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# CANTERBURY DISTRICT HEALTH BOARD
# STATEMENT OF PERFORMANCE EXPECTATIONS 2021/22

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

# Statement of Joint Responsibility

The Canterbury District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2001. Each DHB is categorised as a Crown Agent under the Crown Entities Act and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

This document is the DHB's Statement of Performance Expectations which has been prepared to meet requirements under the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and expectations set by the Minister of Health.

Linking with our Annual Plan and System Level Measures Improvement Plan, the Annual Plan describes our strategic goals and objectives in terms of improving the health of our population and ensuring the sustainability of our health system. This document also presents our financial forecasts and our Statement of Performance Expectations for 2021/22.

The Statement of Performance Expectations is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in our Annual Report, published annually on our website.

The Canterbury DHB works collaboratively and in partnership with other service providers, agencies and community organisations to improve health outcomes for the Canterbury population. This includes participation in our large-scale Canterbury Clinical Network (CCN) District Alliance, with twelve local provider partners, the South Island Regional Alliance with our four South Island DHB partners and our transalpine partnership with the West Coast DHB.

We also recognise our role and responsibility in actively addressing disparities in health outcomes for Māori and we are committed to making a difference. We work closely with Manawhenua Ki Waitaha, our Kaupapa Māori service providers and our Māori communities, both directly and through the CCN Alliance, in a spirit of partnership and co-design that encompasses the principles of Te Tiriti o Waitangi and seeks to achieve health equity for Māori across Canterbury.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity for the coming year and is in line with Government expectations for 2021/22.

**Sir John Hansen**
CHAIR | CANTERBURY DHB

**Barry Bragg**
BOARD MEMBER | CANTERBURY DHB
CHAIR QUALITY AUDIT FINANCE & RISK COMMITTEE

**Dr Peter Bramley**
CHIEF EXECUTIVE | CANTERBURY DHB

September 2021

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# OVERVIEW

## Who are we and what do we do?

# Introducing the Canterbury DHB

## 1.1 Who are we

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

The Canterbury DHB has the third largest population of any DHB in the country. In 2021/22 we will be responsible for 589,390 people, 11.5% of the total New Zealand population.

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

In 2021/22, we will receive approximately $2.232 billion dollars to meet the needs of our population. In accordance with legislation, and consistent with Government objectives, we will use that funding to:

Plan and, in collaboration with clinical leads, alliance partners, and iwi, develop demand strategies and determine the services we need in place to improve the health and wellbeing our population.

Fund the health services required to meet the needs of our population and, through collaborative partnerships and ongoing performance monitoring, ensure these services are safe, equitable and effective.

Provide health services for our population, through our hospital and specialist services.

Protect our population's health and wellbeing through investment in health protection, promotion and education services and the delivery of evidence-based public health initiatives.

## 1.2 What makes us different?

As well as having the third largest population, we are also the second largest DHB by geographical area. Two of our rural districts (Selwyn and Waimakariri) are amongst the fastest growing territorial authorities in the country.

As the second largest tertiary service provider in the country, we own and operate six major hospital facilities across the Canterbury region, (the Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton hospitals).

We operate the largest trauma centre in New Zealand and the fifth largest in Australasia and deliver the second largest number of elective (planned) surgeries in the country and half of all the elective surgery provided in the South Island.

We also own and operate ten smaller rural health facilities and several sector bases across the region.

To deliver healthcare to our population, we employ just over 11,000 people. We also hold and monitor approximately 1,000 service contracts and agreements with other organisations and individuals who provide services for our population. These include: general practice; pharmacy; laboratory; maternity; child health; diagnostic; personal health; mental health; dental; aged care; and community nursing services.

Since 2010, Canterbury DHB has shared operational resources with the West Coast DHB, including a joint chief executive, executive management leads, clinical leads and corporate service teams.

A formal service partnership means Canterbury specialists provide regular surgical lists and outpatient clinics on the West Coast. This arrangement provides more equitable access to specialist services for the West Coast population and supports improved service and workforce planning between both DHBs to reduce the unplanned acute load on Canterbury services.

## 1.3 Our regional role

As the second largest tertiary service provider in the country, we provide an extensive range of highly specialised services to people from other DHB regions where those services or treatments are not available.

This regional demand is complex in nature and growing steadily. In the five years to June 2019, there was a 7% increase in hospital admissions and a 13% increase in demand for outpatient appointments from people coming from regions outside of Canterbury.[1]

In 2018/19, almost 7,000 people from outside of Canterbury were discharged from one of our hospitals and close to 55,000 outpatient appointments were provided by Canterbury staff to people referred from other DHBs.

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

At a national level, we are one of only two DHBs in the country providing paediatric oncology, acute spinal cord impairment surgery, hyperbaric oxygen therapy and specialist burns treatment. Our laboratory service is also one of only two tertiary level laboratories in New Zealand and typically delivers over four million diagnostic laboratory tests a year.

[1] This reference is the five years to June 2019, excluding the impact of COVID-19 on the 2019/20 year.

## 1.4 Our population profile

In the ten years since the earthquakes our population growth has been strong and steady, with an 18% increase in our total population and a 42% increase in our Māori population. Latest population estimates signal that Canterbury's population will reach 600,000 in the next three years.

Our population is spread out geographically across the region, with Selwyn and Waimakariri being two of the fastest growing districts in the country. Our population growth has been well beyond previous projections and is a major challenge for our health system.

Our population is slightly older than the average New Zealand population, and Canterbury has the largest population of people aged over 65 in the country. Latest population figures show 16% of our population are aged over 65, a total of 94,690 people. Our 65+ population will reach 100,000+ in the next three years.

Many long-term conditions become more common with age, including heart disease, stroke, cancer and dementia. As people age they develop more complex health needs and are more likely to need specialist services. We need to consider the growing burden of long-term conditions and the needs of our ageing population in our future planning.

Deprivation is also a strong predictor of the need for health services and a key driver of health inequities. The 2018 Census recorded one in every ten residents living in Canterbury were living in areas classified as socio-economically deprived.

Ethnicity, like age and deprivation, is also a strong predictor of the need for health services and some population groups have less opportunity and are more vulnerable to poor health outcomes than others.

Canterbury has the sixth largest and second fastest growing Māori population in the country. There are currently 59,860 Māori living in Canterbury, a 42% increase in population over the past ten years. In the next three years, our Māori population is expected to increase to over 65,000 people.

While our Pacific population is smaller, it is the fifth largest Pacific population in the country and like our Māori population is growing rapidly. There are currently 17,650 Pacific people living in Canterbury and this population is expected to grow to over 19,000 people in the next three years.

Latest population statistics show 10.2% of our Māori population and 9.9% of our Pacific population are aged under five, compared to 5.6% of our non-Māori population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important for the health system to focus on meeting the health needs of our younger Māori and Pacific populations.

## 1.5 Our population's health

Canterbury's population has very similar life expectancy (81.5 years) to the New Zealand average (81.4 years).

Inequities continue to exist for Māori compared to non-Māori with Māori experiencing poorer overall health and a lower life expectancy (79.1 years). However, the equity gap for life expectancy is closing at a faster rate in Canterbury. At 2.4 years the gap is considerably smaller than nationally, where Māori life expectancy is almost 6.3 years lower than the total population.

The increasing prevalence of long-term physical and mental health conditions is one of the major drivers of demand for health services and the main cause of health loss amongst adults. This is true for Canterbury where an increasing number of people are living with long-term conditions such as cancer, heart disease, respiratory disease, diabetes and depression.

The most recent regional results from the New Zealand (NZ) Health Survey (2014-2017) found that:

- 15% of our total population, 40% of our Māori population and 37% of our Pacific population are current smokers.
- More than a quarter (28%) of our total population, 46% of our Māori population and over half (59%) of our Pacific population are classified as obese.
- 11% of our total population identified as inactive (having little or no physical activity). Rates for Māori and Pacific were similar (12%) and (15%).
- 20% of our adult population (one in five) are likely to drink in a hazardous manner, reflecting hazardous drinking habits in one in every five adults in Canterbury.
- 23% of our population have been diagnosed with a mood or anxiety disorder.

A reduction of known risk factors could dramatically reduce pressure on our health system and greatly improve health outcomes for our population. These risk factors also have strong socio-economic gradients, so population health interventions that reduce these risk factors will also contribute to reducing health inequities between population groups.

### ONGOING HEALTH IMPACTS OF MAJOR EVENTS

The Canterbury population has experienced several major traumatic events over the last decade and, like other DHBs, we are now dealing with the impact of COVID-19 on people's mental health and wellbeing.

While some sections of our population are thriving in their lives, there is clear divergence in our community with a marked increase in demand for specialist mental health support. The proportion of Māori accessing services in Canterbury suggests a greater burden of mental disorder compared to the total population; while this pattern is also seen nationally, it indicates an area where we need increased focus.

## 1.6 Our operating challenges

While Canterbury has made real inroads in achieving an integrated health system, meeting the health needs of a large and growing population is complex.

Persistent inequities in health outcomes tell us that we need to do things differently. We cannot address the wider determinants of health inequity on our own. We need to partner with iwi, other government agencies and service providers to increasingly address socio-economic factors that impact significantly on health status, access and outcomes. We need to rise to the challenge of implementing a whole of system culture shift, to work as a wider, multi-cultural, multi-disciplinary, multi-agency team in response to the needs of our increasingly diverse population.

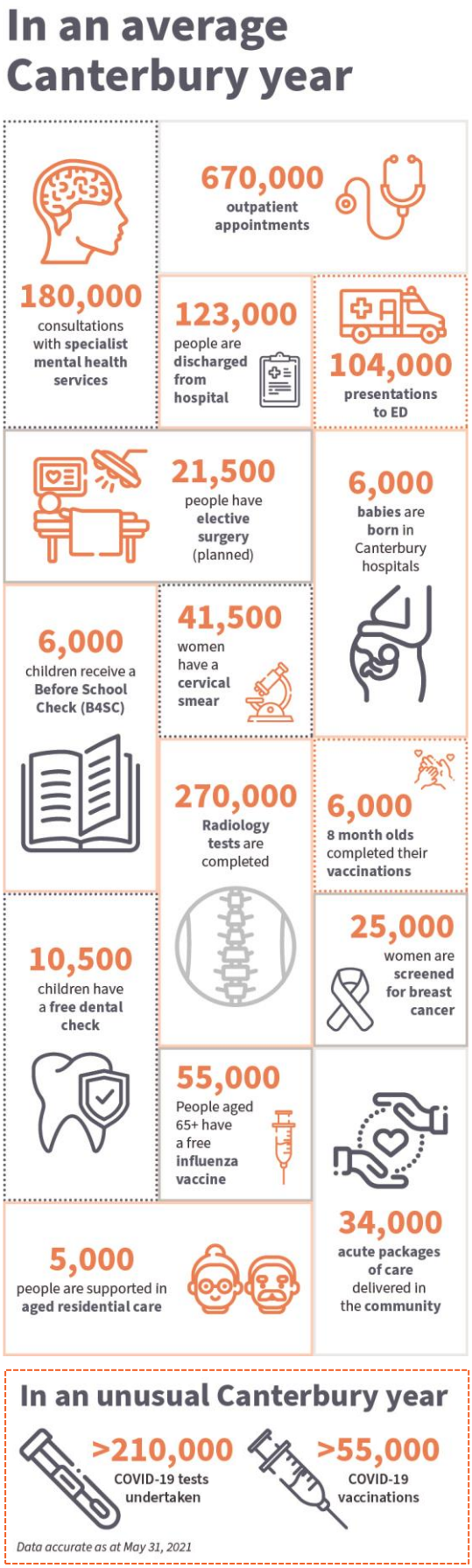
Like the rest of the health sector, we are experiencing growing demand pressures as our population ages and increasing fiscal pressures as treatment, infrastructure and wage costs rise. In the coming year we will continue to support Managed Isolation and Quarantine facilities and COVID-19 testing at our boarders and in our community. We will also roll-out the COVID-19 vaccination programme on an epic scale.

The system is likely to be put under pressure by the redeployment of staff to support the COVID-19 vaccination programme. It is expected that primary, community and public health services will be impacted as they work to deliver vaccinations to our population. Impacts are most likely to be felt across other immunisation programmes, school-based programmes and primary care screening programmes where the workforce will be most stretched.

We also face several unique capacity challenges related to our role as a tertiary provider, continued facilities constraints and expectations related to the demand for highly-complex and resource-intensive services from neighbouring DHBs. Our population has experienced several major traumatic events over the last decade with a marked increase in demand for mental health support.

The Canterbury DHB has a significant financial deficit exacerbated by the steady growth in treatment, infrastructure and wage costs. As part of our focus in the coming year we need to work hard to capture operational efficiencies, make the best use of the resources we have available and ensure we are investing in services that provide the greatest return in terms of health gain to bring our operating costs back into line with expectations.

As we face these challenges, we are also conscious of the pressure on our staff in relation to the increasing demand across the system, ongoing capacity issues and the additional stress related to the COVID-19 pandemic, particularly for those working in managed isolation facilities. The DHB is working hard to maintain safe working environments and ensure the wellbeing and ongoing engagement of our people.



# THE YEAR AHEAD

## What can you expect from us in 2021/22?

# Monitoring Our Performance

## 2.1 Improving health outcomes

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

DHBs have several different roles and associated responsibilities. In our governance role we are concerned with health equity for our population and the sustainability of our health system. In our funder role, we strive to improve the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver, the efficiency with which it is delivered, the experience of the people we serve, and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of our work and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an overarching intervention logic and an outcomes framework which is highlighted in our Statement of Intent, available on our website.

The outcomes framework helps to illustrate our commitment to longer-term outcomes and our population health-based approach to performance improvement by highlighting the difference we want to make in the health and wellbeing of our population. It also encompasses national direction and expectations, through the inclusion of national targets and system level performance measures.

At the highest level, the framework reflects our three strategic objectives and identifies three wellbeing goals, where we believe our success will have a positive impact on the health of our population.

Aligned to each goal, we have identified several population health indicators which will provide insight into how well our system is performing over time. These indicators are also reflected in the DHB's System Level Measures Improvement Plan developed in partnership with our Alliance partners and available on our website.


## 2.2 Improving service performance

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

Having a limited pool of resources and faced with growing demand for health services and increasing fiscal pressures, we are strongly motivated to ensure we are delivering effective and efficient services.

Over the shorter-term, we evaluate our service performance by monitoring ourselves against a forecast of the service we plan to deliver and the standards we expect to meet. The DHB reports annually against our Service Performance alongside our Financial Performance, in our Annual Reports which can be found on our website.

The Intervention Logic Diagram (Appendix 2), illustrates how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to our longer-term goals, the goals of the wider South Island region and the expectations of Government.

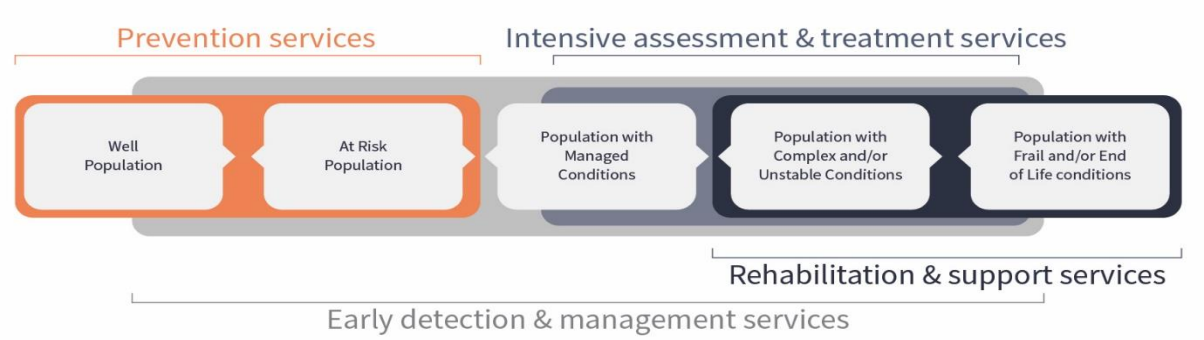
The following section presents the Canterbury DHB's Statement of Performance Expectations for 2021/22.

## 2.3 Accountability to the Minister

As a Crown entity, responsible for Crown assets, the DHB also provides a wide range of financial and non-financial performance reporting to the Ministry of Health on a monthly, quarterly and annual basis.

The DHB's obligations include quarterly performance reporting in line with the Ministry's non-financial performance monitoring framework. This framework aims to provide a rounded view of DHB performance in key priority areas and uses a mix of performance markers across five dimensions. The framework and expectations for 2020/21 are presented in the DHB's Annual Plan.

# Statement of Performance Expectations




## Evaluating our performance

### 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.

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.

It is important to include a mix of service measures under each service class to ensure a balanced, well-rounded picture and provide a fair indication of how well the DHB is performing.

The mix of measures identified in our Statement of Performance Expectations addresses the five key aspects of service performance we believe are most important to our community and stakeholders:

Access (A)
Are services accessible, is access equitable, are we engaging with 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?

Patient Experience (P)
How satisfied are people with the service they receive, do they have confidence in us?

### SETTING STANDARDS

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

Targets reflect the strategic objectives of the DHB: increasing the reach of prevention programmes; reducing acute or avoidable hospital admissions; and maintaining access to services - while at the same time reducing waiting times and delays in treatment. We also seek to improve the experience of people in our care, increase equity of access and health outcomes and increase public confidence in our health system.

In considering our drive towards equity, performance targets are universal, set with the aim of reducing disparities between population groups. Key focus areas have been identified to improve Māori and Pacific health and breakdowns by ethnicity are aligned to each of these measures.

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

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

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

### PERFORMANCE EXPECTATIONS

The pressures on our system in 2021/22 will be compounded by our ongoing response to the COVID-19 pandemic. Over the coming year we will have to engage our public health, general practice, vaccination teams and community providers in supporting the COVID-19 vaccination programme and the DHB will need to continue to support Managed Isolation and Quarantine Facilities and COVID-19.

There is a risk that the redeployment and shift of staff to support the COVID-19 vaccination programme will have some impact on the delivery of other prevention, immunisation and screening services. Depending on how the pandemic plays out in New Zealand we may have to respond to an escalation of events. If another lockdown is imposed, we will expect a far greater impact on service delivery right across our system.

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 baseline results can be subject to change, due to delays in invoicing or reporting.

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

E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources.

## 2.4 Where does the money go?

In 2021/22 the DHB will receive approximately $2.232 billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2021/22, split by service class.

| | 2021/22 $'000 |
|---|---|
| Revenue | |
| Prevention | $47,844 |
| Early detection & management | $463,728 |
| Intensive assessment & treatment | $1,399,537 |
| Rehabilitation & support | $321,298 |
| Total Revenue | $2,232,407 |
| Expenditure | |
| Prevention | $49,927 |
| Early detection & management | $493,667 |
| Intensive assessment & treatment | $1,495,746 |
| Rehabilitation & support | $342,074 |
| Total Expenditure | $2,381,414 |
| Surplus/(Deficit) | ($149,007) |

## 2.4 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. These services include: the use of legislation and policy to protect the population from environmental risks and communicable disease; education programmes and services to raise awareness of risk behaviours and healthy choices; and health protection services such as immunisation and screening programmes that support people to modify lifestyles and maintain good health.

By supporting people to make healthier choices, we 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 also designed to spread consistent messages to large numbers of people and can therefore also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| Population Health Services – Healthy Environments | | | | | |
|---|---|---|---|---|---|
| These services address aspects of the physical, social and built environment to protect health and improve health outcomes. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally | Q [2] | Total | 42 | 96 | E.70 |
| Licensed alcohol premises identified as compliant with legislation | Q [3] | Total | 93% | 100% | 90% |
| Tobacco retailers identified as compliant with legislation | Q [3] | Total | 96% | 97% | 90% |

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Mothers receiving breastfeeding and lactation support in the community | A | Total | 861 | 861 | >600 |
| Babies exclusively/fully breastfed at three months | Q[4] | Māori | 50% | 50% | 70% |
| | | Pacific | 55% | 54% | |
| | | Total | 62% | 62% | |
| People provided with a Green Prescription for additional physical activity | A[5] | Total | 4,818 | 5,158 | >3,500 |
| Green Prescription participants more active 6-8 months after referral | Q | Total | n.a | n.a | >50% |
| Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC) | Q[6] | Māori | 79% | 71% | 90% |
| | | Pacific | 77% | 70% | |
| | | Total | 82% | 73% | |
| Smokers, identified in hospital, receiving advice and support to quit smoking (ABC) | Q | Māori | 92% | 85% | 95% |
| | | Pacific | 93% | 88% | |
| | | Total | 92% | 84% | |
| Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC) | Q[7] | Māori | 78% | 89% | 90% |
| | | Total | 86% | 93% | |

[2] Submissions are made to influence policy in the interests of improving and protecting the health of the population and providing a healthy and safe environment for our population. The number of submissions varies in a given year and may be higher (for example) when Territorial Authorities are consulting on long-term plans.

[3] New Zealand law prevents retailers from selling alcohol or tobacco to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years of age) into licensed premises or tobacco retailers. Compliance is seen as a proxy measure of the success of education and training for retailers and reflects a culture that encourages a responsible approach to alcohol and tobacco.

[4] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. This measure is part of the national Well Child/Tamariki Ora Quality Framework, data from providers is not able to be combined so performance from the largest provider (Plunket) is presented.

[5] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Sport Canterbury has picked up and reintegrated the patient experience survey, previously undertaken by Research NZ on behalf of the Ministry of Health, this will be completed annually.

[6] The ABC programme has a cessation focus and refers to health professionals Asking about smoking status, providing Brief advice and providing Cessation support. The provision of professional advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts.

[7] This data is sourced from the national Maternity Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance Pacific results are not available for publication. Standards have been set nationally in line with other ABC programme targets.

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Four-year-olds provided with a B4 School Check (B4SC) | A[8] | Māori | 100% | 91% | 90% |
| | | Pacific | 92% | 80% | |
| | | Total | 96% | 90% | |
| Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention | Q | Māori | 100% | 97% | 95% |
| | | Pacific | 100% | 100% | |
| | | Total | 100% | 99% | |
| Women aged 25-69 having a cervical cancer screen in the last 3 years | A[9] | Māori | 68% | 63% | 80% |
| | | Pacific | 78% | 67% | |
| | | Total | 72% | 70% | |
| Women aged 45-69 having a breast cancer screen in the last 2 years | A[10] | Māori | 68% | 68% | 70% |
| | | Pacific | 62% | 62% | |
| | | Total | 78% | 73% | |
| People aged 60-74 participating in the national bowel screening programme | A | Māori | new | new | 60% |
| | | Pacific | new | new | |
| | | Total | new | new | |

| Immunisation Services | | | | | |
|---|---|---|---|---|---|
| These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Children fully immunised at eight months of age | A[11] | Māori | 91% | 90% | 95% |
| | | Pacific | 96% | 96% | |
| | | Total | 94% | 94% | |
| Proportion of eight-month-olds 'reached' by immunisation services | Q | Total | 98% | 98% | 95% |
| Children fully immunised at two years | A | Māori | 91% | 92% | 95% |
| | | Pacific | 96% | 98% | |
| | | Total | 93% | 94% | |
| Young people (Year 8) completing the HPV vaccination programme | A[12]✧ | Māori | 31% | 58% | 75% |
| | | Pacific | 34% | 59% | |
| | | Total | 37% | 62% | |
| Older people (65+) receiving a free influenza ('flu') vaccination | A[13]✧ | Māori | 40% | 42% | 75% |
| | | Pacific | 52% | 52% | |
| | | Total | 62% | 64% | |

[8] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing concerns to be identified and addressed early. Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness and can also affect a child's educational attainment and quality of life. A referral for children identified with weight concerns allows families to access support to maintain healthier lifestyles.

[9] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying by allowing for earlier intervention and treatment. The measures refer to participation in national screening programmes and standards are set nationally.

[10] From July 2021 the national expectation for Breast Screening was extended to include women 45 to 69 years. Reported baseline results have been updated from previous years. Results are no longer comparable with previously published results.

[11] Immunisation at eight months is a national performance measure and the subset, children 'reached', is defined as children fully immunised and those whose parents have been contacted and provided with advice - but may have chosen to decline immunisations or opt off the National Immunisation Register.

[12] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV-related cancers later in life. The programme consists of two vaccinations and is free to young people under 26 years of age. Baseline results refer to young girls only, the programme was widened in 2020/21. The 2018/19 HPV result is subject to data quality issues and we believe is under-reflecting performance.

[13] Almost one in four New Zealanders are infected with influenza each year. 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. The vaccine is especially important for people at risk of serious complications, including people aged over 65 and people with long-term or chronic conditions.

## 2.5 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. Cancer, cardiovascular disease, diabetes, and respiratory disease are the four leading long-term conditions for our population.

Early detection and management services are those that help to maintain, improve and enable people's good health and wellbeing. These services include detection of people at risk, identification of disease and the effective management and coordination of services for people with long-term conditions. These services are by nature more generalist and accessible from multiple providers at a number of different locations. Providers include general practice, allied health, personal and mental health service providers and pharmacy, radiology and laboratory service providers.

Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with local primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and helps to improve their quality of life by reducing complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Children (0-4) enrolled in DHB-funded oral health services | A[14]✧ | Māori | 84% | 82% | 95% |
| | | Pacific | 85% | 88% | |
| | | Total | 83% | 86% | |
| Children (0-12) enrolled in DHB-funded oral health services receiving their oral health exam according to planned recall | T✧ | Māori | 89% | 87% | 90% |
| | | Pacific | 85% | 75% | |
| | | Total | 88% | 87% | |
| Adolescents (13-17) accessing DHB-funded oral health services | A[15]✧ | Total | 66% | 62% | 85% |

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Newborns enrolled with a PHO by three months of age | A | Māori | 82% | 80% | 85% |
| | | Pacific | 86% | 93% | |
| | | Total | 95% | 93% | |
| Proportion of the total Canterbury population enrolled with a Primary Health Organisation (PHO) | A | Māori | 85% | 84% | 95% |
| | | Pacific | 108% | 98% | |
| | | Total | 93% | 95% | |
| Youth (0-19) accessing brief intervention counselling in primary care | A[16]Δ | Total | 552 | 435 | >400 |
| Adults (20+) accessing brief intervention counselling in primary care | AΔ | Total | 6,353 | 6,187 | >5,500 |
| Number of skin lesions (including cancer) removed in primary care | AΔ | Total | 2,404 | 2,322 | >2,000 |
| Number of integrated HealthPathways in place across the health system | Q[17] | Total | 699 | 685 | >600 |

[14] Oral health is an integral component of lifelong health and wellbeing. Early and regular contact with oral health services helps to set lifelong patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[15] Adolescent oral health data is provided by the Ministry of Health. No data is available for Māori or Pacific utilisation.

[16] The Brief Intervention Counselling service supports people with mild to moderate mental health concerns, including depression and anxiety. The service includes the provision of free counselling sessions (or extended consultations) and includes face-2-face and phone consultations. The expansion of specifically targeted service options for young people, including the CYMHS and YAMAHA networks, are expected to result in fewer referrals to this service for this age cohort.

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

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of spirometry tests provided in the community rather than in hospital | A[18Δ] | Total | 2,426 | 2,128 | >2,000 |
| People receiving subsidised diabetes self-management support when starting insulin | A[Δ] | Total | 379 | 320 | >300 |
| Population identified with diabetes having an HbA1c test in the last year | A[19Δ] | Māori | 89% | 87% | >90% |
| | | Pacific | 88% | 85% | |
| | | Total | 90% | 88% | |
| Population with diabetes having an HbA1c test and acceptable glycaemic control | Q[Δ] | Māori | 63% | 61% | >60% |
| | | Pacific | 58% | 56% | |
| | | Total | 72% | 71% | |

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of laboratory tests completed for the Canterbury population | A[Δ] | Total | 2.9m | 2.8m | E<2.8m |
| Number of subsidised pharmaceutical items dispensed in the community | A[Δ] | Total | 7.0m | 7.6m | E<10m |
| People on multiple medications receiving medication management support | A[20Δ] | Total | 1,434 | 896 | >1,200 |
| Number of community-referred radiology tests completed | A[Δ] | Total | 55,038 | 51,614 | E>55,000 |
| People receiving their urgent diagnostic colonoscopy within two weeks | T[21] | Total | 77% | 80% | 90% |
| People receiving their MRI scans within six weeks | T | Total | 47% | 76% | 90% |
| People receiving their CT scans within six weeks | T | Total | 65% | 93% | 95% |

[18] Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment and conditions can be identified and treated earlier.

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

[20] The Medical Management Review programme helps to ensure the safe and appropriate use of medications. The programme offers more intense medication therapy assessments for the most complex patients and less complex medication use reviews for others.

[21] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and, by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). The radiology measures are national performance indicators and refer to non-urgent scans.

## 2.6 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.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| Quality and Patient Safety | | | | | |
|---|---|---|---|---|---|
| These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Staff compliant with good hand hygiene practice | Q[22◇] | Total | 82% | 82% | 80% |
| Inpatients (aged 75+) receiving a falls risk assessment | Q◇ | Total | 98% | 92% | 90% |
| Response rate to the national inpatient patient experience survey | P[23] | Total | 24% | 19% | >30% |
| Proportion of patients who felt 'hospital staff included their family/whānau or someone close to them in discussions about their care' | P | Total | 50% | 65% | >65% |

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Proportion of the population (aged 0-19) accessing specialist mental health services | A[24Δ] | Māori | 5.6% | 6.1% | >3.1% |
| | | Pacific | 2.4% | 2.3% | |
| | | Total | 3.7% | 4.1% | |
| Proportion of the population (aged 20-64) accessing specialist mental health services | AΔ | Māori | 9.8% | 10.6% | >3.1% |
| | | Pacific | 4.6% | 4.8% | |
| | | Total | 3.9% | 4.0% | |
| People referred for non-urgent mental health and AOD services seen within 3 weeks | T | Total | 70% | 67% | 80% |
| People referred for non-urgent mental health and AOD services seen within 8 weeks | T | Total | 88% | 83% | 95% |

[22] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. In line with national reporting results refer to the final quarter of each year (April-June). Further detail and quarterly results for the full year can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[23] There is growing evidence that patient experience is a good indicator of the quality of health services and stronger patient partnerships and family-centred care have been linked to better health outcomes. The national DHB inpatient experience survey covers four patient experience domains: communication, partnership, co-ordination and physical and emotional needs.

[24] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. Data is sourced from the national PRIMHD dataset and results are three months in arrears.

| Maternity Services | | | | | |
|---|---|---|---|---|---|
| While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of maternity deliveries in Canterbury DHB facilities | A | Total | 6,044 | 5,943 | E.6,000 |
| Women registered with a Lead Maternity Carer by 12 weeks of pregnancy | A[25]✧ † | Māori | 66% | n.a | 80% |
| | | Pacific | 58% | n.a | |
| | | Total | 79% | n.a | |
| Proportion of maternity deliveries made in primary birthing units | Q[26] | Total | 16% | 16% | >13% |

| Acute and Urgent Services | | | | | |
|---|---|---|---|---|---|
| Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Early intervention can reduce the impact of the event and shorter waiting times are indicative of a responsive system. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of acute demand packages of care provided in the community | A[27]Δ | Total | 35,393 | 35,547 | >30,000 |
| Number of presentations at Canterbury Emergency Departments (ED) | A | Total | 101,130 | 104,907 | E.110k |
| People admitted, discharged or transferred from Canterbury EDs within 6 hours of presentation | T | Māori | 92% | 92% | 95% |
| | | Pacific | 94% | 92% | |
| | | Total | 90% | 91% | |
| Proportion of the population presenting to ED (per 1,000 people) | Q | Total | 178 | 181 | E.<190 |
| Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral | T | Total | 94% | 96% | 90% |

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of First Specialist Assessments provided | A | Total | 66,982 | 55,218 | E.60,000 |
| Proportion of patients waiting longer than four months for their first specialist assessment | T◇ | Total | 69% | 71% | 100% |
| Proportion of First Specialist Assessments that were non-contact (virtual) | Q[28] | Total | 15% | 13% | >15% |
| Number of planned care intervention delivered | A[29] | Total | new | 31,013 | TBC |
| Proportion of patients given a commitment to treat but not treated within four months | T◇ | Total | 55% | 73% | 100% |
| Proportion of people receiving their surgery on the day of admission | P | Total | 87% | 85% | >85% |
| Number of outpatient consultations provided | A | Total | 653,717 | 630,837 | E.650k |
| Outpatient appointments where the patient was booked but did not attend their appointment | Q[30] | Māori | 9% | 7% | <5% |
| | | Pacific | 12% | 10% | |
| | | Total | 5% | 4% | |

[25] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of the mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report. Results for 2019 are yet to be released.

[26] The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women give birth in secondary or tertiary facilities when it is not clinically indicated. This enables the best use of resources and ensures limited secondary services are more appropriately available for those women who need more complex or specialist intervention.

[27] Acute demand packages of care are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people in their own homes or in the community rather than having people presenting to ED or hospital for treatment.

[28] This measure has been updated to include both non-contact (virtual) assessments, where the assessment is provided without the patient needing to be present, and telehealth assessment where a patient has their appointment but 'virtually' via phone call or using telehealth technology to reduce the need for travel. Additional detail is able to be captured regarding patient contacts following the shift to a new patient management system in 2018/19. Prior year's results have been updated to reflect a consistent approach to this measure.

[29] Canterbury's planned care interventions target is made up of three components: elective surgical discharges, Minor Procedures and Non-Surgical Interventions.

[30] When appointments are missed, it can negatively affect people's recovery and long-term outcomes and it is a costly waste of resources for the DHB.

## 2.7 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services are those that provide people with the support they need to continue to live safely and independently in their own homes, or regain functional ability, after a health-related event. Services are mostly provided to older people, or people with mental health or complex personal health conditions, following a clinical assessment of the person's needs.

These services are considered to provide people with a much higher quality of life as a result of being able to stay active and positively connected to their communities. Even when returning to full health is not possible, access to responsive support services enables people to maximise their independence. In preventing acute illness, crisis or deterioration of function, these services have a major impact on the sustainability of our health system, by reducing acute service demand and the need for more complex interventions or residential care. These services also support patient flow by enabling people to go home from hospital earlier.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| 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 being appropriately supported after an event. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| People accessing community-based pulmonary rehabilitation courses | A[31] | Total | 275 | 227 | >250 |
| People (65+) accessing the community-based falls prevention service | A[32] | Total | 2,127 | 1,852 | >1,500 |
| People supported by community rehabilitation and support services | A[33Δ] | Total | 1,933 | 1,686 | >1,600 |
| Proportion of inpatients referred to an organised stroke service after an acute event | Q | Total | 84% | 86% | 80% |
| Proportion of AT&R inpatients discharged to their own home rather than into Aged Residential Care (ARC) | Q[34] | Total | 88% | 84% | >80% |

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2020/21 Target |
| People supported by district nursing services | A[Δ] | Total | 8,820 | 8,568 | E. >7,000 |
| People supported by long-term home-based support services | A[Δ] | Total | 8,466 | 7,870 | E. >8,000 |
| Proportion of the population (65+) supported by long-term, home-based support services | A[Δ] | Total | 9.4% | 8.0% | E. 10% |
| People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI tool | Q[35Δ] | Total | 91% | 91% | 95% |
| People supported by hospice or home-based palliative services | A[Δ] | Total | 3,716 | 3,509 | E. 3,700 |
| Number of Advance Care Plans registered to support end of life care | A | Total | 781 | 782 | >700 |

[31] Respiratory and lung diseases are major contributors to avoidable hospital admissions in Canterbury, particularly over winter. 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.

[32] Falls are one of the leading causes of hospital admission for people aged over 65. The aim of the Falls Prevention Programme is to provide better care for people both 'at-risk' of a fall, or following a fall, and to support people to stay safe and well in their own homes.

[33] The Community Rehabilitation Enablement and Support Team (CREST) provides a range of short-term home-based rehabilitation services to facilitate early discharge from hospital or avoid admission entirely through proactive referral. The measure is the number of people having received unique packages of care.

[34] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge home reflects the effectiveness of services in terms of assisting that person to regain their functional independence.

[35] 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. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services.

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| People supported by community-based mental health crisis respite services | A$^{\Delta}$ | Total | 1,052 | 754 | E.1,000 |
| Occupancy rate of mental health crisis respite beds | A[36]$^{\Delta}$ | Total | 88% | 74% | 85% |
| Older people supported by day care services | A$^{\Delta}$ | Total | 578 | 297 | E.550 |
| Older people accessing aged care respite services | A[37]$^{\Delta}$ | Total | 1,101 | 1,192 | E.1,000 |
| Older people supported by aged care respite services, being discharged to their own home | Q[38]$^{\Delta}$ | Total | 89% | 88% | >80% |

| 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. | Note | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Proportion of the population (75+) accessing rest home level ARC services | A[39]$^{\Delta}$ | Total | 4.3% | 4.0% | E.<4.5% |
| Proportion of the population (75+) accessing hospital-level ARC services | A$^{\Delta}$ | Total | 6.1% | 6.0% | E.6.0% |
| Proportion of the population (75+) accessing dementia ARC services | A$^{\Delta}$ | Total | 2.6% | 2.5% | E. 2.5% |
| Proportion of the population (75+) accessing psychogeriatric ARC services | A$^{\Delta}$ | Total | 0.8% | 0.7% | E. <1% |
| People entering ARC having had a clinical assessment using InterRAI | Q[40]$^{\Delta}$ | Total | 84% | 87% | 95% |

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

[37] Aligns with the Canterbury model of care to keep people in their homes longer.

[38] Respite services aim to support people for short durations, to regain function or to give carers a break. The proportion of people being discharged home (rather than staying on in ARC) reflects the effectiveness of services in terms of assisting people to maintain or regain their functional independence.

[39] 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.

[40] 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. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services.

# Statement of Financial Expectations

## 3.1 Canterbury's financial outlook

Like the rest of the health sector, we are experiencing growing demand pressures as our population ages and increasing fiscal pressures as treatment, infrastructure and wage costs raise. We also face several unique challenges related to rapid population growth, our role as a tertiary provider and facilities constraints which add to our operating challenges.

Increasing demand costs: Significant population growth and the ageing of our population and major evens over the last decade have contributed to increasing demand and treatment related costs, particularly those associated with acute service demand and mental health services. Predicted population growth indicates that even further capacity will be needed to meet system needs.

Interest, depreciation and capital charges: Interest, depreciation and capital charges are driven off upward movements in asset valuations and earthquake repair work which have contributed to significant asset revaluations over the last decade. As anticipated when the business case was approved, the recently commissioned Waipapa facility will add further depreciation and capital charge expense to the DHB. While we will receive capital charge relief for Waipapa, under the new capital charge regulations, the relief is lower than the capital charge expense as the relief formula is adjusted for the deficit incurred by the DHB.

Multi Employment Collective Agreement (MECA) settlement costs: While we received partial funding to offset some of the cost in past years, settled MECAs have significantly exceeded the affordability parameters of the DHB. The flow on impact of these settlements, along with the substantial claims of unsettled expired MECAs and expectations of staff on Individual Employment Agreements over the coming year, will put immense pressure on our financial sustainability. This pressure will also flow onto external providers who will look to the DHB for additional funding to manage their increased costs.

Holidays Act compliance: While we have made a provision for costs associated with compliance with the Holidays Act, this has been based on sampling. The actual liability will not be finalised until after a detailed remediation project has been completed. Ongoing costs associated with this project will impact on employee costs and cashflow to settle the historic amounts will require additional Crown funding.

COVID-19: The cost of resourcing the Managed Isolation & Quarantine Facilities (MIQF), providing testing, immunisations and other COIVD-19 related services are assumed to be fully funded. However, there are a range of unfunded resultant costs associated with the COVID-19 response and recovery that continue to impact negatively on the DHB finances, for example, disruption to supply chain has significantly increased the cost of clinical supplies.

## 3.2 Forecast financial results

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

Canterbury DHB will receive approximately $2.232 billion of total revenue from all sources to meet the needs of our population in 2021/22, including COVID-19 MIQF and testing related services. The DHB is forecasting a deficit of $149 million for 2021/22, including net COVID-19 and Holidays Act related revenue and costs of $16 million.

### OUT-YEARS' SCENARIO

Our fiscal pressures are compounded by significant capital-related charges associated with the repair of damaged buildings, and the building of new ones. Interest, depreciation and capital charges contribute to our total deficit in the outyears of this Plan.

The combined annual interest, depreciation and capital charge (after net capital charge funding adjustments) will increase from $123 million in 2020/21 to approximately $125 million in 2021/22.

The remainder of the deficit is related to operating costs, and the Board and management team have made a strong commitment to identify efficiencies to reduce this operating deficit. We continue to work collaboratively with the Ministry of Health to establish a sustainable financial track for out years, leading to a projected break-even financial result in 2024/25.

## 3.3 Bridging the gap

We have a significant financial deficit. If we are to be sustainable into the future, we must rethink how we will meet our population's needs within a more moderate growth platform.

In the past ten years, our ability to absorb revenue and cost impacts have largely been delivered by slowing our rate of growth in acute demand, reducing our dependence on aged residential care and integrating information and service delivery models between primary, community and hospital settings.

However, future predicted population growth, recent growth in acute demand and additional cost pressures mean we need to further challenge the way health services are delivered and configured. We also need to identify further efficiencies and quality improvements

to ensure we deliver a sustainable model of health care into the future.

In returning to a financially sustainable operating result, a comprehensive program of work and initiatives is being rolled out deliberately focused on making the most effective and efficient use of the resources we have available. This will include modernising service delivery models, optimising the revenue streams, capturing the lessons learnt and successes from across our health system and prioritising resources into services providing the greatest return on investment.

Following the commissioning of Waipapa, we have repatriated outplaced services and will continue to actively work on repatriating clinically appropriate outsourced services back into our facilities over time. This work will also include a purposeful and deliberate approach to clinical services and production planning, with a forward focus on meeting the growing demand for health services. This will be a sizable piece of work and will support improved use of our system resources and significantly reduce our operating expenditure.

The migration to Waipapa will also allow us to introduce our resource optimisation programme, making efficiency savings by co-locating and consolidating services, integrating rosters and supporting more integrated service models pre and post admission to support patient flow.

A strong focus on leave care, absenteeism and the management of sick and annual leave will also contribute to reducing our organisational liabilities without impacting on the quality of service delivery.

Savings identified for the coming year and two out-years have been highlighted in the Delivering Against National Priorities and Targets section of this Plan. Service changes proposed for the coming year are outlined in the Service Configuration section.

The Board and Executive Management Team are committed to reducing the DHB's financial deficit and ensuring sustainable future for our health system. Equity of access and quality of services will remain a key focus and the DHB will continue to work with our people, providers and communities as we move forward in our journey.

## 3.4 Major assumptions

Revenue and expenditure estimates for out-years have been based on current government policy, service delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results. In preparing our financial forecasts, we have made the following assumptions:

- The DHB will retain early payment arrangements.
- Operating deficits will be fully funded, as equity.
- Capital charge for out-years is based on the current rate of 5%. Any rate change in the future is assumed to be financially neutral.
- Capital charge associated with pre-approved and future-approved Crown equity for capital projects is funded, per existing capital charge regulations.
- Capital charge associated with historic and future earthquake settlement proceeds redrawn as equity will continue to be payable to the Crown.
- Any future targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- $94 million (being the forecast undrawn portion of CDHB's $290 million earthquake settlement proceeds transferred to the Crown, as at June 2021), will be available to fund the earthquake repair and reinstatement programme as required.

  The balance of $94 million will be insufficient to address all the required EQ repairs, due to unplanned costs coming out of this settlement related to the redevelopment of the Waipapa Building and completion of the Boiler House and Energy Centre and is fully committed.
- As agreed with the Ministry, revenue and equity timing of the earthquake insurance draw-downs will be flexible and based on DHB requests, rather than necessarily matching the earthquake capital and operating repair spend for a particular year.
- Additional saving targets requiring service changes and/or Ministerial consent are approved in a timely manner.
- The redevelopment of Canterbury facilities is in accordance with the detailed business cases agreed with the Ministry and previous Cabinet. Associated capital expenditure and resulting depreciation and capital charge for formally agreed detailed business cases that will take place during the term of this Plan have been included, as appropriate.
- Revaluations of land and buildings will continue in line with NZ accounting standards. The DHB revalued its land and building assets as at 30 June 2021. The indicative impact, of net valuations, on depreciation and capital charge expenses and capital charge funding, is included in the Plan.
- Employee cost increases for expired wage agreements, including minimum wage flow-on impact if any, will be settled on fiscally sustainable terms, and within the DHB's nominal allowance, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment-related and non-clinical supplies costs will increase in line with known inflation factors, insourcing electives that are currently outsourced

and foreseen adjustments for the impact of service growth.

- National and regional savings initiatives and benefits will be achieved as planned.
- Transformation strategies will not be delayed or derailed due to sector or legislative changes and investment to meet increased demand will be approved in line with the Board's strategy.
- There will be no further disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no further disruptions.

There are several significant risks impacting the CDHB financial plan, as follows:

- MECA increases greater than 1.5% and further industrial action.
- Cost associated with the Euthanasia bill (November 2021) and low and moderate family care support payments, if not fully funded.
- COVID-19 2020/21 non-presentation impact on 2021/22 (increased referrals and admissions to secondary care).
- COVID-19 non-direct supply chain impacts.
- Bowel screening impact of addition of 150 new colon cancer initial and follow-up surgeries not-funded under elective uplift.
- Air ambulance and electricity price uplift greater than assumed.
- CWD pricing national uplift less than projected cost.
- COVID-19 vaccination programme impact on ongoing 'business as usual' (BAU) services.
- Winter demand higher than projected.
- Care Capacity Demand Management (CCDM) costs exceeding assumption.
- Capitation – enrolled population growth continues to be greater than the funded Canterbury population growth.
- Other NGOs price uplift exceeding assumption.
- Pay equity calculations yet to be determined and may exceed top-slice additional funding.
- MOH approval delayed, or not being granted for any service changes related to savings initiatives.
- Transition to Health NZ.

We note that due to the recognition of insurance proceeds in 2012/13 (as required under NZ accounting standards and resulting in an 'atypical' surplus of $287M in 2012/13), some future costs are not able to be offset with the corresponding inflow of insurance proceeds. This creates a timing mismatch in current and out-years.

## 3.5 Capital investment

### NATIONAL BUSINESS CASES

The national business cases currently approved or the DHB is making plans for include:

- Relocation of mental health inpatient services from The Princess Margaret Hospital, approved December 2018.
- Christchurch Hospital Waipapa Tower 3 and Enabling works, approved November 2020.
- Christchurch Hospital Compliance Works project (endorsed in principle by the Ministers of Finance and Health) and revised detailed business case, awaiting formal Ministers approval.
- Hillmorton Hospital campus facility master plan programme business case submitted to the Ministry of Health and Capital Investment Committee in November 2020, awaiting approval.
- Canterbury Health Laboratories and Cancer Centre facilities redevelopment were included in the wider Programme Business Case for the Christchurch Hospital campus submitted to Hospital Redevelopment Partnership Group and Ministry of Health for consideration in November 2019, awaiting approval.

### CAPITAL EXPENDITURE

Canterbury's capital plan for 2021/22, excluding yet to be approved planned strategic investments, totals $122 million and is comprised of:

- $57 million progress payments for the approved detailed business case to relocate inpatient mental health services from The Princess Margaret Hospital.
- $2 million progress project payments for the approved relocation of Child and Family mental health outpatient services currently located on The Princess Margaret Hospital site.
- $16 million for the capital expenditure portion of the earthquake programme of works (includes ring-fenced Christchurch hospital campus compliance works progress spend).
- $4 million progress payments for the approved Selwyn Health and Social Services Hub fit-out.
- $3 million for linear accelerator replacement funded by the Crown.
- $6 million CDHB funded portion for the Parkside (A&B) enhancement tranche 1.
- $34 million for other baseline spend, primarily on replacement assets and systems which are past their economic useful life.

Anticipated investments for out-years, in addition to business cases submitted and under consideration by Crown officials, include but are not limited to:

- Strategic Information Technology developments towards a digital hospital including: Anaesthetic Electronic Record, e-orders (Labs), Payroll replacement system, Health One and ERMS.
- Clinical equipment aligning to strategic service delivery including additional linear accelerator (T5) and additional Cathlab.
- Repair and reinstatement of the Christchurch Hospital Energy Centre and Carpark.
- Continued repair and reinstatement of assets under the DHB's earthquake repair programme.
- Christchurch Hospital campus – remaining Parkside enhancement works, Tower 4, kitchen, fit-out of remaining T3 wards, workplaces etc.
- Compliance and remediation works at other CDHB hospital campuses e.g. passive fire and asbestos removal.
- Chatham Island masterplan and Ashburton hospital inpatient and infrastructure works.

Out-years capital planning will also consider the future use of existing buildings and facilities, in line with our earthquake repair programme, and in response to population growth and service demand. This will include buildings on the Christchurch Hospital and Hillmorton Hospital campuses and the future use of our rural hospital sites.

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

## 3.6 Debt and equity

The Canterbury DHB repaid equity to the Crown of $180 million as part of our contribution towards the Burwood and Christchurch Hospital redevelopments.

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

In June 2014, we paid $290 million (being the unspent portion of the $320 million as at June 2014) of our earthquake settlement insurance proceeds to the Crown to minimise capital charge expenses (arising from an abnormal surplus through recognising the settlement proceeds as income under current NZ accounting standards). As agreed with the Ministry of Health, the $290 million is being progressively drawn down to fund ongoing earthquake repair work.

The forecast amount drawn down as at 30 June 2021, is $196 million, with a balance of $94 million yet to be redrawn.

Considering projected equity movements, the Crown's equity in the DHB will rise from $1.12 billion as at June 2021 to $1.22 billion by June 2022, primarily driven by equity drawdowns for the Mental Health inpatient projects and earthquake capital works. The higher equity balance will result in an increase in the capital charge payable to the Crown.

## 3.7 Additional considerations

### DISPOSAL OF LAND

Under the NZ Public Health and Disability Act 2000, no DHB may dispose of land without the prior written approval of the Minister of Health and the DHB must first have complied with its statutory clearance and public consultation obligations under the Act.

The DHB is yet to determine its future requirements for the former Christchurch Women's Hospital site in the central city and The Princess Margaret Hospital site in Cashmere. The former Women's Hospital site is vacant bare land, the buildings having previously been demolished and removed. The remaining services at The Princess Margaret Hospital will be migrated to new Specialist Mental Health facilities being constructed at on the Hillmorton Hospital campus.

Over the next few years, Canterbury DHB will also consider its future service and facility requirements in some of its rural localities. Necessary approvals will be sought prior to disposal of any DHB land identified as surplus to requirements.

### ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

### ACQUISITION OF SHARES

Under the New Zealand Public Health and Disability Act 2000, no DHB may hold any shares or interests in an entity or in a partnership or joint venture, or settle or be appointed trustee of a trust, except with the consent of the Minister or as permitted by Regulations made under the Act:

The DHB is not intending to subscribe for shares in any bodies corporate or interests in associations in 2021/22.

### ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior years. These are presented in the DHB's Statement of Intent and Annual Report, available on our website.

## 3.8 Group Statement of Financial Performance (Comprehensive Income)

| | 2019/20 Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| REVENUE | | | | | | |
| Ministry of Health revenue (Note 1) | 1,872,987 | 2,000,593 | 2,091,407 | 2,171,185 | 2,273,401 | 2,380,568 |
| Other government revenue | 40,523 | 61,022 | 65,127 | 66,624 | 68,165 | 69,753 |
| Earthquake repair revenue redrawn | 6,846 | 364 | 800 | 300 | - | - |
| Other revenue | 59,149 | 65,133 | 75,073 | 77,480 | 79,745 | 81,769 |
| **Total Revenue** | **1,979,505** | **2,127,112** | **2,232,407** | **2,315,589** | **2,421,311** | **2,532,090** |
| EXPENSE | | | | | | |
| Personnel | 978,834 | 995,203 | 1,029,965 | 1,058,221 | 1,091,874 | 1,126,674 |
| Outsourced personnel & clinical serrvices | 33,232 | 35,597 | 57,640 | 47,743 | 42,877 | 39,060 |
| Clinical supplies | 154,268 | 170,704 | 172,737 | 176,032 | 181,070 | 186,609 |
| Earthquake building repair costs | 6,846 | 364 | 800 | 300 | - | - |
| Infrastructure & non clinical | 118,440 | 125,513 | 119,319 | 120,430 | 123,119 | 125,165 |
| External service providers | 810,043 | 844,188 | 851,785 | 854,613 | 875,976 | 897,875 |
| **Total Expense Before Depreciation & Capital Charge** | **2,101,663** | **2,171,569** | **2,232,246** | **2,257,339** | **2,314,916** | **2,375,383** |
| **Surplus/(Deficit) Before Depreciation & Capital Charge** | **(122,158)** | **(44,457)** | **161** | **58,250** | **106,395** | **156,707** |
| Depreciation and amortisation | 79,773 | 89,676 | 92,104 | 91,741 | 85,993 | 85,491 |
| Capital charge and interest expense | 41,505 | 42,080 | 57,064 | 63,471 | 69,188 | 70,296 |
| **Total Depreciation, Capital Charge & Interest Expense** | **121,278** | **131,756** | **149,168** | **155,212** | **155,181** | **155,787** |
| **Surplus/(Deficit)** | **(243,436)** | **(176,213)** | **(149,007)** | **(96,962)** | **(48,786)** | **920** |
| OTHER COMPREHENSIVE REVENUE & EXPENSE | | | | | | |
| Revaluation of property, plant & equipment | (3,068) | 95,482 | - | - | - | - |
| **Total Comprehensive Income/(Deficit)** | **(246,504)** | **(80,731)** | **(149,007)** | **(96,962)** | **(48,786)** | **920** |

Note 1: Includes capital charge relief funding for Waipapa and asset revaluation, where applicable.

## 3.9 Group Statement of Financial Position

| | 30/06/20 Actual $'000 | 30/06/21 Unaudited Actual $'000 | 30/06/22 Plan $'000 | 30/06/23 Plan $'000 | 30/06/24 Plan $'000 | 30/06/25 Plan $'000 |
|---|---|---|---|---|---|---|
| **CROWN EQUITY** | | | | | | |
| Contributed capital | 410,658 | 1,126,421 | 1,374,917 | 1,584,801 | 1,663,940 | 1,848,210 |
| Revaluation reserve | 423,336 | 518,818 | 518,818 | 518,818 | 518,818 | 518,818 |
| Accumulated surpluses | (343,264) | (519,477) | (668,484) | (765,446) | (814,232) | (813,312) |
| **Total Equity** | **490,730** | **1,125,762** | **1,225,251** | **1,338,173** | **1,368,526** | **1,553,716** |
| REPRESENTED BY: | | | | | | |
| CURRENT ASSETS | | | | | | |
| Cash & cash equivalents | 4,056 | 50,775 | 120,487 | 210,945 | 289,792 | 373,107 |
| Trade & other receivables | 111,502 | 113,435 | 113,435 | 113,435 | 113,435 | 113,435 |
| Inventories | 14,549 | 13,811 | 13,811 | 13,811 | 13,811 | 13,811 |
| Restricted assets | 14,666 | 15,094 | 15,094 | 15,094 | 15,094 | 15,094 |
| Assets held for sale | - | - | - | - | - | - |
| Investments | 750 | 750 | 750 | 750 | 750 | 750 |
| Total Current Assets | 145,523 | 193,865 | 263,577 | 354,035 | 432,882 | 516,197 |
| CURRENT LIABILITIES | | | | | | |
| NZHPL sweep bank account | 11,032 | - | - | - | - | - |
| Trade & other payables | 165,172 | 155,220 | 155,220 | 155,220 | 155,220 | 155,220 |
| Employee benefits | 343,643 | 381,696 | 381,696 | 381,696 | 381,696 | 381,696 |
| Restricted funds | 14,682 | 15,110 | 15,110 | 15,110 | 15,110 | 15,110 |
| Borrowings & Finance Leases | 205 | 1,682 | 1,682 | 1,682 | 1,682 | 1,682 |
| Total Current Liabilities | 534,734 | 553,708 | 553,708 | 553,708 | 553,708 | 553,708 |
| Net Working Capital | (389,211) | (359,843) | (290,131) | (199,673) | (120,826) | (37,511) |
| NON CURRENT ASSETS | | | | | | |
| Investments in Associates & HPL | - | 4,253 | 4,253 | 4,253 | 4,253 | 4,253 |
| Property, plant, & equipment | 866,467 | 1,497,385 | 1,529,834 | 1,554,730 | 1,508,159 | 1,612,004 |
| Intangible assets | 46,314 | 40,537 | 37,865 | 35,433 | 33,510 | 31,540 |
| Restricted assets | 16 | 16 | 16 | 16 | 16 | 16 |
| Total Non-Current Assets | 912,797 | 1,542,191 | 1,571,968 | 1,594,432 | 1,545,938 | 1,647,813 |
| NON CURRENT LIABILITIES | | | | | | |
| Employee benefits | 6,304 | 7,544 | 7,544 | 7,544 | 7,544 | 7,544 |
| Borrowings and Finance Leases | 26,552 | 49,042 | 49,042 | 49,042 | 49,042 | 49,042 |
| Total Non-Current Liabilities | 32,856 | 56,586 | 56,586 | 56,586 | 56,586 | 56,586 |
| **Net Assets** | **490,730** | **1,125,762** | **1,225,251** | **1,338,173** | **1,368,526** | **1,553,716** |

Note: Cash position assumes CDHB receives full equity deficit support indicative funding.

## 3.10 Group Statement of Movements in Equity

| | 2019/20 Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| Total equity at beginning of the year | 597,377 | 490,730 | 1,125,762 | 1,225,251 | 1,338,173 | 1,368,526 |
| Total comprehensive revenue and expense for the year | (246,504) | (80,731) | (149,007) | (96,962) | (48,786) | 920 |
| OTHER MOVEMENTS | | | | | | |
| EQUITY REPAYMENTS | | | | | | |
| *Assets disposal net proceeds remitted to Crown* | - | - | - | - | - | - |
| *Annual depreciation funding repayment* | (1,861) | (1,861) | (1,861) | (1,861) | (1,861) | (1,861) |
| EQUITY INJECTIONS | | | | | | |
| *Earthquake repair capital redrawn* | 5,994 | 9,650 | 28,000 | 65,000 | - | - |
| *Equity support* | 130,000 | 180,000 | 153,000 | 139,000 | 81,000 | 32,000 |
| *Waipapa facility transferred from Crown* | - | 525,050 | - | - | - | - |
| *Mental Health Inpatients equity drawn* | 2,455 | 1,435 | 69,357 | 7,745 | - | - |
| *Chch Hospital Tower 3 facility transferred from Crown* | | | - | - | - | 154,131 |
| *Other movements* | 3,269 | 1,489 | - | - | - | - |
| **Total Equity at End of the Year** | **490,730** | **1,125,762** | **1,225,251** | **1,338,173** | **1,368,526** | **1,553,716** |

Note: Some equity injections are 'non-cash' transactions e.g. Waipapa, Tower 3, Tunnel and Energy Centre. The $9.650M of earthquake repair capital redrawn in 2020/21 relates to capital value of the tunnel asset transferred from the Crown. This amount plus the $525.050M equity for the Waipapa facility transferred from the Crown equates to the $534.700M total equity draw down as set out in the "Handover Agreement for the Christchurch Hospital Hagley and Related Project Works" document.

## 3.11 Group Statement of Cash Flow

| | 2019/20 Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| CASH FLOW FROM OPERATING ACTIVITIES | | | | | | |
| Cash provided from: | | | | | | |
| *Receipts from Ministry of Health* | 1,859,630 | 2,011,643 | 2,091,407 | 2,171,185 | 2,273,401 | 2,380,568 |
| *Earthquake repair revenue redrawn* | 6,846 | 364 | 800 | 300 | - | - |
| *Other receipts* | 106,156 | 120,142 | 139,500 | 143,204 | 146,840 | 150,372 |
| *Interest received* | 695 | 1,075 | 700 | 900 | 1,070 | 1,150 |
| | 1,973,327 | 2,133,224 | 2,232,407 | 2,315,589 | 2,421,311 | 2,532,090 |
| Cash applied to: | | | | | | |
| *Payments to employees* | 880,391 | 955,910 | 1,029,965 | 1,058,221 | 1,091,874 | 1,126,674 |
| *Payments to suppliers* | 1,113,569 | 1,166,049 | 1,202,281 | 1,199,118 | 1,223,042 | 1,248,709 |
| *Capital charge and interest paid* | 28,979 | 54,605 | 57,064 | 63,471 | 69,188 | 70,296 |
| *GST - net* | (1,219) | (370) | - | - | - | - |
| | 2,021,720 | 2,176,194 | 2,289,310 | 2,320,810 | 2,384,104 | 2,445,679 |
| **Net Cash Flow from Operating Activities** | **(48,393)** | **(42,970)** | **(56,903)** | **(5,221)** | **37,207** | **86,411** |
| CASH FLOW FROM INVESTING ACTIVITIES | | | | | | |
| Cash provided from: | | | | | | |
| *Sale of property, plant, & equipment* | 17 | 2,736 | - | - | - | - |
| *Receipt from investments and restricted assets* | - | - | - | - | - | - |
| | 17 | 2,736 | - | - | - | - |
| Cash applied to: | | | | | | |
| *Purchase of investments & restricted assets* | 225 | 1,036 | - | - | - | - |
| *Purchase of property, plant, & equipment* | 63,577 | 80,553 | 121,881 | 69,295 | 37,499 | 33,235 |
| | 63,802 | 81,589 | 121,881 | 69,295 | 37,499 | 33,235 |
| **Net Cash Flow from Investing Activities** | **(63,785)** | **(78,853)** | **(121,881)** | **(69,295)** | **(37,499)** | **(33,235)** |
| CASH FLOW FROM FINANCING ACTIVITIES | | | | | | |
| Cash provided from: | | | | | | |
| Equity Injections | | | | | | |
| *Earthquake repair capital redrawn (Note 2)* | 5,994 | - | 28,000 | 20,090 | - | - |
| *Mental Health Inpatients equity drawn* | 2,455 | 1,435 | 69,357 | 7,745 | - | - |
| *Operating deficit equity support (Note 3)* | 130,000 | 180,000 | 153,000 | 139,000 | 81,000 | 32,000 |
| | 138,449 | 181,435 | 250,357 | 166,835 | 81,000 | 32,000 |
| Cash applied to: | | | | | | |
| *Capital repayments* | 1,661 | 1,861 | 1,861 | 1,861 | 1,861 | 1,861 |
| | 1,661 | 1,861 | 1,861 | 1,861 | 1,861 | 1,861 |
| **Net Cash Flow from Financing Activities** | **136,788** | **179,574** | **248,496** | **164,974** | **79,139** | **30,139** |
| NET CASHFLOW | | | | | | |
| Net increase/(decrease) in cash and cash equivalents | 24,610 | 57,751 | 69,712 | 90,458 | 78,847 | 83,315 |
| Cash and cash equivalents at beginning of year | (31,586) | (6,976) | 50,775 | 120,487 | 210,945 | 289,792 |
| **Cash and cash equivalents at end of year** | **(6,976)** | **50,775** | **120,487** | **210,945** | **289,792** | **373,107** |
| **REPRESENTED BY:** | | | | | | |
| Cash & cash equivalents | 4,056 | 50,775 | 120,487 | 210,945 | 289,792 | 373,107 |
| NZHPL sweep bank account | (11,032) | - | - | - | - | - |
| **CASH & CASH EQUIVALENTS AT END OF YEAR** | **(6,976)** | **50,775** | **120,487** | **210,945** | **289,792** | **373,107** |

Note 2: Excludes Earthquake repair capital redrawn that are 'non-cash' transactions (e.g. Tunnel & Energy Centre).
Note 3: Assumes CDHB receives full equity deficit support.

## 3.12 Summary of revenue and expenses by arm

| | 2019/20 Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| **Funding Arm** | | | | | | |
| REVENUE | | | | | | |
| Ministry of Health revenue | 1,798,466 | 1,920,799 | 2,014,856 | 2,091,466 | 2,190,378 | 2,294,100 |
| Other government revenue | 2,792 | 2,274 | 2,301 | 2,174 | 2,197 | 2,222 |
| Other revenue | 412 | 936 | 8,105 | 7,664 | 7,884 | 8,112 |
| **Total Revenue** | **1,801,670** | **1,924,009** | **2,025,262** | **2,101,304** | **2,200,459** | **2,304,434** |
| EXPENSE | | | | | | |
| Personal Health | 1,371,158 | 1,455,360 | 1,536,563 | 1,574,954 | 1,640,235 | 1,707,029 |
| Mental Health | 174,249 | 185,770 | 194,542 | 199,821 | 206,837 | 214,106 |
| Disability Support | 310,712 | 313,041 | 345,262 | 354,212 | 364,056 | 374,186 |
| Public Health | 23,260 | 21,783 | 18,541 | 4,191 | 4,298 | 4,407 |
| Maori Health | 2,579 | 2,431 | 3,403 | 3,489 | 3,577 | 3,667 |
| **Total Expense Before Depreciation & Capital Charge** | **1,881,958** | **1,978,385** | **2,098,311** | **2,136,667** | **2,219,003** | **2,303,395** |
| **Surplus/(Deficit) Before Depreciation & Capital Charge** | **(80,288)** | **(54,376)** | **(73,049)** | **(35,363)** | **(18,544)** | **1,039** |
| Depreciation and amortisation | - | - | - | - | - | - |
| Capital charge and interest expense | - | - | - | - | - | - |
| **Total Depreciation, Capital Charge & Interest Expense** | **-** | **-** | **-** | **-** | **-** | **-** |
| **Surplus/(Deficit)** | **(80,288)** | **(54,376)** | **(73,049)** | **(35,363)** | **(18,544)** | **1,039** |
| Other comprehensive revenue and expense | - | - | - | - | - | - |
| **Total Comprehensive Income/(Deficit)** | **(80,288)** | **(54,376)** | **(73,049)** | **(35,363)** | **(18,544)** | **1,039** |
| **Governance & Funder Admin** | | | | | | |
| REVENUE | | | | | | |
| Ministry of Health revenue | 5,465 | 5,897 | 6,997 | 5,335 | 5,213 | 5,170 |
| Other government revenue | - | - | - | - | - | - |
| Other revenue | 26 | 8 | - | - | - | - |
| **Total Revenue** | **5,491** | **5,905** | **6,997** | **5,335** | **5,213** | **5,170** |
| EXPENSE | | | | | | |
| Personnel | 10,595 | 9,694 | 11,085 | 11,140 | 11,196 | 11,266 |
| Outsourced personnel & clinical serrvices | 2,281 | 2,955 | 3,815 | 2,978 | 2,915 | 2,894 |
| Clinical supplies | 52 | 95 | 42 | 43 | 44 | 45 |
| Earthquake building repair costs | - | - | - | - | - | - |
| Infrastructure & non clinical | (7,603) | (7,631) | (8,341) | (9,222) | (9,338) | (9,431) |
| External service providers | - | - | - | - | - | - |
| **Total Expense Before Depreciation & Capital Charge** | **5,325** | **5,113** | **6,601** | **4,939** | **4,817** | **4,774** |
| **Surplus/(Deficit) Before Depreciation & Capital Charge** | **166** | **792** | **396** | **396** | **396** | **396** |
| Depreciation and amortisation | 395 | 551 | 396 | 396 | 396 | 396 |
| Capital charge and interest expense | - | - | - | - | - | - |
| **Total Depreciation, Capital Charge & Interest Expense** | **395** | **551** | **396** | **396** | **396** | **396** |
| **Surplus/(Deficit)** | **(229)** | **241** | **-** | **-** | **-** | **-** |
| Other comprehensive revenue and expense | - | - | - | - | - | - |
| **Total Comprehensive Income/(Deficit)** | **(229)** | **241** | **-** | **-** | **-** | **-** |

## Summary of revenue and expenses by arm (continued)

| | 2019/20 Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| **Provider Arm** | | | | | | |
| REVENUE | | | | | | |
| Ministry of Health revenue | 1,140,971 | 1,208,094 | 1,316,080 | 1,356,438 | 1,420,837 | 1,486,818 |
| Other government revenue | 37,731 | 58,748 | 62,826 | 64,450 | 65,968 | 67,531 |
| Earthquake repair revenue redrawn | 6,846 | 364 | 800 | 300 | - | - |
| Other revenue | 58,711 | 64,189 | 66,968 | 69,816 | 71,861 | 73,657 |
| **Total Revenue** | **1,244,259** | **1,331,395** | **1,446,674** | **1,491,004** | **1,558,666** | **1,628,006** |
| EXPENSE | | | | | | |
| Personnel | 968,239 | 985,509 | 1,018,880 | 1,047,081 | 1,080,678 | 1,115,408 |
| Outsourced personnel & clinical serrvices | 30,951 | 32,642 | 53,825 | 44,765 | 39,962 | 36,166 |
| Clinical supplies | 154,216 | 170,609 | 172,695 | 175,989 | 181,026 | 186,564 |
| Earthquake building repair costs | 6,846 | 364 | 800 | 300 | - | - |
| Infrastructure & non clinical | 126,043 | 133,144 | 127,660 | 129,652 | 132,457 | 134,596 |
| **Total Expense Before Depreciation & Capital Charge** | **1,286,295** | **1,322,268** | **1,373,860** | **1,397,787** | **1,434,123** | **1,472,734** |
| **Surplus/(Deficit) Before Depreciation & Capital Charge** | **(42,036)** | **9,127** | **72,814** | **93,217** | **124,543** | **155,272** |
| Depreciation and amortisation | 79,378 | 89,125 | 91,708 | 91,345 | 85,597 | 85,095 |
| Capital charge and interest expense | 41,505 | 42,080 | 57,064 | 63,471 | 69,188 | 70,296 |
| **Total Depreciation, Capital Charge & Interest Expense** | **120,883** | **131,205** | **148,772** | **154,816** | **154,785** | **155,391** |
| **Surplus/(Deficit)** | **(162,919)** | **(122,078)** | **(75,958)** | **(61,599)** | **(30,242)** | **(119)** |
| OTHER COMPREHENSIVE REVENUE & EXPENSE | | | | | | |
| Revaluation of property, plant & equipment | (3,068) | 95,482 | - | - | - | - |
| Impairment of property, plant & equipment | - | - | - | - | - | - |
| **Total Comprehensive Income/(Deficit)** | **(165,987)** | **(26,596)** | **(75,958)** | **(61,599)** | **(30,242)** | **(119)** |
| **In House Elimination** | | | | | | |
| REVENUE | | | | | | |
| Ministry of Health revenue | (1,071,915) | (1,134,197) | (1,246,526) | (1,282,054) | (1,343,027) | (1,405,520) |
| **Total Revenue** | **(1,071,915)** | **(1,134,197)** | **(1,246,526)** | **(1,282,054)** | **(1,343,027)** | **(1,405,520)** |
| EXPENSE | | | | | | |
| Payments to internal providers | (1,071,915) | (1,134,197) | (1,246,526) | (1,282,054) | (1,343,027) | (1,405,520) |
| **Total Expense** | **(1,071,915)** | **(1,134,197)** | **(1,246,526)** | **(1,282,054)** | **(1,343,027)** | **(1,405,520)** |
| **Surplus/(Deficit)** | - | - | - | - | - | - |
| Other comprehensive revenue and expense | - | - | - | - | - | - |
| **Total Comprehensive Income/(Deficit)** | - | - | - | - | - | - |

## Summary of revenue and expenses by arm (continued)

| | 2019/20 Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| **CONSOLIDATED** | | | | | | |
| REVENUE | | | | | | |
| Ministry of Health revenue | 1,872,987 | 2,000,593 | 2,091,407 | 2,171,185 | 2,273,401 | 2,380,568 |
| Other government revenue | 40,523 | 61,022 | 65,127 | 66,624 | 68,165 | 69,753 |
| Earthquake repair revenue redrawn | 6,846 | 364 | 800 | 300 | - | - |
| Other revenue | 59,149 | 65,133 | 75,073 | 77,480 | 79,745 | 81,769 |
| **Total Revenue** | **1,979,505** | **2,127,112** | **2,232,407** | **2,315,589** | **2,421,311** | **2,532,090** |
| EXPENSE | | | | | | |
| Personnel | 978,834 | 995,203 | 1,029,965 | 1,058,221 | 1,091,874 | 1,126,674 |
| Outsourced personnel & clinical serrvices | 33,232 | 35,597 | 57,640 | 47,743 | 42,877 | 39,060 |
| Clinical supplies | 154,268 | 170,704 | 172,737 | 176,032 | 181,070 | 186,609 |
| Earthquake building repair costs | 6,846 | 364 | 800 | 300 | - | - |
| Infrastructure & non clinical | 118,440 | 125,513 | 119,319 | 120,430 | 123,119 | 125,165 |
| External service providers | 810,043 | 844,188 | 851,785 | 854,613 | 875,976 | 897,875 |
| **Total Expense Before Depreciation & Capital Charge** | **2,101,663** | **2,171,569** | **2,232,246** | **2,257,339** | **2,314,916** | **2,375,383** |
| **Surplus/(Deficit) Before Depreciation & Capital Charge** | **(122,158)** | **(44,457)** | **161** | **58,250** | **106,395** | **156,707** |
| Depreciation and amortisation | 79,773 | 89,676 | 92,104 | 91,741 | 85,993 | 85,491 |
| Capital charge and interest expense | 41,505 | 42,080 | 57,064 | 63,471 | 69,188 | 70,296 |
| **Total Depreciation, Capital Charge & Interest Expense** | **121,278** | **131,756** | **149,168** | **155,212** | **155,181** | **155,787** |
| **Surplus/(Deficit)** | **(243,436)** | **(176,213)** | **(149,007)** | **(96,962)** | **(48,786)** | **920** |
| OTHER COMPREHENSIVE REVENUE & EXPENSE | | | | | | |
| Revaluation of property, plant & equipment | (3,068) | 95,482 | - | - | - | - |
| **Total Comprehensive Income/(Deficit)** | **(246,504)** | **(80,731)** | **(149,007)** | **(96,962)** | **(48,786)** | **920** |

# APPENDICES

## Further Information

## Appendices

| | |
|---|---|
| Appendix 1 | Glossary of Terms |
| Appendix 2 | Overarching Intervention Logic Diagram |
| Appendix 3 | Statement of Accounting Policies |

## Documents of interest

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

- Canterbury DHB Annual Plan
- Canterbury DHB Statement of Intent
- Canterbury System Level Measures Improvement Plan
- Canterbury Disability Action Plan

## References

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

# Appendix 1 Glossary of Terms

| | | |
|---|---|---|
| ADMS | Acute Demand Management Service | Refers to the service whereby general practice and acute community nursing deliver packages of care that enable people who would otherwise need an ED visit or hospital admission to be treated in the community or in their own homes. |
| | Baby Friendly Hospital Initiative | A worldwide programme led by the World Health Organization and UNICEF to encourage a high standard of care. An assessment/accreditation process recognises the standard. |
| CCN | The Canterbury Clinical Network District Alliance | The CCN is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury Health System. The Alliance provides leadership to enable the transformation of the health system in collaboration with system partners and on behalf of the population. |
| CREST | Community Rehabilitation Enablement and Support Team | Community Rehabilitation Enablement and Support Team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. The Team is a collaboration across primary and secondary services and has been instrumental in reducing acute demand for hospital services and rates of aged residential care. |
| ERMS | Electronic Referral Management System | ERMS is available from the GP desktop, and enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged. |
| ESPIs | Elective Services Patient flow Indicators | The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including wait times from referral to assessment and wait times from decision to treatment. |
| | Health Connect South | A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in Canterbury, West Coast and South Canterbury, it is being rolled out across the rest of the South Island. |
| interRAI | International Resident Assessment Instrument | A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need. |
| | Manawhenua Ki Waitaha | The Manawhenua Advisory Group made up of the manawhenua health advisors mandated by the Papatipu Rūnanga as the Te Tiriti o Waitangi partners to the Canterbury DHB. Manawhenua Ki Waitaha works independently and alongside the DHB to develop and implement strategies for Māori health gain, support the delivery of health and disability support services consistent with Māori cultural concepts, values, and practices, and support Māori aspirations for health, reducing inequalities between Māori and other New Zealanders. |
| NHI | National Health Index | An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ. |
| PHO | Primary Health Organisation | Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them, either directly or through their provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care. |
| PRIMHD | Programme for the Integration of Mental Health Data | The Ministry of Health's national mental health and addiction information collection holding both activity and outcomes data collected from DHBs and non-governmental organisations. PRIMHD is part of the Ministry's national data warehouse. |
| | Public Health Services | The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. |
| SIAPO | South Island Alliance Programme Office | A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island. |
| | Tertiary Care | Very specialised care often only provided in a small number of locations. |

# Appendix 2 Overarching Intervention Logic Diagram


**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.

# Appendix 3 Statement of Accounting Policies

The prospective financial statements in Canterbury DHB's Annual Plan and Statement of Intent for the year ended 30 June 2021 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. PBE FRS42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

**The following information is provided in respect of this Plan:**

***(i) Cautionary Note***

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

***(ii) Nature of Prospective Information***

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

***(iii) Assumptions***

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

**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. The Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

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

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

- Canterbury Linen Services Ltd (100% owned)
- Brackenridge Services Ltd (100% owned)
- New Zealand Health Innovation Hub Management Ltd (100% owned)

Canterbury DHB holds a 50% interest in the Manawa building property lease by way of a jointly controlled operations. Canterbury DHB recognises its share of revenue and expenses of the jointly controlled operations.

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.

**BASIS OF PREPARATION**

**Statement of Going Concern**

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

Canterbury DHB's Chair received a letter of comfort from the Ministers of Health and Finance to enable the Board of Canterbury DHB to satisfy itself, for the purposes of the 2019/20 financial statements, that it is appropriate to prepare those financial statements on a going concern basis. The letter states that the Government is committed to working with Canterbury DHB over the medium term to maintain its financial viability, and also acknowledges that equity support may be required and the Crown will provide such support where necessary to maintain viability. Canterbury DHB requires this letter of comfort in the event that actual future cashflows are significantly unfavourable to one or more of the assumptions in our cashflow projections. The letter of comfort therefore provides the required basis for the Board of Canterbury DHB to prepare the 2019/20 financial statements on a going concern basis. It also gives the Board comfort that financial support will be provided to maintain financial viability in the medium term if required.

**Statement of Compliance**

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

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

**Measurement Basis**

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

**Functional and Presentation Currency**

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

**Changes in Accounting Policies**

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

**SIGNIFICANT ACCOUNTING POLICIES**

**Basis for Consolidation**

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

**Budget Figures**

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

**Income Tax**

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

**Goods and Services Tax**

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

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

Commitments and contingencies are disclosed as exclusive of GST.

**Critical Accounting Estimates and Assumptions**

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

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

**Standards Issued but Not Yet Effective and Not Early Adopted**

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

***Service performance reporting***

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

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

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

**Revenue**

***Ministry of Health population-based funding***

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

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

***Inter-district flows***

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

***Ministry of Health other contracts***

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

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

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

***ACC revenue***

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

***Provision of other services***

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

***Donations and bequests***

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

***Vested or donated physical assets***

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

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

***Donated services***

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

***Estimates and assumptions: Non-government grants***

*Canterbury DHB must exercise judgement when recognising grant 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.*

**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.

**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.

**Bank Term Deposits**

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

**Cash and Cash Equivalents**

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

**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.

**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.

**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.

**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, 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 2020. 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 +/- $98,000.*

*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 +/- $96,000.*

**Property, Plant and Equipment**

***Owned assets***

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

***Revaluations***

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

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

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

***Disposal of property, plant and equipment***

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

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

***Depreciation***

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

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

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

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

***Additions***

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or

service potential associated with the item will flow to Canterbury DHB and the cost of the item can be measured reliably.

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

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

***Subsequent costs***

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

***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, advances in medical technology, and expected disposal proceeds from the future sale of the assets.*

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

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

**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 | Useful life (years) | Amortisation rate |
|---|---|---|
| Software | 3-20 | 5% – 33.3% |

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.*

**Impairment**

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

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

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

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

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

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

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

**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.

**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.*

**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.

***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.

**Related Parties**

***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 revenue and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

***Associates***

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

CANTERBURY DHB STATEMENT OF PERFORMANCE EXPECTATIONS

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