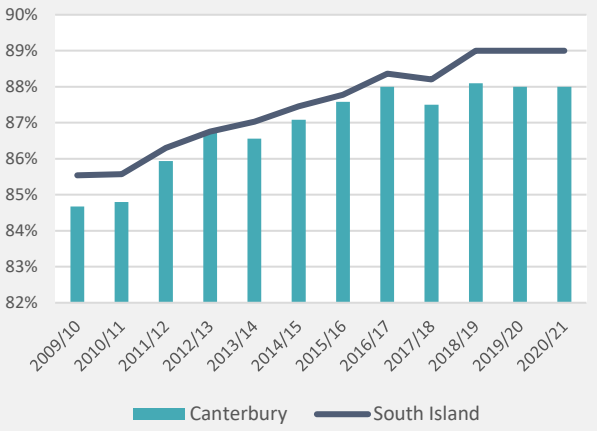
The proportion of the Canterbury population aged over 75 living in their own home has remained stable at 88%. This is a positive trend, particularly as our older population continues to grow. Our over 75-year-old population has increased by 16% over the last five years.

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

Falls are a leading cause of hospitalisation for older people in Canterbury and serious falls lead to hospitalisation, a loss of confidence, and an increased risk of admission to residential care. In 2020/21, 1,889 people accessed our community-based falls prevention programme.

We also saw an increase in the number of people supported by day care and respite services in aged residential care which, by providing a break to people or their families, helps people to remain well in their own homes for longer.

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



[7] This is a national System Level Measure, data is provided by the Ministry of Health via the national minimum data set. This measure is age standardised and presented as a rate per 100,000 people.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People's conditions are diagnosed earlier

Demand for many diagnostics including CT and MRI scans has been growing steadily for a number of years, stretching capacity across both public and private sectors and increasing wait times across the country. Several factors are driving this demand including new drug and treatment programmes that require diagnostic support, increased surgical volumes, and population growth and ageing.

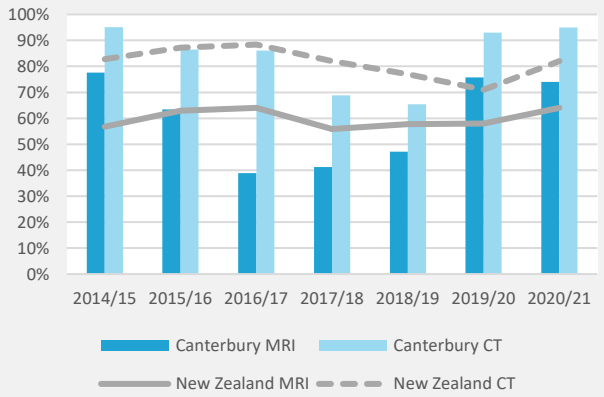
Canterbury receives the majority of specialised tertiary referrals from other South Island DHBs, this puts additional pressure on our radiology services as do lockdowns and changes in alert levels.

The DHB's radiology department has continued to work to improve patient flow and service access over the past year with additional clinics and outsourcing in place to improve throughput. We are now meeting wait time targets for CT scans and although there are still delays for MRI scans, 2,869 more MRI scans were completed within target timeframes in 2020/21 compared to the previous year.

Patient flow and diagnostic capacity remain a focus for the coming year and we are working with our radiology department to support further improvement in this area.

Measure: People receiving their non-urgent MRI or CT scan within six weeks

	2018/19	2019/20	Target	Result
MRI	47%	76%	90%	74%
CT	65%	93%	95%	95%



Fewer avoidable hospital admissions

In 2020/21, Canterbury's ambulatory sensitive hospital (ASH) admission rate for adults was 2,193 per 100,000, well below the target set, and the national average of 3,572.

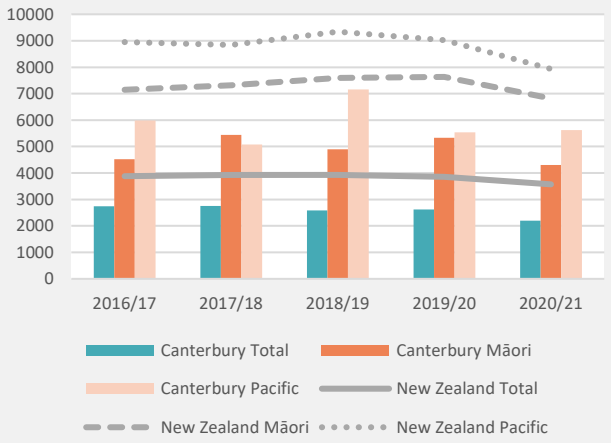
Canterbury's Māori ASH rates have dropped this year and both our Māori and Pacific rates remain well below national rates. It is difficult to pin-point individual actions to reduce these rates, due to the impact small numbers have on results and the wide range of conditions that drive ambulatory sensitive admissions. There were just seven more Pacific events compared to last year and 91 fewer Māori events. However, it is clear we still have an equity gap to address.

Good quality primary care and a well-integrated and connected health system are seen as key to improving performance against this measure. In 2020/21, 96% of adults aged 45-64 in Canterbury were enrolled with primary care and while Pacific enrolment rates are also higher with 94% of 45-64-year olds enrolled, rates for our Māori population are lower at 84%.

Increasing engagement with our Māori, Pacific and more vulnerable populations will continue to be a focus for our health system in the coming year. Equity actions have been highlighted throughout the DHB's 2021/22 Annual Plan with an emphasis on the development of kaupapa Māori services and pathways to support earlier intervention and reduce the need for hospital admissions.

Measure: Ambulatory sensitive hospitalisation for adults (45-64)

2018/19	2019/20	Target	Result
2,590	2,622	<2,561	2,193



Data source: Ministry of Health Performance Reporting[8]

[8] This measure is a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results reflect updated national data provided by the Ministry of Health in June 2021 being results for the 12 months to March 2021.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer falls related hospitalisations

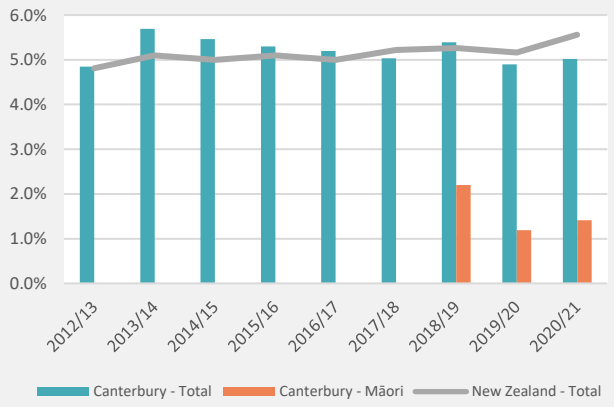
With an aging and growing older population, reducing the rate of falls leading to hospital admissions, reflects a significant investment for the Canterbury health system. Our focus on falls prevention is crucial in supporting people to stay well and independent and reducing demand on services across our health system.

At 5.0%, the proportion of our population (75+) admitted to hospital as a result of a fall in 2020/21 increased slightly compared with the previous year. However, this rate is still well below the national average of 5.6%.

In 2020/21, 1,889 older people accessed our community-based falls prevention programme and over 11,856 people attended group strength and balance classes. We also provided 95% of older people in our hospitals with a falls risk assessment to help them stay safe during their stay.

The rate for Māori admitted to hospital as a result of a fall increased slightly to 1.4%, however the small numbers mean this rate can fluctuate from year to year. We continue to monitor results and support access to services in this area.

Measure: Population (75+) admitted to hospital as a result of a fall	2018/19	2019/20	Target	Result
	5.4%	4.9%	<5.5%	5.0%



Data Source: National Minimum Data Set

People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

As the primary provider of hospital and specialist services in Canterbury, this goal also considers the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment, or unnecessary waits can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population, people's experience of care, and their confidence in the health system. Ineffective or poor quality treatment and long waits for treatment also waste resources and add unnecessary cost.

WHERE ARE WE FOCUSED?

We are in the midst of a significant facilities redevelopment and repair programme and we are transforming the way we deliver services to increase capacity with the resources we have available. We are focusing on improving the flow of patients across our system and reducing duplication of effort to maintain service access, while reducing waiting times for treatment. We also aim to increase the value from our investment in technology to support clinical decision making and improve the quality of the care we provide.

OUTCOME MEASURE – A REDUCTION IN AMENABLE MORTALITY

Amenable mortality rates are produced in arrears by the Ministry of Health. The latest rates are positive, with both total population and Māori rates dropping for Canterbury 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.

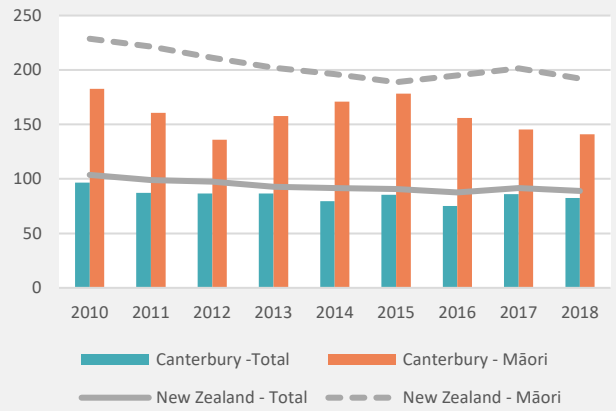
Cancer is one of the leading causes of mortality in Canterbury and contributes to a high proportion of premature deaths. The DHB continues to achieve national Faster Cancer Treatment targets with 95% of people provided with urgent cancer treatment within the target timeframe in 2020/21.

In the past year 2,219 people had a skin lesion removed in primary care without the need (or wait) for a hospital appointment, and 92% of people identified with diabetes had an HbA1c test to monitor and support the management of their diabetes condition (4% higher than the previous year).

The DHB's team also works closely with community-based service providers to ensure a strong continuum of care for people with mental illness and addictions. We continue to support access to brief intervention counselling (BIC) in general practice with 6,377 people accessing BIC support in Canterbury in 2020/21. We are also implementing the Te Tumu Waiora programme to further reduce barriers and wait times for mental health and addictions support in primary care and supporting youth mental health and addiction providers through the CYMHS and Manu Ke Rere networks to address the growth in demand for child and youth services.

Māori are disproportionately impacted by mental illness and addictions and in the coming year we will partner with iwi to undertake a collective redesign process to better tailor our mental health and addictions services to support and achieve equity of outcomes for our Māori population.

Measure: rate of amenable mortality for people aged under 75 (age standardised, per 100,000 people)



Data Source: National Mortality Collection[9]

[9] Performance data for this measure is sourced from the national mortality collection which is three years in arrears. 2018 results are the latest publicly available.

OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

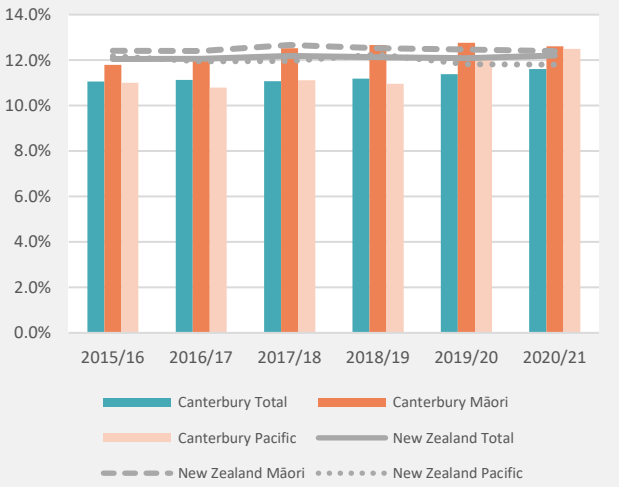
Lower readmission rates are important, as patients who are readmitted to hospital within 28 days of discharge are more likely to experience negative long-term outcomes. Readmissions also reduce public confidence in our health system and increase costs for the system.

Canterbury's readmission rates have remained relatively static for some time and despite a very slight 0.2% increase on last year, our total population rate remain lower than the national average.

Our community-based supported discharge service (CREST), provides home-based rehabilitation to support older people on discharge from hospital and provided care to 1,622 people in 2020/21. Over 9,000 people were also supported by district nursing for support with issues such as wound care and medications management, and more than 8,100 people were supported by home-based support services as part of a restorative package of care aimed at enabling people to stay in their own homes for longer.

The DHB is looking at community rehabilitation, after-hours and palliative support services in rural areas in the coming year, to ensure that people have equitable access to services irrespective of where they live in Canterbury. This work will help to support people to recover or manage their acute episodes of care without the need for a hospital admission.

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



Data Source: National Minimum Data Set[10]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

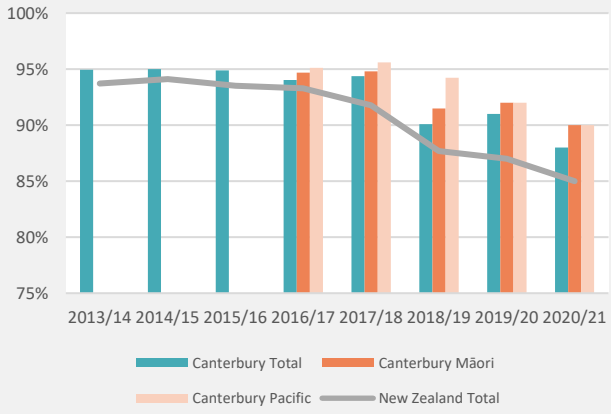
People have shorter waits for urgent care

The increasing numbers of people presenting to emergency departments for treatment are putting urgent care services under pressure across the country. Nationally 85% of people presenting in 2020/21 were seen within the six-hour wait time target with performance dropping compared to the previous year.

Canterbury wait times are following a similar trend. In 2020/21, over 116,500 people presented an emergency department in Canterbury, a 11% increase on the number of presentations in the previous year. The number of people seen within the national wait time target dropped 3%.

Many complex behavioural, social and environmental factors are contributing to this increase in demand. A local improvement programme "Making the System Flow" was initiated in 2021 to identify strategies across both primary and secondary services to improve patient flow, to ensure people are presenting to the right place in the system and reduce barriers to care and unnecessary waits in our system. This will continue to be a key focus for the DHB and our primary care partners in the coming year and actions are highlighted throughout our 2021/22 Annual Plan.

Measure: People are admitted, discharged or transferred from ED within 6 hours	2018/19	2019/20	Target	Result
	90%	91%	95%	88%



Data Source: National Minimum Data Set[11]

[10] The acute readmission rate results are provided nationally, three months in arrears, and results reflect the 12 months to March 2021.

[11] This indicator is a national DHB performance measure and excludes those who did not wait in ED or had pre-arranged appointments.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for planned care

Canterbury DHB's performance against the Elective Services Patient flow Indicators (ESPIs) improved in 2020/21, with waiting times dropping for First Specialist Assessments (ESPI 2) and for treatment (ESPI 5).

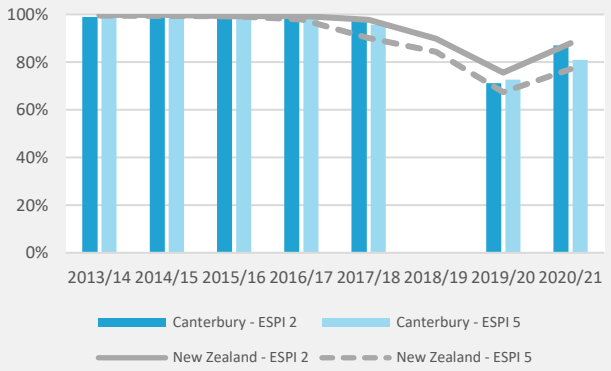
This improvement reflects the hard work of our specialist teams to ensure people are triaged and seen in a timely manner and is particularly noteworthy considering the backlog of rescheduled appointments and procedures that were cleared at the beginning of the year, following the COVID-19 lockdown in 2020.

In 2020/21 our DHB and primary care teams delivered 42,886 planned care interventions, a combination of elective surgeries, minor procedures and non-surgical interventions. This was 37% above the DHB's target for the year of 31,345.

We still have some way to go to meet national wait time targets and COVID-19 continues to impact some services with recruitment challenges due to national specialist shortages, delays in bringing new staff in from overseas and ongoing alert level changes throughout the year.

The DHB has a Planned Care Improvement Plan, focused on ESPI recovery, which will be implemented in 2021/22.

Measure: People receiving specialist assessment and treatment within set timeframes.		2018/19	2019/20	Target	Result
	ESPI 2	n.a.	71%	100%	87%
	ESPI 5	n.a.	73%	100%	81%



Data Source: Ministry of Health Quickplace Warehouse [12]

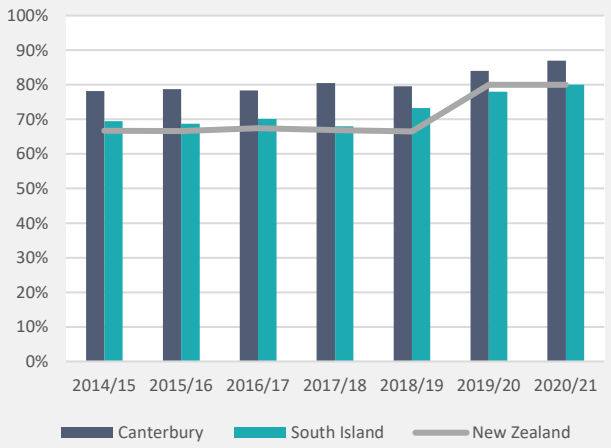
People Are Supported on Discharge

Research indicates that people who have had a psychiatric admission have increased vulnerability immediately following discharge, including risk of readmission and a higher risk of suicide. Those leaving hospital with a formal discharge plan and links to community-based services and supports, are less likely to experience early readmission or an adverse event.

This indicator is a marker of good discharge planning, service integration and continuity of care between hospital and community services and Canterbury's performance has been above the national target and the national average for the past six years.

The DHB's team works closely with community-based service providers to ensure a strong continuum of care and pathways of support for people accessing our services. The focus for the coming year includes the development of a pathway for Pacific people with mental illness to transition from specialist to community services and we are working with our strategic partner, Pasifika Futures, to support this work in 2021/22.

Measure: Inpatients accessing community-based MH and AOD services within seven days of discharge	2018/19	2019/20	Target	Result
	80%	84%	80%	87%



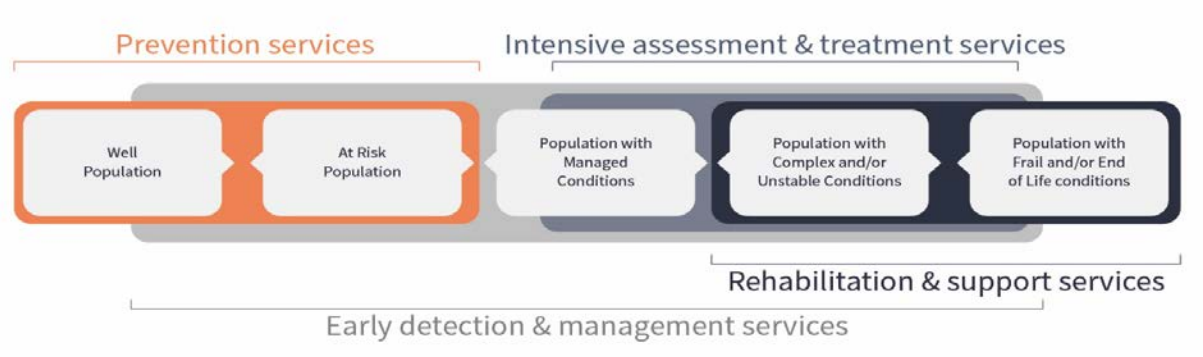
Data Source: National Mental Health KPI Framework. [13]

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

[13] Data for this measure is provided via the national KPI programme.

3. Ā MĀTOU PUAKITANGA | DELIVERING ON OUR PLANS

3.1 Te Tauākī a Ngā Mahi | Statement of Service Performance



Evaluating our performance

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

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes, encompassed in our Outcomes Framework. These longer-term health indicators are highlighted on the previous pages.

We also evaluate our performance on an annual basis by providing a forecast of the services we plan to deliver and the standards we expect to meet. The statement of service performance set out in this section presents the DHB's performance against the 2020/21 forecast, presented in our Statement of Performance Expectations available on our website.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service delivered, services have been grouped into four service classes. These are common to all DHBs and reflect the types 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 identified a mix of service measures that we believe are important to our community and stakeholders and will 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 enough of the right people received the service, or whether the service was delivered at the right time.

To ensure a balanced, well rounded picture, the mix of measures identified address four key aspects of service performance that matter most to our population:

Access (A)

Are services accessible, is access equitable, are we engaging with all of our population?

Timeliness (T)

How long are people waiting to be seen or treated, are we meeting expectations?

Quality (Q)

How effective is the service, are we delivering the desired health outcomes?

Experience (E)

How satisfied are people with the service they receive, do they have confidence in us?

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 27.

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 2020/21 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

2020/21 PERFORMANCE

Going into the 2020/21 year, Canterbury was still contending with an operational backlog related to the COVID-19 lockdown in 2020 which necessitated the postponement of deferrable services and the temporary closure of many community-based services.

It was difficult to predict the impact of COVID on our health system, but we knew that a number of the national standards could be difficult to meet as we addressed the backlog from the previous year and anticipated ongoing constrains in our environment.

While there were no further lockdowns for our region in 2020/21, several COVID-19 outbreaks in other parts of the country led to alert level restrictions in Canterbury which put pressure and restrictions on service delivery through the year, particularly with regards to community-based group programmes and mental health and aged residential services.

The work required to reschedule appointments and catch-up on service delivery is not insignificant and we are grateful to all the people working in our system who made it possible for us to reengage with people and get back on track with service delivery this year.

People's ongoing commitment and dedication has meant we have delivered on or improved performance against the majority of our service targets for the year. Considering the environmental and workforce constraints experienced these are pleasing results.

A number of pressure areas related to COVID are evident in the results.

National workforce shortages are reducing capacity in some specialist services, with fewer people migrating from overseas and long recruitment delays related to limited space in managed isolation. Diagnostic services have been impacted with international shortages of radiology and endoscopy resources impacting on wait times in this area.

General practice and pharmacy are stretched with additional requirements around streaming, testing and supporting COVID vaccinations reducing overall capacity. We have seen an increase in the number of practices limiting enrolments and we are working closely with our PHO partners to address this challenge and ensure people have access to care.

Public confidence levels and behaviours also appear to have changed, along with resilience levels across our community. Increased acute presentations to urgent care, emergency and mental health services felt in Canterbury are reflective of national patterns, with drivers being complex in nature.

Our response to these pressures is highlighted through our Annual Plan for the coming year with a strong focus on equity, patient flow and ensuring the clinical and financial sustainability of our system.

We have included three additional measures to the Statement of Service Performance to help highlight to the reader the use of health system resources in responding to COVID. These cover the delivery of service locally and the support the Canterbury system has provided to other DHBs around the country looking at both COVID testing and the delivery of COVID vaccinations. Footnotes have also been added where it has been clear that performance has been impacted by COVID.

NOTES FOR THE READER

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

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) is reported as the annual result.

◆ The measure is a core Māori health measure. Refer to page 27 for a breakdown of results by ethnicity.

Performance Key		
	Rating	Criteria
✓	Achieved	Standard reached.
↺	Partially Achieved	Standard not reached but performance has been maintained or improved or the equity gap between population groups has been reduced.
✖	Not Achieved	Standard not reached and performance has dropped.

E Some services are demand driven. It is not appropriate to set targets for these services, but service volume estimates are provided to give context in terms of the use of resources across our health system and the direction of travel.

Performance Key for Estimated Volumes		
	Rating	Criteria
✓	Achieved	Performance is moving in the indicated (desired) direction of travel or is within 10% of estimated volumes.
✖	Not Achieved	Performance is moving against the desired direction of travel or variance is greater than 10% of estimated volumes.

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services are those that promote and protect the health of the whole population, or targeted sub-groups, and influence individual behaviours by targeting changes to physical and social environments to engage, influence and support people to make healthier choices.

By supporting people to make healthier choices, the DHB can reduce the major risk factors that contribute to poor health such as smoking, poor diet, obesity, lack of physical exercise and hazardous drinking. High-need population groups are more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore be a very cost-effective health intervention.

SERVICE PERFORMANCE 2020-2021

Population Protection Services – Healthy Environments							
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q[14]	42	96	E.70	43	-	✗
Licensed alcohol premises identified as compliant with legislation	Q[15]	93%	100%	90%	92%	-	✓
Networked drinking water supplies compliant with Health Act	Q[16]	93%	84%	97%	n.a	n.a	-

Health Promotion and Education Services							
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement and healthier choices.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Mothers receiving breastfeeding and lactation support in the community	A	861	861	>600	943	-	✓
Babies exclusively/fully breastfed at three months	Q◆	62%	62%	70%	62%	59%	↺
People provided with a Green Prescription (GPX) for additional physical activity support	A[17]	4,818	5,158	>3,500	3,542	-	✓
GPX participants more active six to eight months after referral	Q[18]	n.a	n.a	>50%	n.a	-	-
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q◆	82%	73%	90%	78%	76%	↺
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q◆	92%	84%	95%	93%	-	↺
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q◆	86%	93%	90%	90%	-	✓

[14] Due to ongoing involvement of public health staff in COVID response work our Community & Public Health (CPH) team have had to prioritise the completion of submissions based on the public health issues addressed and the availability and capacity of CPH staff.

[15] The measure relates to Controlled Purchase Operations (CPO) which involve sending supervised volunteers (under 18 years) into licensed premises. Compliance can be 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. Due to the reprioritisation of CPH staff, no CPOs were conducted in the period 1 July 2020 to 31 December 2020. CPO compliance in this instance refers to the period 1 January 2021 to 30 June 2021.

[16] This measure relates to the percent of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. Water quality reports are published one year in arrears with 2019/20 being the latest available at the time of printing.

[17] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. The reduction in Green Prescription referrals reflects the rollout of the new Te Tumu Waiora service in Canterbury. We have seen a significant drop in referrals from practices who had Health Improvement Practitioners and Health Improvement Coaches introduced into their practices, supporting enrolled patients with nutritional and activity focused advice as part of the wider mental health and wellbeing response.

[18] The DHB has been advised that the biannual survey, which tracked patient activity following referral, is no longer being undertaken by the Ministry of Health. Sport Canterbury is now undertaking the survey with the first full year results expected in 2021/22.

Population-Based Screening Services

These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Four-year olds provided with a B4 School Check (B4SC)	A◆	96%	90%	90%	92%	88%	✓
Four-year olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q◆	100%	99%	95%	99%	93%	✓
Women aged 25-69 having a cervical cancer screen in the last three years	A[19]◆	72%	70%	80%	73%	70%	↺
Women aged 50-69 having a breast cancer screen in the last two years	A[20]◆	75%	75%	70%	76%	68%	✓

Immunisation Services

These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Children fully immunised at eight months of age	A[21]◆	94%	94%	95%	94%	88%	↺
Proportion of eight-month olds 'reached' by immunisation services	Q	98%	98%	95%	97%	94%	✓
Young people (Year 8) completing the HPV vaccination programme	A[22]❖◆	n.a	62%	75%	64%	63%	↺
Older people (65+) receiving a free influenza ('flu') vaccination	A[23]❖◆	62%	64%	75%	74%	67%	↺
Number of COVID-19 vaccinations delivered in Canterbury	A[24]◆	-	-	95,568	97,106	-	✓
Proportion of the eligible Canterbury population fully vaccinated (i.e. receiving two doses)	C[25]◆	-	-	-	9.1%	11.5%	-

[19] Canterbury's result has improved since last year and, while still below the national target, is above the national average. We are pleased the result is heading in the right direction. The number of screens completed for the total population increased by 5,196 compared with the previous year.

[20] Breast screening results are released quarterly by the Ministry of Health. At the time of publishing, the June 2021 results were not available, the year-end result reflects the two years to March 2021.

[21] Canterbury's childhood immunisation programme was impacted through the year by redeployment of NIR, LinKIDS, outreach and public health nursing staff to support the COVID vaccination programme. Despite the workforce pressures and interruptions, we have maintained our performance overall and delivered the second highest total population coverage rate in the country and the third highest coverage rate for Māori.

[22] The Human Papillomavirus (HPV) vaccination programme consists of two vaccinations and is free to young people under 26 years of age. In 2020/21, 575 more young people were immunised than the previous year.

[23] Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. A heightened awareness of respiratory illness in 2020/21 has resulted in increased vaccinations for Canterbury's older population with a big push to ensure vulnerable populations are protected. In 2020/21 Canterbury delivered 11,012 more vaccinations to over 65+ population compared to the previous year.

[24] These measures have been added to the Statement of Performance as a measure of significant interest to our population. The vaccination numbers for the first measure reflect total COVID vaccinations delivered in Canterbury and may include some vaccinations delivered to people who were working or visiting the Canterbury region but who are not domiciled or enrolled here. The target reflects the number agreed with the Ministry of Health as part of vaccination rollout plan and vaccination data has been provided by the Ministry of Health. The total number of vaccinations delivered includes: 58,301 first dose vaccinations and 38,805 second dose vaccinations. Total vaccinations delivered by sequencing group includes: 19,558 delivered to Group 1, 68,194 delivered to Group 2, 7,086 delivered to Group 3 and 2,268 delivered to Group 4.

[25] Fully vaccinated is defined as two doses having been administered to an individual and people eligible for the COVID vaccination programme refers to those aged over 16, which was the age band at the time. The proportion fully vaccinated includes Canterbury residents receiving two doses of the COVID vaccine irrespective of where they received those doses – i.e. overseas or in another DHB region. The proportion of the population vaccinated includes: 6.5% of our Māori population; 8.5% of our Pacific population and 11.7% of our Asian population. There was no population coverage target set for the programme in 2020/21. In line with national reporting by the Ministry of Health, the proportion of the population fully vaccinated at 30 June 2021 has been calculated using the Health Service User (HSU) population. There is an acknowledged difference between the Statistics New Zealand projected population and the HSU population used nationally for tracking the COVID vaccinations programme delivery, however the HSU population enables closer matching for demographics such as location and ethnicity. Further information relating to the national definitions and calculation of these measures can be found along with a comprehensive breakdown of COVID reporting in the Ministry of Health 2020/21 Annual Report.

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.

SERVICE PERFORMANCE 2020-2021

General Practice Services							
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Newborns enrolled with a PHO by three months of age	A◆	95%	93%	85%	94%	89%	✓
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A[26]◆	93%	95%	95%	94%	94%	✗
Young people (0-19) accessing brief intervention counselling in primary care	A[27]Δ	552	435	>500	470	-	↺
Adults (20+) accessing brief intervention counselling in primary care	AΔ	6,353	6,187	>5,500	5,907	-	✓
Number of skin lesions (growths, including cancer) removed in primary care	AΔ	2,404	2,322	>2,000	2,219	-	✓
Number of integrated HealthPathways in place across the system	Q[28]	699	685	E.>600	832	-	✓
Proportion of general practices using the primary care patient experience survey	E	79%	85%	>65%	86%	-	✓

Long-Term Condition Services							
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Number of spirometry tests provided in the community rather than in hospital	AΔ	2,426	2,128	>2,000	2,713	-	✓
People receiving subsidised diabetes self-management support when starting insulin	AΔ	379	320	>300	365	-	✓
Population identified with diabetes having an HbA1c test in last year	A[29]Δ◆	90%	88%	>90%	92%	-	✓
Population with diabetes having an HbA1c test and acceptable glycaemic control	QΔ◆	72%	71%	>60%	72%	-	✓

[26] Population growth within Canterbury appears to be a factor in the lower enrolment rate this year, compounded by a number of general practices limiting enrolments or closing their books to new enrolments. Canterbury's enrolment rate fell during 2020/21 for both the total population and the Māori population despite the total number of people enrolled increasing by 11,319 people compared to the previous year.

[27] The Brief Intervention Counselling (BIC) service supports people with mild to moderate mental health concerns, including depression and anxiety, providing free counselling sessions (or extended consultations) both face-2-face and phone consultations. There has been a decrease in BIC delivery by PHOs in 2020/21 as alternative youth focused mental health and addiction service options and the Te Tumu Waiora primary mental health support programme are embedded. This change is not unexpected as people are offered more service options.

[28] The increase in HealthPathways reflects an increased in the number of pages created in response to COVID and a change in the way some pages are counted, with pages having been split out into individual pathways to provide additional clarity for services. A review of pathways was undertaken in 2020/21 and is expected to lead to continued changes in the HealthPathways site in the coming year.

[29] An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's diabetes. A level of less than 64mmol/mol reflects an acceptable blood glucose level. There were 2,016 more people having an annual test in 2020/21 compared with the previous year.

Oral Health Services							
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Children (0-4) enrolled in DHB funded oral health services	A[30]❖◆	83%	86%	95%	91%	-	↺
Enrolled children (0-12) receiving their oral health exam according to planned recall	T❖◆	88%	87%	90%	88%	-	↺
Adolescents (13-17) accessing DHB funded oral health services	A❖	66%	62%	85%	64%	59%	↺

Pharmacy and Referred Services							
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision making and reduces unnecessary delays in treatment.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Number of laboratory tests completed for the Canterbury population	A[31]Δ	2.9m	2.8m	E<2.8m	3.4m	-	✖
Number of COVID-19 Laboratory tests processed	A[32]	-	-	-	207,401	-	-
Number of subsidised pharmaceutical items dispensed in the community	A[33]Δ	7.0m	7.6m	E<8m	8.7m	-	✖
People on multiple medications receiving medication management support	A[34]Δ	1,434	896	>1,200	652	-	✖
People (65+) being dispensed 11 or more long-term medications (rate per 1,000)	Q[35]❖	4.0	4.0	E<4.1	n.a	n.a	-
Number of community-referred radiology tests completed	AΔ	55,038	51,614	E>40,000	59,864	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T[36]	77%	80%	90%	72%	91%	✖
People receiving their Magnetic Resonance Imaging (MRI) scans within six weeks	T[37]	47%	76%	90%	74%	64%	✖
People receiving their Computed Tomography (CT) scans within six weeks	T[37]	65%	93%	95%	95%	82%	✓

[30] Early and regular contact with oral health services helps to set lifelong patterns, which have lasting benefits in terms of improved nutrition and healthier body weights and reduce risk factors such as poor diet. Canterbury's LinKIDS service continues to support improved enrolment rates, with the number of children aged 0-12 enrolled in oral health services increasing by 7,027 children between 2019 and 2020. The service is working to increase timeliness of examinations and to keep up with the increasing enrolment numbers.

[31] The growth in community lab tests completed reflects population growth and increased demand across the region.

[32] This number reflects the COVID tests processed by the Canterbury DHB's Laboratory Services during the 2020/21 financial year - irrespective of where the person being tested lived. Canterbury Health Laboratories provided significant support to the North Island DHBs in 2020 and 2021. This measure has been added to the Statement of Service Performance as a measure of significant interest to our population, there was no estimate set in 2020/21.

[33] Changes to national pharmacy expectations, in response to supply restrictions, led to increased dispensing over the past year with prescriptions for three-month supplies being reduced to one month at a time for some medications. While pharmaceutical growth is not unexpected as our population grows and ages, this increasing demand is an area of focus for the DHB in the coming year.

[34] The Medical Management Review programme helps to ensure the safe and appropriate use of medications. Service levels have dropped over the last two years, coinciding with the COVID-19 outbreak and additional demands on pharmacy teams from increased dispensing activity due to more interruptions to medicine supply chains, an increased focus on the delivery of vaccinations by pharmacy, restrictions in service delivery through lockdown and alert level changes and workforce pressures. We will be reviewing the sustainability of this programme in the coming year.

[35] Data is sourced from the HQSC Atlas of Healthcare Variation – results for 2020 are yet to be released nationally.

[36] Recruitment challenges and staffing shortages have meant we have not been able to open two additional procedure rooms as early as hoped and this has impacted on our ability to meet demand. We are taking a collaborative approach with our outsourcing/outplacing providers and working with our neighbouring DHBs to reduce wait times as we work to increase our internal capacity.

[37] Demand for CT and MRI scans remains high and continues to impact wait times. Additional clinics are being held as well as outsourcing to improve throughput. We are pleased CT wait times have improved compared with the previous year. There were 6,672 more CT scans reported within timeframes and 2,869 more MRI scans completed within the target timeframe compared to 2019/20.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are those more complex services provided by health professionals and specialists working closely together to respond to the needs of people with more severe, complex or life-threatening health conditions. They are usually (but not always) provided in hospital settings, which enables the co-location of specialist expertise and equipment. Some services are delivered in response to acute events, others are planned, and access is determined by clinical referral and triage, treatment thresholds and national service coverage agreements.

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

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

SERVICE PERFORMANCE 2020-2021

Quality and Patient Safety							
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Staff compliant with good hand hygiene practice	Q[38]◇	82%	82%	80%	84%	86%	✓
Inpatients (aged 75+) receiving a falls risk assessment	Q◇	98%	92%	90%	95%	87%	✓
Response rate to the national inpatient patient experience survey	E[39]	24%	19%	>30%	16%	-	✗
Proportion of patients who felt 'hospital staff included their family/ whānau or someone close to them in discussions about their care'	E	50%	65%	>65%	68%	-	✓

Specialist Mental Health and Alcohol and Other Drug (AOD) 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 demand for services, is indicative of a responsive and efficient service.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Proportion of the population (0-19) accessing specialist mental health services	A$^{\Delta}$	3.7%	4.1%	>3.1%	4.3%	4.0%	✓
Proportion of the population (20-64) accessing to specialist mental health services	A$^{\Delta}$	3.9%	4.0%	>3.1%	3.7%	3.9%	✓
People referred for mental health and AOD services seen within three weeks	T[40]	70%	67%	80%	70%	76%	↺
People referred for mental health and AOD services seen within eight weeks	T	88%	83%	95%	88%	92%	↺

[38] Results for 2020/21 for hand hygiene refers to the last completed quarter January to March 2021, falls assessments results are for March to June 2021. Further detail and results for previous years can be found at www.hqsc.govt.nz.

[39] A slightly higher number of people responded to the patient survey than in the previous year (8,831 in 2020/21 compared with 7,511 in 2019/20) but the number of surveys sent out was higher this year. We are not surprised at the reduction in responses with the increased stressors in people's lives over the past two years and are focused on following up on the feedback from the surveys to improve the quality of the services we provide.

[40] Mental health wait time results are provided three months in arrears and results reflect the twelve months to March 2021. Continued demand and the increased complexity of people accessing our specialist mental health and addiction services puts pressure on our capacity to respond quickly. The DHB has invested in an acute alternative in the community with a community provider offering a peer-led residential service that works closely with specialist services to provide options for people with acute needs. We have supported a network of providers to expand mental health and addictions support for young people and the Te Tumu Waiora primary mental health service is in place in the region with Health Improvement Practitioners and Health Coaches operating out of general practice to enable an earlier response to people's mental health needs. We expect that this investment will reduce demand over time by supporting earlier intervention for our population.

Maternity Services							
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Women registered with an LMC by 12 weeks of pregnancy	A[41]✧◆†	79%	n.a	80%	n.a	-	-
Number of maternity deliveries in Canterbury DHB facilities	A	6,044	5,943	E. 6,000	6,236	-	✓
Proportion of maternity deliveries made in primary birthing units	Q	16%	16%	>13%	16%	-	✓

Acute and Urgent Services							
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Number of acute packages of care provided in community settings	A[Δ]	35,393	35,547	>30,000	38,775	-	✓
Number of presentations at Canterbury emergency departments	A[42]	101,130	104,907	E.<110k	116,599	-	✓
Proportion of the population presenting in ED (per 1,000 people)	Q[42]	178	181	<190	202	230	✗
People admitted, discharged or transferred from ED within 6 hours of presentation	T[43]	90%	91%	95%	88%	85%	✗
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral.	T	94%	96%	90%	95%	87%	✓

Elective and Arranged Services							
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Number of First Specialist Assessments provided	A[44]	66,982	55,218	E.>60,000	55,891	-	✓
Proportion of people that wait <4 months for their First Specialist Assessment	T◇	n.a	71%	100%	87%	88%	↺
Proportion of First Specialist Assessments that were non-contact (virtual)	Q[45]	21%	n.a.	>15%	14%	-	✗
Proportion of people that wait <4 months from a commitment to treat to treatment	T◇	n.a	73%	100%	81%	77%	↺
Number of planned care interventions delivered	A[46]	new	31,013	31,345	42,886	-	✓
Proportion of people receiving their surgery on the day of admission	E	87%	85%	>85%	90%	-	✓
Number of outpatient consultations provided	A	653,717	630,837	E.>650k	675,407	-	✓
Outpatient appointments where the patient was booked but did not attend	Q	5%	4%	<5%	4%	-	✓

[41] Data is sourced from the national Maternity Clinical Indicators report. Results for 2019 and 2020 are yet to be released.

[42] Performance reflects a national pattern of increased acute demand and ED presentations in 2020/21. It is likely that reduced general practice capacity from closed and limited enrolments is contributing to this demand; we are working with our PHO partners to address pressures.

[43] This indicator is a national DHB performance measure and excludes those who did not wait in ED or had pre-arranged appointments. Wait times have been impacted by the significant growth in ED presentations in the past year. A programme of work ('making our system flow') is underway, focused on reducing presentations to the ED and improving the flow of patients across our hospital services to reduce wait times.

[44] A First Specialist Assessment (FSA) is the assessment undertaken by a specialist following referral by a patient's primary care practitioner to determine the treatment to be delivered. An increasing number of minor procedures and non-surgical interventions are being delivered in primary care settings, which can result in fewer FSAs being required. These interventions help to ensure we make best use of specialist surgical capacity to meet demand and reduce patient wait times.

[45] A change in how non-contact FSAs are recorded from July 2019 has resulted in fewer non-contact events compared with 2018/19.

[46] The planned care intervention measure recognises the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing, including those delivered in community settings. There were 22,752 minor procedures completed in 2020/21 - 9,776 more than 2019/20 and 862 additional inpatient surgical interventions.

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.

SERVICE PERFORMANCE 2020-2021

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. Service utilisation is monitored to ensure people are appropriately supported after an event.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
People accessing community-based pulmonary rehabilitation courses	A[47] Δ	275	227	>250	215	-	✗
People (65+) accessing the community-based falls prevention service	A	2,127	1,852	>1,500	1,889	-	✓
People supported by the Community Rehabilitation and Support Team (CREST)	AΔ	1,933	1,686	>1,600	1,622	-	✓
Proportion of inpatients referred to an organised stroke service after an acute event	Q[48]	84%	86%	80%	72%	-	✗
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q	88%	84%	>80%	85%	-	✓

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 a specific health need can be addressed. Largely demand driven, service utilisation is monitored to ensure services are accessible.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
People supported by community-based mental health crisis respite	A[49]Δ	1,052	754	E.1,000	854	-	✗
Occupancy rate of mental health crisis respite beds	AΔ	88%	74%	85%	68%	-	✗
Older people supported by day care services	A[50]Δ	578	297	E.>550	497	-	✗
Older people accessing aged care respite services	A[51]Δ	1,101	1,192	E.<1,000	1,205	-	✗
People supported by aged care respite services being discharged to their own home	QΔ	89%	88%	>80%	88%	-	✓

[47] Pulmonary rehabilitation programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (obstructive lung disease) to manage their symptoms and better manage their condition. There has been a reduction in numbers attending in the first quarter of 2020/21 possibly a continued impact of COVID lockdowns as courses were re-established and people were re-engaging in the programme.

[48] This measure relates to people transferred to a stroke unit within 24 hours of admission. The move to the new Waipapa facility has resulted in changed processes across units, with stroke patients remaining in the Acute Medical Assessment Unit longer before being transferred. We are working through improvements in patient flow as part of the 'making our system flow' project and expect to see improvements in the coming year.

[49] Use of respite beds is positive in that they support people to avoid escalation of their condition which might lead to an acute admission and we have seen a lift this year, after the drop-off in 2019/20. The addition of a new community based alternative acute service and more intensive support for people leaving inpatient services after a short stay may have contributed to the lower utilisation of these respite beds. We will be looking at service utilisation and capacity across respite services in the coming year.

[50] The number of older people supported by day care services has lifted compared with the previous year, which was impacted by the COVID lockdown. Work continues with providers to improve the options available in our community.

[51] Short stays in respite support enable people to stay well in their own homes. As our population ages the complexity of people's conditions may mean a higher level of support is needed with an increased number of people being supported by ARC respite services. Short stays in respite also allow families to have a break from looking after their loved one which reduces stress and pressure on the carer and the wider whānau.

Home-Based and Community Support Services							
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
People supported by district nursing services	A$^{\Delta}$	8,820	8,568	E. >7,000	9,299	-	✓
People supported by long-term home-based support services	A$^{\Delta}$	8,466	7,870	E. >8,000	8,120	-	✓
Proportion of the population (65+) receiving long-term, home-based support	A[52]$^{\Delta}$	9.4%	8.0%	E. 10%	8.5%	-	✗
People supported by hospice or home-based palliative services	A[53]$^{\Delta}$	3,716	3,509	E. 4,000	3,544	-	✗
People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q[54]$^{\Delta}$	91%	91%	95%	89%	-	✗
Number of Advance Care Plans registered to support people's end of life care	A	781	782	>700	928	-	✓
Proportion of people with Advance Care Plans, dying in their place of choice	Q	69%	47%	>70%	73%	-	✓

Aged Residential Care Services							
The DHB subsidises ARC for people who meet the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower level care is indicative of more people being supported in their own homes for longer.	Notes	2018/19 Result	2019/20 Results	2020/21 Target	2020/21 Results	2020/21 NZ Average	
Proportion of the population (75+) accessing rest home level services in ARC	A[55]$^{\Delta}$	4.3%	4.0%	E.<5.0%	4.1%	-	✓
Proportion of the population (75+) accessing hospital level services in ARC	A$^{\Delta}$	6.1%	6.0%	E.6.5%	6.1%	-	✓
Proportion of the population (75+) accessing dementia services in ARC	A$^{\Delta}$	2.6%	2.5%	E. 2.6%	2.7%	-	✓
Proportion of the population (75+) accessing psychogeriatric services in ARC	A$^{\Delta}$	0.8%	0.7%	E. 0.8%	0.7%	-	✓
People entering ARC having had a clinical assessment of need using InterRAI	Q[56]$^{\Delta}$	84%	87%	95%	90%	96%	↺

[52] Service numbers have lifted following a decline due to the COVID lockdown and changes to alert levels. We are hearing that people are less comfortable letting helpers into their homes in the COVID environment and some people have declined non-essential services. We are monitoring service levels and working with our three home-based support service providers to review services over the coming year.

[53] This is a demand driven services and fluctuations can be expected between years. Since 2019 the DHB has worked with PHOs to ensure end of life care is being appropriately provided, this has included ensuring general practices were clear about the service intent and specifications around End-of-Life services. Ongoing improvements have been made to data collection enabling more accurate counting of people accessing end of life care.

[54] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. The decrease in performance is reflective of a national shortage of community-based nurses who are trained to complete InterRAI assessments. There is no impact on patients' access to services when the assessment is not completed straight away as services are put in place while an assessment is being arranged.

[55] The Canterbury region has higher ARC rates than national levels and by providing more services that help older people maintain functional independence for longer, people can remain in their own homes reducing the demand for rest home level care. Access rates for more complex care such as dementia and psychogeriatric care are less amenable and more attributable to the aging of our population. Measures refer to people accessing DHB funded ARC services and exclude people choosing to enter ARC privately or people living independently in retirement villages.

[56] The DHB continues to work with ARC service providers to encourage the use of the InterRAI tool. Shortages in trained assessors is impacting on performance against the national targets.

3.2 Ngā Mahi Hauora Māori 2020-2021 | Māori Health Performance 2020-2021

Like all DHBs, faced with 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 2020/21 using the symbol (◆). The results for Māori are presented below to highlight progress in reducing equity gaps. The NZ average results are the national results for Māori.

SERVICE PERFORMANCE 2020-2021

Māori Health Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Notes	2018/19	2019/20	2020/21 Target	2020/21	2020/21 NZ average	
Māori babies exclusive/fully breastfed at three months	Q	50%	50%	70%	51%	47%	↺
Māori smokers, enrolled with a PHO, receiving advice and help to quit	Q[57]	79%	71%	90%	78%	73%	↺
Māori smokers, identified in hospital, receiving advice and help to quit	Q	92%	85%	95%	94%	-	↺
Pregnant Māori women identified as smokers at confirmation of pregnancy with an LMC receiving advice and support to quit smoking	Q	78%	89%	90%	95%	-	✓
Māori children receiving a B4 School Check at age four	A	100%	91%	90%	92%	81%	✓
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	100%	97%	95%	100%	91%	✓
Māori women aged 25-69 having a cervical cancer screen in the last three years	A[58]	68%	63%	80%	62%	59%	✗
Māori women aged 50-69 having a breast cancer screen in the last two years	A[59]	68%	71%	70%	71%	62%	✓
Māori babies fully immunised at eight months of age	A[60]	91%	90%	95%	87%	77%	✗
Older Māori (65+) having had a seasonal influenza vaccination	A[61]†	40%	42%	75%	54%	59%	↺
Māori newborns enrolled with a PHO by three months of age	A[62]	82%	80%	85%	77%	72%	✗

[57] The ABC programme refers to health professionals Asking about smoking status, providing Brief advice and providing Cessation support. This performance measure reflects smokers given advice and support in general practice in the last 15 months. The number of Māori provided brief advice in general practice increased by 588 compared to the previous year.

[58] The number of screens provided to Māori women increased by 396 compared with the 2019/20 result. Population increases mean we need to work harder to engage women in the programme. An equity focused initiative in Ashburton seeks to use data matching to identify Māori women on the PHO register who are not on the screening registers and engage local health navigators to follow up with women to lift participation in the programme.

[59] Breast screening results are released quarterly by the Ministry of Health. At the time of publishing, the June 2021 results were not available. The year-end result reflects the two years to March 2021.

[60] Canterbury's childhood immunisation programme was impacted through the year by redeployment of NIR, LinKIDS, outreach and public health nursing staff to support the COVID vaccination programme. Despite the workforce pressures and interruptions, we have maintained our performance overall and delivered the third highest coverage rate for Māori in the country, missing the national target by 57 Māori children over the course of the year. Immunisation continues to be a priority and we are focusing on catch-ups for Māori and Pacific children in the coming year.

[61] The number of older Māori having a flu vaccination in 2020 increased by 543 people, compared to 2019.

[62] Canterbury's PHO enrolment rate fell during 2020/21 for both the total population and the Māori population. Population growth within Canterbury appears to be a factor in the lower enrolment rate this year along with capacity in general practice leading to limited enrolments or closed books in some general practices. We are working with the three Canterbury PHOs to address capacity issues and our LinkKIDS services is working to support enrolment of Māori newborns. In 2020/21 – there were 87 fewer Māori enrolled with a PHO by three months of age compared with 2019/20.

Māori Health Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Notes	2018/19	2019/20	2020/21 Target	2020/21	2020/21 NZ average	
Māori population enrolled with a PHO	A[62]	85%	84%	95%	83%	84%	✗
Māori identified with diabetes having a HbA1c test in the last year	A[63]	89%	87%	90%	90%	-	✓
Māori with diabetes having an HbA1c test with acceptable glycaemic control	Q	63%	61%	>60%	62%	-	✓
Māori children (0-4) enrolled in DHB oral health services	A[64†]	51%	86%	95%	82%	-	✗
Māori children (0-12) examined according to planned recall	T[64†]	89%	87%	90%	87%	-	↺
Māori women registered with an LMC by 12 weeks of pregnancy	A[65]	66%	n.a	80%	n.a	-	-
Māori outpatient 'Did not Attend' rates	Q[66]	9%	7%	<5%	7%	-	↺

[63] An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's diabetes. A level of less than 64mmol/mol reflects an acceptable blood glucose level.

[64] Canterbury's LinKIDS service continues to support improved oral health service enrolment rates with the number of Māori children aged 0-4 enrolled increasing by 110 and children aged 0-12 enrolled in oral health services increasing by 394 compared with the previous year. This work to increased enrolment rates continues to be a focus in 2021/22

[65] Data is sourced from the national Maternity Clinical Indicators report, results for 2019 and 2020 are yet to be released.

[66] A Hauora Māori Equity Project has been implemented in the past year. This project aims to reduce inequity for Māori in secondary care, including reducing barriers to accessing appointments and increasing attendance for both inpatient and outpatient appointments for Māori. This will be achieved through trialling new culturally appropriate practices as required and increasing the cultural competence of staff through the Hauora Māori Professional Development Plan.

4. WHAKAHAERETIA Ā MĀTOU MAHI | MANAGING OUR BUSINESS

4.1 Te Whakaruruhau Rangatōpū | Corporate Governance

Statutory Information

This Annual Report presents Canterbury DHB's financial and non-financial performance for the year ended 30 June 2021 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 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 within our region, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB recorded a deficit of $177.131M, which includes unbudgeted items for COVID-19, Holidays Act compliance provision and a one-off land sale loss, against the budgeted $145.006M deficit (2019/20: deficit of $243.436M against the budgeted $180.470M deficit).

BOARD FEES

Board and Committee fees paid, or payable, to current Board and Committee Members for services as at 30 June 2021 were as follows:

	Board Fees $	Committee Fees $
Hon Sir John Hansen	63,522	2,500
Gabrielle Huria	39,698	2,250
Aaron Keown	31,759	1,500
Andrew Dickerson	31,759	3,938
Barry Bragg	31,759	3,875
Catherine Chu	29,112	2,000
Fiona Pimm	6,616	
Gordon Boxall		1,000
Ingrid Taylor	31,759	4,000
James Gough	31,759	4,500
Jan Edwards		1,250
Jo Kane	31,759	5,375
Michelle Turrall		500
Naomi Marshall	31,759	2,875
Olive Webb		750
Peter Ballantyne		2,250
Rawa Karetai		1,000
Rochelle Faimalo		1,000
Rochelle Phipps		1,250
Steve Wakefield		2,250
Tom Callanan		1,250
Yvonne Palmer		1,000
Total	361,261	46,313

Total fees paid, or payable for the year were $407,574 (2019/20: $400,088).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	BOARD		QFARC		HAC		CPH&DSAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Hon Sir John Hansen	13	13	11	12				
Gabrielle Huria	12	13	9	12				
Peter Ballantyne			11	12				
Gordon Boxall							4	5
Barry Bragg	13	13	12	12	3	6		
Sally Buck[67]	0	0			0	0	0	1
Tom Callanan							5	5
Catherine Chu	11	13			3	6	5	5
Andrew Dickerson	10	13	11	12	5	6		
Jan Edwards					5	6		
Rochelle Faimalo							4	5
James Gough	13	13	12	12	6	6		
Jo Kane	13	13	12	12	6	6	5	5
Rawa Karetai							4	5
Aaron Keown	13	13					5	5
Naomi Marshall	13	13			6	6	5	5
Yvonne Palmer							4	5
Rochelle Phipps					5	6		
Fiona Pimm[68]	2	2					0	0
Ingrid Taylor	13	13	12	12	5	6		
Michelle Turrall					1	6	1	5
Steve Wakefield			9	12				
Olive Webb							3	5

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

[67] Leave of Absence from 1 April 2020, resigned 8 July 2020

[68] Appointed 16 April 2021

DIRECTORS' FEES

Directors' fees paid, or due and payable, to directors of subsidiaries during the year are detailed in the table on this page.

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

DIRECTORS' FEES	2021 $'000	2020 $'000
Brian Wood	29	29
Claire Evans	12	11
Erin Black	11	11
Gail Gibson	8	-
Jane Cartwright	23	23
Kath Fox	11	11
Lee Mathias	-	2
Paula Rose	1	11
Stella Ward	8	-
Steve Wakefield	33	28
Total	136	126

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

The following ministerial directions have been issued to DHBs and apply to Canterbury DHB:

ELIGIBILITY DIRECTION

The Eligibility Direction issued in 2011 under Section 32 of the New Zealand Public Health and Disability Act 2000.

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

AUTHENTICATION SERVICES DIRECTION

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

WHOLE OF GOVERNMENT APPROACH

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

Canterbury DHB applies the Government Rules of Sourcing for procurement and 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.

COVID-19 RESPONSE DIRECTION

The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID-19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under Section 11 to give effect to the public health response to COVID-19 in New Zealand.

Several associated directives, epidemic notices and orders have since been issued by the Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction. The direction from the Minister of Health on COVID-19 Response 2020 issued on 17 March 2020 pursuant to Section 32 of the New Zealand Public Health and Disability Act 2000 and Section 103 of the Crown Entities Act 2004, continues to apply.

4.2 Ā Mātou Hua Pūmau | Our Assets

Asset management and performance

Having the right assets in the right place and managing their lifecycle well is critical to the ongoing provision of high quality and cost-effective health services. Asset management is 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 to inform our planning of capital requirements and investment decisions. 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	Asset Classes Within Portfolios	Asset Purpose	NET BOOK VALUE		
			2018/19	2019/20	2020/21
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	$741M	$737M	$1,337M
Clinical Equipment	Equipment	To enable the delivery of health services through diagnosis, monitoring or treatment	$44M	$53M	$95M
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of health services by aiding decision making at the point of care	$35M	$50M	$48M

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

PROPERTY PORTFOLIO					
Asset Performance Indicators	Indicator Class	2018/19	2019/20	2020/21 Standard	2020/21 Result
Percentage of the critical property portfolio with a National Building Standard at or greater than 34% [69]	Condition	83.0%	84.0%	90.0%	81.0%
Theatre Utilisation [70]	Utilisation	88.3%	89.0%	>85.0%	88.1%
Confidence level in the capability of back-up generators to provide back-up power generation 24x7 [71]	Functionality	-	100.0%	100%	99.8%
Energy consumption per sqm (kWh/sqm) [72]	Other	407.19	412.70	<500	350

[69] 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 has been progressively working to restore buildings to this standard. Some of the projects on this list are dependent on the masterplan, plans for regional development and completion of the new energy centre. One of the rural hospitals previously deemed as not Earthquake (EQ) prone is now classed as EQ prone. In addition, there have been delays due to COVID-19 pandemic.

[70] 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".

[71] This measure provides a confidence level in the capability of the 12 back-up generators identified as critical, for providing back-up power generation 24x7. The RMS (Root Mean Square) is calculated for the number of recorded outages for the three routine checks: weekly run tests completed without failure, weekly physical checks completed, and the monthly physical tests completed; the appropriate confidence level is then applied to the result (100% - no recorded outages, 80% - 1 to 3 recorded outages, 50% - greater than 3 recorded outages). The result is not 100% because one of the generators was unavailable for a week. The generator had not failed any tests, however a problem was discovered as part of the preventative maintenance program and the generator was not available to provide back-up while the repairs were completed.

[72] 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. This is an indicator of the functionality of assets implemented to help reduce energy consumption. Previous baselines have been refreshed to align time periods for reports to June of each year.

CLINICAL EQUIPMENT PORTFOLIO					
Asset Performance Indicators	Indicator Class	2018/19	2019/20	2020/21 Standard	2020/21 Result
Percentage of Linacs compliant with the requirements of the Radiation Safety Act	Condition	100%	100%	100%	100%
Percentage of CTs compliant with the requirements of the Radiation Safety Act [73]	Condition	100%	87.5%	100%	75.0%
Percentage of X-Ray rooms compliant with requirements of the Radiation Safety Act [74]	Condition	-	95.0%	100%	89.3%
Linacs - Scheduled Radiation treatment hours as a percentage of available treatment hours [75]	Utilisation	-	90.4%	>85.0%	96.6%
Percentage of Diagnostic Monitors meeting RANZCR QA requirements for primary monitors [76]	Functionality	100%	100%	>95.0%	100%
Percentage of MRI Scanners compliant with requirements of ACR annual quality checks [77]	Functionality	-	100%	100%	100%
Percentage of Diagnostic Ultrasound machines meeting the IANZ specified industry accepted standards [78]	Functionality	-	100%	100%	100%
Percentage of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first cancer treatment within 62 days of referral [79]	Other	94%	96.0%	>90.0%	95%

[73] This is a "point-in-time" snapshot as at the end of 2020/2021 with two CTs reporting errors. One of the CTs is due for replacement, with implementation planned for the end of 2021. The second CT has a reporting error that is being investigated for rectification.

[74] Three failures reported, with two marginally outside regulated limits and will be corrected at the next scheduled service in Q3 2021. There is no safety risk to patients or staff. The third non-compliant item is subject to ongoing corrective action with the vendors' engineers. The equipment continues to be used, based on a combination of manual methods and some further investigation by Medical Physics to allow us to comply with the Act. This is deemed to be a satisfactory interim measure for 4-5 years until the equipment is next due to be replaced.

[75] The number of scheduled treatment hours across the Linac fleet, reflects the utilisation of the Linacs for clinical use by the service. The total available treatment hours are calculated as agreed operation time (in hours) less the scheduled servicing hours.

[76] Diagnostic monitors must remain in a defined calibration range for image display quality, to ensure accurate reporting. The calibration requirements are specified by the RANZCR (Royal Australian & New Zealand College of Radiologists) for various aspects – such as the Grayscale Standard Display Function, Maximum Luminance, Minimum Luminance, Contrast and Uniformity required to pass.

[77] Industry best practice is that MRI equipment complies with the ACR (American College of Radiology) MRI quality programme. The measure is assessed by reviewing annual Quality Assessment (QA) tests (by Medical Physics).

[78] All diagnostic ultrasound machines have to meet the technical requirements specified by IANZ (International Accreditation New Zealand) in their Supplementary Criteria for ultrasound machines. The measure is assessed by review of Canterbury DHB testing by IANZ.

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

INFORMATION COMMUNICATION AND TECHNOLOGY (ICT) PORTFOLIO					
Asset Performance Indicators	Indicator Class	2018/19	2019/20	2020/21 Standard	2020/21 Result
Condition of servers to mitigate against cyber-attacks. Percentage of servers patched (not more than 15 patches outstanding) with critical and security updates [80]	Condition	96.6%	95.0%	>95.0%	95.2%
HealthOne page views[81]	Utilisation	89,900	96,681	>50,000	119,257
Security Penetration/Vulnerability Test - Internally Hosted Internet Facing Websites [82]	Functionality	2.30[82]	2.30[82]	<11	26.1
Security Penetration/Vulnerability Test - Externally Hosted Internet Facing Websites	Functionality	-	-	<50	24

[80] This measure highlights the importance of ensuring that the DHB has mitigated against cyber-attacks. The measure is the proportion of servers with up to date operating system patches. The result is reported on a monthly basis and averaged across the 12 months for a full year measure.

[81] HealthOne is a system which provides clinicians access to a single electronic patient record across the South Island. This record details a patient's treatment, diagnostic tests and prescriptions to enable better and timelier clinical decision making. Utilisation of this service, measured by page views, is an indicator of how well the asset is being used by clinicians towards its patient treatment purpose.

[82] The Network Security External Penetration Test is an important measure that reflects whether the DHB's system can withstand external hacking attacks and whether the DHB's network is appropriately protected. A new scoring mechanism has been implemented for 2020/2021 changing the scoring of five risk levels from 1-5 to 1-100. The target has correspondingly been changed from <2.5 previously to <11 to align with the new scoring system. A penetration/vulnerability test is carried out annually by an independent, external contractor. The final score is calculated as a weighted average of the number of severity issues and the risk levels. The target was not achieved because a number of internally hosted websites were not updated in the past year. The upgrades to these websites are being scheduled.

4.3 Ā Mātou Tāngata | 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.

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.

Leadership, accountability and culture

To deliver on our commitment to care for our people and put them at the heart of all our decisions, 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 Public Services Commission (PSC), formally known as the State Services Commission (SSC), framework used by the core public sector. This approach allows the Canterbury DHB to create transferable leadership skills across DHBs and the public sector.

To develop leadership capability across the Canterbury DHB, we have developed a leadership development initiative called the Hub for the Essentials of Leadership and Management (HELM).

HELM is a learning initiative designed to support everyone to lead through blended learning solutions accessible to all staff. In addition, it offers targeted development programmes to address key areas of leadership development need.

STAFF MIX BY AVERAGE AGE	
Medical	40.71
Nursing	45.28
Allied Health	44.08
Support	50.78
Management & Administration	50.54

STAFF MIX BY GENDER		
Female	9,342	81%
Male	2,237	19%
	11,579	

STAFF IDENTIFYING AS HAVING A DISABILITY[83]	
Yes	316

STAFF ETHNICITY[84]	
New Zealand European	4,879
Other European	1,268
Other Ethnicity	631
European	356
Other Asian	337
Southeast Asian	329
Māori	306
Indian	283
Chinese	237
African	46
Fijian	46
Samoan	46
Middle Eastern	31
Latin American	17
Asian	14
Tongan	12
Other Pacific Peoples	10
Unknown	2,731
Grand Total	11,579

[83] 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

[84] Source: Payroll and max. as at 30 August 2021

Recruitment, selection and induction

Canterbury DHB is committed to a shared approach to talent acquisition and 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 approach from succession planning and strategic sourcing, to selection, candidate care and induction. We are also investing in the review of current workforce strategies to make sure we can attract, source and identify top talent to meet our community's needs. 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. There will be a significant focus on ensuring our recruitment, selection and induction processes are equitable and embrace the development of a diverse workforce. 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 professional leads in Wellbeing, Health and Safety. Our teams include experts in workplace safety, occupational health, rehabilitation, and employee mental health and wellbeing. In addition to working alongside our people and health and safety representatives, advice and support are provided 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 and wellbeing 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 annual influenza vaccinations
- Development and promotion of resources to foster the wellbeing of our people
- Promotion of a safe work environment and safe work practices
- Workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training
- Facilitating connecting to care for our people if they need mental health support

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.

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 arise. This includes a programme of work to improve our policies, a Code of Conduct, and enabling manager capability to address issues and integrate restorative workplace practises. We continue to improve our people's access to advice and resolution services when they are not having a positive experience at work.

Equal opportunities and positive behaviours

We are an organisation that is committed to practices which minimise all forms of discrimination, bullying and harassment in the workplace as well as barriers to the recruitment, retention, development and promotion of our employees. This year, a new Equity and Diversity team was created within our People and Capability function that will lead work to better hire, support and grow our diverse workforce with a particular focus on our Māori workforce as well as Pacific peoples, tāngata with disabilities, our LGBTQIA+ workforce and other minority groups, thereby enabling us as an organisation to better reflect the community we serve. We continue to review our processes and practices, deliver organisational initiatives and learning, and ensure we continue to review our talent acquisition and development practices to enable all people to be successful.

As part of our commitment to diversity and inclusion, we continue to support Project SEARCH, which provides internship opportunities for young people with intellectual disabilities, and we are working to grow our

organisational ability to actively provide more opportunities for people with disabilities who face barriers to employment.

We remain committed to identifying and dealing with all examples of unacceptable behaviour. This year saw a refreshed version of our Code of Conduct developed and communicated to all new and existing staff which clearly outlines a strengths-based approach to how our people are expected to behave at work. We continue to have conversations with staff and managers about what is and is not acceptable behaviour and often take a restorative approach to ensuring people's behaviours are in line with our organisational values.

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, 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.

Culture and engagement

In May 2021 the first employee engagement since 2016 was run to better understand how our tāngata (people) were feeling and to use that information to drive quick wins as well as develop short and long-term goals.

The survey, Tāngata Ora, was composed of around 60 questions and available for 15 days receiving 5,144 responses (42% of staff) from both the Canterbury and West Coast District Health Boards.

Several common themes appeared which assisted both DHBs in developing appropriate and effective actions. In this respect, our divisional leaders utilised the results to develop and implement action plans for their respective teams.

The mahi of Tāngata Ora will continue with a follow-up survey in 2022 establishing an annual measure of employee engagement and satisfaction with the organisation.

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 of leadership and managerial capability building. These development opportunities are structured to support effective transition between different roles and leadership contexts.

Canterbury DHB focuses on creating a great learning experience that is accessible for all employees. This includes partnering with other South Island DHBs to develop a fit for purpose learning management platform to meet our organisational needs.

Canterbury DHB has a system to record performance and development conversations and processes between managers and their staff called My Success and Development. This Service Now based system was a change from the largely paper based approach that the organisation previously used. The online system has been rolled out with feedback reviewed and incorporated into future system updates. This system is also supported by delivery of online learning and workshops to introduce the organisation to having great success and development conversations whilst setting realistic and measurable goals.

5. NGĀ MAHI AHUMONI | FINANCIAL PERFORMANCE

5.1 Ngā Wero Ahumoni | Meeting Our Financial Challenges

STATEMENT OF COMPREHENSIVE REVENUE & EXPENSE *for the year ended 30 June 2021*	Notes	Actual 2021 $'000	Budget 2021 $'000	Actual 2020 $'000
REVENUE				
Patient care revenue	2 [p45]	2,073,834	2,018,450	1,926,350
Other revenue	3 [p47]	52,203	50,208	52,460
Interest revenue		1,075	577	695
Total revenue		2,127,112	2,069,235	1,979,505
EXPENSE				
Employee benefit costs	4 [p47]	1,019,772	967,342	1,000,806
Treatment related costs		177,141	168,059	160,676
External service providers		844,188	814,341	810,046
Depreciation and amortisation		90,315	85,108	79,773
Finance costs		2,210	1,300	3,282
Other expenses	5 [p48]	130,746	129,329	130,222
Capital charge expense	6 [p49]	39,871	48,762	38,136
Total expense		2,304,243	2,214,241	2,222,941
Net Surplus/(deficit)		(177,131)	(145,006)	(243,436)
OTHER COMPREHENSIVE REVENUE & EXPENSE				
Revaluation of land and buildings	7,14 [pp49,55]	95,482	-	-
Total comprehensive revenue & expense	27[p70]	(81,649)	(145,006)	(243,436)

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY ***for the year ended 30 June 2021***	Notes	Actual 2021 $'000	Budget 2021 $'000	Actual 2020 $'000
Total equity at beginning of the year		490,730	558,271	597,378
Total comprehensive revenue & expense for the year		(81,649)	(145,006)	(243,436)
EQUITY INJECTIONS:				
Equity support	7 [p49]	180,000	175,895	130,000
Earthquake capital redrawn	7 [p49]	9,650	28,000	5,994
Mental Health facility drawdown	7 [p49]	1,435	28,400	2,455
Waipapa facility – Crown contribution	7 [p49]	525,050	515,060	-
Donated assets – Crown contribution	7 [p49]	1,489	-	-
EQUITY REPAYMENTS:				
Repayment of equity – annual depreciation funding		(1,861)	(1,861)	(1,861)
OTHER MOVEMENTS:				
NZ Health Innovation Hub Management Ltd	25 [p67]	-	-	200
Total equity at end of the year	7 [p49]	1,124,844	1,158,759	490,730

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION *as at 30 June 2021*	Notes	Actual 2021 $'000	Budget 2021 $'000	Actual 2020 $'000
CROWN EQUITY				
Contributed capital	7 [p49]	1,126,422	1,153,284	410,659
Revaluation reserve	7 [p49]	514,833	429,472	423,335
Accumulated surplus / (deficit)	7 [p49]	(516,411)	(423,997)	(343,264)
Total equity		1,124,844	1,158,759	490,730
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8 [p50]	50,775	31,443	4,056
Trade and other receivables	9 [p51]	113,435	108,902	111,502
Inventories	10 [p52]	13,811	14,549	14,549
Restricted assets	18 [p60]	15,095	14,425	14,677
Investments	11 [p52]	750	750	750
Total current assets		193,866	170,069	145,534
CURRENT LIABILITIES				
NZHPL sweep account	8 [p50]	-	-	11,032
Trade and other payables	12 [p53]	159,290	150,054	165,170
Employee benefit liabilities	13 [p53]	381,697	277,644	343,643
Restricted liabilities	18 [p60]	15,111	14,441	14,693
Borrowings	19[p61]	1,280	-	205
Total current liabilities		557,378	442,139	534,743
Net working capital		(363,512)	(272,070)	(389,209)
NON-CURRENT ASSETS				
Property, plant and equipment	14,16 [pp55,59]	1,493,358	1,394,040	861,821
Intangible assets	15, [p58]	50,310	43,077	50,958
Investment in joint venture	25, [p6758]	1,660	-	-
Restricted assets	18 [p60]	16	16	16
Total non-current assets		1,545,344	1,437,133	912,795
NON-CURRENT LIABILITIES				
Employee benefit liabilities	13 [p53]	7,544	6,304	6,304
Borrowings	19 [p61]	49,444	-	26,552
Total non-current liabilities		56,988	6,304	32,856
Net assets		1,124,844	1,158,759	490,730

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS ***for the year ended 30 June 2021***	Notes	Actual 2021 $'000	Budget 2021 $'000	Actual 2020 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Receipts from Ministry of Health		2,009,011	1,969,552	1,859,630
Other receipts		123,138	99,106	113,002
Interest received		1,075	577	695
		2,133,224	2,069,235	1,973,327
CASH WAS APPLIED TO:				
Payments to employees		956,828	947,983	880,391
Payments to suppliers		1,168,032	1,131,121	1,113,310
Interest paid		2,210	1,300	3,369
Capital charge		52,397	61,288	25,610
GST – net		(369)	-	(1,219)
		2,179,098	2,141,692	2,021,461
Net cash inflow/ (outflow) from operating activities	20 [p63]	(45,874)	(72,457)	(48,134)
CASH FLOW FROM INVESTING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Sale of property, plant & equipment		2,736	-	17
Receipts from restricted assets & investments		14,597	-	16,238
		17,333	-	16,255
CASH WAS APPLIED TO:				
Purchase of investments & restricted assets		15,618	-	16,238
Purchase of property, plant & equipment		80,553	109,917	63,579
		96,171	109,917	79,817
Net cash inflow/ (outflow) from investing activities		(78,838)	(109,917)	(63,562)
CASH FLOW FROM FINANCING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Earthquake repair capital redrawn	16 [p59]	-	18,350	5,994
Mental Health facility drawdown	7 [p49]	1,435	28,400	2,455
Acquisition of subsidiary	25[p67]	-	-	200
Equity support	7 [p49]	180,000	175,895	130,000
Proceeds from borrowings		3,141	-	-
		184,576	222,645	138,649
CASH WAS APPLIED TO:				
Annual depreciation funding repayment	7 [p49]	1,861	1,861	1,861
Repayment of finance leases	19 [p61]	252	-	259
		2,113	1,861	2,120
Net cash inflow/ (outflow) from financing activities		182,463	220,784	136,529
Net increase/ (decrease) in cash and cash equivalents		57,751	38,410	24,833
Cash and cash equivalents at beginning of year		(6,976)	(6,967)	(31,809)
Cash & cash equivalents at end of year	8 [p50]	50,775	31,443	(6,976)

The accompanying notes form part of these financial statements.

5.2 Te Arataki ki Ngā Pūrongo Pūtea | 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)
- NZ Health Innovation Hub Management Ltd (100% owned)

Canterbury DHB holds a 50% share of a joint venture, HealthOne (2021) Limited Partnership. This entity is equity-accounted into the group financial statements. For further details of the joint venture, refer to note 25.

Canterbury DHB holds a 50% interest in the Manawa building property lease by way of a jointly controlled operation. Canterbury DHB recognises its share of revenue and expenses of the jointly controlled operation. 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 2021 and were authorised for issue by the Board on 22 December 2021.

Basis of Preparation

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that Canterbury DHB will require additional funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. If Canterbury DHB was required to settle the holiday

pay liability disclosed in note 13 prior to 1 July 2022, additional financial support would be needed from the Crown for this settlement.

Letter of comfort

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with Canterbury DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

Statement of compliance

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

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

Measurement basis

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

Functional and presentation currency

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

Changes in accounting policies

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

Significant Accounting Policies

Basis for consolidation

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

The group financial statements are prepared using uniform accounting policies for like transactions and other events in similar circumstances. The consolidation of an entity begins from the date the DHB obtains control of the entity and ceases when the DHB loses control of the entity.

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, and 19.

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:

Amendment to PBE IPSAS 2 Cash Flow Statement

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. Canterbury DHB does not intend to early adopt the amendment.

PBE IPSAS 41 Financial instruments

PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. Canterbury DHB has assessed that there will be little change as a result of adopting the new standard as the requirements are similar to those contained in PBE IFRS 9. It does not intend to early adopt the standard.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. Canterbury DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. It does not plan to early adopt the standard.

2. PATIENT CARE REVENUE	2021 $'000	2020 $'000
Ministry of Health population based funding	1,646,260	1,565,331
Inter-district flows	141,486	130,968
Ministry of Health other contracts	197,376	162,239
ACC revenue	37,061	33,209
Other patient related revenue	51,651	34,603
Total patient care revenue	2,073,834	1,926,350

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[85] that report against the use of that funding.

The appropriation revenue received by Canterbury DHB for the 2020/21 financial year is $1,645.803M (2019/20: $1,553.032M) which equals the Government's actual expenses incurred in relation to the appropriation.

[85] The performance measures are set out in the Statement of Service Performance on pages 19-30

MINISTRY OF HEALTH APPROPRIATION REVENUE	Actual $'000	MOH Budget $'000
Crown funding appropriation	1,638,751	1,641,161
Waipapa facility funding	7,052	10,578
Canterbury earthquake funding	-	6,500
Total appropriation revenue	1,645,803	1,658,239

The table above shows the actual and budget Ministry of Health appropriation figures. The variance in the Crown funding appropriation primarily relates to the 2020/21 debt equity swap capital charge funding for the new Waipapa facility and Canterbury earthquake appropriation funding carried forward from previous years.

Note that Canterbury DHB receives other Crown revenue additional to the appropriation.

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.

Other patient related revenue

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	2021 $'000	2020 $'000
Gain on sale of property, plant and equipment	1,653	17
Donations and bequests received	2,384	3,674
Pathology tests	20,848	11,198
Research & development	7,207	7,982
External rental revenue	985	1,024
Cafeteria sales	4,990	4,057
Other	14,136	24,508
Total other revenue	52,203	52,460

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 revenue 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	2021 $'000	2020 $'000
Wages and salaries	949,274	874,804
Board members' fees	361	359
Directors' fees	136	126
Contributions to defined contribution plans[86]	29,508	27,072
Increase/(decrease) in Holidays Act compliance provision	20,421	65,637
Increase/(decrease) in employee benefit provisions	20,072	32,808
Total employee benefit costs	1,019,772	1,000,806

[86] 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 started in 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, and in late 2019 a national approach was agreed to rectify and remediate any Holidays Act non-compliance by DHBs. DHBs also agreed to a Memorandum of Understanding (MOU), which contained a method for determination of individual employee earnings and for calculation of liability for any historical non-compliance.

For employers such as 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 programme associated with the MOU is a significant undertaking and work to assess, rectify and remediate all areas of non-compliance will continue through the 2021/22 financial year. At Canterbury DHB, the formal Review Phase, as set out in the MOU, was completed in March 2020 with all non-compliance issues identified. Efforts are now focused on rectifying payroll systems and processes to ensure ongoing compliance, as well as analysis, testing and remediating the results of retrospective areas of non-compliance for relevant individual employees.

Canterbury DHB recognises it has an obligation to address any historical non-compliance under the MOU. Based on detailed analysis undertaken in the formal Review Phase, calculations and assumptions have been determined and a revised liability estimated (revised from the provisional estimate determined in mid-2019). This was based on selecting a representative sample of current and former employees; analysing leave records against known breaches; making a number of 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 programme. However, until the programme has progressed further, there remain substantial uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and may result in further adjustment to the carrying amount of the provision within the next financial year or payments to employees that differ significantly from the estimation of liability.

5. OTHER EXPENSES	2021 $'000	2020 $'000
Financial statement audit fees	272	255
Additional financial statement audit fees for prior year	-	11
Loss on disposal of property, plant and equipment	4,336	-
Rental costs including operating leases	8,059	5,815
Facilities and infrastructure costs	59,933	53,850
Other non-clinical costs	58,146	70,291
Total other expenses	130,746	130,222

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 2021 the rate was 5% (2019/20: 6%).

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. The value of the relief funding for 2020/21 was $6.916M.

7. EQUITY

	2021 $'000	2020 $'000
CONTRIBUTED CAPITAL		
Opening balance	410,659	274,071
Annual depreciation funding repayment	(1,861)	(1,861)
Equity support	180,000	130,000
Earthquake repair capital redrawn	9,650	5,994
Mental Health facility drawdown	1,435	2,455
Donated asset - Crown contribution	1,489	-
Waipapa facility - Crown contribution	525,050	-
Closing balance	1,126,422	410,659

The operating deficit for 2020 was $243.4M. The Ministry of Health provided $180M of equity support in October 2020.

ACCUMULATED SURPLUS/(DEFICIT)	2021 $'000	2020 $'000
Opening balance	(343,264)	(103,096)
NZ Health Innovation Hub Management Ltd	-	200
Revaluation reserves transfer on disposal	3,984	3,068
Operating deficit	(177,131)	(243,436)
Closing balance	(516,411)	(343,264)
REPRESENTED BY:		
Accumulated surplus in parent and associates	(522,317)	(350,367)
Accumulated surplus in subsidiaries	5,906	7,103
Total accumulated surplus / (deficit)	(516,411)	(343,264)
REVALUATION RESERVE		
Opening balance	423,335	426,403
Transfer to accumulated surplus / deficit on disposal	(3,984)	(3,068)
Revaluation of land, buildings including fitout	95,482	-
Closing balance	514,833	423,335
REPRESENTED BY:		
Revaluation of land	99,150	94,616
Revaluation of buildings including fitout	415,683	328,719
Total revaluation reserve	514,833	423,335
Total equity	1,124,844	490,730

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	2021 $'000	2020 $'000
CURRENT ASSETS			
Bank balances and call deposits	AA-	50,739	4,056
Cash on hand		36	-
Total cash and cash equivalents		50,775	4,056
CURRENT LIABILITIES			
NZHPL sweep account		-	(11,032)
Net cash and cash equivalents		50,775	(6,976)

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 as at 30 June 2021 (2019/20: $88.808M). There has been no change from 2018 until a later annual plan is approved.

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

Credit risk

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

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 NZHPL. 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. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial.

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	2021 $'000	2020 $'000
Trade receivables	13,546	18,267
Receivable from the Ministry of Health	51,574	59,993
Prepayments	6,278	5,649
Other receivables	42,037	27,593
Total trade and other receivables	113,435	111,502
MOVEMENTS IN THE PROVISION FOR IMPAIRMENT OF RECEIVABLES ARE AS FOLLOWS:		
Balance at 1 July	1,336	2,062
Additional provisions made during the year	904	1,863
Receivables written-off during period	(601)	(2,589)
Balance at 30 June	1,639	1,336
THE AGEING OF THE IMPAIRMENT PROVISIONS ARE AS FOLLOWS:		
Current	8	23
< 6 months	623	880
6 months – 1 year	294	207
1 – 2 years	714	150
> 2 years	-	76
Balance at 30 June	1,639	1,336
THE NET AGEING OF RECEIVABLES, EXCLUDING PREPAYMENTS, IS:		
Current	104,180	90,449
< 6 months	2,864	15,312
6 months – 1 year	38	29
1 – 2 years	75	52
2 years	-	11
Balance at 30 June	107,157	105,853

Trade receivables and prepayments are from exchange transactions.

The value of trade receivables that have been impaired on an individual basis total $0.120M, and the impairment on those accounts is $0.065M giving a net carrying value of $0.055M.

Other receivables and receivables from the Ministry of Health are a blend of both exchange and non-exchange transactions. The value of non-exchange balances in other receivables and in receivables from the Ministry of Health is $25.404M (2019/20: $26.827M).

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 2021, the Ministry of Health owed Canterbury DHB $51.574M (2019/20: $59.993M).

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.

10. INVENTORIES	2021 $'000	2020 $'000
Pharmaceuticals	3,148	3,419
Surgical and medical supplies	7,890	7,117
Other supplies	3,812	4,532
	14,850	15,068
Provision for obsolescence	(1,039)	(519)
Total inventories	13,811	14,549

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	2021 $'000	2020 $'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		0.80%	2.03%

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 [p50].

12. TRADE AND OTHER PAYABLES	2021 $'000	2020 $'000
Trade payables	19,714	41,771
Other payables	139,576	123,399
Total trade and other payables	159,290	165,170

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 $56.162M (2019/20: $51.962M).

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	2021 $'000	2020 $'000
CURRENT LIABILITIES		
Annual, lieu and shift leave accruals	103,213	102,381
Holidays Act compliance provision	150,117	130,897
Unpaid days accruals	16,730	13,781
ACC accruals	4,737	5,158
Conference/sabbatical leave and expenses	48,482	35,262
Sick leave	7,037	6,251
Other	51,381	49,913
Total employee benefits - current	381,697	343,643
NON-CURRENT LIABILITIES		
Liability for long service leave	6,668	5,255
Liability for retirement gratuities	876	1,049
Total employee benefits – non-current	7,544	6,304

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 2021. 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 +/- $110,000.

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 +/- $109,000.

14. PROPERTY, PLANT AND EQUIPMENT

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

2020/21 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 2020	139,455	621,969	265,356	37,115	51,923	1,115,818
Additions/transfers	-	509,723	88,232	27,857	554	626,366
Disposals/transfers	(5,707)	-	(4,329)	(30)	-	(10,066)
Revaluation	8,518	(25,889)	-	-	-	(17,371)
Balance at 30 June 2021	142,266	1,105,803	349,259	64,942	52,477	1,714,747
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2020	-	55,926	192,253	5,818	-	253,997
Depreciation	-	60,231	21,165	2,017	-	83,413
Disposals/transfers	-	(695)	(3,137)	664	-	(3,168)
Revaluation	-	(112,853)	-	-	-	(112,853)
Balance at 30 June 2021	-	2,609	210,281	8,499	-	221,389
CARRYING AMOUNT						
At 30 June 2021	142,266	1,103,194	138,978	56,443	52,477	1,493,358

2019/20 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 2019	139,455	597,206	238,461	10,072	49,497	1,034,691
Additions/transfers	-	24,813	30,239	27,043	2,426	84,521
Disposals/transfers	-	(50)	(3,344)	-	-	(3,394)
Revaluation	-	-	-	-	-	-
Balance at 30 June 2020	139,455	621,969	265,356	37,115	51,923	1,115,818
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2019	-	2,087	178,222	3,639	-	183,948
Depreciation	-	53,842	17,349	2,179	-	73,370
Disposals/transfers	-	(3)	(3,318)	-	-	(3,321)
Revaluation	-	-	-	-	-	-
Balance at 30 June 2020	-	55,926	192,253	5,818	-	253,997
CARRYING AMOUNT						
At 30 June 2020	139,455	566,043	73,103	31,297	51,923	861,821

Finance leases

The net carrying amount of assets held under finance leases is $50.724M (2019/20: 25.216M).

Revaluation

Canterbury DHB revalued land, buildings and building fitout (excluding leased building fitout) at 30 June 2021. The revaluation was carried out by an independent registered valuer (TelferYoung (Canterbury) Ltd), which is consistent with PBE IPSAS 17 Property Plant & Equipment.

Impairment

Canterbury DHB has impaired buildings and building fitout at 30 June 2021 in relation to the costs of passive fire remediation required to be undertaken. The impairment is based on independent assessment and totals $41.659M across all campuses.

The disposal of certain properties may be subject to the Ngāi 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.

Additions

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

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

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

Subsequent costs

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

Disposal of property, plant and equipment

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

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

Depreciation

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

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

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

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually.

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.

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 surplus or deficit even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in surplus or deficit 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.

Non-cash-generating assets

Property, plant, 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.

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.

15. INTANGIBLE ASSETS	2021 $'000	2020 $'000
SOFTWARE		
COST		
Opening balance	89,003	70,120
Additions	4,846	18,898
Disposals	(2,355)	(15)
Closing balance	91,494	89,003
AMORTISATION AND IMPAIRMENT LOSSES		
Opening balance	45,914	39,526
Amortisation charge for the year	6,263	6,403
Disposals	(1,220)	(15)
Closing balance	50,957	45,914
Total Software	40,537	43,089
WORK IN PROGRESS - INTANGIBLES		
Opening balance	4,644	10,516
Additions / transfers	2,542	(5,872)
Closing balance	7,186	4,644
INVESTMENT IN NZ HEALTH PARTNERSHIPS LTD		
Opening balance	3,225	3,225
Amortisation charge for the year	(638)	-
Closing balance	2,587	3,225
Carrying amounts	50,310	50,958

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)

No impairment for the NZHPL Change Management and Supply Chain was recognised for the financial year ended 30 June 2021 (2019/20: Nil).

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 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.

NZHPL has issued 100 A class shares held equally by the 20 DHBs with voting rights. Canterbury DHB holds 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.

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

Amortisation

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

Type of asset	Amortisation rate	Useful life (years)
Software	5% – 33.3%	3 - 20

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually.

ESTIMATES AND ASSUMPTIONS

Estimating useful lives of 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. THE CANTERBURY EARTHQUAKES 2010 / 2011

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.

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 and/or rebuild 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	(195.73)
Amount undrawn 30 June 2021	94.27

The undrawn balance can be drawn upon in future periods. The variance between actual and budget revenue draw down is due to the timing of earthquake works and is offset by corresponding variance in earthquake repair costs.

17. JOINTLY CONTROLLED OPERATIONS

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 jointly controlled operations.

	2021 $'000	2020 $'000
Canterbury DHB's result includes the following revenue and expenses as a result of the jointly controlled operations		
Sub tenant revenue	344	290
Manawa lease and facility costs	2,211	2,318

As at 30 June 2021, Canterbury DHB owed Ara Institute $139,466 (30 June 2020: $32,000). Ara Institute owed Canterbury DHB $29,947 (30 June 2020: $1,000).

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 two appointees as Trustees of Māia.

	2021 $'000	2020 $'000
FUNDS HELD DIRECTLY BY CANTERBURY DHB		
Balance at beginning of year	9,098	8,945
Interest received	148	233
Donations and funds received	954	466
Funds transferred to Māia Health Foundation	(84)	(42)
Funds spent	(598)	(504)
Balance at end of year	9,518	9,098
FUNDS HELD WITH MĀIA HEALTH FOUNDATION		
Balance at beginning of year	5,595	5,814
Interest earned on funds held with Māia Health Foundation	75	157
Transfers in from Canterbury DHB	84	42
Funds drawn down by Canterbury DHB	(161)	(418)
Balance at end of year	5,593	5,595
Total Restricted Assets	15,111	14,693
This balance is represented by:		
Current assets	15,095	14,677
Non-current assets	16	16
Total restricted assets	15,111	14,693
Weighted average effective interest rates	0.71%	1.90%

CREDIT QUALITY OF RESTRICTED ASSETS	Credit rating	2021 $'000	2020 $'000
Restricted assets:			
Bank balances	AA-	-	10
Term deposits with maturities of 3-12 months – Canterbury DHB	AA-	9,502	9,072
Term deposits with maturities of 3-12 months – Māia Health Foundation	AA-	5,593	5,595
Perpetual capital notes	BBB+	16	16
Total restricted assets		15,111	14,693

RESIDENTS' TRUST ACCOUNTS	2021 $'000	2020 $'000
Residents' trust account balance	1,105	1,024

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	2021 $'000	2020 $'000
FINANCE LEASES		
Current portion	1,280	205
Non current portion	49,444	26,552
Total borrowings	50,724	26,757

Fair value

The fair value of finance leases is $50.724M (2019/20: $26.757M). Fair value has been determined using contractual cash flows discounted using the relevant rate to each finance lease.

ANALYSIS OF FINANCE LEASES	2021 $'000	2020 $'000
Minimum lease payments		
No later than one year	4,204	1,676
Later than one year and not later than five years	15,390	6,886
Later than five years	80,260	46,682
Total minimum Lease Payments	99,854	55,244
Future finance charges	(49,130)	(28,487)
Present value of minimum lease payments	50,724	26,757
Present value of minimum lease payments payable		
No later than one year	4,039	1,589
Later than one year and not later than five years	12,894	5,715
Later than five years	33,791	19,453
Total present value of minimum lease payments	50,724	26,757

Description of finance leasing arrangements

The group has entered into the following finance leases:

- Manawa building at 30 Oxford Tce;
- Canterbury Linen Services Ltd premises at Dakota Park, 11 George Bellew Road, Yaldhurst;
- Canterbury Linen Services Ltd equipment.

The net carrying amount of the leased items is included in Note 14.

There are no restrictions placed on the group by any of the finance leasing arrangements.

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

ACCOUNTING POLICY

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.

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.

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there

is no certainty as to whether the Canterbury DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

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.

20. RECONCILIATION OF NET SURPLUS/(DEFICIT) FOR THE PERIOD WITH NET CASH FLOWS FROM OPERATING ACTIVITIES	2021 $'000	2020 $'000
Net (deficit)/ surplus before other comprehensive revenue and expense	(177,131)	(243,436)
Add back non-cash items:		
Depreciation and amortisation	90,315	79,773
Add back items classified as investing activities:		
Loss/(gain) on asset sale	(1,087)	30
Movement in term portion provisions/staff entitlements	1,240	402
MOVEMENTS IN WORKING CAPITAL:		
Decrease/(increase) in receivables & prepayments	(1,933)	(14,654)
Decrease/(increase) in stocks	738	(1,340)
Increase/(decrease) in creditors & other accruals	3,930	33,049
Increase/(decrease) in staff entitlements	38,054	98,042
Net cash inflow/(outflow) from operating activities	(45,874)	(48,134)

21. COMMITMENTS	2021 $'000	2020 $'000
CAPITAL COMMITMENTS		
Property	61,023	13,369
Intangible assets	2,977	4,731
Other capital commitments	8,489	14,519
Total capital commitments at balance date	72,489	32,619
NON-CANCELLABLE OPERATING LEASE COMMITMENTS		
Accommodation leases	30,433	29,003
Other leases	1,639	1,626
Total non-cancellable operating lease and supply commitments	32,072	30,629
FOR EXPENDITURE WITHIN:		
Not later than one year	6,665	5,661
Later than one year and not later than five years	14,893	13,643
Later than five years	10,514	11,325
Total non-cancellable operating lease and supply commitments	32,072	30,629

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.

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.

22. CONTINGENCIES

Contingent assets

Canterbury DHB has no contingent assets as at 30 June 2021 (2019/20: Nil).

Contingent liabilities

Canterbury DHB has the following contingent liabilities as at 30 June 2021:

Outstanding legal proceedings

Canterbury DHB has no material outstanding legal proceedings as at 30 June 2021 (2019/20: Nil).

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 [p59] 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 based on information currently available.

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	1-2 years $'000	More than 2 years $'000
2020/21 FINANCIAL YEAR					
Trade and other payables	159,290	159,290	159,290	-	-
Restricted funds	15,111	15,111	15,111	-	-
Finance leases	50,724	99,854	4,204	4,233	91,417
Total financial liabilities	225,125	274,255	178,605	4,233	91,417
2019/20 FINANCIAL YEAR					
NZHPL sweep account	11,032	11,032	11,032	-	-
Trade and other payables	165,170	165,170	165,170	-	-
Restricted funds	14,693	14,693	14,693	-	-
Finance leases	26,757	55,244	1,676	1,702	51,866
Total financial liabilities	217,652	246,139	192,571	1,702	51,866

Contractual maturity analysis of financial assets	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000
2020/21 FINANCIAL YEAR				
Cash and cash equivalents	50,775	50,775	50,775	-
Trade and other receivables[87]	107,157	107,157	107,157	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	15,111	15,111	15,095	16
Total financial assets	173,793	173,793	173,777	16
2019/20 FINANCIAL YEAR				
Cash and cash equivalents	4,056	4,056	4,056	-
Trade and other receivables[88]	105,853	105,853	105,853	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	14,693	14,693	14,677	16
Total financial assets	125,352	125,352	125,336	16

[87] Excludes prepayments

[88] Excludes prepayments

ACCOUNTING POLICY

Classification of financial instruments

The classification of financial instruments under IPSAS 29 and PBE IFRS 9 are as follows:

Financial assets:

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

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 $218,723 of foreign currency accounts as at 30 June 2021 (2019/20: NZD $117,063).

	2021 $'000		2020 $'000	
FOREIGN EXCHANGE RISK	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(22)	20	(12)	11
Total sensitivity	(22)	20	(12)	11

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 Nil. (2019/20: $0.63M). The foreign currency principal amounts were Nil. (2019/20: €0.34M)

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 and 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.

Canterbury Linen Services has relocated to a new site in the 2020/21 financial year, Canterbury DHB have helped to fund the redevelopment through a loan facility charging the same interest rates that are applied to Canterbury DHB by NZ Health Partnerships Ltd and Treasury.

Significant transactions with government related entities

Canterbury DHB has received funding from the Crown, ACC, and other government entities of $1,907.284M to provide health services in Canterbury area for the year ended 30 June 2021 (2019/20: $1,768.092M).

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 $156.961M for the year ended 30 June 2021 (2019/20: $145.418M).

Expenditure to other DHBs for the care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $39.840M for the year ended 30 June 2021 (2019/20: $37.868M).

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 2021 totalled $24.832M (2019/20: $23.388M). 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.

Joint ventures

Joint ventures are those over whose activities Canterbury DHB has joint control and established by contractual agreement. Investment in joint ventures are accounted in Canterbury DHB's financial statement using the equity method of accounting. The investment in a joint venture is initially recognised at cost and the carrying amount in the financial statements is increased or decreased to recognise Canterbury DHB's share of the surplus or deficit of the associate after the date of acquisition. Distributions received from an associate reduce the carrying amount of the investment in the group financial statements.

If the share of deficits of an associate equal or exceed the group's interest in the associate, Canterbury DHB discontinues recognising its share of further deficits. After Canterbury DHB's interest is reduced to zero, additional deficits are provided for, and a liability is recognised, only to the extent that Canterbury DHB has incurred legal or constructive obligations or made payments on behalf of the joint venture. If the joint venture subsequently reports surpluses, Canterbury DHB will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

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 2021	Balance Date
Canterbury Linen Services Ltd	100%	30 June
Brackenridge Services Ltd	100%	30 June
NZ Health Innovation Hub Management Ltd	100%	30 June

Canterbury Linen Services Ltd, Brackenridge Services Ltd and NZ Health Innovation Hub Management 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. NZ Health Innovation Hub Management Ltd (NZHIH) works alongside DHB innovators to develop new products and services that have commercial potential, are based on intellectual property and improve health outcomes and it also provides access to current information about the health landscape, market validation, potential investors and partners.

Canterbury DHB joint venture

ENTITY	Interest held 2021	Balance Date
HealthOne (2021) Limited Partnership	50%	30 June

Canterbury DHB holds 50% interest in HealthOne (2021) Limited Partnership through its wholly owned subsidiary NZHIH with Pegasus Health (Charitable) Limited. HealthOne (2021) Limited Partnership is an unlisted limited partnership. Accordingly, there are no quoted market price for this investment.

Canterbury DHB associates

ENTITY	Interest held 2021	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.

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. 2020/21 charges were $1.291M (2019/20: $1.272M). The amount owing by West Coast DHB relating to this agreement at balance date was $0.247M (2019/20: $0.122M).

Māia Health Foundation

Canterbury DHB provides accounting support, office space, and minor incidentals to the Māia Health Foundation at no charge, as well as assistance with seed funding of $0.250M (2019/20: $0.250M). Also refer note 18 [p60].

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

	2021 $'000	2020 $'000
COMPENSATION OF KEY MANAGEMENT PERSONNEL		
Salaries for executive management team	4,898	3,746
Board and Committee members fees	408	400
Total key management personnel compensation	5,306	4,146

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 (FTE)	2021 FTE	2020 FTE
Full time equivalent Board and Committee members	1.24	1.24
Full time equivalent executive management team	11.87	11.00
Total key management personnel full time equivalents	13.11	12.24

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 $1,937,172 to 32 employees (2019/20: $300,432 to 10 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	2021	2020	SPECIFIED BANDS	2021	2020
100,000-109,999	555	423	360,000-369,999	15	8
110,000-119,999	338	288	370,000-379,999	13	6
120,000-129,999	208	177	380,000-389,999	5	7
130,000-139,999	140	134	390,000-399,999	10	5
140,000-149,999	116	101	400,000-409,999	7	10
150,000-159,999	83	70	410,000-419,999	4	10
160,000-169,999	68	67	420,000-429,999	11	8
170,000-179,999	62	52	430,000-439,999	3	3
180,000-189,999	36	35	440,000-449,999	3	2
190,000-199,999	42	27	450,000-459,999	2	3
200,000-209,999	46	46	460,000-469,999	4	2
210,000-219,999	24	34	470,000-479,999	4	4
220,000-229,999	35	28	480,000-489,999	5	2
230,000-239,999	26	27	490,000-499,999	5	1
240,000-249,999	32	31	500,000-509,999	-	1
250,000-259,999	29	27	510,000-519,999	1	-
260,000-269,999	32	24	530,000-539,999	1	-
270,000-279,999	29	24	540,000-549,999	2	1
280,000-289,999	22	29	550,000-559,999	1	-
290,000-299,999	30	25	610,000-619,999	1	-
300,000-309,999	23	26	630,000-639,999	1	-
310,000-319,999	20	27	640,000-649,999	1	1
320,000-329,999	23	22	770,000-779,999	1	-
330,000-339,999	20	18	790,000-799,999	-	1
340,000-349,999	12	14	1,060,000-1,069,999	1	-
350,000-359,999	12	12			
			Total employees	2,164	1,863

Of the positions identified above, 1,877 (2019/20: 1,605) positions were predominantly clinical and 287 (2019/20: 258) positions were non-clinical.

27. MAJOR VARIANCES TO BUDGET

Canterbury DHB budgeted for a deficit of $145M as published in our unapproved 2020/21 Annual Plan. Explanations for major variance from budget are as follows:

Statement of comprehensive revenue and expense

Included in Canterbury DHB's 2020/21 result are three unbudgeted items being the impact of COVID-19, an increase in the Holidays Act compliance provision ($20.4M) and a one off net loss on sale of land ($3.0M).

Although COVID-19 nets off to a small surplus of $0.7M, this represents revenue of $46.1M and expenses of $45.4M. Please refer to note 29 for details of the impact of COVID-19.

Revenue

Patient care revenue excluding the impact of COVID-19 was $21.5M higher than plan, mainly due to:

- Additional Ministry of Health revenue of $5.6M received for various subcontracts, which have corresponding increases in expenditure. These subcontracts include Planned Care Improvement Action plan revenue for additional surgical volumes delivered and additional PHO Non-Devolved Capitated revenue;
- Additional pharmaceutical revenue of $2.7M, which have corresponding increases in expenditure;
- One off revenue of $2.5M in relation to pay equity; and
- $8.1M more Inter District Flow (IDF) revenue than the Ministry of Health forecast due to more referrals from DHBs outside of the Canterbury region.

Capital charge relief funding (including debt to equity swap) was higher than plan, while there was a funding reduction for capital charge rate change from 6% to 5% (offset by corresponding lower capital charge expense).

Other revenue excluding the impact of COVID-19 and the one off gain on sale of land was lower than budget, due mainly to earthquake repair revenue redrawn $6.2M less than plan. This amount is offset by an equal and opposite favourable variance in earthquake building repair costs.

Expense

Employee benefit costs excluding the impact of COVID-19 and Holidays Act Compliance provision were higher than plan due to planned savings not fully achieved.

External provider excluding the impact of COVID-19 was unfavourable to plan, mainly due to:

- Primary care higher than plan due to changes in the enrolled population;
- Community pharmacy expenditure higher than budget due to increased medicine costs as result of international shortage;
- Age-Related Residential Care higher than budget due to increased demand;
- IDF expenditure was higher than budget due to additional IDF volumes delivered.

The variances above are offset by lower spending in outsourced planned care expenditure, environment support, primary maternity services, and national travel assistance.

The final cost of the Waipapa facility was higher than plan; this impacted the depreciation for the year.

The impact of the reclassification of the Manawa lease (refer note 19) from operating to finance caused an increase in finance costs, an increase in depreciation and a reduction in operating lease costs under other expenses.

Other expense excluding the impact COVID-19 and one off loss on sale of land was favourable to plan. Earthquake building repair costs are favourable to budget by $6.2M due to the timing of repairs. This is offset by the unfavourable earthquake repair revenue redrawn variance.

Capital charge expense is favourable to budget by $8.9M due to lower opening equity than plan and capital charge rate dropping from 6% to 5% from 1 July 2020 (the rate change impact was offset by reduced funding).

Statement of changes in equity

The Equity support budget was $175.9M. Actual equity support funding received was $180.0M. This was $4.1M higher to reflect our immediate cash requirements.

Earthquake capital redrawn and Mental Health facility drawdown are lower than originally planned due to slower progress than anticipated.

The Ministry of Health supplied $1.4M of equipment in the form of a donation, free of capital charge.

Statement of financial position

Cash and cash equivalents were favourable to budget due in part to the extra deficit funding received. Trade and other payables were unfavourable to budget mainly due to the timing of payments.

Employee benefit liabilities include a further provision made for compliance with the Holidays Act and Continuing Medical Education expenses which were not included in the budget.

Property, plant and equipment is higher than budget mainly due to the reclassification of the Manawa lease and the Canterbury Linen Services lease of new premises.

Borrowings (current and non-current) of $50.7M relates to the Manawa and Canterbury Linen Services finance leases.

Statement of cash flows

Operating cashflow was favourable to Plan primarily due to:

- Additional revenue associated with IDF, side contracts and pharmaceutical funding;
- Capital charge relief funding (including debt to equity swap) higher than plan.

Financing cashflow was lower than the Annual Plan due primarily to:

- Lower Earthquake capital redrawn;
- Mental Health facility drawdown progress slower than anticipated;
- Offsetting these is the equity support funding received and borrowings of $3.1M for Canterbury Linen Services equipment.

28. SUBSEQUENT EVENTS

The Minister of Finance and Minister of Health jointly approved the Christchurch Hospital Campus compliance project with a Crown equity contribution of $55.9M on 8 July 2021 (2019/20: Transfer of Waipapa facility on 1 November 2020 and equity support received on 5 October 2020).

COVID-19 continues to have an operational impact on the Canterbury DHB. On 17 August 2021, all of New Zealand moved to Alert Level 4. During September and October 2021 all of New Zealand except Auckland and Northland moved to Alert Level 3 and 2. On 2 December 2021, New Zealand moved to the COVID-19 Protection Framework, also known as the traffic light system. The Ministry of Health has continued to fund applicable COVID-19 response related activities since balance date.

29. THE EFFECTS OF COVID-19 ON CANTERBURY DHB

On 11 March 2020, the World Health Organisation declared the outbreak of the COVID-19 pandemic. Two weeks later the New Zealand Government declared a State of National Emergency.

In February 2021 New Zealand started to roll out the Pfizer vaccine and Canterbury DHB set up a vaccination programme involving a large workforce of nurses and support staff.

The table below shows the effect of COVID-19 on our operations included in the financial statements.

IMPACT OF COVID-19	2021 $'000	2020 $'000
Revenue	46,079	16,910
Employee benefit costs	17,814	7,426
Treatment related costs	8,465	5,146
External service providers	15,942	19,208
Other expenses	3,177	2,266
Total expense	45,398	34,046
Surplus/(Deficit)	681	(17,136)

In the 2019/20 year there were a number of costs that were not funded, in 2020/21 the COVID-19 activity has centred around the running of Managed Isolation Quarantine Facilities (MIQF), border control for the Trans-Tasman bubble and the vaccination programme. All of these activities are funded by the Ministry of Health.

The main impacts on the 2020/21 financial statements due to COVID-19 are explained below.

Government funding

The Ministry of Health provided funding of $33.8M in 2020/21 for the Canterbury DHB COVID-19 response as follows:

- $11.3M related to surveillance and testing in the community;
- $3.9M related to the vaccination programme;
- $14.1M related to Managed Isolation and Quarantine; and
- $4.5M related to Public Health Unit and Primary Mental Health response, carried out by Canterbury DHB's Community & Public Health division.

Other revenue

Canterbury DHB received $12.2M revenue for COVID-19 related laboratory testing which has corresponding staffing and clinical supplies costs such as test kits and consumables. The Auckland region moved to level three lockdown in August 2020 and was again in lockdown in February 2021. Canterbury DHB assisted the Auckland region with laboratory testing during these periods.

Operating expenses

As a result of COVID-19, Canterbury DHB has incurred additional expenditure of $45.4M as follows:

- Employee benefit costs $17.8M - the contributing additional costs include border screening and contact tracing, responsibility for the setting up and oversight of the isolation hotels facilities, laboratory testing and rolling over of the vaccination programme;
- Treatment related costs $8.5M - these additional costs are primarily associated with an additional COVID-19 laboratory testing workload, as well as consumables to ensure that all DHB staff and patients had appropriate access to PPE;
- External provider costs $15.9M;
- Other expenses $3.2M - other expenses include communication costs to keep the community, staff and patients informed.

The net revenue and expense is relatively neutral.

Balance sheet impacts

- At 30 June 21, our trade and other receivables balance included $9.3M of Ministry of Health debt relating to COVID-19 response activities;
- Employee benefits balances are higher due to the extension of CME entitlement from a three year limit to a five year limit because of COVID-19 disruption;
- An impairment assessment has been completed for tangible and intangible assets. No impairments have been recognised as a result of the assessments due to COVID-19.

5.3 Tuhinga whakarāpopoto o Ngā Pūrongo Pūtea | Summary of Revenues and Expenses by Output Class

	Actual 2021 $'000	Budget 2021 $'000
Early detection & management	456,674	400,455
Intensive assessment & treatment	1,312,292	1,349,399
Prevention	55,259	56,615
Rehabilitation & support	302,887	262,766
Total revenue	2,127,112	2,069,235
Early detection & management	492,750	436,636
Intensive assessment & treatment	1,425,384	1,431,583
Prevention	58,666	60,177
Rehabilitation & support	327,443	285,845
Total expenditure	2,304,243	2,214,241
Deficit	(177,131)	(145,006)

6. KŌRERO TĀPIRI | SUPPLEMENTARY INFORMATION

6.1 Arataki | Directory

Board Members

Hon Sir John Hansen KNZM – Chair	
Gabrielle Huria – Deputy Chair	
Barry Bragg	
Sally Buck	Resigned 8 July 2020
Catherine Chu	
Andrew Dickerson	
James Gough	
Jo Kane	
Aaron Keown	
Naomi Marshall	
Fiona Pimm	Appointed 16 April 2021
Ingrid Taylor	

Chief Executive

Dr Peter Bramley

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

7. KAIAROTAKE PŪTEA | INDEPENDENT AUDITOR'S REPORT

Independent Auditor's Report

To the readers of Canterbury District Health Board's group financial statements and performance information for the year ended 30 June 2021

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

Opinion

We have audited:

- the financial statements of the Group on pages 39 to 73, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 7 to 28 and 74.

In our opinion:

- the financial statements of the Group on pages 39 to 73, which have been prepared on the disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Group on pages 7 to 28 and 74:
    - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2021, 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 22 December 2021. This is the date at which our opinion is expressed.

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

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures in the financial statements.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 43 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Group therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

The Group is reliant on financial support from the Crown

Note 1 on pages 43 and 44 outlines the Group's financial performance difficulties. There is uncertainty whether the Group will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to its disestablishment. The Group therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Group with financial support, where necessary.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 4 on page 48, outlines that the Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Group has estimated a provision of $151 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Page 20 outlines the information used by the Group to report on its Covid-19 vaccine coverage. The Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 20. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

We draw attention to the disclosures about the impact of Covid-19 on the Group as set out in note 29 to the financial statements.

Basis for our opinion

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

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

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

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

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

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

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Group for assessing the Group's ability to continue as a going concern. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

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 disestablishment basis of accounting by the Board.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial

statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 6, 29 to 38 and 75, 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: International 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.

John Mackey
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand