Canterbury DHB 2019/20 Annual Report

Our Mission

Tā Mātou Matakite

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

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

Our Values

ā Mātou Uara

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

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

Responsibility for outcomes.
Te Takohanga i ngā hua.

Our Way of Working

Kā Huari Mahi

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

Demonstrate innovation.
Whakaatu te ihumanea hou.

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

our health system

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Part I
Overview

1.1 Foreword from the Chair and Chief Executive

We are pleased to welcome you to our Annual Report for the 2019/20 financial year. As always, the year had its challenges and as always, we have risen to them - and I have every confidence we will continue to do so.

We are a connected health system, centred around people, that aims not to waste their time. Across the system we are always looking to work smarter, improving processes and using technology and new ideas to be more efficient and free up resources for patient care. This has included improving the process for introducing new treatments and technology, Choosing Wisely, Releasing Time to Care, HealthPathways and Safe Staffing for example, and our Collabor8 and Xcelr8 development programmes nurture good ideas from people at every level.

As a District Health Board we take our obligation to live within our means and according to available funding very seriously. We are determinedly working towards reducing our deficit and returning to a break-even position as soon as possible.

The year was dominated by COVID-19 and its ongoing effects on the health and wellbeing of our communities. Our Canterbury health system has been instrumental in the success of the collective national response to date – and as per our integrated health model, it has been very much a whole of system response.

We'd like to acknowledge both our own Canterbury DHB teams and our health system colleagues who, in one sense have done exactly what was expected of them, and have earned our thanks and respect for doing such a great job and so often going above and beyond the call of duty.

From pharmacy, to General Practice, to community-based care and Aged Residential Care, our multi-disciplinary teams in Managed Isolation and Quarantine and of course Community and Public Health, Canterbury Health Laboratories and many hospital-based services – have all demonstrated the utmost professionalism and dedication in continuing to provide care and services as part of our nationwide COVID response.

On behalf of Cantabrians, thank you all for helping keep us all safe through your sterling efforts.

We know there will be further extraordinary demands on our health system over the coming year and we all have a role in doing what is required of us. The stakes are high, as are the nation's expectations.

We thank you in advance for your mahi, for always putting the people we serve first, and for the pride and commitment with which you provide the best possible care.

With the magnificent new Waipapa building on the Christchurch campus now open and new Specialist Mental Health facilities and other facility builds and upgrades underway and planned, we can only look onwards and upwards.

Facilities

Waipapa (formerly known as Christchurch Hospital, Hagley) will open to the public in November 2020.

The name 'Waipapa' was gifted by the Ūpopko (head) of Ngāi Tūāhuriri Rūnanga, Te Maire Tau. It is an honour to receive this gift, strengthening our partnership with Manawhenua Ki Waitaha and acknowledging the mana of Te Ngāi Tūāhuriri Rūnanga who are papatipu rūnanga for the land on which the new building sits.

This is one of the most complex hospital builds ever undertaken in New Zealand, and an achievement we should all feel proud of, in the knowledge Canterbury is better placed to continue to provide the high quality of care for which we are known – and not just to Cantabrians.

Great progress continues to be made on a number of other upgrades to health facilities. Work has started on a new Energy Centre on St Asaph Street that will break our dependency on coal and set us up for being carbon neutral, in terms of our heating, by late next year.

Work is also well underway in preparation for construction of the Integrated Family Services Centre and the High and Complex Needs buildings on our Hillmorton Campus. These new

facilities will support the provision of contemporary, specialist mental health treatment and care.

Keeping people safe and well

Through all the challenges of this year we can report successes such as:

- Children fully immunised at eight months of age (94%)
- New-borns enrolled with a PHO by three months of age (93%)
- Number of acute demand packages of care provided in community settings (35,547)
- Number of planned care interventions delivered (31,013 or 101%)
- Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral (96%)
- Inpatients (aged 75+) receiving a falls risk assessment (92%)
- Proportion of patients who felt 'hospital staff included their family/whānau or someone close to them in discussions about their care' (65%). This is an increase of 15% on the previous year and higher than the national average of 59%.

Public Health has been front and centre as we work to protect our community against the threat posed by COVID-19. The "Keep it out, Stamp it out, Manage it " approach of the team has proven to be an effective one and we continue to be well prepared to respond to each of these stages into the foreseeable future.

While this emphasis is predicated on responding to the actual virus Community and Public Health has also been the co-creator of the very well received Getting Through Together campaign. Working in partnership with Te Herenga Hauora and the Mental Health Foundation this campaign has focused on acknowledging, sharing and celebrating the ways we can care for ourselves and the wellbeing of others at this most challenging of times.

Over the year Community and Public health has drawn on the linkages, relationships and goodwill formed, particularly over the last decade, with our Canterbury colleagues at Ngāi Tahu, in Territorial Local Authorities, Police, Primary Care, the National Emergency Management Agency (NEMA), public service entities and community groups to develop joined-up ways of supporting one another and our communities and these partnerships (e.g alcohol related harm reduction , smokefree, working with disability community, or collegial relationships (e.g sustainability, demand transport) continue to provide energy and value to our Public Health work.

Mana Ake continues to benefit our tamariki

Launched early in 2018 as part of the Government's plan to wrap support around children living in earthquake-affected communities, Mana Ake supports children at school and at home. It provides parents, whānau and teachers with advice, guidance and education about mental health and wellbeing.

A recent report, produced by ImpactLab, estimated the social value (the social impact in dollar terms over a lifetime) for each participant is $23,652 – a return of $13.32 of 'measurable good' to our community for every dollar invested in Mana Ake. Authors noted the real-world impact is likely to be much greater.

People at the heart of all we do

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

We continue to ensure our People and Capability policies and processes across Canterbury DHB reflect best practice, including our Code of Conduct, Health and Safety Policy and Diversity, Inclusion and Belonging Policy.

Leadership, accountability and culture

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

Recruitment, selection and equal opportunities

Canterbury DHB is committed to a shared approach to talent management including

attracting, selecting and engaging people across the Canterbury health system for the needs of today and into the future. The purpose of this approach is to support an integrated Canterbury health system through having more engaged employees and ultimately improving the patient journey, enhanced by a workforce that reflects the diversity of the communities we serve.

We have a diverse, flexible and highly skilled workforce that contributes significantly to the provision of quality, culturally and individually-appropriate services. We are actively auditing and improving our talent management practises to ensure we are fully inclusive in offering all people the opportunity to be a part of Canterbury DHB.

Workplace safety, health and wellbeing

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

A key area of focus for the foreseeable future is minimising the risk of COVID-19 exposure for our staff, and providing ongoing wellbeing support for those who need it.

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

Thank you

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

Hon Sir John Hansen KNZM
CHAIR

Dr Andrew Brant
ACTING CHIEF EXECUTIVE

17 December 2020

1.2 Statement of Responsibility

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

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

In our opinion, except for the substantial uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003 and the uncertain impact on the financial statements as described in note 4 on page 50; these financial statements and the performance information fairly reflect the financial position and operations of Canterbury DHB for the year ended 30 June 2020.

For and on behalf of the Board

Hon Sir John Hansen KNZM
CHAIR

17 December 2020

Gabrielle Huria
DEPUTY CHAIR

Part II
Improving Outcomes

2.1 Are We Making A Difference?

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

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

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

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

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

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

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

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

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

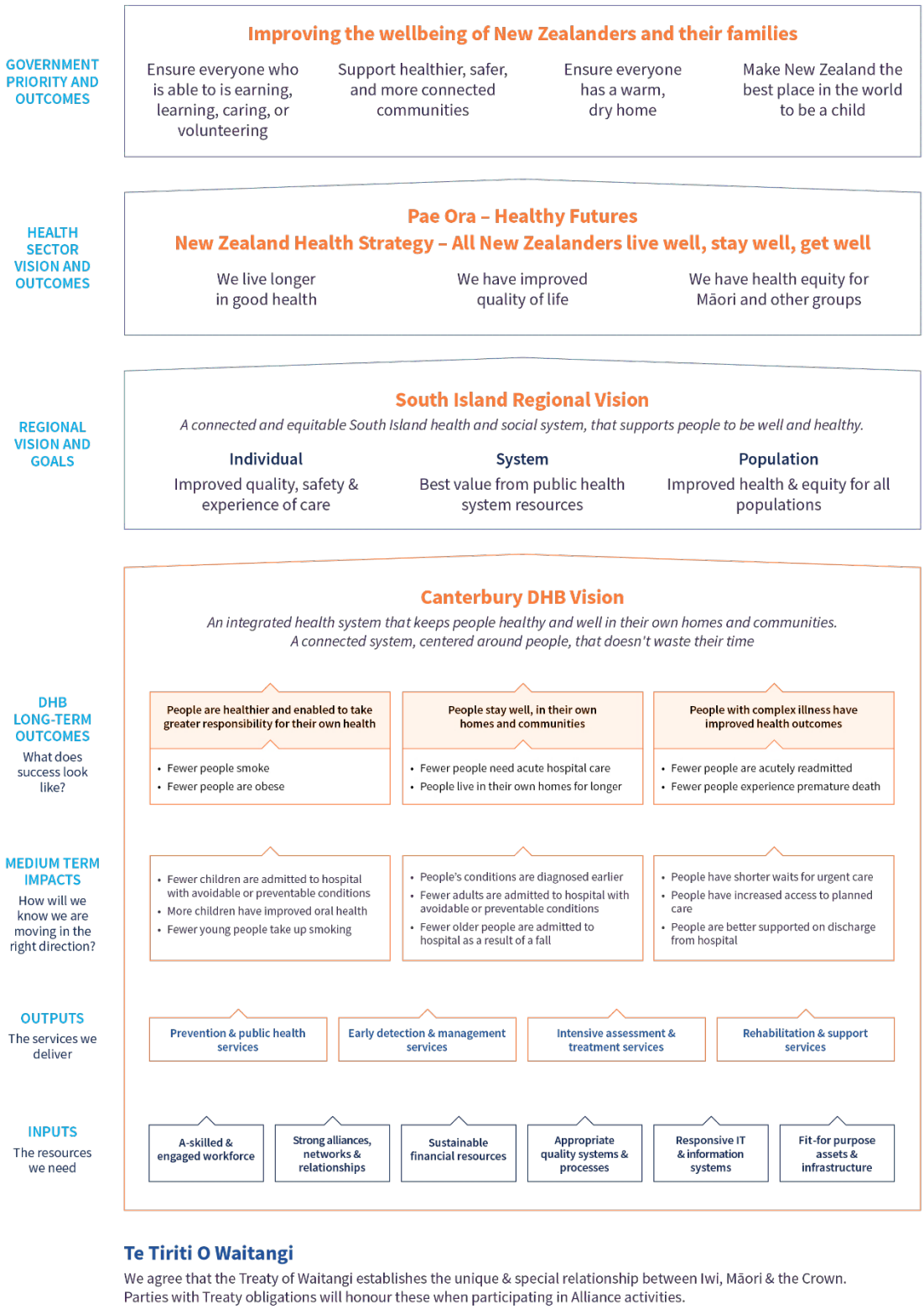
These measures sit alongside our Statement of Performance Expectations (in the following section of this report), which outlines the services we planned to deliver and the standards we expected to meet in the past year, and they form an essential part of the way in which we are held to account.

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

As part of our obligations under legislation, DHBs must work towards achieving equity for all population groups. To promote this goal, the standards set for each measure are the same for all populations. As a means of evaluating whether we have made a difference in reducing inequities, performance has been reported by ethnicity wherever breakdowns are available.

The intervention logic framework on the following page illustrates how we anticipate the services that we fund or deliver (outputs) will have an impact on the health of our population, result in the longer term outcomes desired, and deliver the expectations and priorities of Government.

Canterbury DHB – Overarching Intervention Logic Framework



Te Tiriti O Waitangi

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

Wellbeing Outcomes

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

WHY IS THIS A PRIORITY?

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

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

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

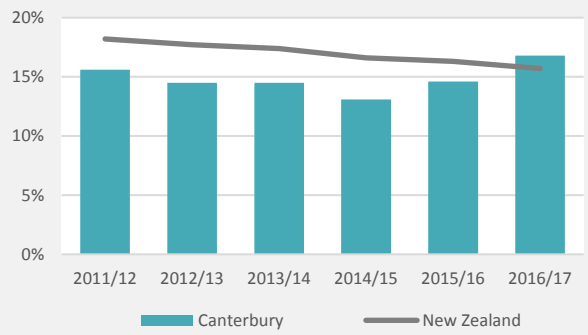
Combined results from 2014-2017 show that smoking rates are highest amongst our Māori and Pacific populations.

We continued to deliver smoking advice and cessation support at all contact points across our health system, with a particular focus on pregnant women. In 2019/20, 93% of pregnant women (identified as smokers) received advice and support to stop smoking (7% higher than the previous year).[19]

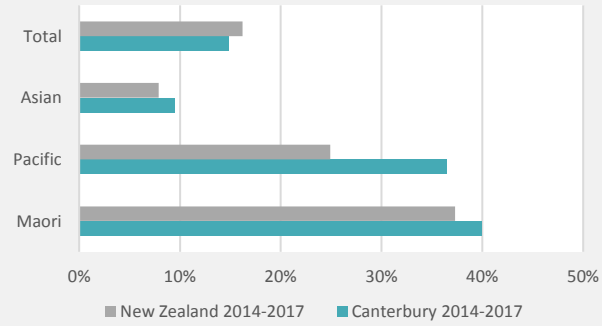
In 2019/20 84% of smokers identified in our hospitals were provided with brief advice and support and 73% of smokers received advice and support in primary care.

This equates to an estimated 39,459 people being provided with brief advice and support to stop smoking in the past 12 months, with over 1,900 people enrolling in Te Hā Waitaha (Canterbury's cessation programme) despite a significant disruption in services and face-two-face contacts due to the COVID-19 lockdown.

Proportion of the population (15+) who currently smoke



Proportion of the population (15+) who currently smoke



Data source: National NZ Health Survey [2]

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

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

OUTCOME MEASURE – A REDUCTION IN OBESITY RATES

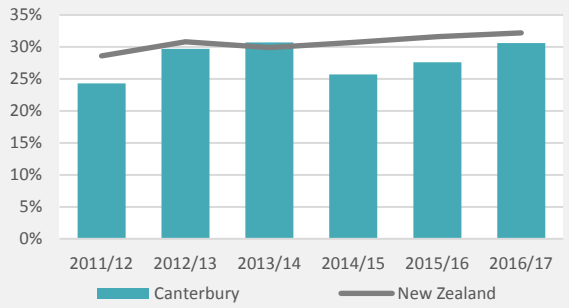
Obesity impacts on people's quality of life and is a significant risk factor for many long term conditions. While many of the drivers sit outside of the direct control of the health system, we have a role in supporting the creation of health promoting environments and the delivery of programmes that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

The latest NZ Health Survey (2016/17) reported that Canterbury's obesity rate remains just below the national rate at 31% however, like the rest of the country, there has been a steady rise in obesity rates across all ages, genders and ethnicity groups.

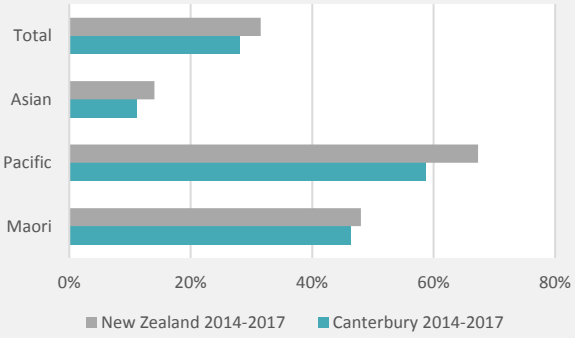
We continue to identify children and families who may need support at their B4 School (health) Check, prior to starting school. In 2019/20, 90% of four-year-olds received their B4 School Check and 99% of those children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice (just a single child was missed during the year).

We also continue to invest in lifestyle programmes that support people to increase physical activity or make healthy food choices, including, Active Families and Green Prescription programmes. In 2019/20, 5,181 people were referred to the Green Prescription programme by their health professional.

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



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



Data source: National NZ Health Survey [3]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

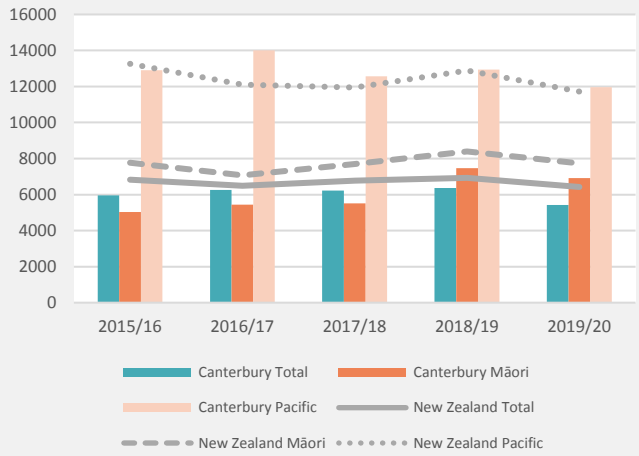
Fewer avoidable hospital admissions

In 2019/20, Canterbury's ambulatory sensitive hospital (ASH) admission rate for children under five was 5,427 per 100,000, achieving the target set and remaining below the national average of 6,423. Māori and Pacific rates both fell between 2018/19 and 2019/20

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system that engages earlier with parents and children. In the past year, 86% of all new-borns were enrolled with a primary care team before three months of age and 94% of eight-month-olds were fully immunised.

Upper respiratory and ear, nose and throat infections are the largest contributor to this year's ASH rate and the DHB has a particular focus on Pacific children where rates are higher. The DHB's Pacific Health Action Plan was approved and launched in August 2020.

Measure: Rate of Ambulatory sensitive hospitalisations for children (0-4)	2017/18	2018/19	Target	Result
	6,223	6,357	<6,871	5,427



Data Source: Ministry of Health Performance Reporting [4]

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

[4] This is a national DHB performance indicator and captures hospital admissions for conditions considered preventable, including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The ASH results are published three months in arrears and the results reflect the 12 months to March 2020.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

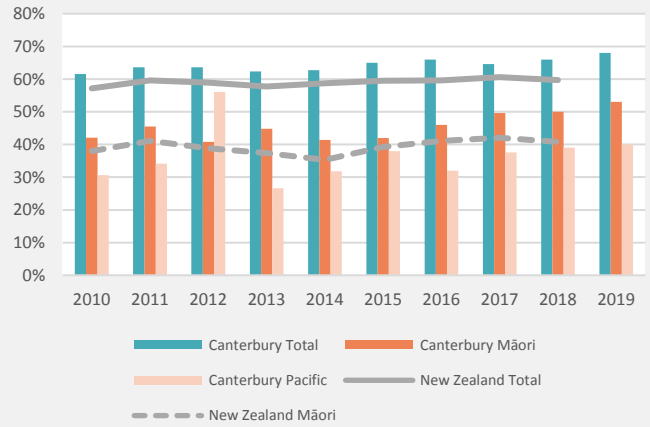
Children have improved oral health

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

The DHB has established a transalpine Oral Health Alliance with the West Coast DHB, to address equity gaps and improved data sharing across child services is helping to better identify children and help establish contact with families.

The percentage of five-year-old children whose teeth are caries free (have no holes or fillings) has improved slightly for all ethnicities with a total population result of 68% Māori rate of 53% and Pacific rate of 40%. This is the third-year performance has increased in Canterbury. While there is work still to be done to close the equity gap, significant improvements have been in the past twelve months.

Measure: Children caries-free at age 5	2017	2018	Target	Result
	65%	66%	67%	68%



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

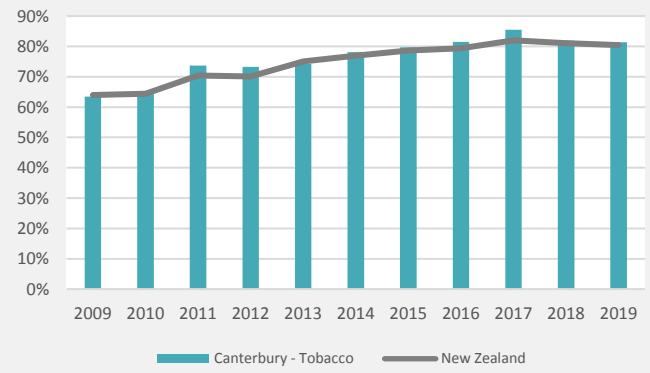
Fewer young people take up smoking

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

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

As vaping becomes more accepted and prevalent we are starting to monitor vaping rates among year 10 students through the ASH survey as well. A growing number of year 10 students are trying or vaping regularly. We will continue to monitor this to establish what impact vaping may have on tobacco use among young people.

Measure: 'Never Smokers' amongst Year 10 students	2017	2018	Target	Result
	86%	82%	>82%	81%



Data Source: National ASH Year 10 Survey [6]

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

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

People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

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

WHERE ARE WE FOCUSED?

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

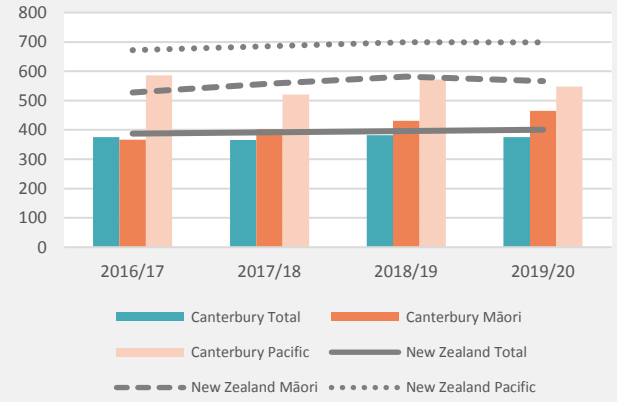
OUTCOME MEASURE – A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand. In 2019/20, 60% of admissions to Christchurch Hospital were acute.

Acute hospital bed-days are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatments that reduces the crisis and deterioration that leads to an acute hospital admission. The measure also reflects the quality and effectiveness of discharge planning in supporting people to go home earlier.

Our community-based Acute Demand Management Programme continues to contribute to a lower rate of acute hospital bed days, through various initiatives including availability of packages of care in general practice which provide for long consultations, repeat visits and in-practice observation. More than 35,000 packages of care were provided in the community in 2019/20.

Rate of acute hospital bed-days



Data Source: National Minimum Data Set[7]

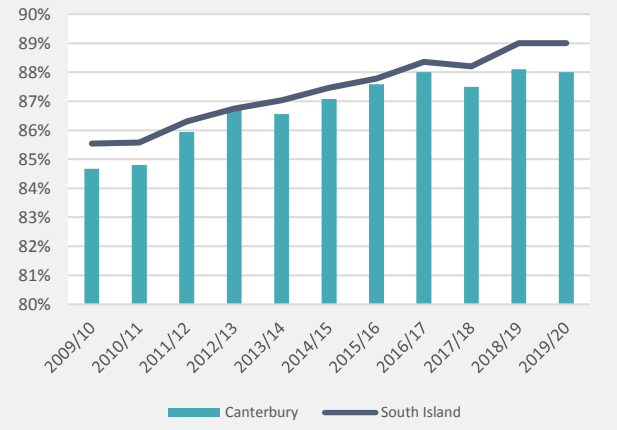
OUTCOME MEASURE – MORE PEOPLE LIVING IN THEIR OWN HOME

The proportion of the Canterbury population (aged 75+) living in their own homes has remained stable at 88%. This is a positive trend particularly as our older population continues to grow, with our over 75-year-old population increasing by 18% over the last five years.

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

Falls in frail older people are common and a leading cause of hospitalisation in Canterbury. Serious falls lead to injury and hospitalisation, a loss of confidence, and an increased risk of admission to residential care. In 2019/20, 1,852 people accessed our community-based falls prevention programme (despite COVID-19 restrictions in quarter three and four). A recent audit also showed that 92% of older people in our hospitals received a falls assessment to help them stay safe during their stay.

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



[7] This is a national System Level Measure, data is provided by the Ministry of Health via the national minimum data set. There is a difference in presentation to the 2019-23 Statement of Intent as the Ministry baselines were originally presented against calendar year. These have been reset during the 2019/20 year to financial years. The baseline results have been reset to reflect the current series. This measure is age standardised and presented as a rate per 100,000 people.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

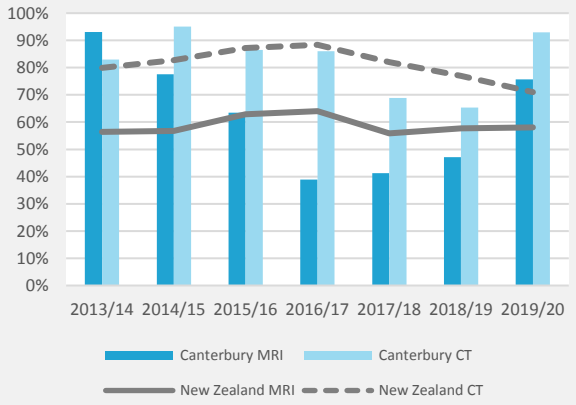
People's conditions are diagnosed earlier

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

Canterbury receives the majority of specialised tertiary referrals from other South Island DHBs, and this puts additional pressure on our radiology services. While demand remains high, work within the radiology department to improve patient flow and improve service access, has resulted in significant improvement to both MRI and CT wait times over the past year. Canterbury's performance while still below target is now above national rates for both MRI and CT wait times.

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

	2017/18	2018/19	Target	Result
MRI	41%	47%	90%	76%
CT	69%	65%	95%	93%



Fewer avoidable hospital admissions

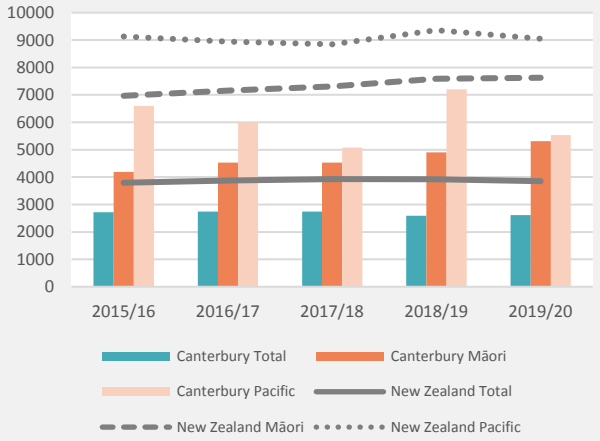
In 2019/20, Canterbury's ambulatory sensitive hospital (ASH) admission rate for adults was 2,613 per 100,000, slightly above the target set, however well below the national average of 3,858.

Canterbury's Māori and Pacific ASH rates also remain well below national rates. The Māori ASH rate increased slightly between 2018/19 and 2019/20 and the Pacific rate decreased from 7,205 to 5,539; however these shifts reflect small population numbers with 39 fewer Pacific events and 62 more Māori events during the year.

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system and as at July 2020, 97% of adults in Canterbury aged 45-64 were enrolled with a primary care team. This low rate is also supported by our community-based Acute Demand Management Services which helps to reduce avoidable admissions to hospital.

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

2017/18	2018/19	Target	Result
2,754	2,590	<2,596	2,613



Data source: Ministry of Health Performance Reporting[8]

[8] This measure is a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results reflect updated national data provided by the Ministry of Health in June 2020 being results for the 12 months to March 2020.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer falls related hospitalisations

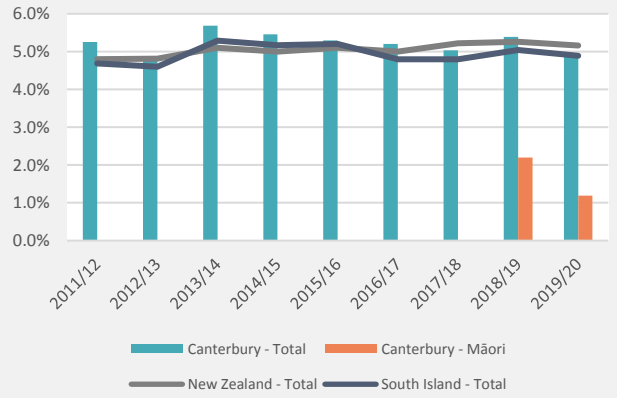
With an aging and growing older population, reducing the falls rate reflects a significant investment for the Canterbury health system. Our focus on falls prevention is crucial in supporting people to stay well and independent and reducing demand on our services.

At 4.9%, the proportion of our population (75+) admitted to hospital as a result of a fall in 2019/20 has fallen to its lowest point since 2012/13 year and is 0.3% lower than the national average.

In 2019/20, 1,852 older people accessed our community-based falls prevention programme and over 11,700 people attended group strength and balance classes despite the service not operating as normal during COVID-19 lockdown and alert levels two and three.

Since we have started tracking rates for Māori admitted to hospital as a result of a fall the rate has dropped from 2.2% to 1.2%. Despite the smaller cohort impacting the results this is a positive indicator for engagement with older Māori.

Measure: Population (75+) admitted to hospital as a result of a fall	2017/18	2018/19	Target	Result
	5.0%	5.4%	<5.5%	4.9%



Data Source: National Minimum Data Set

People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

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

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN AMENABLE MORTALITY

The last available mortality rates are positive, with both total population and Māori rates dropping for Canterbury, and both remaining below national rates.

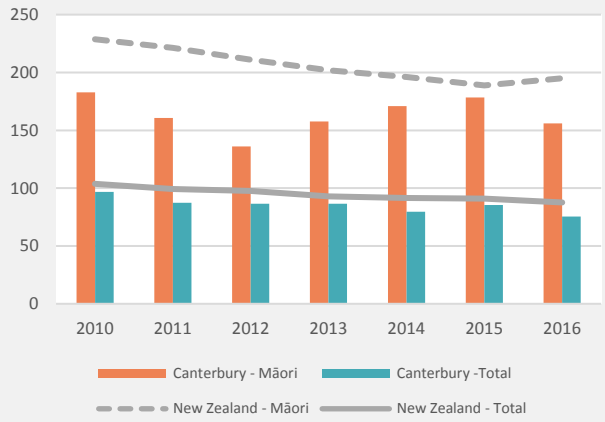
Prevention, screening and long term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment.

Cancer is one of the leading causes of mortality in Canterbury and contributes to a high proportion of premature deaths. The DHB continues to achieve national Faster Cancer Treatment targets with 96% of people provided with urgent cancer treatment within the target timeframe in 2019/20. In the past year 2,322 people had a skin lesion removed in primary care without the need (or wait) for a hospital appointment.

Mental illness also contributes greatly to premature mortality and mental health remains a major focus for the DHB. In the past year 6,622 people accessed Brief Intervention Support in primary care and 4% of our adult population accessed specialist mental health support in Canterbury.

A new model of primary mental health support (Te Tumu Waiora) is being implemented across our system. The model puts mental health and wellbeing at the heart of general practice with Health Improvement Practitioners and Health Coaches working as part of the general practice team. This model is expected to will support earlier intervention and continuity of care for our population.

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



Data Source: National Mortality Collection[9]

[9] Performance data for this measure is sourced from the national mortality collection which is three years in arrears. 2017 results were not available at the time of printing.

OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

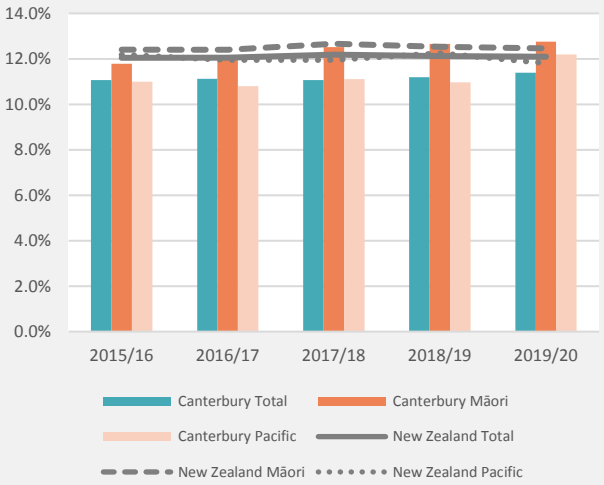
Lower readmission rates are important as patients who are readmitted to hospital within 28 days of discharge are more likely to experience negative long term outcomes. Readmissions also reduce public confidence in our health system and increase costs.

Canterbury's overall readmission trend remains about 0.7% lower than the national average despite a slight increase in readmission rates. Our Pacific rate increased by 1.2%. Our Māori rate remains stable

Service quality, patient safety and good discharge planning are key factors in reducing acute readmissions. The DHB has ran a pilot project in 2019/20 to define aspects of healthcare important to patients and their whānau. Feedback has included ensuring information provided uses plain language and people have advance warning about discharge.

Our community based supported discharge service (CREST), provides home based rehabilitation packages to support older people on discharge from hospital and supported 1,686 people in 2019/20. More than 8,568 people were also supported by district nursing services in Canterbury in the past year.

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



Data Source: National Minimum Data Set

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for urgent care

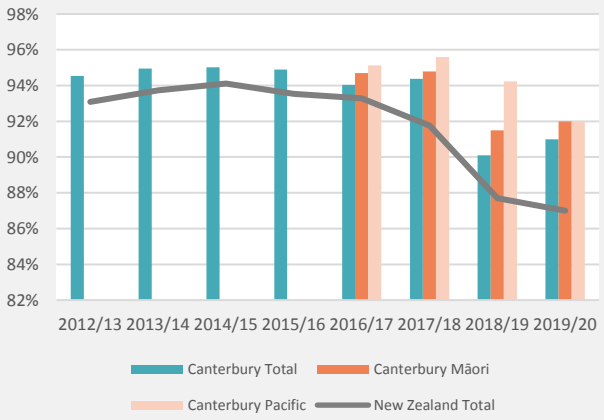
Increasing ED presentations are putting pressures on emergency departments across the country, with national result falling to an average of 87% in 2019/20.

Over 104,900 people attended ED in Canterbury in 2019/20. Presentations have grown consistently in the past several years with the growth rate of ED presentations outstripping population growth for the region by around 4%.

Considering the increased demand and ongoing capacity constraints, while we waited for the DHB's acute services building (Waipapa) to be operational, achieving wait times above the national average is a solid performance.

This result reflects both the commitment of our specialist teams in our hospitals but also our primary care partners who are supporting an increasing number of people in the community with 35,547 of people receiving acute packages of care in the community (through our Acute Demand Management Service).

Measure: People are admitted, discharged or transferred from ED within 6 hours	2017/18	2018/19	Target	Result
	94%	90%	95%	91%



Data Source: National Minimum Data Set[10]

[10] This indicator is a national DHB performance measure and excludes those who did not wait in ED or had pre-arranged appointments. The DHB was unable to verify data from the second and third quarters of 2018/19 due to changes in data capture and coding due to the introduction of a new patient management system (Canterbury achieved 93% in Quarter 1 and 90.1% in Q4) and the Q4 result is reflected for that year. The issues have been addressed and results for 2019/20 reflect the full year's performance.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for planned care

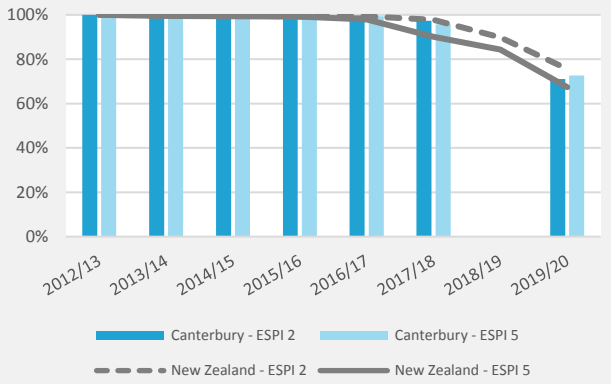
Canterbury DHB's performance for 2018/19 reflects the impact of a series of events in 2018/19 where service closures due to flooding and the Terrorist event in March 2018 meant a backlog of assessments and treatments had to be caught-up. In 2019/20 the COVID-19 lockdown and distancing restrictions have had a similar impact. More than 11,000 outpatient events and over 1,700 inpatient procedures had to be cancelled and rescheduled, significantly impacting on the length of time patients have waited for assessment and treatment.

The impact of COVID-19 has likewise been felt across the country, as is evidenced by the falling national averages for assessment and treatment within target wait times in 2019/20.

Positively, a huge effort by our teams has meant that a total of 31,013 planned care interventions were delivered in 2019/20 - above the DHB's target for the year.

Measure: People receiving specialist assessment and treatment within set timeframes.

	2017/18	2018/19	Target	Result
ESPI 2	97%	n.a.	100%	71%
ESPI 5	96%	n.a.	100%	73%



Data Source: Ministry of Health Quickplace Warehouse [11]

People Are Supported on Discharge

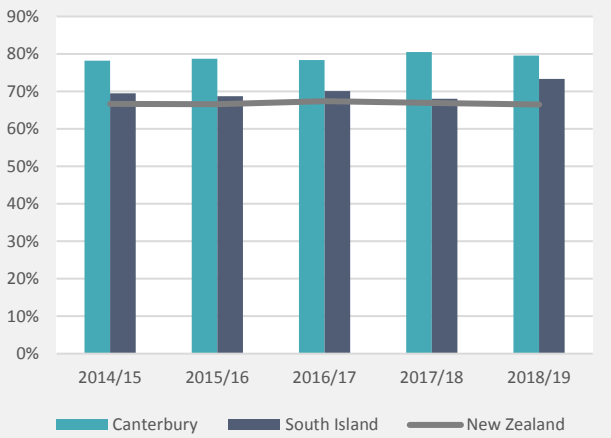
Research indicates that people having a psychiatric admission have increased vulnerability immediately following discharge, including higher risk of suicide, while those leaving hospital with a formal discharge plan and links to community-based services and supports, are less likely to experience early readmission.

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

Canterbury DHB works closely with community-based service providers to ensure a strong continuum of care and there are single access pathways for Community Support Workers (CSWs) and other Packages of Care (POC).

Measure: Inpatients accessing community-based MH and AOD services within seven days of discharge

2017/18	2018/19	Target	Result
81%	80%	80%	n.a.



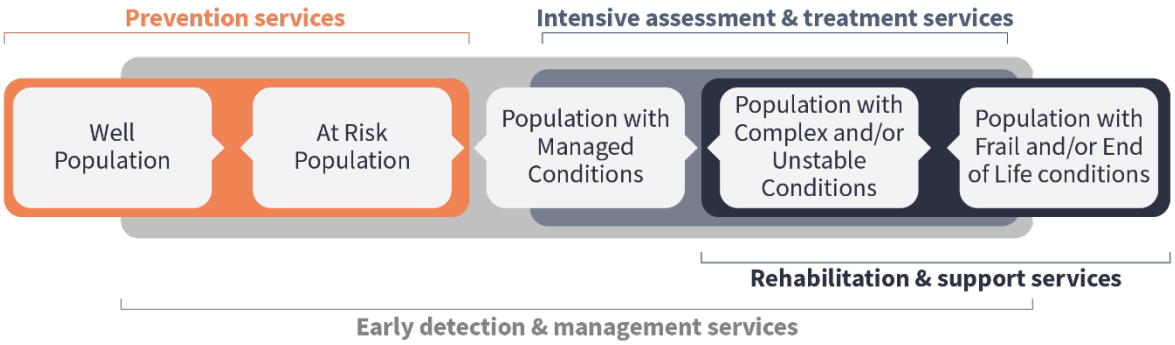
Data Source: National Mental Health KPI Framework. [12]

[11] These indicators are two of the national Elective Services Patient Flow Indicators (ESPIs), established to track system performance. In line with national ESPI reporting, the annual results refer to the final month of each year (June). ESPI 2 represented those people receiving their First Specialist Assessment within four months and ESPI 5 represents those given a commitment to treatment receiving that treatment within four months. During 2018/19 Canterbury migrated from its old legacy patient management system to a new patient management system – the South Island Patient Information Care System (PICS). A number of issues during the migration related to data capture and coding affected the quality and accuracy of wait time performance and the DHB elected not to reflect the results for 2018/19. We continue to work with individual services to improve ESPI performance. Canterbury now has an ESPI recovery plan which outlines how compliance will be achieved by 30 June 2021.

[12] Data for this measure is provided via the national KPI programme and the results for 2019/20 have not yet been released to DHBs.

Part III
Delivering on our Plans

3.1 Statement of Service Performance



Evaluating our performance

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

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

We also evaluate our performance on an annual basis by providing a forecast of the services we plan to deliver and the standards we expect to meet. The statement of service performance set out in this section presents the DHB's performance against the 2019/20 forecast, presented in our 2019-2023 Statement of Intent and available on our website.

IDENTIFYING PERFORMANCE MEASURES

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

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

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

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time.

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

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

Timeliness (T)
How long are people waiting to be seen or treated, are we meeting expectations?

Quality (Q)
How effective is the service, are we delivering the desired health outcomes?

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

As part of our obligations under legislation DHBs must also work towards achieving equity. To promote this goal and as a means of evaluating whether we have made a difference for our Māori population, we have identified a core set of performance measures that are important in terms of Māori health. These measures are presented by ethnicity on page 29.

SETTING STANDARDS

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

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

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

In areas where we do have more influence, targets set for 2019/20 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

Going into the 2019/20 year, Canterbury was still contending with operational constraints following the earthquakes, the March 15 terrorist event and the outpatient building flooding, with capacity severely constrained and services working overtime to reschedule cancelled services.

We knew that a number of the national standards would be difficult to meet in this constrained environment and we retained 2018/19 standards against a number of our discretionary measures.

What we could not predict at the time was the unprecedented events of 2020, with the COVID-19 pandemic affecting all parts of the health system. The lockdown and level three and four restrictions severely limited access to services and service delivery models had to be redesigned to support social distancing and ensure the safety of both patients and staff.

Services most impacted were those face-2-face and group session services and services where older people would be at risk. Some providers changed their service models from visits to phone calls and while this meant services were still being provided, not everyone had systems in place to record these sessions. Other services were unable to function in level three and four and could only resume again in level two.

The diversion of general practice and hospital services onto the COVID-19 response including community testing along with people staying away from general practice and pharmacy during lockdown has meant many routine wellness checks have not been completed such as brief advice on smoking, cervical screening, medications management and diabetes reviews.

Non-urgent specialist assessments and outpatient appointments had to be reduced or cancelled in response to COVID-19 restrictions and waiting time targets have been particularly difficult to meet following the cancellation of sessions, assessments or treatments during lockdown.

However it is pleasing to note that while service volumes have been lower than the previous year, many of the service targets have been met due to the efforts of providers to reschedule assessments and treatments following the lockdown. Footnotes have been added to the sections where it has been clear that performance has been impacted by COVID-19.

NOTES FOR THE READER

We note that a number of national performance measures were dropped from the DHB performance framework during the 2019/20 year. This included acute and elective lengths of stay which the DHB was tracking as part of its Statement of Performance Expectations set. With the national data no longer available the DHB has not been able to report results for these two measures for 2019/20. We have also footnoted where other national data has been delayed and was not available at the time of printing.

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

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

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

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

◆ The measure is a core Māori health measure. Refer to page 29 for a breakdown of results by ethnicity.

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

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

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

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

SERVICE PERFORMANCE 2019-2020

Population Protection Services – Healthy Environments							
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q	78	42	E.90	96	-	✓
Licensed alcohol premises identified as compliant with legislation	Q [13]	83%	93%	90%	100%	-	✓
Networked drinking water supplies compliant with Health Act	Q [14]	85%	93%	97%	n.a	-	-

Health Promotion and Education Services							
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement and healthier choices.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Mothers receiving breastfeeding and lactation support in the community	A	980	861	>600	861	-	✓
Babies exclusively/fully breastfed at three months	Q[15]◆	61%	62%	70%	n.a	n.a	-
People provided with a Green Prescription (GPX) for additional physical activity support	A[16]	4,087	4,818	>3,000	5,158	-	✓
GPX participants more active six to eight months after referral	Q	61%	n.a	>50%	n.a	-	-
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q[17]◆	93%	82%	90%	73%	80%	×
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q[18]◆	95%	92%	95%	84%	-	×
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[19]◆	86%	86%	90%	93%	-	✓

[13] The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. Compliance can be seen as a proxy measure of the success of education and training for licensed premises and reflects a culture that encourages a responsible approach to alcohol. Due to COVID-19 restrictions, no Controlled Purchase Operations were conducted in the period 1 January 2020 to 30 June 2020. Controlled Purchase Operations compliance in this instance refers to the period 1 July 2019 to 31 December 2019 only.

[14] This measure relates to the percent of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. Water quality reports are published one year in arrears with 2018/19 being the latest available at the time of printing.

[15] Data is provided by the Ministry of Health. Results for 2018/19 results were provided this year but results for 2019/20 have not yet been released.

[16] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. During COVID-19, green prescriptions continued to be provided virtually and so were not impacted by the lockdown restrictions. The DHB has been advised that the bi-annual survey, which tracked patient activity following referral, is no longer being undertaken by the Ministry of Health.

[17] The ABC programme refers to health professionals asking about smoking status, providing Brief advice and providing cessation support. This performance measure reflects smokers given advice and support in general practice in the last 15 months and results have been impacted by the diversion of general practice into responding to the March 2019 terrorist event, the 2019 Measles outbreak and the COVID-19 pandemic in 2019/20.

[18] The proportion of people being offered smoking advice in our hospitals continues to drop, following a changed in the way inpatient smoking data is collected. Work to highlight the importance of gathering this information has been delayed, as staff have been diverted onto responding to the COVID-19 pandemic. This will be relooked at in the coming year.

[19] This data is sourced from the national Maternity Dataset and is provided by the Ministry of Health. The 2019/20 result reflects the performance of the Canterbury region in quarters one, two, and four. Data for quarter three has not been provided by the Ministry of Health.

Population-Based Screening Services							
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Four-year-olds provided with a B4 School Check (B4SC)	A[20]◆	97%	96%	90%	90%	73%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q◆	98%	100%	95%	99%	96%	✓
Women aged 25-69 having a cervical cancer screen in the last three years	A[21]◆	74%	72%	80%	70%	70%	×
Women aged 50-69 having a breast cancer screen in the last two years	A[22]◆	76%	75%	70%	75%	71%	✓

Immunisation Services							
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Children fully immunised at eight months of age	A[23]◆	94%	94%	95%	94%	91%	↺
Proportion of eight-month-olds 'reached' by immunisation services	Q	98%	98%	95%	98%	95%	✓
Young people (Year 8) completing the HPV vaccination programme	A[24]❖◆	65%	n.a	75%	62%	61%	×
Older people (65+) receiving a free influenza ('flu') vaccination	A[25]❖◆	62%	62%	75%	64%	57%	↺

[20] B4 School checks were not carried out during the COVID-19 lockdown, Canterbury's year-end result while lower than previous year's reflects the significant work done to catch up after level three restrictions were lifted. Lower results reflect the diversion of general practice over the past two years in the last 15 months and results have been impacted by the diversion of general practice into responding to the March 2019 terrorist event, the 2019 Measles outbreak and the COVID-19 pandemic in 2019/20

[21] Rates for cervical screening in Canterbury are below target for the total population but above the national average for Māori. Lower results many reflect the diversion of general practice over the past two years into responding to the terrorist event and Measles outbreak in 2019 and the COVID-19 pandemic in 2020. The DHB continues to work closely with BreastScreen South and the PHOs to support improved uptake of cervical screening.

[22] Breast Screening results are released quarterly by the Ministry of Health. At the time of publishing the June 2020 results were not available and the year-end results reflects for the last two years to March 2020.

[23] Immunisation at eight months is a national performance measure. Interruptions to immunisation services caused by COVID-19 restrictions have impacted results in quarter four. Canterbury achieved 95% in the first three quarters of the year and 94.3% in quarter four. Canterbury missed the national target by 48 children and the Māori target by 49 children over the course of the year.

[24] The Human Papillomavirus (HPV) vaccination aims to protect young people from 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. An error was identified in the Ministry of Health's calculation for HPV in 2018/19, results for the current year more accurately reflect performance. Work is ongoing with schools and PHOs to support delivery of the HPV vaccinations to young people in Canterbury.

[25] 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. Canterbury delivered 2,909 more vaccinations in 2019/20 than the previous year and preliminary results for 2020/21 indicate coverage has increased significantly in response to COVID-19 messaging.

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

SERVICE PERFORMANCE 2019-2020

General Practice Services							
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A◆	93%	93%	95%	95%	95%	✓
Newborns enrolled with a PHO by three months of age	A◆	82%	95%	85%	93%	86%	✓
Young people (0-19) accessing brief intervention counselling in primary care	A[26]Δ	579	552	>500	435	-	×
Adults (20+) accessing brief intervention counselling in primary care	AΔ	6,396	6,353	>5,500	6,187	-	✓
Number of skin lesions (growths, including cancer) removed in primary care	AΔ	2,609	2,404	>2,000	2,322	-	✓
Number of integrated HealthPathways in place across the system	Q	691	699	E.>600	685	-	✓
Proportion of general practices using the primary care patient experience survey	E	62%	79%	>65%	85%	-	✓

Long-Term Condition Services							
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of spirometry tests provided in the community rather than in hospital	AΔ	2,493	2,426	>2,000	2,128	-	✓
People receiving subsidised diabetes self-management support when starting insulin	AΔ	400	379	>300	320	-	✓
Population identified with diabetes having an HbA1c test in last year	A[27]Δ◆	90%	90%	>90%	88%	-	×
Population with diabetes having an HbA1c test and acceptable glycaemic control	QΔ◆	74%	72%	>60%	71%	-	✓

[26] 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 include face-2-face and phone consultations. COVID-19 restrictions have impacted on total numbers of people being seen during the year, in comparison to the previous year.

[27] An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's diabetes. A level of less than 64mmol/mol reflects an acceptable blood glucose level. The number of people who received an HbA1c test increased by 37 compared with the previous year, however this was offset by an increase in the number of people being identified with diabetes. A number of factors contribute to this growth including the growing and ageing population in Canterbury and more people registering with a PHO and having their conditions identified. The DHB continues to work with the three Canterbury PHOs to support improvements in diabetes management.

Oral Health Services							
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Children (0-4) enrolled in DHB-funded oral health services	A[28]❖◆	76%	83%	95%	86%	-	↺
Enrolled children (0-12) receiving their oral health exam according to planned recall	T❖◆	88%	88%	90%	87%	-	×
Adolescents (13-17) accessing DHB-funded oral health services	A❖	63%	66%	85%	62%	-	×

Pharmacy and Referred Services							
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of laboratory tests completed for the Canterbury population	AΔ	2.9m	2.9m	E<2.8m	2.8m	-	✓
Number of subsidised pharmaceutical items dispensed in the community	AΔ	6.8m	7.0m	E<8m	7.6m	-	✓
People on multiple medications receiving medication management support	A[29]Δ	1,316	1,434	>1,200	896	-	×
People (65+) being dispensed 11 or more long term medications (rate per 1,000)	Q[30]❖	4.0	n.a	E<4.6	n.a	-	-
Number of community-referred radiology tests completed	AΔ	49,832	55,038	E>40,000	51,614	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T[31]	93%	77%	90%	80%	90%	↺
People receiving their Magnetic Resonance Imaging (MRI) scans within six weeks	T[32]	41%	47%	90%	76%	58%	↺
People receiving their Computed Tomography (CT) scans within six weeks	T[32]	69%	65%	95%	93%	71%	↺

[28] 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. Canterbury's LinKIDS service continues to support improved enrolment rates with the number of children aged 0-12 enrolled in oral health services increasing by 693 children between 2018 and 2019. The service is working to increase timeliness of examinations and to keep up with the increasing enrolment numbers. Work to identify barriers to adolescent oral health access is ongoing led by the transalpine Oral Health Service Development Group established to improve oral health performance.

[29] The Medical Management Review programme helps to ensure the safe and appropriate use of medications. The number of reviews delivered in 2019/20 was impacted by the COVID-19 lockdown with home visits stopped and visits to pharmacies limited.

[30] Data is sourced from the HQSC Atlas of Healthcare Variation – Results have not been made available since 2017.

[31] Colonoscopy wait times are growing nationally due to increasing referral numbers. In 2019/20 the number of people scanned or waiting for an urgent colonoscopy but still within the timeframe was 852 compared with 690 the previous year and 314 in 2017/18. This growth in demand places significant pressure on DHB services.

[32] Work to improve wait times has enabled the DHB to make significant progress in reducing waiting times in 2019/20 with additional clinics being held as well as outsourcing to improve throughput. Performance by the final month of the year (June 2020) lifted to 87.6% of people receiving their MRI within 6 weeks and 98.7% of people receiving their CT scan within 6 weeks.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

SERVICE PERFORMANCE 2019-2020

Quality and Patient Safety							
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Staff compliant with good hand hygiene practice	Q[33]◇	82%	82%	80%	82%	85%	✓
Inpatients (aged 75+) receiving a falls risk assessment	Q◇	97%	98%	90%	92%	88%	✓
Proportion of patients with a hospital acquired pressure injury	Q[34]◇	226	281	<204	310	-	×
Response rate to the national inpatient patient experience survey	E[35]	22%	24%	>30%	19%	24%	×
Proportion of patients who felt 'hospital staff included their family/ whānau or someone close to them in discussions about their care'	E	68%	50%	>65%	65%	59%	✓

Specialist Mental Health and Alcohol and Other Drug (AOD) Services							
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Proportion of the population (0-19) accessing specialist mental health services	A[Δ]	3.6%	3.7%	>3.1%	4.1%	4.0%	✓
Proportion of the population (20-64) accessing to specialist mental health services	A[Δ]	3.8%	3.9%	>3.1%	4.0%	4.1%	✓
People referred for mental health and AOD services seen within three weeks	T[36]	74%	70%	80%	67%	77%	×
People referred for mental health and AOD services seen within eight weeks	T	91%	88%	95%	83%	91%	×

[33] In order to support the response to the COVID-19 pandemic, the Health Quality & Safety Commission temporarily suspended the requirement for DHBs to report on manually collected quality and safety markers from March until June 2020. Results for 2019/20 for the first two measures refer to the last completed quarter October to December 2019. Further detail and results for previous years can be found at www.hqsc.govt.nz.

[34] A change in approach introduced in July 2019, led to all pressure injuries, regardless of severity, being coded and reported against this measure. The increase in pressure injuries reflected for 2019/20 is not unexpected and not directly comparable to previous year' results.

[35] In 2020 the usual national DHB inpatient experience survey was replaced with a one off COVID-19 survey. The last full patient experience survey was completed in November 2019 and this result is reflected here. Although the response rate was lower than previous years the number of surveys sent out increased by 1,828 with 76 fewer people completing them compared with 2018/19.

[36] Mental health wait time results are provided three months in arrears and results reflect the twelve months to March 2020. This measure has been updated to align with the national reporting definition. This change reflects that some patients are referred and seen within 48 hours. Continued demand and the increased complexity of people accessing our specialist mental health and addiction services has reduced our capacity to respond quickly. A focus on earlier intervention in the community is a key strategy in reducing the number of people requiring specialist care. The DHB has invested in an acute alternative in the community with a community provider offering a peer led residential service that works closely with specialist services to provide another option for people with acute needs. The DHB is also implementing the national Te Tumu Waiora programme in the coming year with Health Improvement Practitioners and Health Coaches operating out of general practice to enable an earlier response to people's mental health needs. These programmes are expected to support an improved response for our community.

Maternity Services							
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Women registered with a LMC by 12 weeks of pregnancy	A[37]✧◆†	80%	79%	80%	n.a	-	-
Number of maternity deliveries in Canterbury DHB facilities	A	6,056	6,044	E.6,000	5,943	-	✓
Proportion of maternity deliveries made in Primary Birthing Units	Q	16%	16%	>13%	16%	-	✓

Acute and Urgent Services							
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of acute demand packages of care provided in community settings	A[Δ]	32,701	35,393	>30,000	35,547	-	✓
Number of presentations at Canterbury Emergency Departments	A	103,116	101,130	E.<110k	104,907	-	✓
Proportion of the population presenting in ED (per 1,000 people)	Q	185	178	<190	181	220	✓
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral.	T	95%	94%	90%	96%	85%	✓
Average acute inpatient length of stay (bed days per 1,000 people)	Q [38]	2.38	2.44	<2.35	n.a	-	-

Elective and Arranged Services							
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of First Specialist Assessments provided	A[39]	73,913	66,982	E.>60,000	55,218	-	✖
Proportion of First Specialist Assessments that were non-contact (virtual)	Q[40]	19%	21%	>15%	n.a.	-	-
Number of planned care intervention delivered	A[41]	new	new	30,675	31,013	-	✓
Proportion of people receiving their surgery on the day of admission	E	94%	87%	>85%	85%	-	✓
Average elective inpatient length of stay (bed days per 1,000 people)	Q[38]	1.57	1.56	<1.54	n.a	-	-
Number of outpatient consultations provided	A[42]	694,629	653,717	E.>650k	630,837	-	✖
Outpatient appointments where the patient was booked but did not attend	Q	4%	5%	<5%	4%	-	✓

[37] Data is sourced from the national Maternity Clinical Indicators report. Results for 2019/20 are yet to be released.

[38] This measure is no longer being reported by the Ministry of Health and comparable results are not available for the 2019/20 year.

[39] A first specialist assessment is the assessment undertaken by a specialist following referral by a patient's primary care practitioner to determine the treatment to be delivered. A change in how non-contact FSAs are recorded from July 2019 along with a drop in FSA delivered due to COVID-19 restrictions has resulted in a drop in the number of events compared with 2018/29.

[40] Non-contact assessments are those where assessment is provided without the need (or the wait) for a hospital appointment. A change in how non-contact FSAs are recorded from July 2019 has meant not all non-contact assessments are being picked up and coded. The DHB is working on realigning data capture to identify this subset of FSAs. The Results are unable to be confirmed at the time of printing.

[41] The planned care intervention measure recognises the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing, including those delivered in community settings. Canterbury's planned care interventions target is made up of three components: elective surgical discharges, minor procedures and non-surgical interventions. Despite having to cancel and reschedule surgeries and procedure following the lockdown, a significant effort by our teams resulted in achievement of the target for 2019/20.

[42] Non-urgent outpatient appointments were cancelled from late March due to COVID-19 restrictions and in quarter four there were around 25,000 fewer appointments than the previous year including more than 11,500 cancelled appointments. As at August 2020, 82% of the outpatient appointments that were cancelled have been resolved.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

SERVICE PERFORMANCE 2019-2020

Assessment, Treatment and Rehabilitation (AT&R) Services							
These services restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Service utilisation is monitored to ensure people are appropriately supported after an event.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
People accessing community-based pulmonary rehabilitation courses	A[43]Δ	270	275	>250	227	-	×
People (65+) accessing the community-based falls prevention service	A[44]	1,653	2,127	>1,500	1,852	-	✓
People supported by the Community Rehabilitation and Support Team (CREST)	A[45]Δ	1,839	1,933	>1,600	1,686	-	✓
Proportion of inpatients referred to an organised stroke service after an acute event	Q	80%	84%	80%	86%	-	✓
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q	86%	88%	>80%	84%	-	✓

Respite and Day Support Services							
These services provide people with a break from a routine or regimented programme, so that crisis can be averted, or a specific health need can be addressed. Largely demand driven, service utilisation is monitored to ensure services are accessible.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
People supported by community-based mental health crisis respite services	A[46]Δ	1,081	1,052	E.>850	754	-	×
Occupancy rate of mental health crisis respite beds	AΔ	85%	88%	85%	74%	-	×
Older people supported by day care services	A[47]Δ	727	578	E.>550	297	-	×
Older people accessing aged care respite services	AΔ	1,697	1,101	E.<1,500	1,192	-	✓
People supported by aged care respite services, being discharged to their own home	QΔ	84%	89%	>80%	88%	-	✓

[43] 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. The 2018/19 result has been updated from 238, to include late reporting received after the publication date of the previous annual report. These are group programmes and the number of people accessing rehabilitation service in 2020 was impacted in quarters three and four due to COVID-19 restrictions.

[44] As with the pulmonary programme, the number of people accessing the falls prevention service was impacted in quarters three and four due to COVID-19 restrictions. The service returned to normal operations from level two.

[45] 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 number of people accessing CREST services was impacted in quarters three and four due to COVID-19 restrictions. CREST activity returned to normal operations from level two.

[46] The number of people accessing respite in drop in quarter three and four as people complied with COVID-19 lockdown restrictions.

[47] The number of older people supported by day-care services was impacted by COVID-19 restrictions in quarters three and four. During lockdown this service provider supported people by other means such as telephone calls to help with loneliness and isolation. The service resumed at level two.

Home-Based and Community Support Services							
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
People supported by district nursing services	A[Δ]	7,698	8,820	E. >7,000	8,568	-	✓
People supported by long-term home-based support services	A[48Δ]	8,554	8,466	E. >8,000	7,870	-	×
Proportion of the population (65+) receiving long-term, home-based support	A[48Δ]	9.7%	9.4%	E. 10%	8.0%	-	×
People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q[49Δ]	92%	91%	95%	91%	-	↺
People supported by hospice or home-based palliative services	A[50Δ]	4,033	3,716	E. 4,000	3,509	-	×
Number of Advance Care Plans registered to support people's end of life care	A	697	781	>700	782	-	✓
Proportion of people with Advance Care Plans, dying in their place of choice	Q[51]	68%	69%	>70%	47%	-	×

Aged Residential Care Services							
The DHB subsidises ARC for people who meet the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Proportion of the population (75+) accessing rest home level services in ARC	A[52Δ]	4.7%	4.3%	E.<5.0%	4.0%	-	✓
Proportion of the population (75+) accessing hospital-level services in ARC	A[Δ]	6.3%	6.1%	E.6.5%	6.0%	-	✓
Proportion of the population (75+) accessing dementia services in ARC	A[Δ]	2.7%	2.6%	E. 2.6%	2.5%	-	✓
Proportion of the population (75+) accessing psychogeriatric services in ARC	A[53Δ]	0.8%	0.8%	E. 0.8%	0.7%	-	×
People entering ARC having had a clinical assessment of need using InterRAI	Q[54Δ]	93%	84%	95%	87%		↺

[48] The number of people supported by home-based support services was impacted in quarter three and four due to COVID restrictions with services prioritised to those with higher needs to ensure the safety of clients and staff who had to reduce the number of different homes being visited.

[49] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. The results are lower than we would like to see and the DHB continues to work with services to increase capacity to deliver assessments as our population ages.

[50] This is a demand driven services and fluctuations can be expected between years. In 2019 improved guidelines were developed by the three Canterbury PHOs to ensure general practice were clearer about the service intent and specifications around End-of-Life services being made available in the last 90 days of life. Improvement were also made to PHO reporting helping to better track service utilisation.

[51] This measure is based on the number of people who have died during the period, in a place that corresponds with the wishes articulated in their Advance Care Plan. To calculate the number of people dying in their place of choice the DHB needs notification of a person's death as well as a confirmed place of death, the reported result is based on the information available at the time of reporting.

[52] 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.

[53] While the proportion of our population accessing psychogeriatric residential care services has fallen below 10% of estimated volumes, appropriateness for these services is assessed using the InterRAI assessment tool. The difference in volumes is the result of 25 fewer people being assessed as requiring aged related psychogeriatric care compared with the previous year and is not seen as an indication of poor performance.

[54] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services. The DHB continues to work with service providers to encourage the use of the tool.

3.2 Māori Health Performance 2019-2020

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

Working with local stakeholders, the DHB has identified a number of key areas of focus and a set of core performance indicators. These are indicators seen as particularly important to our community in terms of improving and monitoring Māori health outcomes. These indicators were identified in our forecast Statement of Performance Expectations for 2019/20 using the symbol (◆). The results for Māori are presented below to highlight progress in reducing equity gaps. The NZ average results are the national results for Māori.

SERVICE PERFORMANCE 2019-2020

Māori Health Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Notes	2017/18	2018/19	2019/20 Target	2019/20	2019/20 NZ average	
Māori babies exclusive/fully breastfed at three months	Q[55]	52%	50%	70%	n.a	n.a.	-
Māori smokers, enrolled with a PHO, receiving advice and help to quit	Q[56]	87%	79%	90%	71%	78%	×
Māori smokers, identified in hospital, receiving advice and help to quit	Q[57]	95%	92%	95%	85%	-	×
Pregnant Māori women, identified as smokers at confirmation of pregnancy with an LMC receiving advice and support to quit smoking	Q[58]	90%	78%	90%	89%	-	↺
Māori children receiving a B4 School Check at age four	A	95%	100%	90%	91%	67%	✓
Māori four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q	97%	100%	95%	97%	97%	✓
Māori women aged 25-69 having a cervical cancer screen in the last three years	A[59]	64%	68%	80%	63%	62%	×
Māori women aged 50-69 having a breast cancer screen in the last two years	A	67%	68%	70%	71%	67%	✓
Māori babies fully immunised at eight months of age	A[6023]	92%	91%	95%	90%	84%	×
Older Māori (65+) having had a seasonal influenza vaccination	A[61†]	42%	40%	75%	42%	45%	↺
Māori population enrolled with a PHO	A	84%	85%	95%	84%	87%	×
Māori new-borns enrolled with a PHO by three months of age	A[62]	85%	82%	85%	80%	75%	×
Māori identified with diabetes having a HbA1c test in the last year	A[63]	88%	89%	90%	87%	-	×
Māori with diabetes having an HbA1c test with acceptable glycaemic control	Q	63%	63%	>60%	61%	-	✓

[55] Data is provided by the Ministry of Health. Results for 2018/19 results were provided this year but results for 2019/20 have not yet been released.

[56] The ABC programme refers to health professionals asking about smoking status, providing Brief advice and providing cessation support. This performance measure reflects smokers given advice and support in general practice in the last 15 months and results have been impacted by the diversion of general practice into responding to the March 2019 terrorist event, the 2019 Measles outbreak and the COVID-19 pandemic in 2019/20.

[57] The proportion of people being offered smoking advice in our hospitals continues to drop, following a changed in the way inpatient smoking data is collected. Work to highlight the importance of gathering this information has been delayed, as staff have been diverted onto responding to the COVID-19 pandemic. This will be relooked at in the coming year.

[58] This data is sourced from the national Maternity Dataset and is provided by the Ministry of Health. The 2019/20 result reflects the performance of the Canterbury region in quarters one, two, and four. Data for quarter three has not been provided by the Ministry of Health.

[59] Rates for cervical screening while above the national average are still below target and the previous year's performance. Lower results many reflect the diversion of general practice over the past two years into responding to the terrorist event and Measles outbreak in 2019 and the COVID-19 pandemic in 2020. The DHB continues to work closely with BreastScreen South and the PHOs to support improved uptake of cervical screening.

[60] Interruptions to immunisation services caused by COVID-19 restrictions have impacted results in quarter four. Canterbury achieved 91% in the first two quarters of the year and 90% in quarters three and four. Canterbury missed the national target by 49 Māori children over the course of the year.

[61] The number of older Māori having a flu vaccination in 2019 increased by 178 people, compared to 2018.

[62] Canterbury experienced a slight drop in the Māori newborn enrolment numbers compared with the previous three quarters. We are monitoring enrolment rates to identify any emerging issues.

[63] An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's diabetes. A level of less than 64mmol/mol reflects an acceptable blood glucose level. The number of Māori who received a test remained the same as the previous year, however this was offset by an increase in the number of Māori identified with diabetes which increased by 56. There were 36 fewer Māori with acceptable control compared with 2018/19. A number of factors contribute to this growth including the growing and ageing population in Canterbury and more people registering with a PHO and having their conditions identified. The DHB continues to work with the three Canterbury PHOs to support improvements in diabetes management.

Māori Health Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Notes	2017/18	2018/19	2019/20 Target	2019/20	2019/20 NZ average	
Māori children (0-4) enrolled in DHB oral health services	A[64†]	53%	51%	95%	86%	-	↺
Māori children (0-12) examined according to planned recall	T†	86%	89%	90%	87%	-	×
Māori women registered with an LMC by 12 weeks of pregnancy	A[65]	68%	66%	80%	n.a	-	-
Māori outpatient 'Did not Attend' rates	Q[66]	7%	9%	<5%	7%	-	×

[64] Results for 2018/19 and 2019/20 have been recalculated using the new master ethnicity data collection introduced in 2019/20. This takes ethnicity information from DHB, General Practice and National Immunisation Register to ensure consistent ethnicity use for the Canterbury population. Canterbury's LinKIDS service continues to support improved enrolment rates, the service is working to increase timeliness of examinations and to keep up with the increasing enrolment numbers.

[65] Data is sourced from the national Maternity Clinical Indicators report, results for 2019/20 are yet to be released.

[66] DNA rates have improved over the past year but continue to be a focus of the DHB.

Part IV
Managing Our Business

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

4.1 Corporate Governance

Statutory Information

This Annual Report presents Canterbury DHB's financial and non-financial performance for the year ended 30 June 2020 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

Board's Report & Statutory Disclosure

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, Canterbury DHB recorded a deficit of $243.436M against the budgeted $180.470M deficit (2018/19: deficit of $177.839M against the budgeted $98.475M deficit).

BOARD FEES

Board and Committee fees paid, or payable, to current Board and Committee Members for services as at 30 June 2020 were as follows:

	Board Fees $	Committee Fees $
Hon Sir John Hansen	35,688	1,250
Gabrielle Huria	22,303	500
Aaron Keown	29,463	-
Andrew Dickerson	29,463	4,313
Barry Bragg	29,463	3,938
Catherine Chu	17,843	250
Ingrid Taylor	17,843	1,500
James Gough	17,843	1,000
Jan Edwards	-	750
Jo Kane	29,463	5,125
Naomi Marshall	17,843	500
Olive Webb	-	500
Peter Ballantyne	-	2,750
Rochelle Faimalo	-	250
Rochelle Phipps	-	1,250
Sally Buck	26,817	1,500
Steve Wakefield	-	2,000
Tom Callanan	-	750
Total	274,032	28,126

Board and Committee fees paid, or payable, to Board and Committee Members who left during 2019/20 were as follows:

	Board Fees $	Committee Fees $
Dr John Wood	23,924	1,250
Tā Mark Solomon	14,525	1,000
Anna Crighton	11,620	1,438
Chris Mene	11,620	250
David Morrell	11,620	2,500
Hans Wouters	-	750
Susan Foster-Cohen	-	750
Tracey Chambers	11,620	313
Trevor Read	-	1,000
Wendy Dallas-Katoa	-	1,500
William Tate	-	2,250
Total	84,929	13,001

Total fees paid, or payable for the year were $400,088 (2018/19: $381,243).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	BOARD		QFARC		HAC		CPH&DSAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Hon Sir John Hansen	7	7	5	5				
Dr John Wood	6	6	5	6				
Gabrielle Huria	6	7	2	5				
Tā Mark Solomon	6	6	4	6				
Peter Ballantyne			12	12				
Barry Bragg	12	13	11	12	2	5		
Sally Buck	6	13			3	5	3	4
Tom Callanan							3	4
Tracey Chambers	4	6					1	3
Catherine Chu	7	7			1	1		
Anna Crighton	4	6			2	3	3	3
Wendy Dallas-Katoa					2	2	4	4
Andrew Dickerson	13	13	11	12	5	5		
Jan Edwards					3	5		
Rochelle Faimalo							1	4
Susan Foster-Cohen							3	4
James Gough	7	7	3	3	1	1		
Jo Kane	12	13	11	12	5	5	4	4
Rawa Karetai							0	0
Aaron Keown	12	13					0	1
Naomi Marshall	7	7			1	1	1	1
Chris Mene	5	6					1	3
David Morrell	5	6	5	6	3	3	2	3
Yvonne Palmer							0	4
Rochelle Phipps					5	5		
Trevor Read					4	4		
William Tate			9	10				
Ingrid Taylor	7	7	5	5	1	1		
Michelle Turrall					0	1		
Steve Wakefield			8	12				
Olive Webb							2	4
Hans Wouters							3	4

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

DIRECTORS' FEES

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

	2020 $'000	2019 $'000
Brian Wood	29	29
Jane Cartwright	23	22
Claire Evans	11	11
Kath Fox	11	11
Paula Rose	11	11
Steve Wakefield	28	11
Erin Black	11	6
Lee Mathias	2	-
Total	126	101

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

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD OR SUBSIDIARIES' INFORMATION

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

INFORMATION ON MINISTERIAL DIRECTIONS

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

ELIGIBILITY DIRECTION

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

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

WHOLE OF GOVERNMENT APPROACH

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

Canterbury DHB applies the Government Rules of Sourcing for procurement and works closely with the Government Chief Information Officer to ensure compliance with directions in relationship to ICT.

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

COVID-19 RESPONSE DIRECTION

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

Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction.

4.2 Our Assets

Asset management and performance

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

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

ASSET PORTFOLIO					
Asset Portfolio	Asset Classes Within Portfolios	Asset Purpose	NET BOOK VALUE		
			2017/18	2018/19	2019/20
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	$576M	$741M	$737M
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	$46M	$44M	$53M
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of health service by aiding decision making at the point of care	$28M	$35M	$50M

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

PROPERTY PORTFOLIO					
Asset Performance Indicators	Indicator Class	2017/18	2018/19	2019/20 Standard	2019/20 Result
Percentage of the critical property portfolio with a National Building Standard at or greater than 34% [67]	Condition	82%	83%	100%	84%
Theatre Utilisation [68]	Utilisation	87.5%	88.3%	>85%	89%
Confidence level in the capability of back-up generators to provide back-up power generation 24x7 [69]	Functionality	-	-	100%	100%
Energy consumption per sqm (kWh/sqm) [70]	Other	402.7	407.2	<500	412.7

[67] All critical property, i.e. providing or supporting the provision of critical clinical services, should have a National Building Standard at or greater than 34%. The DHB is engaged in a significant redevelopment/remediation/repair programme following the earthquakes and has been progressively working to restore buildings to this standard. In the case of the main Christchurch Hospital campus, the timing and pace of achieving this standard is dependent on the migration of services from existing buildings to the new Waipapa building, to release the space for accessibility to commence the work.

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

[69] This measure provides a confidence level in the capability of 12 back-up generators identified as critical, for providing back-up power generation 24x7. The RMS (Root Mean Square) is calculated for the number of recorded outages for the three routine checks: Weekly run tests completed without failure, Weekly physical checks completed, and the Monthly physical tests completed; the confidence level is then applied to the result.

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

CLINICAL EQUIPMENT PORTFOLIO					
Asset Performance Indicators	Indicator Class	2017/18	2018/19	2019/20 Standard	2019/20 Result
Percentage of Linacs compliant with the requirements of the Radiation Safety Act	Condition	100%	100%	100%	100%
Percentage of CTs compliant with the requirements of the Radiation Safety Act [71]	Condition	-	100%	100%	87.5%
Percentage of X-Ray rooms complaint with requirements of the Radiation Safety Act [72]	Condition	-	-	100%	95.0%
Linacs - Scheduled Radiation treatment hours as a percentage of Available treatment hours [73]	Utilisation	-	-	>85.0%	90.4%
Percentage of Diagnostic Monitors meeting RANZCR QA requirements for primary monitors [74]	Functionality	97.0%	100%	>90.0%	100%
Percentage of MRI Scanners compliant with requirements of ACR Annual quality checks [75]	Functionality	-	-	100%	100%
Percentage of Diagnostic Ultrasound machines meeting the IANZ specified industry accepted standards [76]	Functionality	-	-	100%	100%
Percentage of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first cancer treatment within 62 days of referral [77]	Other	94.0%	95.5%	>90.0%	95.0%

INFORMATION COMMUNICATION AND TECHNOLOGY (ICT) PORTFOLIO					
Asset Performance Indicators	Indicator Class	2017/18	2018/19	2019/20 Standard	2019/20 Result
Condition of servers to mitigate against cyber-attacks. Percentage of servers patched (not more than 15 patches outstanding) with critical and security updates [78]	Condition	86.0%	96.6%	>95.0%	95.0%
HealthOne page views[79]	Utilisation	65,152	89,900	>50,000	96,681
Network Security External Penetration Test (external facing websites) [80]	Functionality	2.30	2.30	<2.50	2.30

[71] The non-compliant item is on the 2020/21 replacement plan.

[72] The non-compliant item is subject to ongoing corrective action with the vendors' engineers. The equipment continues to be used, based on a combination of manual methods and some further investigation by Medical Physics to allow us to comply with the Act. This is deemed to be a satisfactory interim measure for 4-5 years till the equipment is next due to be replaced.

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

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

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

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

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

[78] This measure highlights the importance of ensuring that the DHB has mitigated against cyber-attacks. The result is reported monthly and the 2019/20 result is for June.

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

[80] The Network Security External Penetration Test is an important measure that reflects whether the DHB's system can withstand external hacking attacks and whether the DHB's network is appropriately protected.

4.3 Our People

People at the heart of all we do

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

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

Leadership, accountability and culture

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

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

STAFF MIX BY AVERAGE AGE	
Medical	40.99
Nursing	44.76
Allied Health	44.01
Support	49.29
Management & Administration	49.76

STAFF MIX BY GENDER		
Female	9,179	81%
Male	2,173	19%
	11,352	

STAFF IDENTIFYING AS HAVING A DISABILITY[81]	
Yes	313

STAFF ETHNICITY	
NZ European	5,187
Other European	1,231
Unknown	1,058
Other ethnicity	991
European - not further defined	681
NZ Māori	418
Southeast Asian	354
Indian	308
Refused to answer	299
Chinese	249
Other Asian	180
Asian - not further defined	131
Samoan	65
African	59
Middle Eastern	39
Fijian	37
Cook Island Māori	19
Latin American / Hispanic	17
Tongan	15
Other Pacific Island	9
Niuean	3
Pacific Island - not further defined	2
	11,352

SOURCE: PAYROLL AND MAX. AS AT JULY 2020

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

Recruitment, selection and induction

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

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

Workplace safety, health and wellbeing

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

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

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

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

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

We do not tolerate any form of harassment, workplace bullying or discrimination. We are continually improving our policies, procedures and responses when issues of bullying, harassment or discrimination do arise. This includes a programme of work to improve our policies, code of conduct, manager capability to address issues and integrate restorative workplace practises. We continue to improve our people's access to advice and resolution services when they are not having a positive experience at work.

Equal opportunities and positive behaviours

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

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

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

We are committed to identifying and dealing with all examples of unacceptable behaviour. All individuals on joining Canterbury DHB are made familiar with our organisational values and our

policies that guide how we do things at Canterbury DHB. We actively have conversations about behaviour with our people to identify and change any behaviour that does not live up to our Care Starts Here behaviours of Valuing Everyone, Doing the Right Thing and Being and Staying Well.

Remuneration, recognition and conditions

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

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

Employee engagement

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

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

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

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

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

Employee development and promotion

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

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

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

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

Part V
Financial Performance

5.1 Meeting Our Financial Challenges

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE *for the year ended 30 June 2020*	Notes	Actual 2020 $'000	Budget 2020 $'000	Actual 2019 $'000
REVENUE				
Patient care revenue	2 [p48]	1,926,350	1,893,179	1,789,652
Other revenue	3 [p49]	45,614	40,822	39,524
Earthquake repair revenue redrawn from the Ministry of Health	16 [p61]	6,846	10,800	4,460
Interest revenue		695	909	627
Total revenue		1,979,505	1,945,710	1,834,263
EXPENSE				
Employee benefit costs	4 [p50]	1,000,806	915,002	915,945
Treatment related costs		160,676	164,749	140,795
External service providers		810,046	773,439	752,786
Depreciation and amortisation		79,773	83,165	54,084
Impairment of investment in NZHPL	15 [p60]	-	-	3,108
Finance costs		3,282	600	552
Other expenses	5 [p51]	123,376	124,561	116,131
Earthquake building repair costs	16 [p61]	6,846	10,800	4,460
Capital charge expense	6 [p51]	38,136	53,864	24,241
Total expense		2,222,941	2,126,180	2,012,102
Net Surplus/(deficit)		(243,436)	(180,470)	(177,839)
OTHER COMPREHENSIVE REVENUE & EXPENSE				
Revaluation of land and buildings	7,14,16 [pp51,57,61]	-	-	137,345
Total comprehensive revenue & expense	27[p74]	(243,436)	(180,470)	(40,494)

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY *for the year ended 30 June 2020*	Notes	Actual 2020 $'000	Budget 2020 $'000	Actual 2019 $'000
Total equity at beginning of the year		597,378	662,638	496,271
Total comprehensive revenue & expense for the year		(243,436)	(180,470)	(40,494)
EQUITY INJECTIONS:				
Equity support	7 [p51]	130,000	112,579	81,611
Earthquake capital redrawn	7 [p51]	5,994	29,000	1,044
Mental Health facility drawdown	7 [p51]	2,455	7,503	-
Waipapa facility – Crown contribution		-	503,560	-
Outpatients facility - earthquake capital redrawn	7 [p51]	-	-	53,607
Outpatients facility – Crown contribution	7 [p51]	-	-	7,200
EQUITY REPAYMENTS:				
Repayment of equity – annual depreciation funding		(1,861)	(1,861)	(1,861)
OTHER MOVEMENTS:				
NZ Health Innovation Hub Management Ltd	25 [p70]	200	-	-
Total equity at end of the year	7 [p51]	490,730	1,132,949	597,378

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION *as at 30 June 2020*	Notes	Actual 2020 $'000	Budget 2020 $'000	Actual 2019 $'000
CROWN EQUITY				
Contributed capital	7 [p51]	410,659	924,852	274,071
Revaluation reserve	7 [p51]	423,335	426,403	426,403
Accumulated surpluses / (deficits)	7 [p51]	(343,264)	(218,306)	(103,096)
Total equity		490,730	1,132,949	597,378
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8 [p52]	4,056	627	4,766
Trade and other receivables	9 [p53]	111,502	96,848	96,848
Inventories	10 [p54]	14,549	13,208	13,209
Restricted assets	18 [p63]	14,677	14,685	14,743
Investments	11 [p55]	750	750	750
Total current assets		145,534	126,118	130,316
CURRENT LIABILITIES				
NZHPL sweep account	8 [p52]	11,032	63,024	36,575
Trade and other payables	12 [p55]	165,170	123,995	125,195
Employee benefit liabilities	13 [p56]	343,643	180,342	245,601
Restricted liabilities	18 [p63]	14,693	14,701	14,759
Borrowings	19[p65]	205	-	-
Total current liabilities		534,743	382,062	422,130
Net working capital		(389,209)	(255,944)	(291,814)
NON-CURRENT ASSETS				
Property, plant and equipment	14,16 [pp57,61]	861,821	1,358,112	850,743
Intangible assets	15,16 [pp60,61]	50,958	36,667	44,335
Restricted assets	18 [p63]	16	16	16
Total non-current assets		912,795	1,394,795	895,094
NON-CURRENT LIABILITIES				
Employee benefit liabilities	13 [p56]	6,304	5,902	5,902
Borrowings	19 [p65]	26,552	-	-
Total non-current liabilities		32,856	5,902	5,902
Net assets		490,730	1,132,949	597,378

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS *for the year ended 30 June 2020*	Notes	Actual 2020 $'000	Budget 2020 $'000	Actual 2019 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Receipts from Ministry of Health		1,852,784	1,841,187	1,733,676
Earthquake repair revenue redrawn from Ministry of Health		6,846	10,800	4,460
Other receipts		113,002	92,814	94,154
Interest received		695	909	627
		1,973,327	1,945,710	1,832,917
CASH WAS APPLIED TO:				
Payments to employees		880,391	895,964	822,566
Payments to suppliers		1,113,310	1,092,587	1,026,260
Interest paid		3,369	600	211
Capital charge		25,610	53,864	24,241
GST – net		(1,219)	-	12,144
		2,021,461	2,043,015	1,885,422
Net cash inflow/ (outflow) from operating activities	20 [p66]	(48,134)	(97,305)	(52,505)
CASH FLOW FROM INVESTING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Sale of property, plant & equipment		17	-	123
Receipts from restricted assets & investments		16,238	-	17,642
		16,255	-	17,765
CASH WAS APPLIED TO:				
Purchase of investments & restricted assets		16,238	-	18,787
Purchase of property, plant & equipment		63,579	80,563	43,378
		79,817	80,563	62,165
Net cash inflow/ (outflow) from investing activities		(63,562)	(80,563)	(44,400)
CASH FLOW FROM FINANCING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Earthquake repair capital redrawn	16 [p61]	5,994	29,000	1,044
Mental Health facility drawdown	7 [p51]	2,455	7,503	-
Acquisition of subsidiary	25[p70]	200	-	-
Equity support	7 [p51]	130,000	112,579	81,611
		138,649	149,082	82,655
CASH WAS APPLIED TO:				
Annual depreciation funding repayment	7 [p51]	1,861	1,861	1,861
Repayment of finance leases	19 [p65]	259	-	-
		2,120	1,861	1,861
Net cash inflow/ (outflow) from financing activities		136,529	147,221	80,794
Net increase/ (decrease) in cash and cash equivalents		24,833	(30,647)	(16,111)
Cash and cash equivalents at beginning of year		(31,809)	(31,750)	(15,698)
Cash & cash equivalents at end of year	8 [p52]	(6,976)	(62,397)	(31,809)

The accompanying notes form part of these financial statements.

5.2 Guide to Our Financial Reports

Notes to and forming part of the financial statements

1. STATEMENT OF ACCOUNTING POLICIES

Reporting entity and statutory base

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

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

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

- Canterbury Linen Services Ltd (100% owned)
- Brackenridge Services Ltd (100% owned)
- NZ 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. For further details of the lease, refer to note 17.

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

The financial statements of Canterbury DHB are for the year ended 30 June 2020 and were authorised for issue by the Board on 17 December2020.

Basis of Preparation

Statement of going concern

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

Canterbury DHB's Chair received a letter of comfort from the Ministers of Health and Finance to enable the Board of Canterbury DHB to satisfy itself, for the purposes of the 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 notes 4, 13, 14, 15, and 19.

Standards issued but not yet effective and not early adopted

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

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.

2. PATIENT CARE REVENUE	2020 $'000	2019 $'000
Ministry of Health population based funding	1,565,331	1,463,233
Inter-district flows	130,968	122,670
Ministry of Health other contracts	162,239	138,563
ACC revenue	33,209	30,862
Other patient related revenue	34,603	34,324
Total patient care revenue	1,926,350	1,789,652

Under the Public Finance Act 1989, Canterbury DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation, and the service performance measures[82] that report against the use of that funding.

The appropriation revenue received by Canterbury DHB for the 2019/20 financial year is $1,553.032M (2018/19: $1,431.953M) which equals the Government's actual expenses incurred in relation to the appropriation.

MINISTRY OF HEALTH APPROPRIATION REVENUE	Actual $'000	MOH Budget $'000
Crown funding appropriation	1,546,186	1,546,186
Waipapa facility funding	-	10,578
Canterbury earthquake funding	6,846	14,000
Total appropriation revenue	1,553,032	1,570,764

The table above shows the actual and budget Ministry of Health appropriation figures. The variance in the Crown funding appropriation relates to the 2019/20 debt equity swap capital charge funding for the new Waipapa facility. This appropriation has been held in reserve within the Ministry of Health due to the delay in the rebuild, i.e. there is no additional corresponding capital charge cost to Canterbury DHB for that facility for 2019/20.

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

ACCOUNTING POLICY

Revenue

Ministry of Health population based funding

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

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

Inter-district flows

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

Ministry of Health other contracts

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

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

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

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

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

ACC revenue

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

Other patient related revenue

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

3. OTHER REVENUE	2020 $'000	2019 $'000
Gain/(loss) on sale of property, plant and equipment	17	133
Donations and bequests received	3,674	4,067
Pathology tests	11,198	8,811
Research & development	7,982	7,647
External rental revenue	1,024	896
Cafeteria sales	4,057	4,568
Other	17,662	13,402
Total other revenue	45,614	39,524

ACCOUNTING POLICY

Revenue

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

ESTIMATES AND ASSUMPTIONS

Non-government grants

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

4. EMPLOYEE BENEFIT COSTS	2020 $'000	2019 $'000
Wages and salaries	874,804	816,130
Board members' fees	359	326
Directors' fees	126	101
Contributions to defined contribution plans[83]	27,072	25,422
Increase/(decrease) in Holidays Act compliance provision	65,637	65,260
Increase/(decrease) in employee benefit provisions	32,808	8,706
Total employee benefit costs	1,000,806	915,945

Holidays Act Compliance

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

Work started in 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, and in late 2019 a national approach was agreed to rectify and remediate any Holidays Act non-compliance by DHBs. DHBs also agreed to a Memorandum of Understanding (MOU), which contained a method for determination of individual employee earnings and for calculation of liability for any historical non-compliance.

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

The remediation programme associated with the MOU is a significant undertaking and work to assess, rectify and remediate all areas of non-compliance will continue through the 2020/21 financial year. At Canterbury DHB, the formal Review Phase, as set out in the MOU, was completed in March 2020 with all non-compliance issues identified. Efforts are now focused on rectifying payroll systems and processes to ensure ongoing compliance, as well as analysis, testing and remediating the results of retrospective areas of non-compliance for relevant individual employees.

Canterbury DHB recognises it has an obligation to address any historical non-compliance under the MOU. Based on detailed analysis undertaken in the formal Review Phase, calculations and assumptions have been determined and a revised liability estimated (revised from the provisional estimate determined in mid-2019). This was based on selecting a representative sample of current and former employees; analysing leave records against known breaches; making a number of assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this programme. However, until the programme has progressed further, there remain substantial uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

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

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

5. OTHER EXPENSES

	2020 $'000	2019 $'000
Financial statement audit fees	255	239
Additional financial statement audit fees for prior year	11	-
Rental costs including operating leases	5,815	9,025
Facilities and infrastructure costs	53,850	50,309
Other non-clinical costs	63,445	56,558
Total other expenses	123,376	116,131

ACCOUNTING POLICY

Operating lease payments

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

6. CAPITAL CHARGE

Canterbury DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December, less an allowance for donated assets. For the year ended 30 June 2020 the rate was 6% (2018/19: 6%).

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

In July 2019, the Minister of Health announced that DHBs would be funded for capital charge on new facilities, with any deficit reducing the funding. This will benefit Canterbury DHB particularly with the new Waipapa facility coming on stream in the 2020/21 financial year.

7. EQUITY

	2020 $'000	2019 $'000
CONTRIBUTED CAPITAL		
Opening balance	274,071	132,470
Annual depreciation funding repayment	(1,861)	(1,861)
Equity support	130,000	81,611
Earthquake repair capital redrawn	5,994	1,044
Mental Health facility drawdown	2,455	-
Outpatients facility - earthquake capital redrawn	-	53,607
Outpatients facility - Crown contribution	-	7,200
Closing balance	410,659	274,071

The operating deficit for 2019 was $177.8M. The Ministry of Health provided $130M of equity support in April 2020.

ACCUMULATED SURPLUS/(DEFICIT)	2020 $'000	2019 $'000
Opening balance	(103,096)	74,743
NZ Health Innovation Hub Management Ltd	200	-
Realised gain on disposal transferred from revaluation reserve	3,068	-
Operating deficit	(243,436)	(177,839)
Closing balance	(343,264)	(103,096)
REPRESENTED BY:		
Accumulated surplus in parent and associates	(350,367)	(106,542)
Accumulated surplus in subsidiaries	7,103	3,446
Total accumulated surplus / (deficit)	(343,264)	(103,096)
REVALUATION RESERVE		
Opening balance	426,403	289,058
Realised gain on disposal transferred to retained earnings	(3,068)	-
Revaluation of land, buildings including fitout	-	137,345
Closing balance	423,335	426,403
REPRESENTED BY:		
Revaluation of land	94,616	94,616
Revaluation of buildings including fitout	328,719	331,787
Total revaluation reserve	423,335	426,403
Total equity	490,730	597,378

ACCOUNTING POLICY

Equity

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

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

Revaluation reserve

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

8. CASH AND CASH EQUIVALENTS	Credit rating	2020 $'000	2019 $'000
CURRENT ASSETS			
Bank balances and call deposits	AA-	4,056	4,766
Total cash and cash equivalents		4,056	4,766
CURRENT LIABILITIES			
NZHPL sweep account		(11,032)	(36,575)
Net cash and cash equivalents		(6,976)	(31,809)

Bank facility

Canterbury DHB is a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Ltd (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and

invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at a credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one-twelfth of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Canterbury DHB, that equates to $88.808M (2018/19: $88.808M). There has been no change from 2018, as both the Minister of Health and the Minister of Finance advised that they have not approved the 2018/19 Annual Plan nor the 2019/20 Annual Plan.

Credit risk

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

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

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

ACCOUNTING POLICY

Bank term deposits

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

Cash and cash equivalents

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

9. TRADE AND OTHER RECEIVABLES	2020 $'000	2019 $'000
Trade receivables	18,267	18,327
Receivable from the Ministry of Health	59,993	41,636
Prepayments	5,649	5,838
Other receivables	27,593	31,047
Total trade and other receivables	111,502	96,848
MOVEMENTS IN THE PROVISION FOR IMPAIRMENT OF RECEIVABLES ARE AS FOLLOWS:		
Balance at 1 July	2,062	1,940
Additional provisions made during the year	1,863	925
Receivables written-off during period	(2,589)	(803)
Balance at 30 June	1,336	2,062
THE AGEING OF THE IMPAIRMENT PROVISIONS ARE AS FOLLOWS:		
Current	23	-
< 6 months	880	975
6 months – 1 year	207	322
1 – 2 years	150	457
> 2 years	76	308
Balance at 30 June	1,336	2,062

THE NET AGEING OF RECEIVABLES, EXCLUDING PREPAYMENTS, IS:

Current	90,449	86,955
< 6 months	15,312	3,815
6 months – 1 year	29	88
1 – 2 years	52	100
2 years	11	52
Balance at 30 June	105,853	91,010

Trade receivables and prepayments are from exchange transactions.

The value of trade receivables that have been impaired on an individual basis total $0.428M, and the impairment on those accounts is $0.372M giving a net carrying value of $0.056M.

Other receivables and receivables from the Ministry of Health are a blend of both exchange and non-exchange transactions. The value of non-exchange balances in other receivables and in receivables from the Ministry of Health is $26.827M (2018/19: $25.400M).

Concentrations of credit risk from trade and other accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor. It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2020, the Ministry of Health owed Canterbury DHB $59.993M (2018/19: $41.636M).

ACCOUNTING POLICY

Trade and other receivables

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

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

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

10. INVENTORIES	2020 $'000	2019 $'000
Pharmaceuticals	3,419	2,824
Surgical and medical supplies	7,117	7,793
Other supplies	4,532	3,403
	15,068	14,020
Provision for obsolescence	(519)	(811)
Total inventories	14,549	13,209

ACCOUNTING POLICY

Inventories

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

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

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

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

11. INVESTMENTS

	Credit rating	2020 $'000	2019 $'000
Investments are represented by:			
Term deposits with maturities of 3-12 months	AA-	750	750
Total investments		750	750
Weighted average effective interest rates		2.03%	3.28%

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

Fair value interest rate risk

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

Information relevant to Canterbury DHB credit risk can be found in note 8 [p52].

12. TRADE AND OTHER PAYABLES

	2020 $'000	2019 $'000
Trade payables	41,771	23,613
Other payables	123,399	101,582
Total trade and other payables	165,170	125,195

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

Trade payables are from exchange transactions. The value of non-exchange balances in other payables is $51.962M (2018/19: $33.662M).

Trade and other payables are measured at fair value.

ACCOUNTING POLICY

Provisions

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

13. EMPLOYEE BENEFIT LIABILITIES	2020 $'000	2019 $'000
CURRENT LIABILITIES		
Annual, lieu and shift leave accruals	233,278	155,237
Unpaid days accruals	13,781	7,087
ACC accruals	5,158	4,816
Conference/sabbatical leave and expenses	35,262	28,619
Sick leave	6,251	5,668
Other	49,913	44,174
Total employee benefits - current	343,643	245,601
NON-CURRENT LIABILITIES		
Liability for long service leave	5,255	4,616
Liability for retirement gratuities	1,049	1,286
Total employee benefits – non-current	6,304	5,902

ACCOUNTING POLICY

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

ACC Partnership Programme

Canterbury DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme Canterbury DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the

end of the five year period, Canterbury DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

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

ESTIMATES AND ASSUMPTIONS

Retirement and long service leave

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

The discount rates used have been obtained from the NZ Treasury published risk-free discount rates as at 30 June 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.

14. PROPERTY, PLANT AND EQUIPMENT

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

2019/20 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2019	139,455	597,206	238,461	10,072	49,497	1,034,691
Additions/transfers	-	24,813	30,239	27,043	2,426	84,521
Disposals/transfers	-	(50)	(3,344)	-	-	(3,394)
Revaluation	-	-	-	-	-	-
Balance at 30 June 2020	139,455	621,969	265,356	37,115	51,923	1,115,818
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2019	-	2,087	178,222	3,639	-	183,948
Depreciation	-	53,842	17,349	2,179	-	73,370
Disposals/transfers	-	(3)	(3,318)	-	-	(3,321)
Revaluation	-	-	-	-	-	-
Balance at 30 June 2020	-	55,926	192,253	5,818	-	253,997
CARRYING AMOUNT						
At 30 June 2020	139,455	566,043	73,103	31,297	51,923	861,821

2018/19 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2018	129,918	518,485	224,649	10,109	24,538	907,699
Additions/transfers	-	65,948	13,898	160	24,959	104,965
Disposals/transfers	-	(4,540)	(86)	(197)	-	(4,823)
Revaluation	9,537	17,313	-	-	-	26,850
Balance at 30 June 2019	139,455	597,206	238,461	10,072	49,497	1,034,691
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2018	-	79,310	164,065	3,535	-	246,910
Depreciation	-	35,786	14,765	290	-	50,841
Disposals/transfers	-	(2,514)	(608)	(186)	-	(3,308)
Revaluation	-	(110,495)	-	-	-	(110,495)
Balance at 30 June 2019	-	2,087	178,222	3,639	-	183,948
CARRYING AMOUNT						
At 30 June 2019	139,455	595,119	60,239	6,433	49,497	850,743

Finance leases

The net carrying amount of assets held under finance leases is $25.216M for buildings (2018/19: Nil).

Work in progress

Please note that Work in Progress has been split between PPE and intangible assets this year, prior year comparisons have been updated to reflect this (affecting both note 14 and 15).

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

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

ACCOUNTING POLICY

Property, plant and equipment

Owned assets

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

Revaluations

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

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

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

Disposal of property, plant and equipment

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

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

Depreciation

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

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

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

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

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, advance in medical technology, and expected disposal proceeds from the future sale of the assets. Any adjustments are disclosed within this note.

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

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

15. INTANGIBLE ASSETS	2020 $'000	2019 $'000
SOFTWARE		
COST		
Opening balance	70,120	58,731
Additions	18,898	11,389
Disposals	(15)	-
Closing balance	89,003	70,120
AMORTISATION AND IMPAIRMENT LOSSES		
Opening balance	39,526	36,283
Amortisation charge for the year	6,403	3,243
Disposals	(15)	-
Closing balance	45,914	39,526
Total Software	43,089	30,594
WORK IN PROGRESS - INTANGIBLES		
Opening balance	10,516	9,960
Additions / transfers	(5,872)	556
Closing balance	4,644	10,516
INVESTMENT IN NZ HEALTH PARTNERSHIPS LTD		
Opening balance	3,225	5,187
Capital call – National Oracle Solution revised business case	-	1,146
Impairments for the year	-	(3,108)
Closing balance	3,225	3,225
Carrying amounts	50,958	44,335

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

NZ Health Partnerships Limited (NZHPL)

No impairment for the NZHPL Change Management and Supply Chain was recognised for the financial year ended 30 June 2020 (2018/19: $3.108M).

NZHPL has issued B Class Shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain (FPSC) Shared Service.

The rights attached to "B" Class shares include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and, therefore, the benefits conferred through this access.

NZHPL has issued 100 A class shares held equally by the 20 DHBs with voting rights. Canterbury DHB holds 5 shares.

ACCOUNTING POLICY

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Staff training and other costs

associated with maintaining computer software are recognised as an expense when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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

Amortisation

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

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

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

ESTIMATES AND ASSUMPTIONS

Estimating useful lives of software assets

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

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

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

16. IMPAIRMENT AND THE EFFECTS OF THE CANTERBURY EARTHQUAKES

A 7.1 magnitude earthquake occurred in the Canterbury region on 4 September 2010, with subsequent large aftershocks, including a 6.3 magnitude earthquake on 22 February 2011, and a further 6.3 magnitude earthquake on 13 June 2011. These events caused significant damage to many of Canterbury DHB's buildings and assets.

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

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

Canterbury DHB continually reviews whether the carrying value of land and buildings exceeds their recoverable amount.

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

Repair costs for buildings that have been impaired due to the earthquakes which resulted in an increase in service potential have been capitalised. From 1 July 2013 new insurance policies were placed for all of the 20 DHBs as part of their Insurance Collective, through NZ Health Partnerships Ltd. For the Material Damage and Business Interruption Policy the cover provided for Canterbury DHB has been significantly reduced for earth

movement. As well as significantly higher deductibles (excesses) than was historically the case and limited coverage for buildings assessed at less than 33% of New Building Standard (Importance level 3), Canterbury DHB does not have full replacement cover for its buildings. Under the policy cover is restricted to "actual cash value" rather than the replacement cover made available to the other DHBs, unless and until repairs have been completed. This, in the event of further earthquake damage, materially limits insurance coverage and therefore likely recoveries.

Agreement with Ministry of Health

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

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

DRAWDOWN	$M
Initial payment to Ministry of Health	290.00
Drawdown	(181.08)
Amount undrawn 30 June 2020	108.92

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

ACCOUNTING POLICY

Impairment

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

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

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

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

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

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

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

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

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.

17. JOINTLY CONTROLLED OPERATIONS

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

	2020 $'000	2019 $'000
Canterbury DHB's revenue included the following as a result of the jointly controlled operations:		
Sub tenant revenue	290	286
Canterbury DHB's expenditure included the following as a result of the jointly controlled operations:		
Manawa lease and facility costs	2,318	1,982

As at 30 June 2020, Canterbury DHB owed Ara Institute $32,000 (30 June 2019: $76,000). Ara Institute owed Canterbury DHB $1,000 (30 June 2019: $9,000).

18. RESTRICTED ASSETS & RESIDENTS' TRUST ACCOUNTS

RESTRICTED ASSETS

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

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

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

	2020 $'000	2019 $'000
FUNDS HELD DIRECTLY BY CANTERBURY DHB		
Balance at beginning of year	8,945	10,577
Interest received	233	299
Donations and funds received	466	536
Funds transferred to Māia Health Foundation	(42)	(1,798)
Funds spent	(504)	(669)
Balance at end of year	9,098	8,945
FUNDS HELD WITH MĀIA HEALTH FOUNDATION		
Balance at beginning of year	5,814	4,016
Interest earned on funds held with Māia Health Foundation	157	-
Transfers in from Canterbury DHB	42	1,798
Funds drawn down by Canterbury DHB	(418)	-
Balance at end of year	5,595	5,814
Total Restricted Assets	14,693	14,759
This balance is represented by:		
Current assets	14,677	14,743
Non-current assets	16	16
Total restricted assets	14,693	14,759
Weighted average effective interest rates	1.90%	3.28%

CREDIT QUALITY OF RESTRICTED ASSETS	Credit rating	2020 $'000	2019 $'000
Restricted assets:			
Bank balances	AA-	10	58
Term deposits with maturities of up 3 months – Canterbury DHB	AA-	-	175
Term deposits with maturities of 3-12 months – Canterbury DHB	AA-	9,072	8,696
Term deposits with maturities of 3-12 months – Māia Health Foundation	AA-	5,595	5,814
Perpetual capital notes	BBB+	16	16
Total restricted assets		14,693	14,759

RESIDENTS' TRUST ACCOUNTS	2020 $'000	2019 $'000
Residents' trust account balance	1,024	1,009

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

19. BORROWINGS	2020 $'000	2019 $'000
CURRENT PORTION		
Finance leases	205	-
NON-CURRENT PORTION		
Finance leases	26,552	-
Total borrowings	26,757	-

Fair value

The fair value of finance leases is $26.757M. Fair value has been determined using contractual cash flows discounted using a rate of 5.5%.

ANALYSIS OF FINANCE LEASES	2020 $'000
Minimum lease payments	
No later than one year	1,676
Later than one year and not later than five years	6,886
Later than five years	46,682
Total minimum Lease Payments	55,244
Future finance charges	(28,487)
Present value of minimum lease payments	26,757

Present value of minimum lease payments payable	
No later than one year	1,589
Later than one year and not later than five years	5,715
Later than five years	19,453
Total present value of minimum lease payments	26,757

Description of finance leasing arrangements

The group has entered into a finance lease for the Manawa building. The net carrying amount of the leased item is shown in Note 14.

The building lease is for an initial period of thirty years ending 16 July 2048, with rights of renewal for a further period of five years, and an annual rental escalation clause of 1.5% with rent reviews every five years.

At the time of signing the lease, Canterbury DHB assessed the lease as an operating lease. Audit NZ hold the view that this is a finance lease. Canterbury DHB has therefore reclassified the lease as a finance lease. A finance lease requires the authority of the Minister of Health and the Minister of Finance under Schedule 3, clause 45 of the New Zealand Public Health and Disability Act 2000 and sections 160 and 162 of the Crown Entities Act 2004. This was not obtained at the time of entering into the arrangement. Canterbury DHB will now seek joint Ministerial approval for continuing the borrowing under the agreement.

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

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

ACCOUNTING POLICY

Liquidity risk

Liquidity risk is the risk that Canterbury DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, the availability of

funding through an adequate amount of committed credit facilities and the ability to close out market positions.

Borrowings

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

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

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the Canterbury DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

ESTIMATES AND ASSUMPTIONS

Leases classification

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

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

20. RECONCILIATION OF NET SURPLUS/(DEFICIT) FOR THE PERIOD WITH NET CASH FLOWS FROM OPERATING ACTIVITIES

	2020 $'000	2019 $'000
Net (deficit)/ surplus before other comprehensive revenue and expense	(243,436)	(177,839)
Add back non-cash items:		
Depreciation and amortisation	79,773	54,084
Impairment in investment in NZ Health Partnerships Ltd	-	3,108
Add back items classified as investing activities:		
Loss/(gain) on asset sale	30	(123)
Movement in term portion provisions/staff entitlements	402	(274)
MOVEMENTS IN WORKING CAPITAL:		
Decrease/(increase) in receivables & prepayments	(14,654)	(6,457)
Decrease/(increase) in stocks	(1,340)	(2,038)
Increase/(decrease) in creditors & other accruals	33,049	2,794
Increase/(decrease) in staff entitlements	98,042	74,240
Net cash inflow/(outflow) from operating activities	(48,134)	(52,505)

21. COMMITMENTS	2020 $'000	2019 $'000
CAPITAL COMMITMENTS		
Property	13,369	10,404
Intangible assets	4,731	8,430
Other capital commitments	14,519	13,665
Total capital commitments at balance date	32,619	32,499

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

NON-CANCELLABLE OPERATING LEASE COMMITMENTS		
Accommodation leases	29,003	77,692
Other leases	1,626	35
Total non-cancellable operating lease and supply commitments	30,629	77,727
FOR EXPENDITURE WITHIN:		
Not later than one year	5,661	6,739
Later than one year and not later than five years	13,643	18,296
Later than five years	11,325	52,692
Total non-cancellable operating lease and supply commitments	30,629	77,727

The classification of the property lease for the Manawa building situated at 276 Antigua Street has changed from operating to finance lease in the 2019/20 financial year. This has reduced our operating lease commitments from prior year.

External service providers

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

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

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

Operating leases as lessee

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

ESTIMATES AND ASSUMPTIONS

Leases classification

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

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

22. CONTINGENCIES

Contingent assets

Canterbury DHB has no contingent assets as at 30 June 2020 (2018/19: Nil).

Contingent liabilities

Canterbury DHB has the following contingent liabilities as at 30 June 2020:

Outstanding legal proceedings

Canterbury DHB has no material outstanding legal proceedings as at 30 June 2020 (2018/19: Nil).

Defined benefit contribution schemes

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

Canterbury earthquakes

In respect of the Canterbury earthquakes there are a number of repair costs yet to be determined and incurred, both of an operational and capital nature, which will be brought to account as they become quantifiable and a liability crystallises. See note 16 [p61] for further information.

Land and building contamination

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

23. CONTRACTUAL MATURITY OF FINANCIAL ASSETS AND LIABILITIES

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

Contractual maturity analysis of financial liabilities	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	More than 2 years $'000
2019/20 FINANCIAL YEAR					
NZHPL sweep account	11,032	11,032	11,032	-	-
Trade and other payables	165,170	165,170	165,170	-	-
Restricted funds	14,693	14,693	14,693	-	-
Finance leases	26,757	55,244	1,676	1,702	51,866
Total financial liabilities	217,652	246,139	192,571	1,702	51,866
2018/19 FINANCIAL YEAR					
NZHPL sweep account	36,575	36,575	36,575	-	-
Trade and other payables	125,195	125,195	125,195	-	-
Restricted funds	14,759	14,759	14,759	-	-
Total financial liabilities	176,529	176,529	176,529	-	-

Contractual maturity analysis of financial assets	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000
2019/20 FINANCIAL YEAR				
Cash and cash equivalents	4,056	4,056	4,056	-
Trade and other receivables[84]	105,853	105,853	105,853	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	14,693	14,693	14,677	16
Total financial assets	125,352	125,352	125,336	16
2018/19 FINANCIAL YEAR				
Cash and cash equivalents	4,766	4,766	4,766	-
Trade and other receivables[84]	91,009	91,009	91,009	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	14,759	14,759	14,743	16
Total financial assets	111,284	111,284	111,268	16

ACCOUNTING POLICY

Classification of financial instruments

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

Financial assets:

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

All financial liabilities are measured at amortised cost.

Sensitivity analysis

The table below illustrates the potential effect on the surplus or deficit for reasonable possible market movements, with all other variables held constant, based on Canterbury DHB's financial instrument exposure at balance date. Canterbury DHB's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the group, as investments are generally held to maturity.

Canterbury DHB held NZD $117,063 of foreign currency accounts as at 30 June 2020 (2018/19: NZD $990,953).

	2020 $'000		2019 $'000	
FOREIGN EXCHANGE RISK	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(12)	11	(99)	90
Total sensitivity	(12)	11	(99)	90

[84] Excludes prepayments

ACCOUNTING POLICY

Foreign currency

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

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

Derivative financial instruments

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

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

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

Foreign exchange contracts

The notional principal amounts of outstanding forward foreign exchange contracts in NZ dollars were $0.63M (2018/19: $4.07M). The foreign currency principal amounts were €0.34M (2018/19: €2.25M)

24. CAPITAL MANAGEMENT

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

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

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

25. RELATED PARTIES

Canterbury DHB is a wholly owned entity of the Crown.

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

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

they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms for such transactions.

Canterbury Linen Services is relocating to a new site in the 20/21 financial year, Canterbury DHB have helped to fund the redevelopment through a loan facility charging the same interest rates that are applied to Canterbury DHB by NZ Health Partnerships Ltd and Treasury.

Significant transactions with government related entities

Canterbury DHB has received funding from the Crown, ACC, and other government entities of $1,768.092M to provide health services in Canterbury area for the year ended 30 June 2020 (2018/19: $1,638.484M).

Revenue earned from other DHBs for the care of patients domiciled outside Canterbury DHB's district as well as services provided to other DHBs amounted to $145.418M for the year ended 30 June 2020 (2018/19: $138.654M).

Expenditure to other DHBs for the care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $37.868M for the year ended 30 June 2020 (2018/19: $35.921M).

Other significant transactions with government-related entities

In conducting its activities, Canterbury DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. Canterbury DHB is exempt from paying income tax.

Canterbury DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2020 totalled $23.388M (2018/19: $23.265M). These purchases included blood products from the New Zealand Blood Service, travel through Air New Zealand and services from NZ Health Partnerships Ltd.

ACCOUNTING POLICY

Subsidiaries

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

Transactions eliminated on consolidation

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

Associates

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

Canterbury DHB subsidiaries

ENTITY	Interest held 2020	Balance Date
Canterbury Linen Services Ltd	100%	30 June
Brackenridge Services Ltd	100%	30 June
NZ Health Innovation Hub Management Ltd	100%	30 June

Canterbury Linen Services Ltd, Brackenridge Services Ltd and NZ Health Innovation Hub Management Ltd are incorporated in New Zealand. Canterbury Linen Services Ltd provides laundry services. Brackenridge Services Ltd provides residential accommodation and ongoing care for intellectually disabled persons.

NZ Health Innovation Hub Management Ltd (NZHIH) was a joint venture originally established by Counties Manukau, Auckland, Waitemata and Canterbury DHBs. As of 1 July 2019 NZHIH became a wholly owned subsidiary of Canterbury DHB.

NZHIH works alongside DHB innovators to develop new products and services that have commercial potential, are based on intellectual property and improve health outcomes and it also provides access to current information about the health landscape, market validation, potential investors and partners.

Canterbury DHB associates

ENTITY	Interest held 2020	Balance Date
South Island Shared Service Agency Limited	47%	30 June

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

West Coast DHB

Canterbury DHB provides key management personnel services (including Chief Executive services) under contract to the West Coast DHB.

Canterbury DHB charges the West Coast DHB for these services. 2020 charges were $1.272M (2018/19: $1.253M). The amount owing by West Coast DHB relating to this agreement at balance date was $0.122M (2018/19: Nil).

Māia Health Foundation

Canterbury DHB provides accounting support, office space, and minor incidentals to the Māia Health Foundation at no charge, as well as assistance with seed funding of $0.250M (2018/19: $0.125M). Also refer note 18 [p63].

Key management personnel

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

26. EMPLOYEE REMUNERATION

	2020 $'000	2019 $'000
COMPENSATION OF KEY MANAGEMENT PERSONNEL		
Salaries for executive management team	3,746	3,689
Board and Committee members fees	400	381
Total key management personnel compensation	4,146	4,070

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

KEY MANAGEMENT PERSONNEL FULL TIME EQUIVALENTS (FTE)	2020 FTE	2019 FTE
Full time equivalent Board and Committee members	1.24	1.33
Full time equivalent executive management team	11.00	10.65
Total key management personnel full time equivalents	12.24	11.98

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

Payments in respect of termination of employment

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

The total payments made by Canterbury DHB were $300,432 to 10 employees (2018/19: $510,218 to 16 employees) comprising negotiated settlements with the employees.

Remuneration of employees

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

SPECIFIED BANDS	2020	2019	SPECIFIED BANDS	2020	2019
100,000-109,999	423	419	340,000-349,999	14	22
110,000-119,999	288	262	350,000-359,999	12	16
120,000-129,999	177	145	360,000-369,999	8	7
130,000-139,999	134	126	370,000-379,999	6	12
140,000-149,999	101	87	380,000-389,999	7	6
150,000-159,999	70	77	390,000-399,999	5	5
160,000-169,999	67	45	400,000-409,999	10	7
170,000-179,999	52	56	410,000-419,999	10	7
180,000-189,999	35	40	420,000-429,999	8	2
190,000-199,999	27	26	430,000-439,999	3	11
200,000-209,999	46	28	440,000-449,999	2	4
210,000-219,999	34	26	450,000-459,999	3	3
220,000-229,999	28	27	460,000-469,999	2	3
230,000-239,999	27	22	470,000-479,999	4	3
240,000-249,999	31	22	480,000-489,999	2	3
250,000-259,999	27	24	490,000-499,999	1	2
260,000-269,999	24	32	500,000-509,999	1	1
270,000-279,999	24	17	540,000-549,999	1	-
280,000-289,999	29	37	560,000-569,999	-	1
290,000-299,999	25	23	640,000-649,999	1	1
300,000-309,999	26	24	680,000-689,999	-	1
310,000-319,999	27	20	790,000-799,999	1	-
320,000-329,999	22	24			
330,000-339,999	18	9			
			Total employees	1,863	1,735

Of the positions identified above, 1,605 (2018/19: 1,502) positions were predominantly clinical and 258 (2018/19: 233) positions were management/administrative.

27. MAJOR VARIANCES TO BUDGET

Canterbury DHB budgeted for a deficit of $180.5M as published in our 2019/20 Annual Plan.

Statement of comprehensive revenue and expense

Listed below are the major factors that make up the variance between the planned deficit of $180.5M and the actual deficit of $243.4M:

- We received $16.9M additional funding to cover costs of $34.0M in relation to the COVID-19 pandemic. The revenue received was mainly to cover expenditure to community providers. The costs are employee benefit costs, treatment related costs, external service providers costs and other expenses.
- Of the additional unbudgeted revenue received, most was fully offset by additional expenditure, including $4.4M received for In-Between Travel, $3.5M additional side contracts and $4.9M additional pharmaceutical funding for increased costs of medicines.
- We received $3.5M more Inter District Flow (IDF) revenue than the Ministry of Health forecast due to more referrals from DHBs outside of the Canterbury region.
- Earthquake repair revenue redrawn was $4.0M less than plan due to the timing of earthquake repairs. This amount is offset by an equal and opposite favourable variance in earthquake building repair costs.
- Employee benefit costs were higher than plan due to a number of factors, including:
  - a further provision for compliance with the Holidays Act of $66.0M.
  - a further provision to align Continuing Medical Education expenses and leave liability to the associated MECAs and additional costs due to the delay into Waipapa of $3.5M.
  - COVID-19 pandemic related employee costs of $7.4M.
  - transitioning cleaning services to an in-house model from 1 December 2019. The payroll cost increase for the 7 months was $4.5M. This is offset by a reduction of $5.4M in cleaning costs reported in other expenses.
- Treatment related costs were favourable against budget due primarily to lower patient activity during the COVID-19 pandemic 'lock-down' period, although there were additional clinical costs directly attributable to support COVID-19 pandemic of $5.1M.
- Pharmaceutical expenditure has seen significant cost increases from new products on the pharmacy schedule, particularly immunotherapy and central nervous system pharmaceuticals.
- External service provider costs include $19.2M of COVID-19 pandemic related costs. The CDHB's contribution to the National Haemophilia Management Group increased by $1.4M during the year and represents our share of the agreed national increase of $14.5M. In addition, higher PCT expenditure has been reported under external service providers in 2019/20.
- Immunisation expenditure was $1.3M higher than budgeted due to continued efforts to expand coverage of the Influenza immunisation programme. In response to COVID-19 there has been a continued focus on how to reach our priority population ahead of the flu season, increasing coverage and therefore increasing costs.
- IDF expenditure was $2.5M higher than budget due to a greater number of inpatient events for our population delivered by hospitals outside of the Canterbury region.
- Depreciation and amortisation was favourable to plan by $3.4M primarily due to the delayed Waipapa facility.
- Finance costs were unfavourable to plan due to the reclassification of the Manawa lease (refer note 19). The impact of the reclassification of the lease is an increase in finance costs, an increase in depreciation and amortisation, and a reduction in operating lease costs under other expenses. $1.5M is the net impact of the reclassification.
- Other expenses associated with COVID-19 pandemic were $2.3M.
- Earthquake building repair costs are favourable to budget by $4.0M due to the timing of repairs. This is offset by the unfavourable earthquake repair revenue redrawn variance above.
- Capital charge expense is favourable to budget by $15.7M. The two main drivers are capital charge on the delayed Waipapa facility, as well as the Holidays Act compliance accrual made at 30 June 2019.

Statement of changes in equity

The Equity support budget was comprised of $112.6M for the 2018/19 year deficit excluding the Holidays Act compliance provision. Actual equity support funding received was $130.0M. This was $17.4M higher to reflect our immediate cash requirements.

Earthquake capital redrawn is $23.0M less than plan due primarily to the delayed transfer of the tunnel, Emergency entrance, and Avon generator, all of which are linked to the Waipapa facility transfer.

The Mental Health facility drawdown was $5.0M less than originally planned due to slower progress than anticipated.

The variance in the Crown contribution for Waipapa is associated with the delay of the facility, which was anticipated during 2019/20 but will now occur post in 2020/21.

Statement of financial position

Employee benefit liabilities include a further provision made for compliance with the Holidays Act of $66.0M.

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

Property, plant and equipment is lower than budget due to the delay in the transfer of Waipapa, offset by an increase of $25.2M for the Manawa lease reclassification.

Borrowings (current and non-current) of $26.8M relate to the Manawa lease reclassification.

Statement of cash flows

Operating cashflow was higher than the Annual Plan due primarily to:

- Additional revenue primarily associated with COVID-19 funding, In-Between Travel, side contracts and pharmaceutical funding.
- Lower capital charge paid as a result of delayed transfer of the new Waipapa facility and the Holidays Act compliance accrual made at 30 June 2019.

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

- Delayed transfer of the tunnel, Emergency entrance, and Avon generator, all of which are linked to the Waipapa facility transfer.

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

- Lower Earthquake capital redrawn of $23.0M as a result of delayed transfer of the tunnel, Emergency entrance, and Avon generator and lower Mental Health facility equity redrawn of $5.0M, offset by higher equity support funding received than planned of $17.4M.

28. SUBSEQUENT EVENTS

Canterbury DHB received $180M from the Ministry of Health for equity support on 5 October 2020.

As part of Canterbury DHB's facilities redevelopment programme, the Crown transferred the Waipapa facility (including the Waipapa building, the emergency services entrance, the link bridge, and the tunnel works) totalling $549.8M to Canterbury DHB by Order in Council on 1 November 2020.

Other than these, there were no events after 30 June 2020, which could have a material impact on the information in Canterbury DHB's financial statements (2018/19: Nil).

29. THE EFFECTS OF COVID-19 ON CANTERBURY DHB

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

lockdown at Alert Level 4 from 26 March to 27 April, and then remained in lockdown at Alert Level 3 until 13 May.

The effect of COVID-19 on our 2019/20 operations is reflected in these financial statements, based on the information available as at 30 June 2020. The forecasted impact of COVID-19 on Canterbury DHB's outyears performance is dependent on several uncertain parameters and the long-term impact will take some time to determine; and will include factors impacting our variable revenue streams such as electives, IDF and ACC, and the costs associated with these such as:

- outsourcing required to catch up on lost throughput to meet performance targets, and
- the unknown additional healthcare needs accruing to patients who had COVID-19 and now need additional healthcare services as a result which would not have been necessary if they had not contracted COVID-19.

The main impacts on the 2019/20 financial statements due to COVID-19 are explained below.

Government funding

The Ministry of Health provided funding of up to $18.3M in 2019/20 for the Canterbury DHB COVID-19 response. $16.3M of this revenue was recognised in 2019/20 as follows:

- $14.8M related to External Service Providers response, and
- $1.5M related to Public Health Unit and Primary Mental Health response, carried out by Canterbury DHB's Community & Public Health division

Approximately $2M has been carried forward to 2020/21 for specifically tagged Public Health Unit and Primary Mental Health response.

Other revenue

During the pandemic, we received revenue for COVID-19 related laboratory testing, which has corresponding clinical supplies costs such as test kits and consumables. Offsetting this additional revenue is:

- loss of commercial linen revenue by Canterbury Linen Services Ltd (wholly owned subsidiary) due to drop in demand for linen services from accommodation providers and;
- loss of pathology revenue due to significant reduction in pathology tests referrals from other DHBs and;
- loss of café revenue in the hospital cafes due to a reduction in the number of patients and their visitors and the social distancing restrictions that were put in place.

Operating expenses

As a result of COVID-19, Canterbury DHB has incurred additional expenditure of $34.0M as follows:

- Payroll $7.4M - The pandemic presented unique challenges for staffing and roster modelling to ensure both staff and patient safety, which has led to higher payroll costs. Other contributing additional costs include border screening and contact tracing, responsibility for the setting up and oversight of the isolation hotels facilities as well as substantially lower level of leave taken since the pandemic declaration.
- Treatment related costs $5.1M - These additional costs are primarily associated with an additional COVID-19 laboratory testing workload, as well as consumables to ensure that all DHB staff and patients had appropriate access to PPE.
- Other expenses $2.3M - Other expenses include communication costs to keep the community, staff and patients informed.
- External provider costs $19.2M- External Provider Costs exceeded MOH revenue for the External Service Provider response by $4.4M. This was mainly driven by the cost of carrying out COVID-19 tests in General Practice of $4.3M against the allocated funding of only $0.9M.

The operating costs above are partially offset by additional government funding and other revenue as outlined above.

Balance sheet impacts

- At 30 June, our Trade and other receivables balance includes $10.0M of Ministry of Health debt relating to COVID-19 Personal Protective Equipment (PPE) purchases on their behalf.

- Doubtful debt provision has increased as at June. Whilst the closing of international borders has seen a reduction in the number of ineligible patients arriving into NZ, there are a number of patients who would otherwise have returned home but are still here in NZ and receiving ongoing care.
- Employee benefits balances are higher due to both lower annual leave taken and CME entitlements being extended by 12 months increasing the liability.
- Valuation of land and buildings: Canterbury DHB has received advice that there has been no material movement in land values due to the pandemic. Building valuations have been undertaken on an Optimised Depreciated Replacement Cost basis and there have been no material changes to these key inputs due to COVID-19.

An impairment assessment has been completed for tangible and intangible assets. No impairments have been recognised as a result of the assessments due to COVID-19.

5.3 Summary of Revenues and Expenses by Output Class

	Actual 2020 $'000	Budget 2020 $'000
Early detection & management	384,690	377,932
Intensive assessment & treatment	1,250,868	1,229,107
Prevention	50,662	50,022
Rehabilitation & support	293,285	288,649
Total revenue	1,979,505	1,945,710
Early detection & management	440,058	414,022
Intensive assessment & treatment	1,392,960	1,344,274
Prevention	55,653	53,217
Rehabilitation & support	334,270	314,667
Total expenditure	2,222,941	2,126,180
Deficit	(243,436)	(180,470)

Part VI
Supplementary Information

6.1 Directory

Board Members

Hon Sir John Hansen KNZM – Chair	Term commenced 9 December 2019
Gabrielle Huria – Deputy Chair	Term commenced 9 December 2019
Naomi Marshall	Term commenced 9 December 2019
James Gough	Term commenced 9 December 2019
Catherine Chu	Term commenced 9 December 2019
Ingrid Taylor	Term commenced 9 December 2019
Barry Bragg	
Sally Buck	
Andrew Dickerson	
Jo Kane	
Aaron Keown	
Dr John Wood – Chair	Term ended 8 December 2019
Tā Mark Solomon – Deputy Chair	Term ended 8 December 2019
Tracey Chambers	Term ended 8 December 2019
Anna Crighton	Term ended 8 December 2019
Chris Mene	Term ended 8 December 2019
David Morrell	Term ended 8 December 2019

Acting Chief Executive

Dr Andrew Brant

Corporate Office

Level 1
32 Oxford Terrace
Christchurch

New Zealand Business Number

9429000098045

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Bank of New Zealand

Part VII
Independent Auditor's Report

Independent Auditor's Report

To the readers of Canterbury District Health Board Group's financial statements and performance information for the year ended 30 June 2020

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

We have audited:

- the financial statements of the Group on pages 42 to 77, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the Group on pages 9 to 30 and 78.

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Group on pages 42 to 77:

- present fairly, in all material respects:
    - its financial position as at 30 June 2020; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information - our work was limited in the prior year because the Group was unable to report reliably on emergency department waiting times for only part of the year

In our opinion, except for the possible effects of the matter described in the *Basis for our qualified opinion* section of our report, the performance information of the Group on pages 9 to 30 and 78:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2020, including:

- for each class of reportable outputs:
  - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
  - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 17 December 2020. This is the date at which our opinion is expressed.

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

Basis for our unmodified opinion on the financial statements and qualified opinion on the performance information

An important part of the Group's performance information is reporting on emergency department waiting times. In respect of the 30 June 2019 comparative information only, as explained in footnote 10 on page 16 of the performance information, difficulties arose following the implementation of the new patient management system in 2018. This meant that the Group was unable to obtain accurate information on this measure for the second and third quarters of the year ended 30 June 2019. The comparative information therefore only includes the Group's performance against this measure for the first and fourth quarters.

Because no reliable information was available for the second and third quarters, our work on the affected performance information for the comparative year was limited and there were no practicable audit procedures we could apply to obtain assurance that the reported information fairly reflected the Group's performance against this measure for the prior year. Our audit opinion on the performance information for the year ended 30 June 2019 was modified accordingly.

This issue has been has been resolved for the 30 June 2020 year. As the limitation on our work cannot be resolved for the 30 June 2019 year, the Group's performance information reported for this measure for the 30 June 2020 year may not be directly comparable to the 30 June 2019 performance information.

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our unmodified opinion on the financial statements and the basis for the qualified opinion on the performance information.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures:

The Group is reliant on financial support from the Crown

Note 1 on page 46 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Group will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Group over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

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

Note 4 on page 50 of the financial statements explains that the Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Group has made progress during the 30 June 2020 year, and estimated a provision of $131 million, as at 30 June 2020 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

Unauthorised borrowings

Note 19 on page 65 of the financial statements outlines the Group's non-compliance with Schedule 3, clause 45 of the New Zealand Public Health and Disability Act 2000, and sections 160 and 162 of the Crown Entities Act 2004, because the Group entered into a finance lease for the Manawa building without the prior consent of the Ministers of Health and Finance.

Impact of Covid-19

Note 29 on pages 75 to 77 of the financial statements outlines the impact of Covid-19 on the Group.

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

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

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

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

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

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material

misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 2 to 8, 32 to 40 and 80, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

Other than in our capacity as auditor, we have no relationship with, or interests in, the Group.

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