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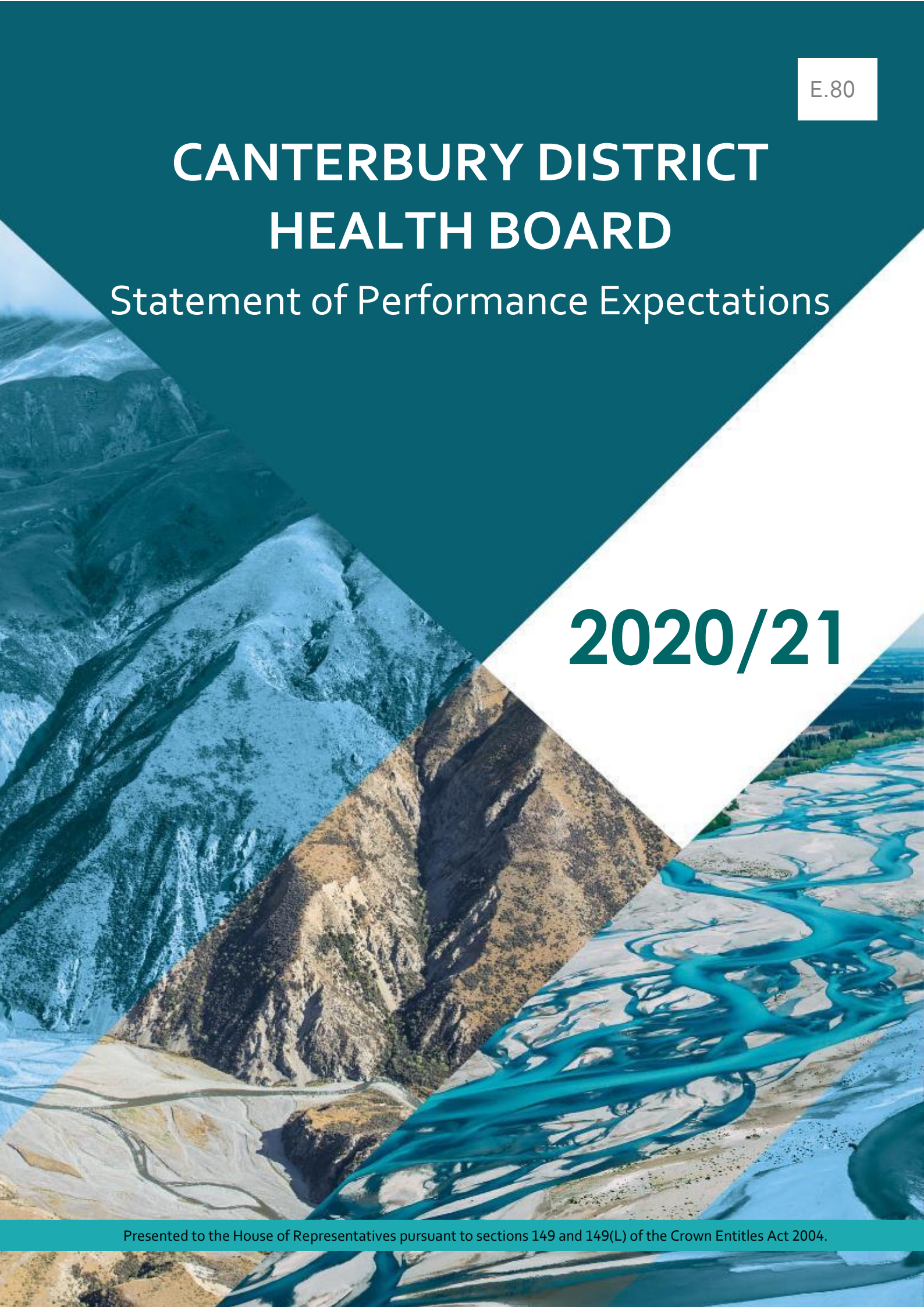
CANTERBURY DISTRICT HEALTH BOARD

Statement of Performance Expectations

2020/21



Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entitles Act 2004.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Statement of Joint Responsibility

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

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

Linking with our Statement of Intent and Annual Plan, the Statement of Performance Expectations describes actions we will take to deliver on national priorities and expectations in the coming year, the standards and targets we expect to meet and our includes our projected financial position.

The Statement of Performance Expectation is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in our Annual Report

The Canterbury DHB has made a strong commitment to 'whole of system' service planning. We work collaboratively and in partnership with other service providers, agencies and community organisations to meet the needs of our population and support several clinically-led Alliances as key vehicles for implementing system improvement and change.

We share a joint vision for the future of our health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our large-scale Canterbury Clinical Network (CCN) District Alliance, with twelve local provider partners, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the West Coast DHB.

We recognise our role in actively addressing disparities in health outcomes for Māori and we are committed to making a difference. We work closely with Manawhenua Ki Waitaha, Te Matau a Māui and our Māori communities, both directly and through the CCN Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of Te Tiriti o Waitangi.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity for the coming year and is in line with Government expectations for 2020/21.

Sir John Hansen
BOARD CHAIR

Barry Bragg
BOARD MEMBER

David Meates
CHIEF EXECUTIVE

14 August 2020

Table of Contents

OVERVIEW

Who are we and what do we do?

Introducing the Canterbury DHB

1.1 Who are we

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

We have the third largest population of all the DHBs in the country and cover the second largest geographical area. In 2020/21 we will be responsible for 578,290 people, over 11.5% of the total New Zealand population.

We own and operate six major health facilities: Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton Hospitals, and many smaller urban and rural facilities from Kaikoura in the north to Ashburton in south.

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

To deliver to our population, we employ just over 10,800 people, making us the largest employer in the South Island. We also hold and monitor over 1,000 service contracts and agreements with other organisations and individuals who provide services for our population. This includes: general practice; pharmacy; laboratory; maternity; child health; diagnostic; personal health; mental health; dental; aged care; and community nursing services.

1.2 What do we do

In 2020/21, we will receive approximately $2.069 billion dollars of revenue from Government (and other sources) with which to meet the needs of the Canterbury population.

In accordance with legislation and consistent with Government objectives, we use that funding to:

Plan the future direction of our health system and, in collaboration with our community, clinical leaders and alliance partners, determine the services required to meet the needs of our population.

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

Provide health services to our population, through our hospital and specialist services, laboratory services, and community-based support services.

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

1.3 Our regional role

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

This regional demand is complex in nature and growing steadily. In the five years to June 2019, there was a 9% increase in hospital admissions and a 13.4% increase in demand for outpatient appointments.

In 2018/19, almost 7,000 people from outside of Canterbury were discharged from one of our hospitals and close to 73,000 outpatient appointments were provided by our staff to people referred by other DHBs.

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

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

TRANSALPINE PARTNERSHIP

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

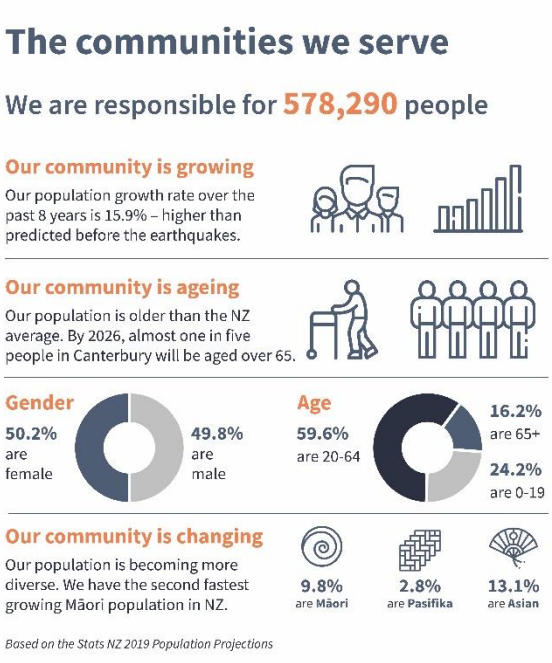
A formal service partnership means Canterbury specialists provide regular surgical lists and outpatient clinics on the West Coast. This arrangement provides more equitable access to specialist services for the West Coast population, supports improved workforce planning between both DHBs and helps to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

1.4 Our population profile

The Canterbury region has undergone rapid population growth over the last decade. Following an initial dip and a redistribution of our population post-earthquake, we have experienced far greater population growth than predicted following the 2013 Census.

There has been a 15.9% increase in our population in the last eight years. We had not anticipated reaching our current population levels until 2028/29.

The latest population estimates signal that while our population will remain static for 2020/21, the growth will continue in the following years – reaching a population of over 600,000 by 2024/25.



Our population remains older than NZ as a whole, and Canterbury has the largest number of people aged over 65 in the country. The latest population figures show 16.2% of our population are aged over 65, a total of 93,420 people. By 2026 almost one in every five people in Canterbury will be aged over 65.

Many long-term conditions become more common with age, including heart disease, stroke, cancer and dementia. As people age they develop more complex health needs and are more likely to need specialist services. Our ageing population will put significant pressure on our workforce and infrastructure.

We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others.

Ethnicity, like age and deprivation, is a strong predictor of need for health and disability services and Canterbury has the sixth largest and second fastest growing Māori population in the country. There are 56,710 Māori living in Canterbury, 9.8% of our total population, up 27% since the 2013 Census. By 2026 Māori will represent 10.5% of our population.

Our Māori and Pacific populations have much younger age structures, with 11% of our Māori and Pacific populations aged under five, compared to 5.8% of the total population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on our younger Māori and Pacific populations.

1.5 Our population's health

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

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

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

A reduction in known risk factors such as smoking, poor diet, lack of physical activity and hazardous drinking could dramatically reduce pressure on our health system and greatly improve health outcomes for our population. All four major risk factors have strong socio-economic gradients, so population health interventions that reduce these risk factors will also contribute to reducing health inequities between population groups.

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

- 28% of our adult population are classified as obese and rates amongst our Māori (46%) and Pacific (59%) populations are significantly higher.
- 20% of our adult population (one in five) were identified as likely to drink in a hazardous manner
- 15% of our total population are current smokers with smoking rates for our Māori (40%) and Pacific (37%) populations significantly higher.
- 11% of our total population identified as inactive (having little or no physical activity). Māori (12%) and Pacific (15%) rates are again slightly higher.

ONGOING HEALTH IMPACTS OF MAJOR EVENTS

The Canterbury population has experienced several major traumatic events over the last decade. While some sections of our population are thriving in their lives, there is clear divergence in our community with a marked increase in demand for mental health support.

The NZ Health Survey reported 23% of our population have been diagnosed with a mood or anxiety disorder, compared to 19% of the population nationally.

Recovery from major disasters and trauma is complex and takes time. The long-term health impacts for children are particularly worrying. In recognition of the impacts, the Ministry is providing additional support for Canterbury children through the Mana Ake initiative and funding additional support for people and families impacted by the mosque attacks in 2019.

1.6 Our operating challenges

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

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

POPULATION PRESSURES

In the past nine years our population growth has been rapid, with a 15.9% increase in our total population and a 4.1% increase in our Māori population. Our population has also spread out across geographically across the region, with the Selwyn, Waimakariri and Ashburton being three of the fastest growing districts in the country. This population growth has been well beyond previous population projections and is a major challenge for our health system.

DEMAND PRESSURES

In line with our population growth, service demand patterns have changed and demand for rural health services is growing. The age and ethnicity mix of our population is also driving increasing acute service demand and complexity of the patients presenting in our hospitals with a 12.7% increase in acute surgical volumes in the last five years.

As a major tertiary provider, we are also dealing with increasing demand for highly complex and resource-intensive services from neighbouring DHBs, with a 9% increase in hospital admissions for people from outside of Canterbury over the last five years. Our theatres, intensive care, radiology and oncology services are under pressure as the South Island population grows and ages. This also adds to fiscal pressures as costs are not always fully covered by the intra-district payments or national contract prices.

CAPACITY PRESSURES

The completion of the Hagley Building (Acute Services) in 2020 will be a significant step change in capacity. With twelve new operating theatres and procedure rooms, an expanded intensive care unit, emergency department and inpatient wards, the new facility will allow us to perform more than 3,000 additional surgeries a year.

However, our growing population, changing service demand patterns, and increasing regional service expectations mean the Hagley Building alone will not provide enough space and capacity to meet our growing population's needs. Further investment and changes in service models will be required to meet medical, oncology and mental health service needs.

While we wait for the Hagley Building to be complete, we have a shortfall of 10 operating theatres. We are leasing private theatres for our staff to work in and outsourcing surgeries and procedures in the private sector to cover capacity gaps. The cost is significant.

CAPITAL AND DEPRECIATION PRESSURES

Our fiscal pressures are compounded by significant capital-related charges associated with the repair of damaged buildings, and the building of new ones. Interest, depreciation and capital charges makes up almost ninety percent of our total deficit in 2020/21.

WORKFORCE PRESSURES

The DHB is working hard to maintain a safe environment and ensure the wellbeing of our staff. Repair disruptions, construction delays, service relocation and parking issues are causing increasing stress for staff and patients alike. Staff sick leave rates have risen rapidly, and our rates are now among the highest in the country.

FINANCIAL VIABILITY

We have a significant financial deficit and are committed to reducing this. We need to review service delivery models and investment right across our system to ensure we are capturing operational efficiencies and committing resources and funding where activity will provide the greatest return in terms of health gain. Change is not easy, and it will be disruptive, but it is necessary for the future sustainability of our health system. Our resources are limited and the multifaceted pressures facing our health system mean that services cannot continue to be provided in the same way.

COVID-19 RESPONSE AND RECOVERY

The pressures on our system will be further compounded by the unknown impact of the COVID 19 pandemic. Our future environment may be quite different, depending on how the pandemic plays out in New Zealand and around the world.

While many of the longer-term population goals and service level expectations are unlikely to change, our ability to deliver against them will be compromised.

Population health outcomes are heavily influenced by changes in people's environments and economic situations, and negative impacts are anticipated. The pandemic has also already impacted on service volumes and wait times for the 2019/20 year across primary, community and hospital settings.

However not all the impacts are bleak. Several service changes and innovative models of service delivery developed during the lockdown have been positively received by staff and patients. We will capture the learnings and permanently adopt some of the more efficient and effective changes in 2020/21.

THE YEAR AHEAD

What can you expect from us?

Monitoring Our Performance

2.1 Improving health outcomes

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

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

There is no single performance measure or indicator that can easily reflect the impact of our work and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an over-arching intervention logic and system outcomes framework.

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

At the highest level the framework reflects our three

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

Aligned to each wellbeing goal we have identified several longer-term population health indicators which will provide insight into how well our system is performing over time. These outcomes indicators are set out in detail in our Statement of Intent and reported against annually, in our Annual Report.

The long-term outcomes are also captured in our local System Level Measure Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

Refer to Appendix 2 for the Intervention Logic Diagram which illustrates how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to the goals of the wider South Island region and delivers on the expectations of Government.

2.2 Accountability to our community

Over the shorter-term, we evaluate our performance by monitoring ourselves against a forecast of the service we plan to deliver to our community and the standards we expect to meet. This forecast is referred to as our Statement of Performance Expectations and sits alongside our Statement of Finance Performance.

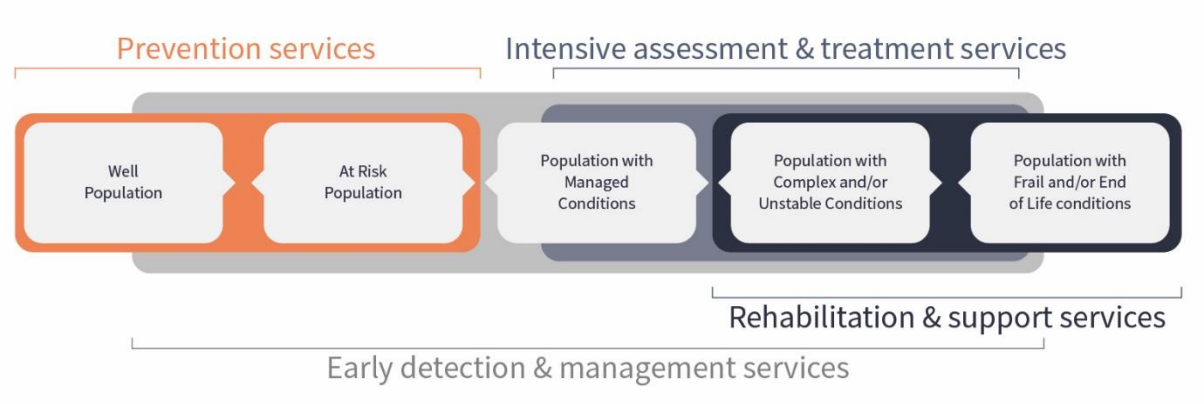
The results are reported publicly in our Annual Report, alongside our year-end financial performance.

2.3 Accountability to the Minister

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

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

Statement of Performance Expectations



3.1 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.

Having a limited resource pool, a growing demand for health services and increasing fiscal pressures, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

Over the longer term, we evaluate the effectiveness of our decisions 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 also highlighted in the DHB's Statement of Intent.

On an annual basis, we track our performance against a statement of performance expectations, our forecast of the services we plan to delivery and the standards we expect to meet. The results are presented in our Annual Report at the end of every year.

The following section presents the Canterbury DHB's Statement of Performance Expectations for 2020/21.

IDENTIFYING PERFORMANCE MEASURES

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

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

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

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

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

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

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

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

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

SETTING STANDARDS

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

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

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

It is not appropriate to set targets for these services; however, they are an important part of the picture of health need and service delivery in our region. Service

level estimates have been provided to give context in terms of the use of resources across our health system.

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB.

All our targets are universal, with the aim of reducing inequities between population groups. Several focus areas have been identified as health priorities for Māori. These are signalled with the following symbol (◆). These service measures will be reported by ethnicity in our Annual Report to highlight progress in achieving our equity goal.

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

PERFORMANCE EXPECTATIONS

Canterbury's hospitals are operating at full capacity and we are heavily reliance on private facilities to meet the needs of our growing population. In the coming year, we anticipate regaining some of this lost capacity with the completion of the Hagley (acute services) Building, however the decanting and relocation of multiple services into the new building will be disruptive and the migration will impact on service deliver levels when this happens in 2020/21.

The pressures on our system will be compounded by the unknown impact of the COVID 19 pandemic. Our future environment may be quite different, depending on how the pandemic plays out in New Zealand and around the world. While many of the longer-term population goals and service level expectations (outlined in our Statement of Intent and Statement of Performance Expectations) are unlikely to change, our ability to deliver against them will be compromised.

Population health outcomes are heavily influenced by changes in people's environments and economic situations, and negative impacts are anticipated.

NOTES FOR THE READER

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

- Δ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.
- ❖ Performance data relates to the calendar year rather than the financial year.
- E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources
- ◆ This measure has been identified as a key focus area for Māori. Progress by ethnicity will be reported in the DHB's Annual Report.

3.2 Where does the money go?

In 2020/21 the DHB will receive approximately $2.069 billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2020/21, split by service class.

	2020/21
Revenue	
Prevention	$56,615
Early detection & management	$400,455
Intensive assessment & treatment	$1,349,399
Rehabilitation & support	$262,766
Total Revenue - $'000	$2,069,235
Expenditure	
Prevention	$60,177
Early detection & management	$436,636
Intensive assessment & treatment	$1,431,583
Rehabilitation & support	$285,845
Total Expenditure - $'000	$2,214,241
Surplus/(Deficit) - $'000	($145,006)

3.3 Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services are those that promote and protect the health of the whole population, or targeted sub-groups, and influence individual behaviours by targeting changes to physical and social environments to engage, influence and support people to make healthier choices. These services include: the use of legislation and policy to protect the population from environmental risks and communicable disease; education programmes and services to raise awareness of risk behaviours and healthy choices; and health protection services such as immunisation and screening programmes that support people to modify lifestyles and maintain good health.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

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	2020/21 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [1]	78	42	E.70
Licensed alcohol premises identified as compliant with legislation	Q [2]	83%	93%	90%
Networked drinking water supplies compliant with Health Act	Q [3]	85%	93%	97%

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	2020/21 Target
Mothers receiving breastfeeding and lactation support in the community	A	980	861	>600
Babies exclusively/fully breastfed at three months	Q[4]◆	61%	62%	70%
People provided with a Green Prescription for additional physical activity support	A[5]	4,087	4,818	>3,500
Green Prescription participants more active six to eight months after referral	Q	61%	n.a	>50%
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q[6]◆	93%	82%	90%
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q◆	95%	92%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[7]◆	86%	86%	90%

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

[2] New Zealand law prevents alcohol retailers from selling alcohol to young people aged under 18 years. 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.

[3] This measure relates to the percent of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies: large, medium, minor, small and rural agricultural. Water quality annual reports are published one year in arrears, the latest report can be found on the Ministry of Health website.

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

[5] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and data is sourced from a biannual national patient survey competed by Research New Zealand on behalf of the Ministry of Health. 2018/19 results are not yet available.

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

[7] This data is sourced from the national Maternity Dataset Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance. Standards have been set nationally in line with other ABC programme targets.

Population-Based Screening Services				
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2017/18 Result	2018/19 Results	2020/21 Target
Four-year-olds provided with a B4 School Check (B4SC)	A[8]	97%	96%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q	98%	100%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A[9]	74%	72%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A	76%	75%	70%

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	2020/21 Target
Children fully immunised at eight months of age	A[10]	94%	94%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q	98%	98%	95%
Young people (Year 8) completing the HPV vaccination programme	A[11]	65%	37%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A[12]	62%	62%	75%

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

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

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

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

[12] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including people aged over 65 and people with long-term or chronic conditions.

3.4 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

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	2020/21 Target
Newborns enrolled with a PHO by three months of age	A◆	82%	95%	85%
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A◆	93%	93%	95%
Young people (0-19) accessing brief intervention counselling in primary care	A[13]Δ	579	552	>500
Adults (20+) accessing brief intervention counselling in primary care	AΔ	6,396	6,353	>5,500
Number of skin lesions (growths, including cancer) removed in primary care	AΔ	2,609	2,404	>2,000
Number of integrated HealthPathways in place across the health system	Q[14]	691	699	E. >600
Proportion of general practices using the primary care patient experience survey	E[15]	62%	79%	>65%

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	2020/21 Target
Number of spirometry tests provided in the community rather than in hospital	A[16]Δ	2,493	2,426	>2,000
People receiving subsidised diabetes self-management support when starting insulin	AΔ	400	379	>300
Population identified with diabetes having an HbA1c test in the last year	A[17]Δ◆	90%	90%	>90%
Population with diabetes having an HbA1c test and acceptable glycaemic control	QΔ◆	74%	72%	>60%

[13] 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.

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

[15] The Patient Experience Survey is a national online survey being rolled-out across the country to determine patients' experience in primary care and how well their overall care is managed. The information will be used to improve the quality of service delivery and patient safety.

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

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

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	2020/21 Target
Children (0-4) enrolled in DHB-funded oral health services	A[18]❖◆	76%	83%	95%
Enrolled children (0-12) receiving their oral health exam according to planned recall	T❖◆	88%	88%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A❖	63%	66%	85%

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	2020/21 Target
Number of laboratory tests completed for the Canterbury population	AΔ	2.9m	2.9m	E<2.8m
Number of subsidised pharmaceutical items dispensed in the community	AΔ	6.8m	7.0m	E<8m
People on multiple medications receiving medication management support	A[19]Δ	1,316	1,434	>1,200
People (65+) being dispensed 11 or more long term medications (rate per 1,000)	Q[20]❖	4.0	n.a	E<4.1
Number of community-referred radiology tests completed	AΔ	49,832	55,038	E>40,000
People receiving their urgent diagnostic colonoscopy within two weeks	T[21]	93%	77%	90%
People receiving their Magnetic Resonance Imaging (MRI) scans within six weeks	T	41%	47%	90%
People receiving their Computed Tomography (CT) scans within six weeks	T	69%	65%	95%

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

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

[20] The use of multiple medications is most common in the elderly and can lead to reduce drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and higher costs for the system with little health benefits. Multiple medication use requires monitoring and review to validate whether all of the medications are complimentary and necessary. Data is sourced from the HQSC Atlas of Healthcare Variation and the 2018 result is not yet available.

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

3.5 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 collocation of specialist expertise and equipment. Some services are delivered in response to acute events, others are planned and access is determined by clinical referral and triage, treatment thresholds and national service coverage agreements.

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2017/18 Result	2018/19 Results	2020/21 Target
Staff compliant with good hand hygiene practice	Q[22]◇	82%	82%	80%
Inpatients (aged 75+) receiving a falls risk assessment	Q◇	97%	98%	90%
Response rate to the national inpatient patient experience survey	E[23]	22%	24%	>30%
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%

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	2020/21 Target
Proportion of the population (0-19) accessing specialist mental health services	A[24]Δ	3.6%	3.7%	>3.1%
Proportion of the population (20-64) accessing to specialist mental health services	AΔ	3.8%	3.9%	>3.1%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T	74%	70%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	91%	88%	95%

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

[23] There is growing evidence that patient experience is a good indicator of the quality of health services and stronger patient partnerships and family-centred care have been linked to better health outcomes. The national DHB inpatient experience survey covers four patient experience domains: communication, partnership, co-ordination and physical and emotional needs. Response rates vary around the country, with an average of 24% across all DHBs in Q2 2019. Canterbury aims to be consistently above this level.

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

Maternity Services				
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2017/18 Result	2018/19 Results	2020/21 Target
Number of maternity deliveries in Canterbury DHB facilities	A	6,056	6,044	E.6,000
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[25]✧◆†	80%	n.a	80%
Proportion of maternity deliveries made in Primary Birthing Units	Q[26]	16%	16%	>13%

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	2020/21 Target
Number of acute demand packages of care provided in community settings	A[27]Δ	32,701	35,393	>30,000
Number of presentations at Canterbury Emergency Departments (ED)	A	103,116	101,130	E.<110k
People admitted, discharged or transferred from ED within 6 hours of presentation	T	94.3%	90.1%	95%
Proportion of the population presenting in ED (per 1,000 people)	Q	185	178	<190
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral.	T	95%	94%	90%

Elective and Arranged Services				
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2017/18 Result	2018/19 Results	2020/21 Target
Number of First Specialist Assessments provided	A	73,913	66,982	E.>60,000
Proportion of people that wait <4 months for their First Specialist Assessment	T◇	97%	69%	100%
Proportion of First Specialist Assessments that were non-contact (virtual)	Q[28]	19%	21%	>15%
Proportion of people that wait <4 months from a commitment to treat to treatment	T◇	96%	55%	100%
Number of planned care intervention delivered	A[29]	new	new	TBC
Proportion of people receiving their surgery on the day of admission	E [30]	94%	87%	>85%
Number of outpatient consultations provided	A	694,629	653,717	E.>650k
Outpatient appointments where the patient was booked but did not attend	Q[31]	4%	5%	<5%

[25] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report - data is a year in arrears and the 2018 data is yet to be released.

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

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

[28] Non-contact assessments are those where assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients.

[29] The new planned care intervention measure reflects a change in national expectation, recognising 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. At the time of printing the target was yet to be confirmed by the Ministry of Health.

[30] With the introduction of the DHB's new patient information system the definition for this measure has been reset. Previous year's results are not directly comparable.

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

3.6 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Service utilisation is monitored to ensure people are appropriately supported after an event.	Notes	2017/18 Result	2018/19 Results	2020/21 Target
People accessing community-based pulmonary rehabilitation courses	A[32]	270	275	>250
People (65+) accessing the community-based falls prevention service	A[33]	1,653	2,127	>1,500
People supported by the Community Rehabilitation and Support Team (CREST)	A[34Δ]	1,839	1,933	>1,600
Proportion of inpatients referred to an organised stroke service after an acute event	Q	80%	84%	80%
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q[35]	86%	88%	>80%

Home-Based and Community Support Services				
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2017/18 Result	2018/19 Results	2020/21 Target
People supported by district nursing services	A[Δ]	7,698	8,820	E. >7,000
People supported by long-term home-based support services	A[Δ]	8,554	8,466	E. >8,000
Proportion of the population (65+) receiving long-term, home-based support	A[Δ]	9.7%	9.4%	E. 10%
People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q[36Δ]	92%	91%	95%
People supported by hospice or home-based palliative services	A[Δ]	4,033	3,716	E. 4,000
Number of Advance Care Plans registered to support people's end of life care	A	697	781	>700
Proportion of people with Advance Care Plans, dying in their place of choice	Q[37]	61%	69%	>70%

[32] Respiratory and lung diseases are major contributors to avoidable hospital admissions in Canterbury, particularly over winter. Pulmonary rehabilitation programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (obstructive lung disease) to manage their symptoms and better manage their condition.

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

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

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

[36] 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.

[37] This measure is based on the number of people who have died during the period, where we know the location of death, in a place that corresponds with the wishes articulated in their Advance Care Plan.

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	2020/21 Target
People supported by community-based mental health crisis respite services	A$^{\Delta}$	1,081	1,052	E.1,000
Occupancy rate of mental health crisis respite beds	A[38]$^{\Delta}$	85%	88%	85%
Older people supported by day care services	A$^{\Delta}$	727	578	E.>550
Older people accessing aged care respite services	A[39]$^{\Delta}$	1,697	1,101	E.<1,000
People supported by aged care respite services, being discharged to their own home	Q[40]$^{\Delta}$	84%	89%	>80%

Aged Residential Care Services				
The DHB subsidises ARC for people who meet the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2017/18 Result	2018/19 Results	2020/21 Target
Proportion of the population (75+) accessing rest home level services in ARC	A[41]$^{\Delta}$	4.7%	4.3%	E.<5.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A$^{\Delta}$	6.3%	6.1%	E.6.5%
Proportion of the population (75+) accessing dementia services in ARC	A$^{\Delta}$	2.7%	2.6%	E. 2.6%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A$^{\Delta}$	0.8%	0.8%	E. 0.8%
People entering ARC having had a clinical assessment of need using InterRAI	Q[42]$^{\Delta}$	93%	84%	95%

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

[39] A decision was made in 2018/19 to reduce the number of older people accessing aged care respite directly from hospital, where they can suffer from deconditioning, and instead provide more wraparound services that people can access in their own homes. This aligns with the Canterbury model of care to keep people in their homes longer. The target for this measure has been updated to align with this new model.

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

[41] 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.

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

Statement of Financial Expectations

4.1 Canterbury's financial outlook

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

Increasing demand costs: Significant population growth and the ageing of our population over the last decade have contributed to increasing demand and treatment related costs, particularly those associated with increased acute services demand. Population growth predicted into the future will also mean that even after the DHB's new acute services facilities come online, capacity will continue to be stretched.

Outsourcing costs: Our theatre and bed capacity is significantly constrained and completion of the Hagley Building is behind schedule. The DHB is leasing private theatres for our staff to work from and outsourcing surgeries to close the gap. The costs are significant, and construction delays are also impacting on our ability to achieve anticipated savings from the consolidation of services.

Interest, depreciation and capital charges: Because interest, depreciation and capital charges are driven off upward movements in asset valuations, our earthquake repair and redevelopment work has resulted in significant additional charges over the last decade. In 2020/21, the Canterbury DHB will pay an estimated $50.1M million in capital charges to the Crown, based on existing capital charge regulations and assuming Hagley will not transfer before 1 October 2020 (i.e. only six months of capital change will be incurred for 2020/21 in relation to the new Hagley facility).

The amount includes $9 million of capital charge payable on the DHB's earthquake settlement proceeds being redrawn as equity, which will continue to erode the settlement proceeds available to the DHB for essential earthquake repair and capital works.

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

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

4.2 Forecast financial results

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

It is anticipated that the Canterbury DHB will receive $2.069 billion of total revenue from all sources to meet the needs of our population in 2020/21.

We are forecasting a $145 million deficit result for the 2020/21 year.

This forecast deficit considers Canterbury's allocated share of population-based funding (demographic and cost pressures) but excludes any cost associated with the flow-on impact of the Holidays Act liability, which is still being assessed by the DHB sector. It is also based on the assumption that Hagley will be fully operational from 1 October 2020.

OUT-YEARS' SCENARIO

The combined annual interest, depreciation and capital charge will increase from $116 million in 2019/20 to approximately $150 million by 2023/24.

In July 2019 there was a national announcement in relation to new equity attracting a portion of revenue to assist offsetting the increased capital charge. The exact calculation methodology has not yet been clarified by the Ministry of Health. In the interim, a notional estimate of capital charge funding has been included for Crown equity associated with Hagley.

The remainder of Canterbury DHB's deficit is related to operating costs, and the Board and management team have made a strong commitment to identify efficiencies and savings to reduce this operating deficit to a break-even position within the next three years.

4.3 Bridging the gap

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

Since establishing our vision in 2006, we have been purposeful and deliberate in planning how we would meet growing demand for health services.

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

However, rapid population growth, future predicted growth and additional cost pressures mean we need to further challenge the way health services are delivered and configured and identify further efficiencies and quality improvements to ensure we deliver a sustainable model of health care into the future.

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

On completion of the Hagley Building, we will immediately begin the repatriation of outplaced and outsourced services back into our facilities. This will be a sizable piece of work and will significantly reduce our operating expenditure.

The migration to the Hagley Building will also allow us to introduce our resource optimisation programme, making efficiency savings by co-locating and consolidating services, integrating rosters and supporting more responsive, integrated service models.

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

Savings identified for the coming year and two out-years have been highlighted in the DHB's Annual Plan along with the anticipated service changes for the coming year.

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

4.4 Major assumptions

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

- The DHB will retain early payment arrangements.
- The Hagley Building will be completed and fully operational by 1 October 2020. Any further delay will significantly, negatively impact on the planned results.
- Operating deficits will be fully funded as equity.
- Capital charge for out-years is based on the current rate of 6%. Any rate change in the future is assumed to be financially neutral.
- Capital charge associated with pre-approved and future-approved Crown equity (and pre-approved debt being swapped to equity) for capital projects is fully funded, as per existing capital charge regulations. The exact calculation methodology of this funding has not yet been clarified by the Ministry of Health. In the interim, a notional estimate of capital charge funding has been included for Crown equity associated with Hagley.
- Capital charge associated with historic and future earthquake settlement proceeds redrawn as equity will continue to be payable to the Crown.
- Any targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- The $5.5 million annual funding provided by the Ministry of Health in 2016, to cover increased demand for mental health services following the earthquakes, will cease. This has a negative financial impact on Canterbury DHB, as costs to meet mental health service pressures continue.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- $109 million (being the forecast, as at June 2020, of undrawn portion of Canterbury's $290 million earthquake settlement proceeds transferred to the Crown to minimise capital charge expenses), will be available to fund the earthquake repair and reinstatement programme as required.
- As agreed with the Ministry, revenue and equity timing of the earthquake insurance draw-downs will be flexible and based on DHB requests, rather than necessarily matching the earthquake capital and operating repair spend for a particular year.
- Additional saving targets requiring service changes and/or Ministerial consent are approved in a timely manner.

- The redevelopment of Canterbury facilities is in accordance with the detailed business cases agreed with the Ministry and previous Cabinet. Associated capital expenditure and resulting capital charge for formally agreed detailed business cases that will take place during the term of this Plan have been included, as appropriate.
- Revaluations of land and buildings will continue. Any increase in building valuations will impact on depreciation expense, and as this impact is unknown it is excluded from the forecast results. In addition to regular periodic revaluations, further impairment in relation to earthquakes may be necessary.
- Employee cost increases for expired wage agreements, including minimum wage flow-on impact if any, will be settled on fiscally sustainable terms, and within CDHB's nominal allowance, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors, in-basing some electives that are currently outsourced and foreseen adjustments for the impact of service growth.
- National and regional savings initiatives and benefits will be achieved as planned.
- Transformation strategies will not be delayed or derailed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved, in line with the Board's strategy.
- There will be no further disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no further disruptions.

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

4.5 Capital investment

NATIONAL BUSINESS CASES

The detailed business case for the redevelopment of the Christchurch Hospital site was approved in March 2013. Construction of the Hagley Building has been significantly delayed but is now scheduled for completion 1 October 2020.

The detailed business case for replacement of our patient administration systems with one South Island Patient Information Care System was approved in 2014. This system has been implemented across all major Canterbury DHB sites, and on-going regional enhancements will be support in the coming year.

The detailed business case for the relocation of mental health services from The Princess Margaret Hospital, was approved in December 2018. This project is expected to be completed by 2023. A further business case is being developed for the relocation of Child and Family outpatient services, which were excluded in the approved business case.

A detailed business case for the future of the Christchurch Hospital Campus has been jointly developed by the DHB and Ministry of Health and submitted to Capital Investment Committee alongside a re-purposed programme business case. Following the advice of Crown agencies, a revised business case incorporating a reduced scope was submitted. This is yet to be announced or approved.

The DHB has also completed an initial strategic assessment regarding investment in a facility for Canterbury's tertiary laboratory and pathology services. This was submitted to the Ministry of Health for consideration and will be considered alongside the programme business case outlined above.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, Canterbury's capital plan for 2020/21 totals $635 million (including $525 million of capital assets transacted as non-cash transfers between the Crown and the DHB and is comprised of:

- $515 million for Hagley (non-cash transacted transfer)
- $9.7 million Christchurch hospital campus tunnel capital portion (non-cash transacted transfer)
- $15.1 million Hagley additional scope
- $28 million progress spend for the approved detailed business case to relocate inpatient mental health services from The Princess Margaret Hospital.
- $1 million scoping and other preliminary costs for the relocation of Child and Family mental health outpatient services currently located on The Princess Margaret Hospital site.
- $19 million for the capital expenditure portion of the strategic earthquake programme of works (exclude tunnel and Hagley additional scope related spend accounted for above).
- $1 million residue spend for the South Island Patient Information Care System.
- $5 million progress spend for Selwyn IFHC fit-out.
- $3 million progress spend for Hillmorton AT&R and PSAID.
- $38 million for other baseline spend, primarily on replacement assets and systems which are past their economic useful life.

Anticipated investment for out-years includes:

- Strategic Information Technology developments towards a digital hospital including: further implementation of the Patient Information Care System, Electronic Medication Management, Health One and investment in the patient portal.
- Repair and reinstatement of the Christchurch Hospital Energy Centre and Carpark.
- Continued repair and reinstatement of assets under the DHB's earthquake repair programme.
- Further Christchurch Hospital Campus redevelopment as set out in the detailed business case and programme business case.

  This will incorporate the development of appropriate and compliant facilities to accommodate services currently located in earthquake damaged and/or below building code facilities (Riverside, Parkside and Food Services buildings) and other key facilities such as the Oncology and the Laboratories building.

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

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

4.6 Debt and equity

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

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

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

The forecast amount drawn down as at 30 June 2020, is $181 million, with a balance of $109 million yet to be redrawn. This is now unlikely to be sufficient in light of unplanned costs coming out of this settlement related to the redevelopment of the Hagley Building and completion of the Boiler House and Energy Centre.

Considering projected equity movements, the Crown's equity in the DHB will rise from $558 million as at June 2020 to $1.373 billion by June 2024. The higher equity balance will result in a significant increase in the capital charge payable to the Crown.

4.7 Additional considerations

DISPOSAL OF LAND

Under the NZ Public Health and Disability Act, no DHB may dispose of land without approval of the Minister of Health. Ministerial approval will only be given where the DHB has complied with its statutory clearance and public consultation obligations under the Act.

Anticipated activity for 2020/21 includes the disposal of parcel of land on St Asaph Street to the Crown (required for the Metro Sports Facility) and disposal of two parcels of land on Tuam Street to the Crown (for a Bus Super Stop).

We are yet to determine the future of the former Christchurch Women's Hospital site in the central city and The Princess Margaret Hospital site in Cashmere. Over the coming years we will also consider the future use of our rural hospitals and hospital sites.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

Before the Canterbury DHB or any of our associates or subsidiaries can subscribe for, purchase, or otherwise acquire shares in any company or other organisation, our Board will consult the responsible Minister(s) and obtain their approval.

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year and are attached as Appendix 3.

4.8 Group Statement of Financial Performance (Comprehensive Income)

	2018/19 Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
REVENUE						
Ministry of Health revenue (Note 1)	1,740,451	1,878,360	1,962,952	2,034,189	2,115,498	2,198,907
Other government revenue	36,687	40,523	42,144	43,830	45,584	47,407
Earthquake repair revenue redrawn	4,460	1,846	6,600	2,600	200	-
Other revenue	52,665	59,149	57,539	65,295	77,066	77,952
Total Revenue	**1,834,263**	**1,979,878**	**2,069,235**	**2,145,914**	**2,238,348**	**2,324,266**
EXPENSE						
Personnel	895,206	912,834	947,983	953,451	996,251	1,025,592
Outsourced personnel & clinical serrvices (Note 2)	31,126	33,232	29,739	24,264	23,625	23,242
Clinical supplies	134,853	154,268	162,506	165,282	173,808	178,241
Earthquake building repair costs	4,460	1,846	6,600	2,600	200	-
Infrastructure & non clinical	114,835	121,663	117,902	115,489	119,148	118,669
External service providers	752,786	815,419	814,341	799,574	804,515	828,740
Total Expense Before Depreciation & Capital Charge	**1,933,266**	**2,039,262**	**2,079,071**	**2,060,660**	**2,117,547**	**2,174,484**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(99,003)**	**(59,384)**	**(9,836)**	**85,254**	**120,801**	**149,782**
Depreciation and amortisation	54,084	77,973	85,108	70,868	68,694	69,296
Capital charge and interest expense (Note 3)	24,753	38,538	50,062	72,391	78,900	80,265
Total Depreciation, Capital Charge & Interest Expense	**78,837**	**116,511**	**135,170**	**143,259**	**147,594**	**149,561**
Surplus/(Deficit)	**(177,840)**	**(175,895)**	**(145,006)**	**(58,005)**	**(26,793)**	**221**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	137,346	3,068	-	-	-	-
Impairment of property, plant & equipment	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(40,494)**	**(172,827)**	**(145,006)**	**(58,005)**	**(26,793)**	**221**

Surplus/(Deficit) excluding new Hagley's Net depreciation and capital charge is outlined below

	2018/19 Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Surplus/(Deficit)	**(177,840)**	**(175,895)**	**(145,006)**	**(58,005)**	**(26,793)**	**221**
Add:/Less: Hagley Net Depreciation & Capital Charge						
Depreciation Hagley			10,470	16,370	16,370	16,370
Capital charge expense Hagley			15,450	30,900	30,900	30,900
Capital charge relief funding Hagley			(10,170)	(20,350)	(20,350)	(20,350)
Surplus/(Deficit) - excluding Hagley Net Depreciation & Capital Charge	**(177,840)**	**(175,895)**	**(129,256)**	**(31,085)**	**127**	**27,141**

Note 1: Includes notional capital charge relief funding associated with Hagley, subject to new capital charge regulations and assumed at 6 months for 2020/21 and full year thereafter, subject to final transfer date and amount

Note 2: Excludes outsourced/outplaced payments to external providers.

Note 3: Includes capital charge on earthquake proceeds redrawn as equity and indicative Hagley capital charge expense assumed at 6 months for 2020/21 and full year thereafter, subject to final transfer date and amount

4.9 Group Statement of Financial Position

	30/06/19 Actual $'000	30/06/20 Forecast $'000	30/06/21 Plan $'000	30/06/22 Plan $'000	30/06/23 Plan $'000	30/06/24 Plan $'000
CROWN EQUITY						
Contributed capital	274,070	407,790	1,153,284	1,359,869	1,427,513	1,452,445
Revaluation reserve	426,404	429,472	429,472	429,472	429,472	429,472
Accumulated surpluses	(103,096)	(278,991)	(423,997)	(482,002)	(508,795)	(508,574)
Total Equity	**597,378**	**558,271**	**1,158,759**	**1,307,339**	**1,348,190**	**1,373,343**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	4,766	4,065	31,443	109,947	144,927	169,650
Trade & other receivables	96,848	108,902	108,902	108,902	108,902	108,902
Inventories	13,209	14,549	14,549	14,549	14,549	14,549
Restricted assets	14,685	14,425	14,425	14,425	14,425	14,425
Investments	808	750	750	750	750	750
Total Current Assets	130,316	142,691	170,069	248,573	283,553	308,276
CURRENT LIABILITIES						
NZHPL sweep bank account	36,575	11,032	-	-	-	-
Trade & other payables	125,254	162,580	150,054	150,054	150,054	150,054
Employee benefits	245,602	277,644	277,644	277,644	277,644	277,644
Restricted funds	14,701	14,441	14,441	14,441	14,441	14,441
Total Current Liabilities	422,132	465,697	442,139	442,139	442,139	442,139
Net Working Capital	(291,816)	(323,006)	(272,070)	(193,566)	(158,586)	(133,863)
NON CURRENT ASSETS						
Property, plant, & equipment	861,262	845,962	1,394,040	1,464,502	1,471,295	1,473,125
Intangible assets	33,818	41,603	43,077	42,691	41,769	40,369
Restricted assets	16	16	16	16	16	16
Total Non-Current Assets	895,096	887,581	1,437,133	1,507,209	1,513,080	1,513,510
NON CURRENT LIABILITIES						
Employee benefits	5,902	6,304	6,304	6,304	6,304	6,304
Total Non-Current Liabilities	5,902	6,304	6,304	6,304	6,304	6,304
Net Assets	**597,378**	**558,271**	**1,158,759**	**1,307,339**	**1,348,190**	**1,373,343**

4.10 Group Statement of Movements in Equity

	2018/19 Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Total equity at beginning of the year	496,272	597,378	558,271	1,158,759	1,307,339	1,348,190
Total comprehensive revenue and expense for the year	(40,494)	(172,827)	(145,006)	(58,005)	(26,793)	221
OTHER MOVEMENTS						
EQUITY REPAYMENTS						
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Other equity movement		(4,013)				
EQUITY INJECTIONS						
Earthquake repair capital redrawn	54,650	5,994	28,000	20,000	-	-
Operating deficit support (Note 4)	81,611	130,000	175,895	145,006	58,005	26,793
Mental Health Relocation DBC (Note 5)	-	3,600	28,400	35,500	11,500	-
Outpatients facility transferred from the Crown (Note 6)	7,200	-	-	-	-	-
Hagley facility transferred from the Crown (Note 7)	-	-	515,060	-	-	-
Parkside residue - facilities redevelopment DBC (Note 8)	-	-	-	7,940	-	-
Total Equity at End of the Year	**597,378**	**558,271**	**1,158,759**	**1,307,339**	**1,348,190**	**1,373,343**

Note 4: 2019/20 and outyears, it is assumed operating deficit support is fully funded and received in the following year.
Note 5: Figures reflect indicative progressive draw down of pre-approved equity.
Note 6: Represents Crown equity portion of the capital cost of Outpatients (the balance was funded by CDHB's EQ proceeds redrawn).
Note 7: Represents indicative Crown equity portion of the capital cost of Hagley (the balance of the indicative transfer value, including the additional scope, is funded by CDHB's EQ proceeds redrawn and cash). Figures are subject to final cost and transfer amount.
Note 8: The $7.9M represents the residual approved amount for Parkside per the 2012 approved Facilities Redevelopment DBC i.e. original approved amount of $21M less $13.06M transferred to Hagley building per Minister of Health's advice.

4.11 Group Statement of Cash Flow

	2018/19 Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health (Note 9)	1,733,136	1,912,292	1,962,952	2,034,189	2,115,498	2,198,907
Earthquake repair revenue redrawn	4,460	1,846	6,600	2,600	200	-
Other receipts	94,694	95,037	99,106	108,215	121,590	124,139
Interest received	627	695	577	910	1,060	1,220
	1,832,917	2,009,870	2,069,235	2,145,914	2,238,348	2,324,266
Cash applied to:						
Payments to employees	822,566	880,390	947,983	953,451	996,251	1,025,592
Payments to suppliers	1,026,495	1,138,587	1,131,121	1,107,245	1,121,332	1,148,892
Capital charge and interest paid	24,452	26,012	62,588	72,391	78,900	80,265
GST - net	12,144	6,077	-	-	-	-
	1,885,657	2,051,066	2,141,692	2,133,087	2,196,483	2,254,749
Net Cash Flow from Operating Activities	**(52,740)**	**(41,196)**	**(72,457)**	**12,827**	**41,865**	**69,517**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash provided from:						
Sale of property, plant, & equipment	123	7	-	-	-	-
Receipt from investments and restricted assets	-	-	-	-	-	-
	123	7	-	-	-	-
Cash applied to:						
Purchase of investments & restricted assets	912	2,459	-	-	-	-
Purchase of property, plant, & equipment	43,378	68,298	109,917	140,908	74,529	69,726
	44,290	70,757	109,917	140,908	74,529	69,726
Net Cash Flow from Investing Activities	**(44,167)**	**(70,750)**	**(109,917)**	**(140,908)**	**(74,529)**	**(69,726)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provided from:						
Equity Injections						
Earthquake repair capital redrawn	1,044	1,981	18,350	27,940	-	-
Mental Health Relocation DBC	-	3,600	28,400	35,500	11,500	-
Parkside residue - facilities redevelopment DBC (Note 10)	-	-	-	-	-	-
Operating deficit support	81,611	130,000	175,895	145,006	58,005	26,793
	82,655	135,581	222,645	208,446	69,505	26,793
Cash applied to:						
Capital repayments (Note 11)	1,861	(1,207)	1,861	1,861	1,861	1,861
	1,861	(1,207)	1,861	1,861	1,861	1,861
Net Cash Flow from Financing Activities	**80,794**	**136,788**	**220,784**	**206,585**	**67,644**	**24,932**
NET CASHFLOW						
Net increase/(decrease) in cash and cash equivalents	(16,113)	24,842	38,410	78,504	34,980	24,723
Cash and cash equivalents at beginning of year	(15,696)	(31,809)	(6,967)	31,443	109,947	144,927
Cash and cash equivalents at end of year (Note 9)	**(31,809)**	**(6,967)**	**31,443**	**109,947**	**144,927**	**169,650**
REPRESENTED BY:						
Cash & cash equivalents	4,766	4,065	31,443	109,947	144,927	169,650
NZHPL sweep bank account	(36,575)	(11,032)	-	-	-	-
CASH & CASH EQUIVALENTS AT END OF YEAR	**(31,809)**	**(6,967)**	**31,443**	**109,947**	**144,927**	**169,650**

Note 9: Includes inter-district flow revenue.
Note 10: Assume non-cash transaction until further advice
Note 11: Assume operating deficit support is fully funded and received in the following year.

4.12 Summary of revenue and expenses by arm

	2018/19 Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Funding Arm						
REVENUE						
Ministry of Health revenue	1,670,002	1,798,466	1,887,559	1,956,614	2,035,651	2,117,503
Other government revenue	2,916	2,792	2,208	2,036	2,054	2,072
Other revenue	1,250	412	1,186	1,186	1,186	936
Total Revenue	**1,674,168**	**1,801,670**	**1,890,953**	**1,959,836**	**2,038,891**	**2,120,511**
EXPENSE						
Personal Health	1,250,092	1,370,080	1,443,807	1,477,883	1,503,668	1,564,428
Mental Health	167,916	175,330	184,407	191,078	198,917	206,794
Disability Support	297,587	310,712	310,219	319,950	331,109	343,535
Public Health	4,469	23,260	5,529	3,259	3,288	3,317
Maori Health	1,958	2,579	2,283	2,158	2,200	2,244
Total Expense Before Depreciation & Capital Charge	**1,722,022**	**1,881,961**	**1,946,245**	**1,994,328**	**2,039,182**	**2,120,318**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(47,854)**	**(80,291)**	**(55,292)**	**(34,492)**	**(291)**	**193**
Depreciation and amortisation	-	-	-	-	-	-
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(Deficit)	**(47,854)**	**(80,291)**	**(55,292)**	**(34,492)**	**(291)**	**193**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(47,854)**	**(80,291)**	**(55,292)**	**(34,492)**	**(291)**	**193**
Governance & Funder Admin						
REVENUE						
Ministry of Health revenue	4,139	5,465	6,054	4,900	4,931	5,020
Other government revenue	-	-	-	-	-	-
Other revenue	167	26	-	-	-	-
Total Revenue	**4,306**	**5,491**	**6,054**	**4,900**	**4,931**	**5,020**
EXPENSE						
Personnel	9,895	10,595	10,907	10,961	11,015	11,070
Outsourced personnel & clinical serrvices	1,458	2,281	2,628	2,628	2,628	2,793
Clinical supplies	208	52	60	61	62	63
Earthquake building repair costs	-	-	-	-	-	-
Infrastructure & non clinical	(8,602)	(7,603)	(7,934)	(9,146)	(9,170)	(9,266)
External service providers	-	-	-	-	-	-
Total Expense Before Depreciation & Capital Charge	**2,959**	**5,325**	**5,661**	**4,504**	**4,535**	**4,660**
Surplus/(Deficit) Before Depreciation & Capital Charge	**1,347**	**166**	**393**	**396**	**396**	**360**
Depreciation and amortisation	292	395	393	396	396	360
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**292**	**395**	**393**	**396**	**396**	**360**
Surplus/(Deficit)	**1,055**	**(229)**	**-**	**-**	**-**	**-**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**1,055**	**(229)**	**-**	**-**	**-**	**-**

4.12 Summary of revenue and expenses by arm—continued

	2018/19 Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Provider Arm						
REVENUE						
Ministry of Health revenue	1,035,545	1,140,971	1,201,243	1,267,429	1,309,583	1,367,962
Other government revenue	33,771	37,731	39,936	41,794	43,530	45,335
Earthquake repair revenue redrawn	4,460	1,846	6,600	2,600	200	-
Other revenue	51,248	58,711	56,353	64,109	75,880	77,016
Total Revenue	**1,125,024**	**1,239,259**	**1,304,132**	**1,375,932**	**1,429,193**	**1,490,313**
EXPENSE						
Personnel	885,311	902,239	937,076	942,490	985,236	1,014,522
Outsourced personnel & clinical serrvices	29,668	30,951	27,111	21,636	20,997	20,449
Clinical supplies	134,645	154,216	162,446	165,221	173,746	178,178
Earthquake building repair costs	4,460	1,846	6,600	2,600	200	-
Infrastructure & non clinical	123,437	129,266	125,836	124,635	128,318	127,935
Total Expense Before Depreciation & Capital Charge	**1,177,521**	**1,218,518**	**1,259,069**	**1,256,582**	**1,308,497**	**1,341,084**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(52,497)**	**20,741**	**45,063**	**119,350**	**120,696**	**149,229**
Depreciation and amortisation	53,792	77,578	84,715	70,472	68,298	68,936
Capital charge and interest expense	24,753	38,538	50,062	72,391	78,900	80,265
Total Depreciation, Capital Charge & Interest Expense	**78,545**	**116,116**	**134,777**	**142,863**	**147,198**	**149,201**
Surplus/(Deficit)	**(131,042)**	**(95,375)**	**(89,714)**	**(23,513)**	**(26,502)**	**28**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	137,346	3,068	-	-	-	-
Impairment of property, plant & equipment	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**6,304**	**(92,307)**	**(89,714)**	**(23,513)**	**(26,502)**	**28**
In House Elimination						
REVENUE						
Ministry of Health revenue	(969,235)	(1,066,542)	(1,131,904)	(1,194,754)	(1,234,667)	(1,291,578)
Total Revenue	**(969,235)**	**(1,066,542)**	**(1,131,904)**	**(1,194,754)**	**(1,234,667)**	**(1,291,578)**
EXPENSE						
Payments to internal providers	(969,236)	(1,066,542)	(1,131,904)	(1,194,754)	(1,234,667)	(1,291,578)
Total Expense	**(969,236)**	**(1,066,542)**	**(1,131,904)**	**(1,194,754)**	**(1,234,667)**	**(1,291,578)**
Surplus/(Deficit)	1	-	-	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	1	-	-	-	-	-

4.12 Summary of revenue and expenses by arm—continued

	2018/19 Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
CONSOLIDATED						
REVENUE						
Ministry of Health revenue	1,740,451	1,878,360	1,962,952	2,034,189	2,115,498	2,198,907
Other government revenue	36,687	40,523	42,144	43,830	45,584	47,407
Earthquake repair revenue redrawn	4,460	1,846	6,600	2,600	200	-
Other revenue	52,665	59,149	57,539	65,295	77,066	77,952
Total Revenue	**1,834,263**	**1,979,878**	**2,069,235**	**2,145,914**	**2,238,348**	**2,324,266**
EXPENSE						
Personnel	895,206	912,834	947,983	953,451	996,251	1,025,592
Outsourced personnel & clinical serrvices	31,126	33,232	29,739	24,264	23,625	23,242
Clinical supplies	134,853	154,268	162,506	165,282	173,808	178,241
Earthquake building repair costs	4,460	1,846	6,600	2,600	200	-
Infrastructure & non clinical	114,835	121,663	117,902	115,489	119,148	118,669
External service providers	752,786	815,419	814,341	799,574	804,515	828,740
Total Expense Before Depreciation & Capital Charge	**1,933,266**	**2,039,262**	**2,079,071**	**2,060,660**	**2,117,547**	**2,174,484**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(99,003)**	**(59,384)**	**(9,836)**	**85,254**	**120,801**	**149,782**
Depreciation and amortisation	54,084	77,973	85,108	70,868	68,694	69,296
Capital charge and interest expense	24,753	38,538	50,062	72,391	78,900	80,265
Total Depreciation, Capital Charge & Interest Expense	**78,837**	**116,511**	**135,170**	**143,259**	**147,594**	**149,561**
Surplus/(Deficit)	**(177,840)**	**(175,895)**	**(145,006)**	**(58,005)**	**(26,793)**	**221**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	137,346	3,068	-	-	-	-
Total Comprehensive Income/(Deficit)	**(40,494)**	**(172,827)**	**(145,006)**	**(58,005)**	**(26,793)**	**221**

APPENDICES

Further Information

Appendices

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

Documents of interest

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

- Canterbury DHB Annual Plan
- Canterbury System Level Measures Improvement Plan
- Canterbury Disability Action Plan
- South Island Regional Health Services Plan

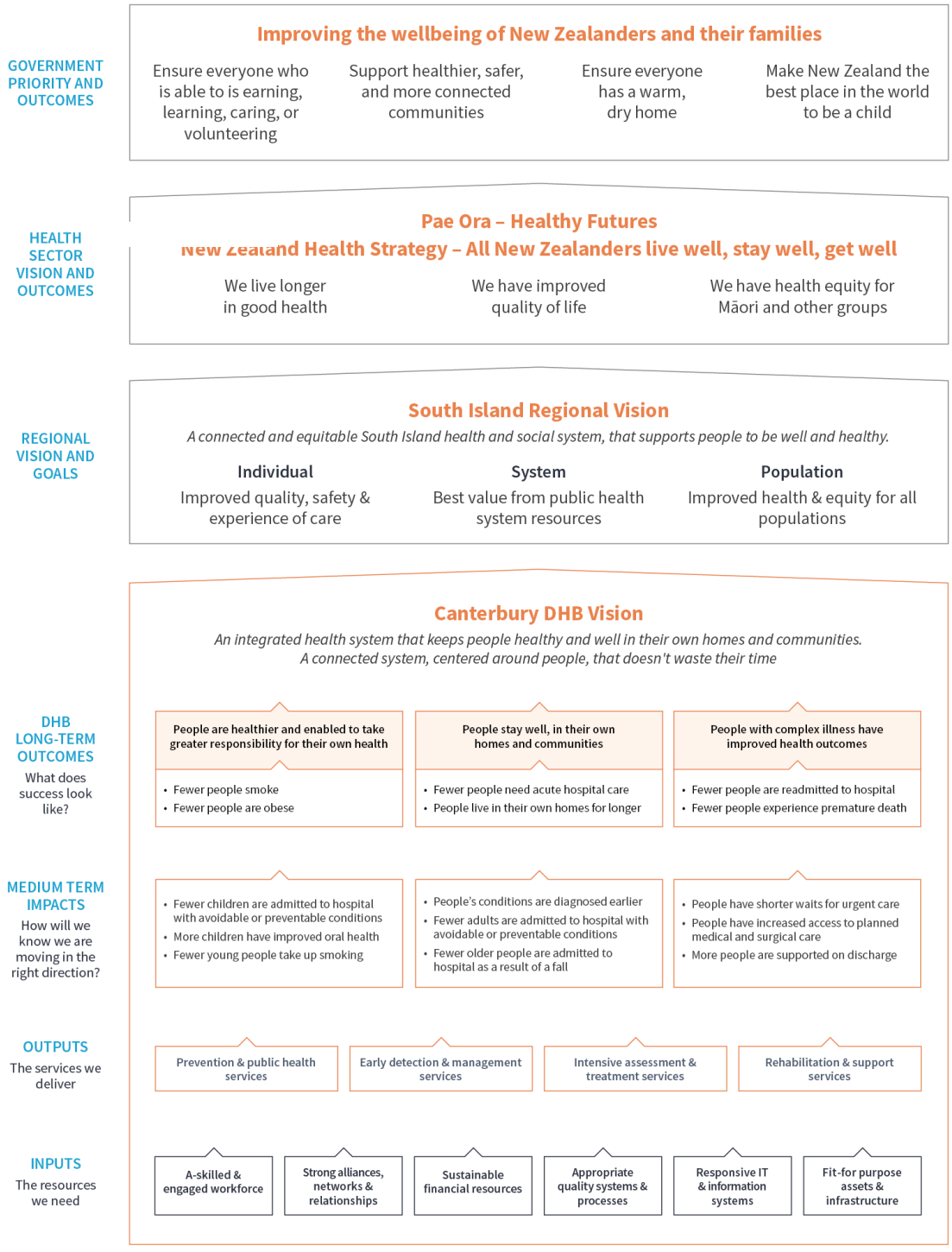
References

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

Appendix 1 Glossary of Terms

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

Appendix 2 Overarching Intervention Logic Diagram



Te Tiriti O Waitangi

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

Appendix 3 Statement of Accounting Policies

The prospective financial statements in Canterbury DHB's Annual Plan and Statement of Performance Expectations for the year ended 30 June 2020 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. PBE FRS42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 4 of this document.

STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY AND STATUTORY BASE

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

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

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

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

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

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

BASIS OF PREPARATION

Statement of Going Concern

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

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

Statement of Compliance

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

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

Measurement Basis

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

Functional and Presentation Currency

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

Changes in Accounting Policies

With the exception of the accounting policy change in Trade and Other Receivables, the accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

Budget Figures

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

Income Tax

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

Goods and Services Tax

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

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

Commitments and contingencies are disclosed as exclusive of GST.

Critical Accounting Estimates and Assumptions

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

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

Standards Issued but Not Yet Effective and Not Early Adopted

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

Service performance reporting

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

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

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

Interests in other entities

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

Revenue

Ministry of Health population-based funding

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

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

Inter-district flows

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

Ministry of Health other contracts

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

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

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

ACC revenue

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

Provision of other services

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

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

Estimates and assumptions: Non-government grants

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

Operating Lease Payments

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

Equity

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

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

Revaluation Reserve

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

Bank Term Deposits

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

Cash and Cash Equivalents

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

Trade and Other Receivables

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

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

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

Previous Accounting Policy for Impairment of Receivables

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

Inventories

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

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

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

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

Provisions

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

Employee Entitlements

Defined contribution plans

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

Defined benefit plans

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

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

Long service leave, sabbatical, retirement gratuities and sick leave

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

ACC Partnership Programme

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

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

Estimates and assumptions: Retirement and long service leave

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

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

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

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

Property, Plant and Equipment

Owned assets

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

Revaluations

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

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

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

Disposal of property, plant and equipment

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

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

Depreciation

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

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

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

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

Additions

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

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

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

Subsequent costs

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

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

Estimates and assumptions: Useful lives and residual value

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

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

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

In light of the Canterbury earthquakes, Canterbury DHB continuously reviews the carrying value of land and buildings.

Intangible assets

Software development and acquisition

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

Amortisation

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

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

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

Non-cash-generating assets

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

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

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

Estimates and assumptions: Estimating useful lives of software assets

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

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

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

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

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.

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.

Commitments

Estimates and assumptions: Leases classification

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

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

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

Contractual Maturity of Financial Assets and Liabilities

Classification of financial instruments

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

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

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

Foreign currency

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

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

Derivative financial instruments

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

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

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

Related Parties

Subsidiaries

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

Transactions eliminated on consolidation

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

Associates

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

CANTERBURY DHB STATEMENT OF PERFORMANCE EXPECTATIONS

Produced August 2020
Pursuant to Section 149 of the Crown Entities Act 2004

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