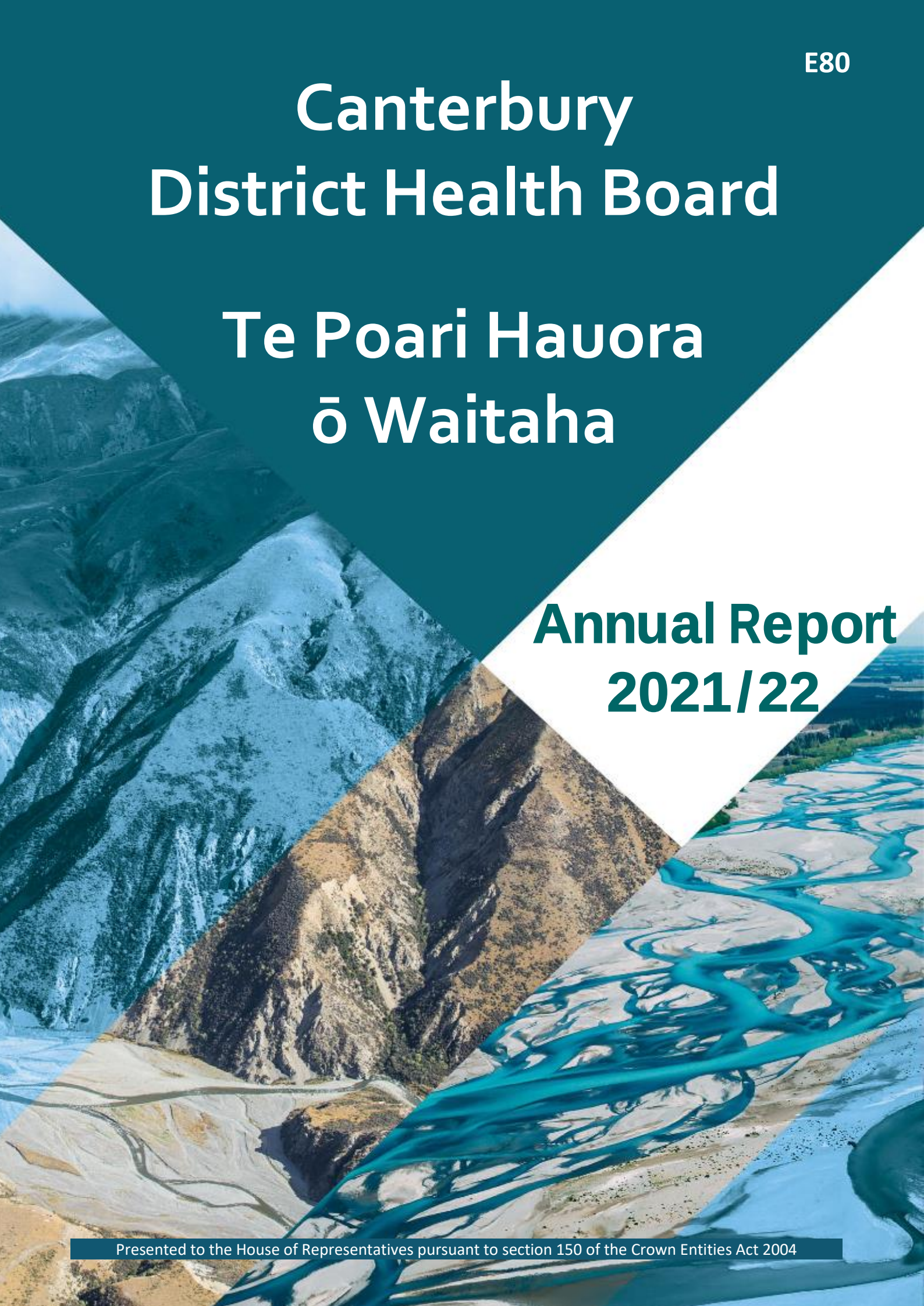
E80

Canterbury District Health Board

Te Poari Hauora ō Waitaha

Annual Report 2021/22



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

TĀ MĀTOU MATAKITE | OUR MISSION

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

Ā MĀTOU UARA | OUR VALUES

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

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

Te Takohanga i ngā hua.
Responsibility for outcomes.

KĀ HUARI MAHI | OUR WAY OF WORKING

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

Whakaatu te ihumanea hou.
Demonstrate innovation

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

Rārangi Take | Table of Contents

1. KUPU ARATAKI | INTRODUCTION

The 2021 – 2022 year was both extraordinary and challenging for the Canterbury Health System as we dealt with respiratory syncytial virus (RSV), COVID-19 and influenza.

The country entered a Level 4 lockdown on 17 August 2021 triggered by the COVID-19 Delta variant and a 'no visitor' policy was implemented for our hospitals, along with the postponement of most planned and elective surgery and outpatient appointments. In just under a month, Canterbury returned to Alert Level 2 however the disruption to health services was far-reaching. Many of our community-based and public health programmes were interrupted or suspended, and the focus of our public health teams had shifted almost entirely to supporting the COVID-19 response.

This first disruption was followed by the first community case of the highly contagious COVID-19 Omicron variant reported in Auckland in late December 2021. After only 17 reported community cases in Canterbury in January 2022, the numbers increased quickly with 4,062 cases in February and 65,984 in March. Between 1 January and 30 June 2022, there were 177,677 community cases of COVID-19 in Canterbury.

In March, we were seeing an average of 45 people per day hospitalised with COVID-19 and the virus re-emerged in our aged care facilities. By April, there were on average 52 people with COVID-19 in hospital each day and by May the number had increased to 57 per day.

As COVID-19 infections grew amongst our staff and their close contacts, our ability to continue to provide health care was significantly impacted. In April, there were 764 staff registered with the COVID-19 Return to Work programme during the month. In May that number increased to 828 staff. Between 26 February and 30 June 2022, 3,499 staff, or approximately 29% of our total workforce, registered periods of COVID-19 related absence.

The level of staff illness and absence saw further postponement of many planned and elective surgeries and outpatient appointments. Staffing levels at four of our rural hospitals (Oxford, Ellesmere, Waikari and Darfield) meant they had to be closed with elderly residents relocated to aged residential care facilities to ensure continuity of care through the outbreak.

This extraordinary pressure also necessitated the deployment of staff to areas of the health service most in need, and a call out for qualified clinical staff working in non-clinical roles and who still held valid practising certificates, to temporarily step back into clinical duties.

This pressure was not just felt across our hospital services. The high number of staff absences coupled with widespread respiratory illness in the community saw increased pressure across the whole health system. General Practice teams operated at capacity, district nursing and home-based support providers had to prioritise care to the most urgent and vulnerable, community-based programmes and support in people's homes, community halls and Maraes had to be cancelled to reduce the risk of transmission. During the year every aged care facility in Canterbury had COVID-19 outbreaks. To support the sector a large number of staff from Canterbury District Health Board provided support to Aged Residential Care facilities.

People worked tirelessly to support each other, their patients and our community during this time.

A Canterbury Hauora Coordination Hub, established in December 2021, brought together health and social services to provide care and support to those affected by COVID-19, who weren't registered with a General Practice team and to support General Practice teams with highly complex COVID-19 cases. Māori and Pacific providers stepped in to offer wrap-around support to whānau with COVID-19 and those struggling as a result.

Our COVID-19 vaccination programme saw strong public engagement and uptake from our community with 175,244 vaccines administered in Canterbury in August, 217,576 in September, and 219,054 in October; up from 70,078 in July. Between July 2021 and June 2022 there were 1,217,906 vaccinations provided in Canterbury.

The efforts of our staff and those people working for our community providers is evident in our performance results this year. Where we might have expected to miss all our performance targets for the year, we have not. Despite COVID-19 demand, staff illness and lockdowns we have delivered against many of the targets and in many areas delivered well above national averages.

Administrators and clinical teams worked tirelessly to reschedule appointments and ran weekend clinics to reduce wait times. People across the system volunteered to shift locations to work in services most in need and many worked in aged residential care facilities, managed isolation, vaccination clinics and emergency planning teams to support the system response. It is hard to express our thanks to all those people who made a difference over the past year - but we do thank you and acknowledge the critical role you played in supporting our population.

In looking forward, the largest health reform in our history is underway and will transform our system over the next few years. Our teams are already getting involved in Te Whatu Ora working groups and taskforces to help address barriers to service access and to improve outcomes for our population. The development of Te Aka Whai Ora and Iwi Partnership Boards will further promote and support the voice of Māori in decision making in our future health system and a stronger regional focus will see us working closer with our South Island counterparts. This is a different sort of challenge for our teams, but one we look to embrace as we continue to support the communities of Canterbury and the Chatham Islands.

Peter Bramley

District Director
Te Whatu Ora Waitaha

2. TIRO WHĀNUI | OVERVIEW

2.1 Tohu Tūrangatanga | Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Canterbury DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

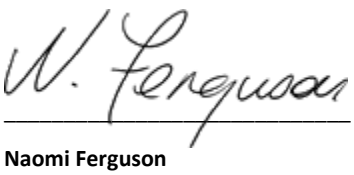
The Board and Management of Te Whatu Ora take responsibility for the preparation of the Canterbury District Health Board group's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the Canterbury DHB group under section 19A of the Public Finance Act.

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

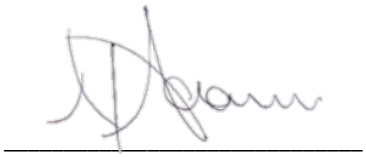
In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Canterbury District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:



Naomi Ferguson
Acting Chair

Dated: 6 March 2023



Hon Amy Adams
Board member

Dated: 6 March 2023

3. WHAKATAUNGA | IMPROVING OUTCOMES

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

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

As a DHB, we had several different roles and associated responsibilities. In our governance role, we strived to improve health outcomes for our population. As a funder, we were concerned with the effectiveness of the health system and the return on investment in terms of health outcomes. As a provider, we were concerned with the quality of the services delivered and the efficiency with which they were delivered.

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

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

Under each outcome goal we identified a small number of long-term population health indicators which helped to provide insight into how well our health system was performing over time.

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

To evaluate our performance over the shorter term, we identified a secondary set of contributory measures, where our performance impacted on the outcomes we were seeking. Because change will be evident over a shorter period, these contributory (or impact) measures were selected as our main measures of performance.

Tracking our performance against these indicators helped us to evaluate our success in areas that were important to our community, our Board and Government. As such, we set performance standards for these contributory measures in 2021/22 to determine whether we are moving in the right direction.

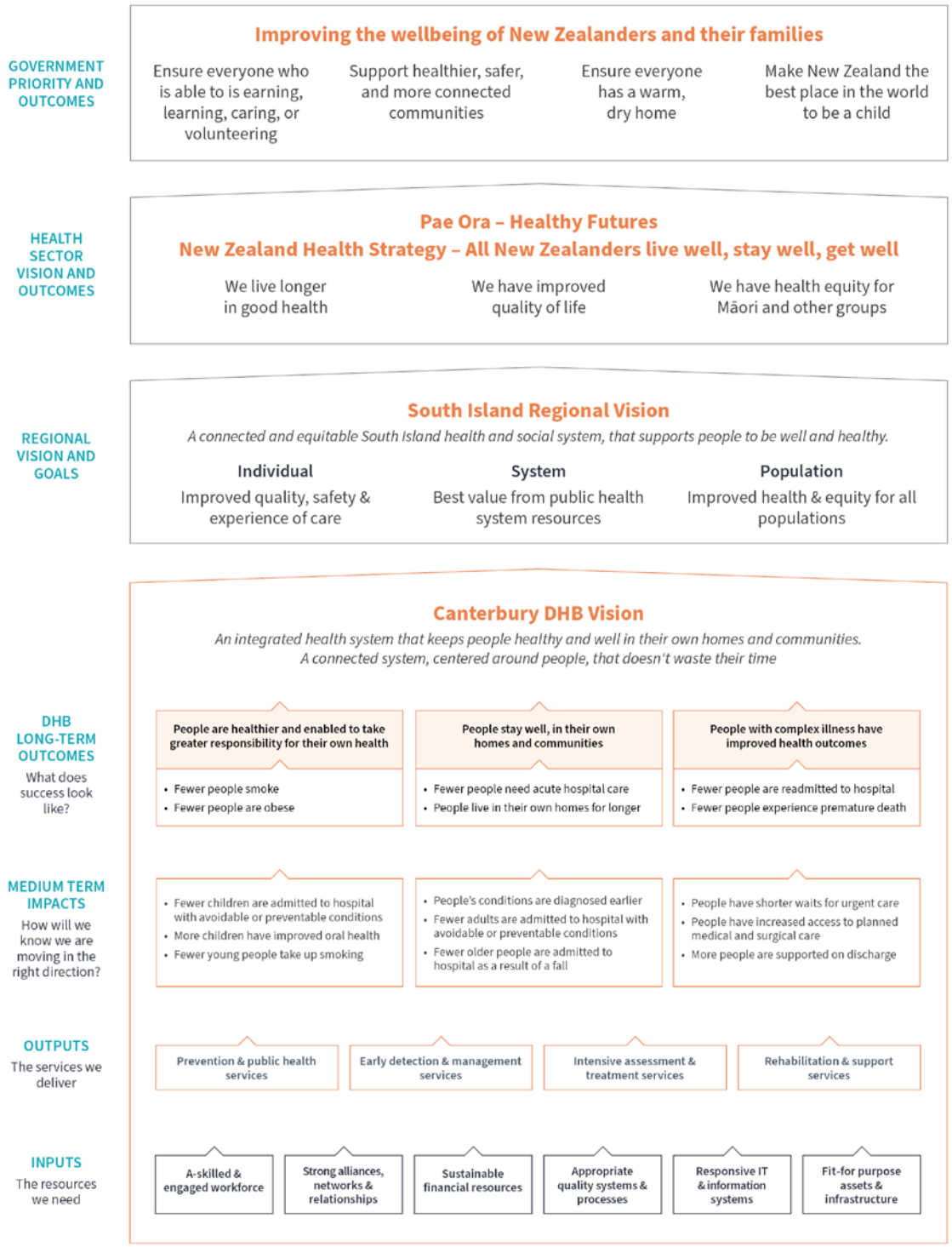
These outcome measures sat alongside our Statement of Performance Expectations (the following section of this report), which outlined the services we planned to deliver and the standards we expected to meet in 2021/22. Collectively these measures formed an essential part of the way in which we were held to account.

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

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

The intervention logic framework on the following page illustrates how we anticipated the services that we fund or deliver (outputs) would impact on the health of our population, contribute to the longer-term population health outcomes desired, and deliver on the expectations and priorities of Government.

Canterbury DHB - Overarching Intervention Logic Framework



Te Tiriti O Waitangi

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

Wellbeing Outcomes

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

WHY IS THIS A PRIORITY?

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

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

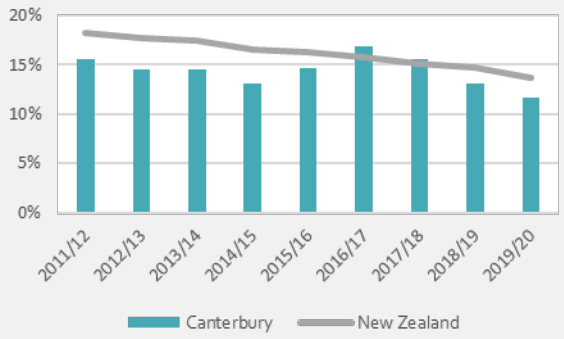
The 2019-20 NZ Health Survey (the latest available with DHB breakdowns) reports that 12% of the Canterbury population were current smokers, compared to 14% of the New Zealand population. A positive trend is clear with total population smoking rates falling from 16% in 2011/12 to 12% in 2019/20.

Combined results from 2017-2020 Surveys show that, like national trends, smoking rates continue to be highest amongst our Māori and Pacific populations. Positively, our Māori and Pacific rates dropped significantly over this time reflecting our equity focus on these populations.

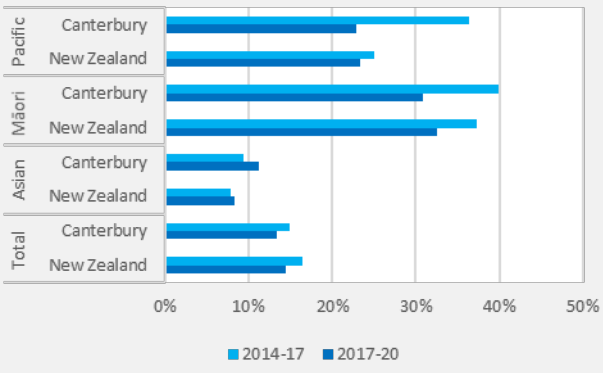
Primary, community and hospital-based teams continued to work hard in a challenging environment to provide brief smoking cessation advice and link people up with smoking cessation services.

In 2021/22, 75% of smokers identified in primary care received advice and support to stop smoking (8% higher than national rates) and 93% of smokers identified in our hospitals received advice and support to quit. Pregnant smokers were also a key focus for our health system over the past year and 89% of pregnant women (identified as smokers) received advice and support to stop smoking in 2021/22.

Proportion of the population (15+) who currently smoke



Proportion of the population (15+) who currently smoke



Data source: NZ Health Survey [2]

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

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

OUTCOME MEASURE – A REDUCTION IN OBESITY RATES

Like smoking, obesity impacts on the quality of people's lives and is a significant risk factor for many long-term conditions. The health system has a key role in supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to make healthier choices.

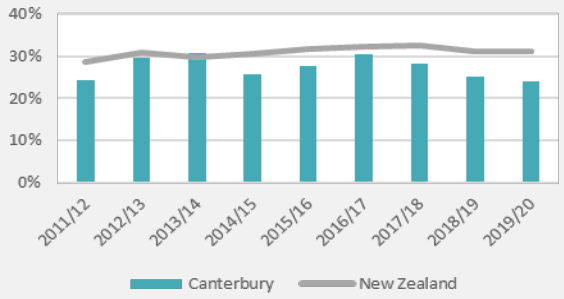
The 2019/20 NZ Health Survey reported that Canterbury's obesity rate was 7% below the national rate at 24%. Unlike the rest of the country, a steady drop in obesity rates was evident for our population across all ethnicity groups.

We continue to identify children who may need support prior to starting school, as part of the B4 School Check programme. In 2021/22, 99% of children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice.

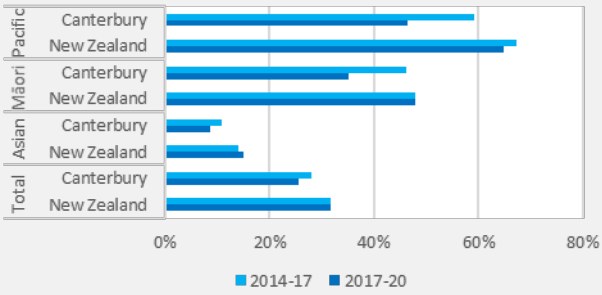
We also continue to invest in lifestyle programmes that support adults to increase their physical activity levels and make heathier choices. While the delivery of lifestyle programmes was disrupted by the COVID-19 outbreak, 2,921 people were still referred to the Green Prescription programme by their health professional in 2021/22.

A review of our investment in lifestyle programmes in 2021/22 resulted in a refocus onto programmes that will target our high need populations, with the aim of improving outcomes for our Māori and Pacific populations.

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



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



Data source: NZ Health Survey [3]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

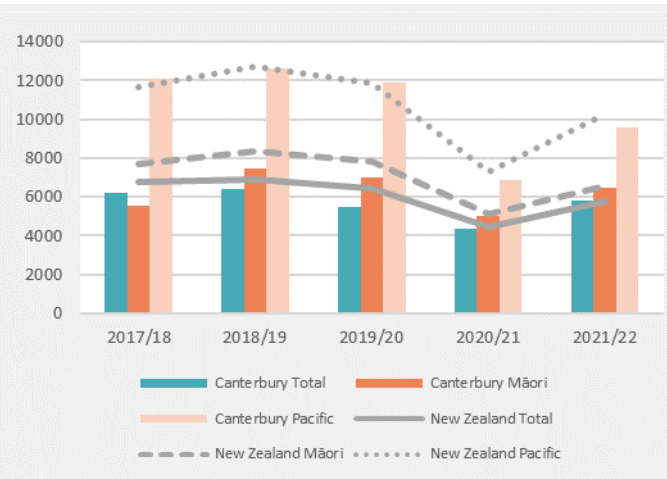
Fewer avoidable hospital admissions

Canterbury's ambulatory sensitive hospital (ASH) admission rate for children under five increased to 5,785 per 100,000. There was a drop in ASH admissions following the international border closure; and the subsequent increase in rates in 2021/22 was not unexpected as health mandates were relaxed.

The ASH target was met for our total and Māori populations but not for our Pacific population, which is more heavily influenced by small population numbers. There were 50 additional Pacific admissions over the course of the year compared with 2020/21.

This measure is seen as a marker of good quality primary care and a connected health system that engages earlier with children and their care givers to prevent unnecessary hospital admissions. In the past year, 92% of all new born children were enrolled with a primary care team before three months of age, 93% of babies were fully immunised at eight months of age and 89% of pregnant smokers were provided with advice and support to quit smoking.

Measure: Rate of Ambulatory sensitive hospitalisations for children (0-4)	2019/20	2020/21	2021/22 Target	2021/22 Result
	5,468	4,351	<6,871	5,785



Data Source: Ministry of Health Performance Reporting [4]

[3] The 2019/20 NZ Health Survey is the most recently released time series with regional (DHB) breakdowns available and while total population results are presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers. The Survey defines 'Obese' as having a Body Mass Index (BMI) of >30, or >32 for people of Māori and Pacific ethnicity.

[4] This is a national indicator and captures hospital admissions for conditions considered preventable, including: vaccine-preventable disease, dental conditions, asthma and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim was to maintain performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between populations. The results are published three months in arrears and results reflect the 12 months to March 2022. Minor edits to previous results reflect coding updates.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

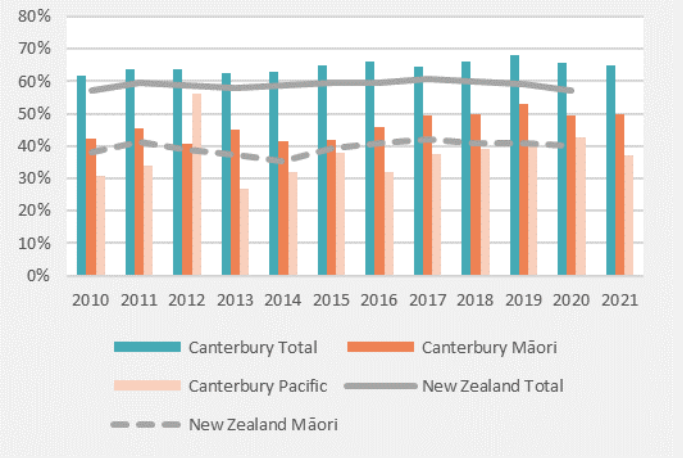
Children have improved oral health

The percentage of five-year-old children whose teeth were caries free (had no holes or fillings) fell slightly for the total and Pacific populations but increased slightly (by 1%) for Māori children.

Over 2021/22 our Oral Health Service made changes to its recall processes moving to a 6-month, 12-month or 18-month recall system, prioritising our hard-to-reach population groups. This change in process targets those most at need of assessment and support and is expected to help reduce equity gaps in terms of access and longer-term outcomes for Māori and Pacific children.

Several other lifestyle factors influence good oral health for young children including investment in breastfeeding and pregnancy & parenting programmes which will continue to help improve these rates in the future.

Measure: Children caries-free at age 5	2019	2020	2021/22 Target	2021/22 Result
	68%	66%	67.4%	65%



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

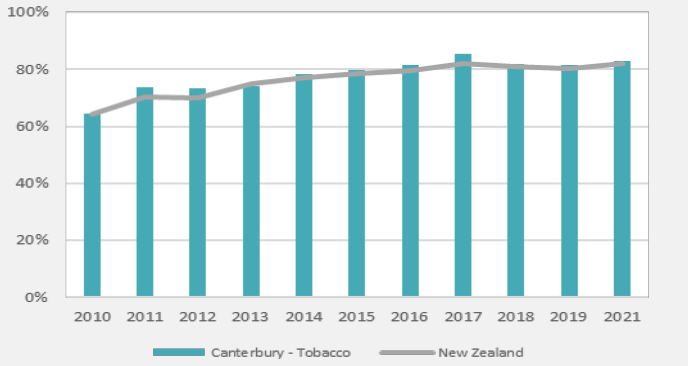
Fewer young people take up smoking

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

The 2021 survey result shows a slight increase in students reporting having never smoked at year 10 (14-15 years). However, we note a growing number of year 10 students are trying or vaping regularly. Our public health service will continue to monitor this to establish what impact vaping may have on tobacco use among young people.

Our public health team was not able to undertake controlled purchase operations in 2021/22 due to COVID-19 restrictions and the prioritisation of our public health teams onto the COVID-19 response. These will resume in 2022/23.

Measure: 'Never Smokers' amongst Year 10 students	2019	2020	2021/22 Target	2021/22 Result
	81%	n.a	>82%	83%



Data Source: National ASH Year 10 Survey [6]

[5] This performance measure was a national DHB performance indicator and was reported annually for the school year. National results for 2021 were not available at the time of publishing, results for 2022 will not be available until 2023.

[6] The ASH Survey is a national survey used to monitor student smoking rates since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students who are aged 14 or 15 years at the time of the survey. Ethnicity breakdowns are not provided due to small survey numbers. The ASH Survey was not completed in 2020 due to the COVID-19 outbreak. Results for 2022 are expected to be released in early in 2023. For further information see www.ash.org.nz.

People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

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

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

Acute (unplanned) hospital admissions account for almost two thirds of all hospital admissions in New Zealand, challenging capacity for planned care. In 2021/22, 51% of admissions to Christchurch Hospital were acute.

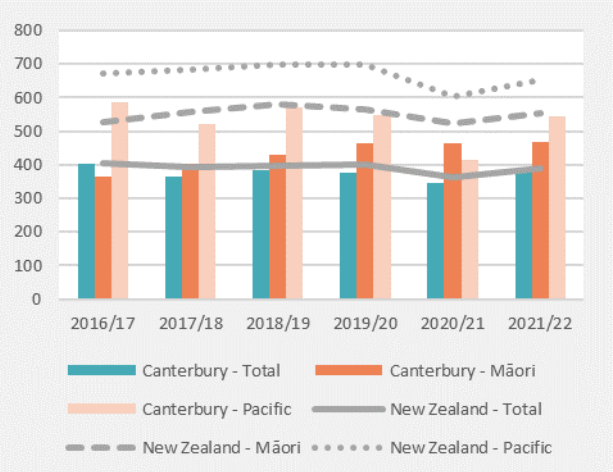
Acute hospital bed-day rates are used as a proxy indicator of good long-term conditions management and timely access to treatment as they reduce the type of crisis and deterioration that leads to an acute hospital admission.

Canterbury's rates rose slightly over the past year, with acute bed days for our Pacific population increasing the most in comparison with 2020/21. Positively, our Māori and Pacific rates remained well below national rates.

Canterbury's community-based Acute Demand Management Programme continues to contribute to lower acute hospital admissions, and more than 42,000 packages of care were provided through the programme in 2021/22.

Improving access to primary care has been a key a focus as we work to alleviate pressure on hospital services and reduce acute presentations. This includes improving primary care enrolment rates and working with Primary Care Organisations to ensure people can book timely appointments.

Rate of acute hospital bed-days



Data Source: National Minimum Data Set[7]

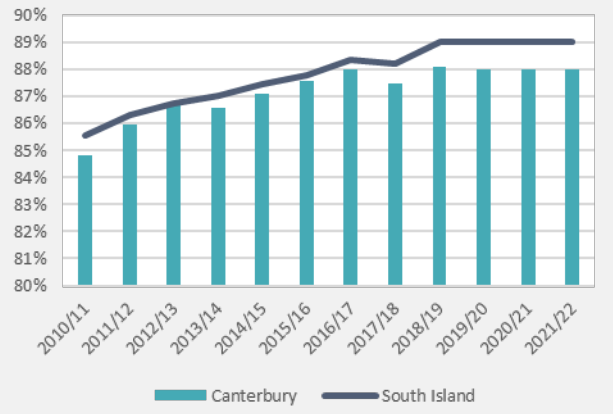
OUTCOME MEASURE – MORE PEOPLE LIVING IN THEIR OWN HOME

The proportion of the Canterbury population aged over 75 living in their own home has remained stable at 88%. This is a positive trend, particularly as Canterbury's older population has grown by 11% over the past five years.

Several local programmes supported our older population to maintain their health and wellbeing in 2021/22. These included age related harm prevention and long-term condition strategies, falls prevention programmes, restorative rehabilitation and home-based support and respite services.

Falls are a leading cause of hospitalisation for older people in Canterbury and serious falls lead to hospitalisation, a loss of confidence, and an increased risk of admission to residential care. Despite the considerable disruption COVID-19 caused to the delivery of community-based services, over 3,500 older people accessed community-based falls prevention and rehabilitation programmes in 2021/22.

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



[7] This is a national System Level Measure, data is provided by the Ministry of Health via the national minimum data set. This measure is age standardised and presented as a rate per 1,000 people.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People's conditions are diagnosed earlier

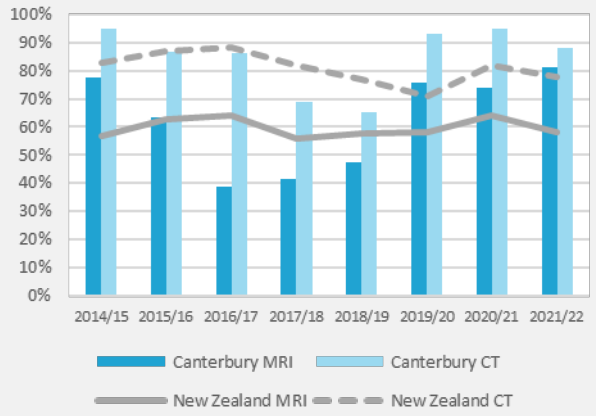
Demand for diagnostics including CT and MRI scans has been growing steadily for several years, stretching capacity across both public and private sectors and increasing wait times. Several factors are driving this demand including new drug and treatment programmes that require diagnostic support, increased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

Canterbury responds to most of the specialised tertiary referrals from other South Island DHBs. This puts additional pressure on our radiology services. Like most service areas COVID-related workforce challenges have also impacted the throughput of radiology services.

The radiology department responded to the pressures over the past year with additional clinics and outsourcing to improve throughput and reduce wait times. There was an improvement in MRI wait times with over 1,000 additional scans completed compared to the previous year. However, wait times for CT increased with the impact of COVID-19 meaning 2,400 fewer scans were completed compared to the previous year.

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

Measure: People receiving their non-urgent MRI or CT scan within six weeks	2019/20	2020/21	2021/22 Target	2021/22 Result
MRI	76%	74%	90%	81%
CT	93%	95%	95%	88%



Fewer avoidable hospital admissions

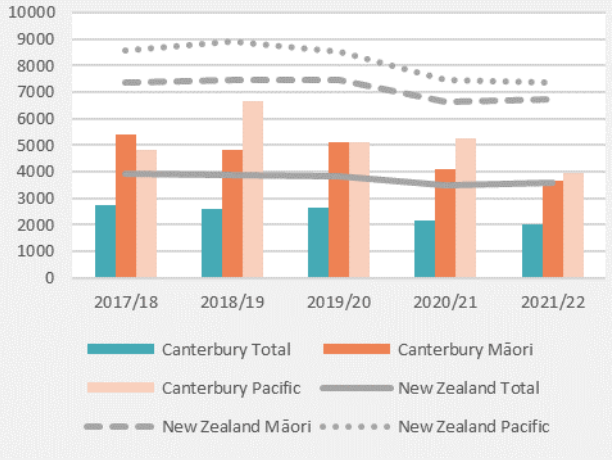
In 2021/22, Canterbury's ambulatory sensitive hospital (ASH) admission rate for adults was 2,011 per 100,000, achieving the target set, and well below the national average of 3,590. Canterbury's overall ASH rate continued its year on year improvement sitting at just 56% of the national rate. Rates for Māori and Pacific were around 50% of their respective national rates.

While these trends are positive we note that ASH rates have been impacted by COVID-19 restrictions and closed borders. Close monitoring is needed to ensure these lower rates are maintained.

Good quality primary care and a well-connected health system are key to improving performance against this measure. As of June 2022, 95% of adults aged 45-64 in Canterbury were enrolled with a general practice. While positive, with enrolment rates for Pacific also high (91%), further work is needed to lift rates for Māori (83%) and we are working closely with Primary Health Organisations to ensure access to general practice across the region.

Heart disease is the leading driver of ASH rates in Canterbury and a new Heart Conditions Pathway, supported by both Primary and Secondary Care teams, is expected to make a positive difference in this space over the coming year.

Measure: Ambulatory sensitive hospitalisation for adults (45-64)	2019/20	2020/21	2021/22 Target	2021/22 Result
	2,617	2,167	<2,298	2,011



Data source: Ministry of Health Performance Reporting[8]

[8] This measure was a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine preventable diseases, chest pain, respiratory conditions, dental conditions and gastroenteritis. The aim was to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results reflect national data provided by the Ministry of Health in June 2022 being results for the 12 months to March 2022.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

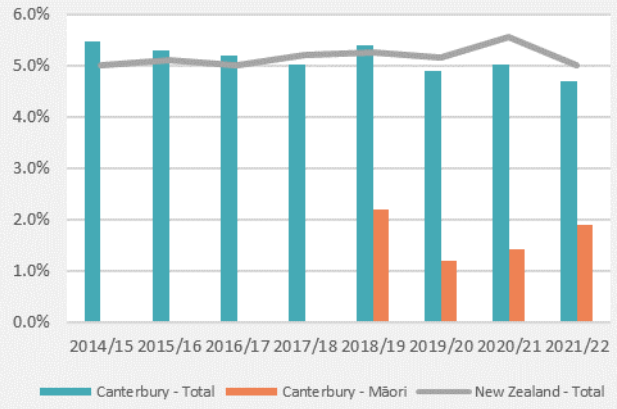
Fewer falls related hospitalisations

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

At 4.7%, the proportion of our population (75+) admitted to hospital because of a fall fell to the lowest level seen in eight years and remains below the national average of 5.0%. The rate of Māori falls increased for the third year however these numbers were very small with only six additional falls admissions compared with 2020/21.

In 2021/22, 1,729 older people accessed our community-based falls prevention programme. Our Quality teams also provided 98% of older people in our hospitals with a falls risk assessment to help them stay safe during their stay.

Measure: Population (75+) admitted to hospital as a result of a fall	2019/20	2020/21	2021/22 Target	2021/22 Result
	4.9%	5.0%	<5.5%	4.7%



Data Source: National Minimum Data Set

People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

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

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN AMENABLE MORTALITY

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

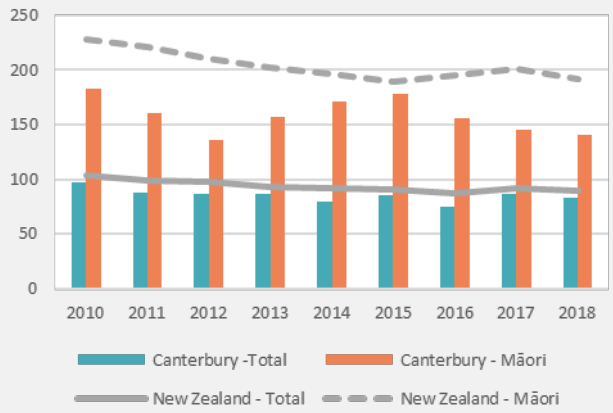
Prevention, screening and long-term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment.

Cancer is one of the leading causes of mortality in Canterbury and contributes to a high proportion of premature deaths. In the past year 1,905 people had a skin lesion removed in primary care without the need (or wait) for a hospital appointment. Canterbury also continued to achieve national Faster Cancer Treatment targets with 91% of people provided with urgent cancer treatment within the target timeframe in 2021/22.

Diabetes and Heart Disease also remain amongst the leading causes of premature mortality and 90% of people identified with diabetes had an HbA1c test to monitor and support the management of their diabetes condition in 2021/22. Of those having an HbA1c test 75% had acceptable glycaemic control indicating their condition was well managed.

Our teams also worked closely with community-based service providers to ensure a strong continuum of care for people with mental illness and addictions. We continued to support access to brief intervention counselling (BIC) in general practice with 5,048 people accessing support in 2021/22.

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



Data Source: National Mortality Collection[9]

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

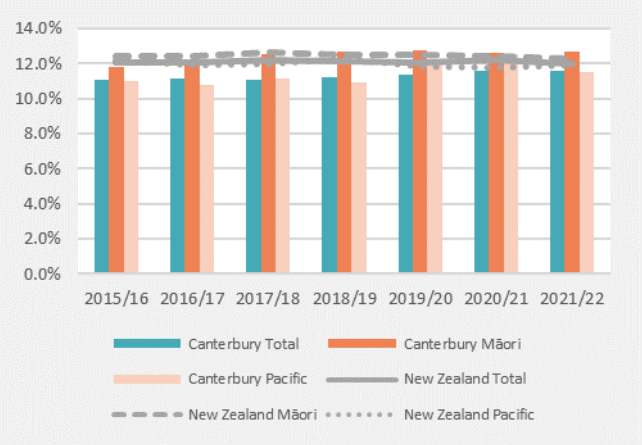
OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

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

Canterbury's readmission rates have remained static for several years, Māori rates increased very slightly (0.1%) and pacific rates dropped slightly (1%).

Our community-based early supported discharge service provided home-based rehabilitation to support 1,938 older people discharged from hospital in 2021/22. Over 9,000 people were supported by district nursing for issues such as wound care and medications management, and more than 7,000 people were supported by home-based support services as part of a restorative package of care to enable people to stay in their own homes for longer.

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



Data Source: National Minimum Data Set [10]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

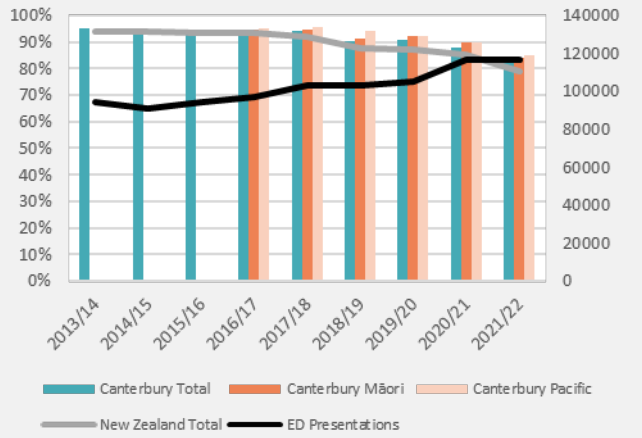
People have shorter waits for urgent care

The proportion of people presenting to our emergency departments who were seen and treated within 6 hours fell to 82% in 2021/22. Although 3% higher than the national average, high presentation numbers, COVID-19 pressures and workforce challenges have impacted significantly on wait times.

The number of people presenting to ED has remained high with more than 116,000 presentations for the second year in a row. Acute service demand is also being seen in community services with our Acute Demand Management Service supporting more than 42,000 people in the community over the past year.

Addressing urgent care demand and hospital service flow are priorities for our health system. Workgroups have been established to ensure people are presenting to the right place in the system and that barriers to care and unnecessary waits are identified and addressed. This includes our Making the System Flow and our Planned Care programmes incorporating activity across both primary and secondary care.

Measure: People are admitted, discharged or transferred from ED within 6 hours	2019/20	2020/21	2021/22 Target	2021/22 Result
	91%	88%	95%	82%



Data Source: National Minimum Data Set [11]

[10] The Acute Readmission rate results were provided nationally, three months in arrears and results reflect the twelve months to March 2022.

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

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for planned care

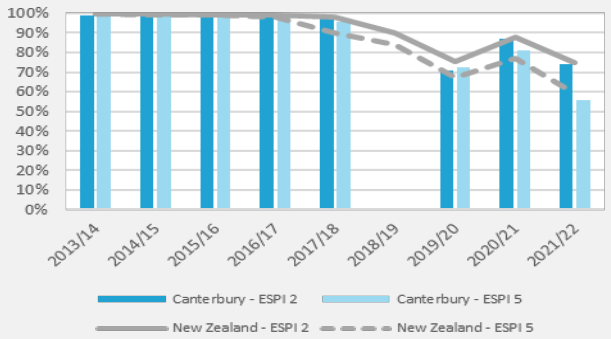
While we met our Elective Services volume targets, delivering 36,344 planned care interventions, our performance against the Elective Services Patient flow Indicators (ESPIs) dropped in 2021/22. Wait times increased for both First Specialist Assessments (ESPI 2) and Elective Treatments (ESPI 5).

The prioritisation of urgent and acute services along with the capacity pressures related to COVID-19 related infection control measures, alert level restrictions, staff and patient COVID-19 related sickness and the diversion of staff onto the COVID-19 response have combined to significantly impact the timeliness of delivery of First Specialist Assessments and Elective Treatments.

This was a national pattern and a national Planned Care taskforce has been established to address the backlog across the country.

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

	2019/20	2020/21	2021/22 Target	2021/22 Result
ESPI 2	71%	87%	100%	73%
ESPI 5	73%	81%	100%	56%



Data Source: Ministry of Health Quickplace Warehouse [12]

People Are Supported on Discharge

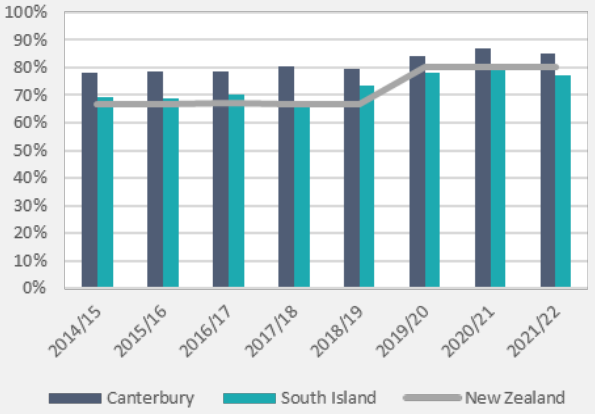
Research indicates that people who have had a psychiatric admission have increased vulnerability immediately following discharge, including risk of readmission and a higher risk of suicide. Those leaving hospital with a formal discharge plan and links to community-based services and supports, are less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

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

Our Specialist Mental Health Services team works closely with community-based service providers to ensure a strong continuum of care and pathways of support for people accessing our services.

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

2019/20	2020/21	2021/22 Target	2021/22 Result
84%	87%	80%	85%



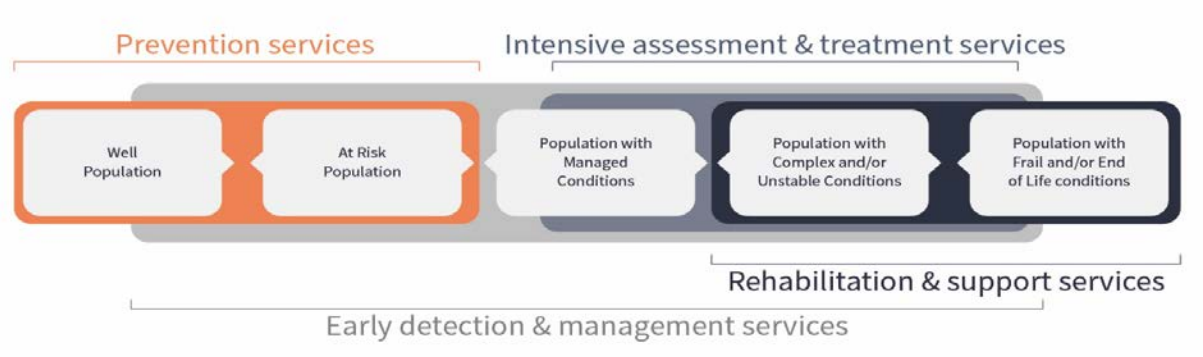
Data Source: National Mental Health KPI Framework. [13]

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

[13] Data for this measure is provided via the national Mental Health KPI programme. Further detail can be found on the national website

4. Ā MĀTOU PUAKITANGA | DELIVERING ON OUR PLANS

4.1 Te Tauākī a Ngā Mahi | Statement of Service Performance



Evaluating our performance

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

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

We also evaluated our performance on an annual basis by providing a forecast of the services we planned to deliver and the standards we expected to meet. The statement of service performance set out in this section presents Canterbury's performance against the 2021/22 forecast, available on our website.

IDENTIFYING PERFORMANCE MEASURES

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

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

Under each service class we identified a mix of service measures that we believed to be important to our community and stakeholders and that would provide a fair indication of how well the DHB performed.

In health, the number of people who received a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time. To ensure a balanced, well rounded picture, the mix of measures identified in our Statement of Service Performance address four key aspects of service performance that matter most to our population:

Access (A)

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

Timeliness (T)

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

Quality (Q)

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

Patient Experience (P)

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

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

SETTING STANDARDS

In setting performance standards for 2021/22, we considered the changing demographic of our population, areas of increasing demand, and the assumption that resources and funding growth would be limited.

While targeted interventions can reduce demand in some areas, there will always be some service areas where we

cannot influence demand, such as maternity, diagnostic, dementia or palliative care services.

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

In areas where we had more influence, targets set for 2021/22 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

2021/22 PERFORMANCE

Going into the 2021/22 year, we were conscious of the operational backlog related to the COVID-19 lockdown in 2020 and the impact alert level restrictions, diversion of staff and COVID-19 outbreaks could have on our system and our service performance.

We knew that many of the national standards could be difficult to meet if we experienced lockdowns or outbreaks and that primary and community service delivery would be interrupted by staff sickness, restrictions around group activities and prioritisation of COVID-19 related services.

The beginning of the 2021/22 year saw the DHB diverting considerable public health, primary care and pharmacy staffing resources to rolling out the COVID-19 vaccination programme across our region – reaching 94% of our population by 30 June 2022.

Our system was then greatly impacted by the COVID-19 outbreak in 2022 with our primary, community and hospital services all stretched to capacity as we responded to demand with a reduction in staffing numbers due to pandemic leave and vacancies, increasing infection control expectations, and alert level restrictions.

Our smaller rural hospitals were closed and residents transferred to aged residential care to ensure continuity of care during the height of the outbreak. Many community-based services, operating from community halls, people's homes, schools and marae were paused to comply with alert level and infection control restrictions and many others had to prioritise service delivery due to staff sickness levels.

With over 176,000 confirmed or probable cases of COVID-19 in Canterbury during the year (largely between March-June 2022), services were required to prioritise urgent and acute demand. Wait times grew across almost all services and many of our normal service delivery targets were not achieved.

The work required to reschedule appointments and catch-up on service delivery was significant and we are grateful to all the people working in our system who supported this work.

People's ongoing commitment and dedication meant Canterbury often maintained service delivery and performance levels above national averages. Considering the extraordinary operating environment and the workforce constraints experienced over the past year, these were pleasing results.

We have included three additional COVID-19 related measures in our Statement of Service Performance for 2021/22 to help highlight to the reader the diversion of health system resources in responding to COVID-19. These cover the delivery of COVID-19 vaccination and testing services. Footnotes have also been added to the document where it has been clear that performance has been impacted by COVID-19.

NOTES FOR THE READER

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

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

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

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

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

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

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

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

SERVICE PERFORMANCE 2021-2022

Population Health Services – Healthy Environments								
These services address aspects of the physical, social and built environment to protect health and improve health outcomes.	Note	29J?=L %JGMH	2019/20 Results	2020/21 Results	□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [14]	Total	96	43	E.70	44	-	↺
Licensed alcohol premises identified as compliant with legislation	Q	Total	100%	92%	90%	94%	-	✓
Tobacco retailers identified as compliant with legislation	Q [15]	Total	97%	83%	90%	-	-	-

[14] The number of submissions varies in a given year and may be higher (for example) when Territorial Authorities are consulting on long-term plans. In the past year the ongoing involvement of a significant proportion of our public health staff in the COVID-19 response meant the team had to reprioritise this work and completed submissions based on the significance of the public health issues addressed and the availability of staff.

[15] New Zealand law prevents retailers from selling tobacco to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years of age) into a tobacco retailer. Due to the diversion of our public health staff onto the COVID-19 response, and changes to alert levels during the year, no CPOs were conducted in the past year.

Health Promotion and Education Services								
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement and healthier choices.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Mothers receiving breastfeeding and lactation support in the community	A	Total	861	943	>600	1,013	n.a	✓
Babies exclusively/fully breastfed at three months	Q[16]	Māori	50%	51%	70%	n.a	n.a	-
		Pacific	54%	50%		n.a	n.a	-
		Total	62%	62%		n.a	n.a	-
People provided with a Green Prescription for additional physical activity	A[17]	Total	5,158	3542	>3,500	2,921	-	✖
Green Prescription participants more active 6-8 months after referral	Q[18]	Total	n.a	n.a	>50%	n.a	-	-
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q[19]	Māori	71%	78%	90%	72%	64%	✖
		Pacific	70%	73%		71%	74%	✖
		Total	73%	78%		75%	67%	✖
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q	Māori	85%	94%	95%	94%	-	↺
		Pacific	88%	91%		95%	-	✓
		Total	84%	93%		93%	-	↺
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[20]	Māori	89%	95%	90%	83%	-	✖
		Total	93%	90%		89%	-	✖

[16] This measure is part of the national Well Child/Tamariki Ora Quality Framework and results are provided by the Ministry of Health, who hold the national contract with Plunket. Results for 2021/22 were not available at the time of printing.

[17] A Green Prescription is a health professional referral for a patient to support them to be more physically active, as part of their health management. The reduction in Green Prescription referrals has been attributed to a combination of the impact of the COVID-19 outbreak and the introduction of the Te Tumu Waiora service in Canterbury. Te Tumu Waiora introduced Health Improvement Practitioners and Health Improvement Coaches into general practices, supporting enrolled patients with activity and nutritional advice as part of a wider mental health and wellbeing response. Patients are able to see the HIP and HIC in the general practice, reducing the need for Green Prescription referrals.

[18] Sport Canterbury picked up and reintegrated the patient experience survey, previously undertaken by Research NZ on behalf of the Ministry of Health, however, results were not available at the time of reporting.

[19] The ABC programme has a cessation focus and refers to health professionals Asking about smoking status, providing Brief advice and providing Cessation support. The reprioritisation of primary care services onto the COVID-19 response, impacted performance over the past year. There were 5,010 fewer people offered brief advice in the 2021/22 period compared with 2020/21, this includes 944 Māori and 131 Pacific people. Improved results are expected as PHO and GP resources shift back to delivering business as usual services.

[20] Stretched capacity across our maternity providers has seen performance drop in this area.

Population-Based Screening Services								
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Note	Target Group	2019/20 Results	2020/21 Results	□□□.□□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Four-year-olds provided with a B4 School Check (B4SC)	A[21]	Māori	91%	92%	90%	73%	65%	✖
		Pacific	80%	91%		65%	59%	✖
		Total	90%	92%		90%	66%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q	Māori	97%	100%	95%	99%	92%	✓
		Pacific	100%	100%		100%	95%	✓
		Total	99%	99%		99%	93%	✓
Women aged 25-69 having a cervical cancer screen in the last 3 years	A[22]	Māori	63%	62%	80%	60%	55%	✖
		Pacific	67%	67%		61%	56%	✖
		Total	70%	73%		72%	67%	✖
Women aged 45-69 having a breast cancer screen in the last 2 years	A	Māori	68%	67%	70%	67%	59%	↺
		Pacific	62%	62%		62%	63%	↺
		Total	73%	76%		76%	66%	✓
People aged 60-74 participating in the national bowel screening programme	A[23]	Māori	new	new	60%	56%	49%	✖
		Pacific	new	new		42%	39%	✖
		Total	new	new		63%	59%	✓

[21] 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. Changing alert levels, school closures, and sickness amongst children and staff has made delivery of this programme challenging in 2021/22. We are expecting service levels to improve in the coming year, there is a strong focus as part of the catch-up programme on engaging with our Māori and Pacific children.

[22] This measure refers to participation in the national cervical screening programme. Performance was impacted by the COVID-19 outbreak and stretched capacity in primary care combined with an increase in the population eligible for the programme with 600 additional women who became eligible for inclusion in the programme over this period, including 460 Māori women. This is a focus area for our system in 2022/23 with self-testing kits one of the things being trialled as a means of increasing rates.

[23] The National Bowel Screening Programme (NBSP) is for people aged 60 to 74, eligible people are invited to complete a faecal immunochemical test (FIT) in the comfort of the own homes and return the test for analysis. The FIT can detect tiny traces of blood in bowel motions that may be an early sign of pre-cancerous polyps (growths) or bowel cancer. If a test is positive, participants are invited for additional screening, usually a colonoscopy. The National Bowel Screening programme went live in Canterbury in October 2020, as such there is no previous data to compare against. All districts have started the programme at different times and so national comparisons should be treated with caution.

Immunisation Services								
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Children fully immunised at eight months of age	A[24]	Māori	90%	87%	95%	85%	72%	×
		Pacific	96%	94%		89%	84%	×
		Total	94%	94%		93%	86%	×
Proportion of eight-month-olds 'reached' by immunisation services	Q	Total	98%	97%	95%	97%	91%	✓
Children fully immunised at two years	A[24]	Māori	92%	88%	95%	81%	70%	×
		Pacific	98%	92%		92%	82%	↺
		Total	94%	94%		91%	84%	×
Young people (Year 8) completing the HPV vaccination programme	A[25]✧	Māori	58%	58%	75%	60%	48%	↺
		Pacific	59%	54%		58%	46%	↺
		Total	62%	64%		70%	54%	↺
Older people (65+) receiving a free influenza ('flu') vaccination	A[26]✧	Māori	42%	54%	75%	50%	53%	×
		Pacific	52%	66%		65%	67%	×
		Total	64%	74%		70%	63%	×
Number of COVID-19 vaccinations delivered in Canterbury	A[27]	Total	-	-	n/a	1.2m	-	-
Proportion of the eligible Canterbury population fully vaccinated (i.e. receiving two COVID-19 vaccination doses)	C[28]	Māori	-	-	90%	84%	77%	×
		Pacific	-	-		84%	80%	×
		Total	-	-		85%	80%	×

[24] Canterbury's childhood immunisation programme continued to be impacted by redeployment of our National Immunisation Register, LinKIDS, Immunisation Outreach and Public Health Nursing teams to support the COVID-19 vaccination programme. Despite the workforce pressures, alert level restrictions and COVID-19 illness amongst staff, children and whānua, Canterbury managed to maintain high performance overall and delivered the second highest rate for the total population and the fourth highest coverage rate for Māori in the country at eight months of age.

[25] 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. While the target was not reached, vaccination numbers increased across all ethnic groups compared with the 2020/21 year which is a positive result considering the COVID-19 and capacity-related challenges faced by primary care and our vaccination teams over the past year.

[26] Influenza vaccinations can reduce the risk of influenza-associated hospitalisations and has 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 over 65 years old and people with long-term or chronic conditions. The number of vaccinations delivered fell by just over 1,600 compared with the previous year, with performance being impacted by the focus on COVID-19 vaccinations, and a significant increase in the 65+ population eligible for vaccinations.

[27] The COVID-19 vaccination measures have been added to our Statement of Service Performance as measures of significant interest to our community and a part of the picture of resource allocation across our system in 2021/22. The vaccination numbers for the first measure reflect total number of vaccinations given in Canterbury and may include vaccinations for people who were visiting or working in the region but not domiciled here. In 2021/22 there were 1,238,912 vaccinations delivered in Canterbury.

[28] Fully vaccinated was defined as two doses of the COVID-19 vaccination having been administered to an individual and people eligible for the COVID-19 vaccination programme as those aged 12 and over. The proportion fully vaccinated included Canterbury residents who received two doses irrespective of where they received those doses – i.e. overseas or in another DHB region. In line with national reporting by the Ministry of Health, the population fully vaccinated was calculated using the Health Service User (HSU) population. Previous results have been removed due to the changes in eligible population and HSU population between years. There was an acknowledged difference between the Statistics New Zealand projected population and the HUS population used for tracking the COVID-19 vaccination programme delivery, however the HSU population enabled closer matching for demographics such as location and ethnicity. For further information relating to the national definitions and calculations refer to the Ministry of Health's 2021/22 Annual Report and the attached additional performance information on page 80.

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.

SERVICE PERFORMANCE 2021-2022

Oral Health Services								
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Children (0-4) enrolled in DHB-funded oral health services	A[29]❖	Māori	86%	82%	95%	80%	-	×
		Pacific	88%	86%		87%	-	↺
		Total	86%	91%		90%	-	×
Children (0-12) enrolled in DHB-funded oral health services receiving their oral health exam according to planned recall	T[29]❖	Māori	87%	87%	90%	81%	-	×
		Pacific	75%	86%		82%	-	×
		Total	87%	88%		83%	-	×
Adolescents (13-17) accessing DHB-funded oral health services	A[30]❖	Total	62%	64%	85%	61%	60%	×

[29] Community Oral health services are delivered in schools and services were greatly impacted by alert level restrictions, school closures and student and staff sickness – the service also reported an increase in reluctance from caregivers to bring children (particularly unvaccinated children) in for check-ups resulting in a significant drop in overall enrolments and attendances, leading to arrears increasing by more than 3,000 children compared with the previous year, including over 700 Māori children. A telephone campaign by the Dental Contact Centre has focussed on rebooking children who were identified as most at risk, to prioritise them for appointments.

[30] Adolescent oral health data was provided by the Ministry of Health, no data was available for Māori or Pacific utilisation. There were 675 fewer adolescents accessing services in 2021 compared with the prior year. COVID-related challenges with staff sickness and changing alert levels impacted on the delivery and uptake of this service in 2021/22.

General Practice Services

These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Note	Target Group	2019/20 Results	2020/21 Results	□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Newborns enrolled with a PHO by three months of age	A	Māori	80%	77%	85%	77%	67%	↺
		Pacific	93%	88%		82%	79%	×
		Total	93%	94%		92%	85%	✓
Proportion of the total Canterbury population enrolled with a Primary Health Organisation (PHO)	A[31]	Māori	84%	83%	95%	83%	83%	↺
		Pacific	98%	93%		91%	97%	×
		Total	95%	94%		95%	94%	✓
Youth (0-19) accessing brief intervention counselling in primary care	A[32Δ]	Total	435	470	>400	261	-	×
Adults (20+) accessing brief intervention counselling in primary care	A[32Δ]	Total	6,187	5,907	>5,500	4,787	-	×
Number of skin lesions (including cancer) removed in primary care	A[33Δ]	Total	2,322	2,219	>2,000	1,905	-	×
Number of integrated HealthPathways in place across the health system	Q[34]	Total	685	832	>600	1,137	-	✓

Long-Term Condition Services

These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Note	Target Group	2019/20 Results	2020/21 Results	□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Number of spirometry tests provided in the community rather than in hospital	A[Δ]	Total	2,128	2,713	>2,000	2,404	-	✓
People receiving subsidised diabetes self-management support when starting insulin	A[35Δ]	Total	320	365	>300	205	-	×
Population identified with diabetes having an HbA1c test in the last year	A[36Δ]	Māori	87%	90%	>90%	88%	-	×
		Pacific	85%	89%		89%	-	↺
		Total	88%	92%		90%	-	✓
Population with diabetes having an HbA1c test and acceptable glycaemic control	Q[Δ]	Māori	61%	62%	>60%	67%	-	✓
		Pacific	56%	57%		61%	-	✓
		Total	71%	72%		75%	-	✓

[31] Population growth within Canterbury continued to impact enrolment rates in Canterbury. The number of people enrolled with a GP increased by 9,500 and the total number of Māori and Pacific enrolments also grew, but less than population growth in the region. A number of general practices in Canterbury have limited enrolments or are closed to new enrolments and we are working closely with PHOs and the LinKIDS service to ensure people are able to access general practice services.

[32] The Brief Intervention Counselling (BIC) service supports people with mild to moderate mental health concerns, including depression and anxiety, providing free counselling sessions (or extended consultations) through both face-2-face and phone consultations. There was a decrease in BIC delivery in 2021/22. Some of this was expected as referrals and access to alternative youth focused mental health and addiction service options along with the Te Tumu Waiora primary mental health support programme increased. There was also an impact on service performance related to COVID-19 challenges including alert level restrictions, primary care capacity and staff and client illness. We are monitoring BIC service numbers alongside the uptake of the Te Tumu Waiora programme to ensure continued access to primary mental health services in our region.

[33] Skin lesion excision is a subsidised procedure in Canterbury that supports timely access to the removal of potentially dangerous skin cancers in a primary care setting that would otherwise require a specialist appointment. While this service is demand-driven, a reduction in people accessing general practice during COVID-19 was likely to have contributed to lower volumes seen this year.

[34] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The growth in HealthPathways was a result of new pathways being developed during the COVID-19 response.

[35] Diabetes support when starting insulin is a subsidised service provided in general practice which aims to help people manage their diabetes with training and information on using insulin. Alert level restrictions and prioritised capacity in general practice have impacted on service delivery.

[36] An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's diabetes. A level of less than 64mmol/mol reflects an acceptable blood glucose level. There were 392 more people having an annual test in 2021/22 compared with the previous year, including 33 Māori and 67 Pacific people. However, the number of people identified with diabetes (and eligible for a diabetes annual review) grew faster than testing capacity over the past year. This remains an area of focus for 2022/23.

Pharmacy and Referred Services								
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Note	Target Group	2019/20 Results	2020/21 Results	□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Number of laboratory tests completed for the Canterbury population	A[37Δ]	Total	2.8m	3.4m	E<2.8m	3.3m	-	✖
Number of COVID-19 laboratory tests processed	A[38]	Total	-	207,401	-	361,802	-	-
Number of subsidised pharmaceutical items dispensed in the community	A[Δ]	Total	7.6m	8.7m	E<10m	8.7m	-	✓
People on multiple medications receiving medication management support	A[39Δ]	Total	896	652	>1,200	326	-	✖
Number of community-referred radiology tests completed	A[Δ]	Total	51,614	59,864	E>55,000	58,435	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T[40]	Total	80%	72%	90%	73%	90%	↺
People receiving their MRI scans within six weeks	T[41]	Total	76%	74%	90%	81%	58%	↺
People receiving their CT scans within six weeks	T[41]	Total	93%	95%	95%	88%	78%	✖

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

[38] This number reflects the COVID-19 tests processed by the Canterbury DHB's Laboratory Services during the 2021/22 year, irrespective of where the person being tested lived. Canterbury Health Laboratories provided significant support to the North Island DHBs during the COVID-19 response. This measure was added to the Statement of Service Performance as a measure of significant interest to our population, in terms of the use of resource to support the COVID-19 outbreak. No estimates or targets were set in relation to the measure.

[39] The Medical Management Review programme was established to help ensure the safe and appropriate use of medications. Service levels dropped over the last two years and over the last year the COVID-19 outbreak and additional demands on pharmacy teams meant the programme uptake dropped dramatically. This programme ceased in June 2022 however medication management support, available under the Long-term Conditions Pharmacy Service, continues and is being strengthened, there are over 16,500 people supported by the Long-term Conditions Pharmacy Service in Canterbury.

[40] Recruitment challenges and COVID-related staff sickness continued to impact delivery of colonoscopy services this year. A focus on booking in people who had been waiting over the maximum wait time has been positive. Recruitment of staff and the planning of new procedure rooms is underway which will increase capacity and output in the coming year.

[41] Demand for MRI and CT scans remained high and capacity issues continued to impact wait times. We were pleased MRI wait times improved compared with the previous year - an additional 1,059 MRI scans were completed within the target timeframe compared to 2020/21. However, the service struggled to meet demand for CT scans. Additional clinics are being held as well as outsourcing to improve throughput and reduce waits.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

SERVICE PERFORMANCE 2021-2022

Quality and Patient Safety								
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Note	Target Group	2019/20 Results	2020/21 Results	□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Staff compliant with good hand hygiene practice	Q[42]◇	Total	82%	84%	80%	87%	87%	✓
Inpatients (aged 75+) receiving a falls risk assessment	Q[43]◇	Total	92%	95%	90%	98%	-	✓
Response rate to the national inpatient patient experience survey	P	Total	19%	16%	>30%	19%	-	↺
Proportion of patients who felt 'hospital staff included their family/whānau or someone close to them in discussions about their care'	P[44]	Total	65%	68%	>65%	62%	-	×

Specialist Mental Health and Alcohol and Other Drug (AOD) Services								
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Note	Target Group	2019/20 Results	2020/21 Results	□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Proportion of the population (aged 0-19) accessing specialist mental health services	A[45Δ]	Māori	6.1%	5.7%	>3.1%	5.3%	4.2%	✓
		Pacific	2.3%	2.4%		2.1%	2.2%	×
		Total	4.1%	4.3%		4.2%	3.8%	✓
Proportion of the population (aged 20-64) accessing specialist mental health services	A[45Δ]	Māori	10.6%	8.8%	>3.1%	8.7%	7.1%	✓
		Pacific	4.8%	3.7%		3.5%	3.5%	✓
		Total	4.0%	3.7%		3.7%	3.7%	✓
People referred for non-urgent mental health and AOD services seen within 3 weeks	T[46]	Total	67%	70%	80%	74%	79%	↺
People referred for non-urgent mental health and AOD services seen within 8 weeks	T[46]	Total	83%	88%	95%	90%	94%	↺

[42] Quality results are provided in arrears - for 2021/22 for hand hygiene refers to the last completed quarter January to March 2022. Further detail and results for previous years can be found at www.hqsc.govt.nz.

[43] Falls assessments data are no longer being reported by the Health, Quality and Safety Commission. The result presented above is locally collected for the quarter to June 2022, in line with previously reported HQSC data.

[44] Canterbury's quality and safety team continue to monitor these results and work through solution to improve uptake and experience of patients.

[45] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. Pacific access rates are lower than other population groups and our specialist services have been working with a local Pacific provider to establish a mental health pathway to ensure people can access the services they need.

[46] Mental health wait time results are provided three months in arrears and results reflect the twelve months to March 2022. Continued demand and the increased complexity of people accessing our specialist mental health and addiction services put pressure on our capacity to respond quickly and while targets were yet to be met, progress is being made in reducing wait times. We invested in an acute alternative

Maternity Services

While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Number of maternity deliveries in Canterbury DHB facilities	A	Total	5,943	6,236	E.6,000	6,093	-	✓
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[47]❖†	Māori	69%	75%	80%	n.a	-	-
		Pacific	65%	69%		n.a	-	-
		Total	82%	85%		n.a	-	-
Proportion of maternity deliveries made in primary birthing units	Q[48]	Total	16%	16%	>13%	14%	-	×

Acute and Urgent Services

Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Early intervention can reduce the impact of the event and shorter waiting times are indicative of a responsive system.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Number of acute demand packages of care provided in the community	A[49Δ]	Total	35,547	38,775	>30,000	42,414	-	✓
Number of presentations at Canterbury Emergency Departments (ED)	A	Total	104,907	116,599	E.110k	116,963	-	✓
People admitted, discharged or transferred from Canterbury EDs within 6 hours of presentation	T[50]	Māori	92%	90%	95%	82%	86%	×
		Pacific	92%	90%		85%	78%	×
		Total	91%	88%		82%	79%	×
Proportion of the population presenting to ED (per 1,000 people)	Q	Total	181	202	E.<190	198	222	✓
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral	T	Total	96%	95%	90%	91%	84%	✓

in the community that offered a peer-led residential service that worked closely with our specialist services to provide options for people with acute needs and supported a network of providers to expand mental health and addictions support for young people. The Te Tumu Waiora primary mental health service is also in place in the region with Health Improvement Practitioners and Health Coaches operating out of general practice to enable an earlier response to people's mental health needs. We expect that this investment will reduce demand over time by supporting earlier intervention for our population.

[47] Data is sourced from the national Maternity Clinical Indicators report. Results for 2021 are yet to be released.

[48] Our aim is 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. Fewer over-all deliveries in 2021/22 impacted results this year. The opening of our primary birthing unit in Selwyn in May of 2022 will enable more births closer to home in one of Canterbury's fastest growing regions.

[49] Acute demand packages of care are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people in their own homes or in the community rather than having people presenting to ED or hospital for treatment. Growth reflected the increasing Canterbury population as well as the increase in acute care volumes which are being experienced nationally.

[50] This indicator was a national DHB performance measure and excludes those who did not wait in ED or had pre-arranged appointments. Wait times were impacted by the sustained high ED presentation volumes as well as workforce challenges and COVID-19 impacting staffing levels. A programme of work focused on reducing ED pressure and improving the flow of patients across our hospital services to reduce wait times continues alongside work being undertaken nationally.

Elective and Arranged Services								
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Note	Target Group	2019/20 Results	2020/21 Results	□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Number of First Specialist Assessments provided	A[51]	Total	55,218	55,891	E.60,000	49,171	-	×
Proportion of patients waiting less than four months for their first specialist assessment	T[51]◇	Total	71%	87%	100%	73%	74%	×
Proportion of First Specialist Assessments that were non-contact (virtual)	Q[52]	Total	13%	14%	>15%	23%	-	✓
Number of planned care intervention delivered	A[53]	Total	31,013	42,886	31,695	36,344	-	✓
Proportion of patients given a commitment to treat and treated within four months	T[54]◇	Total	73%	81%	100%	56%	59%	×
Proportion of people receiving their surgery on the day of admission	P	Total	85%	90%	>85%	91%	-	✓
Number of outpatient consultations provided	A	Total	630,837	675,407	E.650k	646,536	-	✓
Outpatient appointments where the patient was booked but did not attend their appointment	Q	Māori	7%	7%	<5%	7%	-	↺
		Pacific	10%	11%		10%	-	↺
		Total	4%	4%		4%	-	✓

[51] A First Specialist Assessment (FSA) is the assessment undertaken by a specialist following referral by a patient's primary care practitioner to determine the treatment to be delivered. Delivery of FSAs were impacted by COVID-19 demand and COVID-related workforce challenges across our hospital services and in primary care. A national programme of work is underway to address Planned Care delivery impacted by COVID.

[52] Non-contact or virtual FSAs improve public access to planned care services while reducing the need for unnecessary travel. The increase in rates was a result of the fewer FSAs being delivered and a desire to maintain social distancing in the COVID-19 environment. There is a focus nationally to support more tele-health service options, improving access especially for people who live in more rural areas.

[53] The planned care intervention measure recognises the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing, including those delivered in community settings. There were 15,680 inpatient discharges, 20,036 minor procedures and 628 non-surgical interventions completed in 2021/22.

[54] The delivery of Elective (planned) care was severely impacted by the COVID-19 outbreak, with changes in alert levels and increased infection prevention protocols during the outbreak limiting the number of people that could be seen, the number of COVID-19 patients being cared for in our hospitals reducing spare capacity along with impact of COVID-related workforce challenges across our hospital services. Since March 2022, urgent and non-deferrable planned care services were prioritised meaning lower-level and less urgent care was deferred and wait times increased. This was a national issue and a Te Whatu Ora Planned Care Taskforce is now in place to help improve capacity and increase planned care output across all the country.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

SERVICE PERFORMANCE 2021-2022

Assessment, Treatment and Rehabilitation (AT&R) Services								
These services restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Service utilisation is monitored to ensure people are being appropriately supported after an event.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
People accessing community-based pulmonary rehabilitation courses	A[55]	Total	227	215	>250	195	-	×
People (65+) accessing the community-based falls prevention service	A[56]	Total	1,852	1,889	>1,500	1,729	-	✓
People supported by community rehabilitation and support services	AΔ	Total	1,686	1,622	>1,600	1,938	-	✓
Proportion of inpatients referred to an organised stroke service after an acute event	Q[57]	Total	86%	72%	80%	57%	-	×
Proportion of AT&R inpatients discharged to their own home rather than into Aged Residential Care	Q	Total	84%	85%	>80%	85%	-	✓

[55] Pulmonary rehabilitation programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (obstructive lung disease) to manage their symptoms and better manage their condition. The low volumes in 2021/22 were a result of COVID-19 challenges relating to alert level restrictions where community programmes were typically put on hold for the safety of these very vulnerable patients. A trial during the last outbreak enabled some sessions to continue with additional infection prevention controls and fewer participant numbers. We anticipate these programmes getting back on track in 2022/23 with restrictions lifting.

[56] 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. The number of falls prevention classes delivered in people's homes dropped this year as COVID-19 precautions impacted delivery, especially to vulnerable populations. We anticipate these programmes getting back on track in 2022/23 with restrictions lifting.

[57] Several factors impacted the referral of stroke patients to a stroke ward over the past year, with staffing pressures and hospital flow creating challenges. Additional auditing of stroke patient flow is being undertaken to improve rates including enabling duty nurse managers to make moving eligible patients to a stroke ward a priority. We are closely tracking the performance here and anticipate improvement in the coming year.

Home-Based and Community Support Services

These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
People supported by district nursing services	A[Δ]	Total	8,568	9,299	E. >7,000	9,346	-	✓
People supported by long-term home-based support services	A[Δ]	Total	7,870	8,120	E. >8,000	7,323	-	✓
Proportion of the population (65+) supported by long-term, home-based support services	A[58Δ]	Total	8.0%	8.5%	E. 10%	7.5%	-	×
People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI tool	Q[59Δ]	Total	91%	89%	95%	88%	-	×
People supported by hospice or home-based palliative services	A[Δ]	Total	3,509	3,544	E. 3,700	3,701	-	✓
Number of Advance Care Plans registered to support end of life care	A[60]	Total	782	928	>700	487	-	×

Respite and Day Support Services

These services provide people with a break from a routine or regimented programme, so that crisis can be averted, or a specific health need can be addressed. Largely demand driven, service utilisation is monitored to ensure services are accessible.	Note	Target Group	2019/20 Results	2020/21 Results	□□□□ □□ 29J?=L	2021/22 Results	2021/22 NZ Av	
People supported by community-based mental health crisis respite services	A[61Δ]	Total	754	854	E.1,000	n.a.	-	-
Occupancy rate of mental health crisis respite beds	A[61Δ]	Total	74%	68%	85%	n.a.	-	-
Older people supported by day care services	A[62Δ]	Total	297	497	E.550	424	-	-
Older people accessing aged care respite services	A[Δ]	Total	1,192	1,205	E.1,000	1,091	-	✓
Older people supported by aged care respite services, being discharged to their own home	Q[Δ]	Total	88%	88%	>80%	88%	-	✓

[58] The reduction in people supported by long-term home-based support was the result of workforce shortages as COVID-19 spread through the community. A review of service capacity during the outbreak led to the prioritisation of services to ensure the people with the greatest need received support. Staffing challenges and shortages remain a challenge and we are working with our providers to support ongoing service delivery.

[59] 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. Performance was reflective of a national shortage of community-based nurses trained to complete InterRAI assessments and capacity at the height of the COVID-19 outbreak. Services were put in place while an assessment was being arranged.

[60] An advance care plan is a written record that includes people's wishes, preferences, values and goals relevant to all their current and future medical care, written after discussion with the person/their whānau and their healthcare team. Over 90% of Advance Care Plans were developed in general practice and this work was significantly impacted by the COVID-19 outbreak and capacity of general practice over the past year. We anticipate that this work will pick back up now that COVID-19 restrictions have lifted.

[61] Changes to national collections/reporting for PRIMHD data meant crisis respite numbers were incomplete and not comparable with previous years. We have chosen not to report the 2021/22 results while we work with the PRIMHD team and providers to address data completeness and definitions.

[62] There was a reduction in the number of older people reported as being supported by day care services in the 2021/22. However, the result reported excludes data from three providers (partially or wholly) so cannot be considered a full-year result. We are working with these providers to resolve reporting issues and determine the full result for the year.

Aged Residential Care Services								
The DHB subsidised ARC for people who met the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Note	Target Group	2019/20 Results	2020/21 Results	□□□.□□ 29J?=L	2021/22 Results	2021/22 NZ Av	
Proportion of the population (75+) accessing rest home level ARC services	A[63Δ]	Total	4.0%	4.1%	E.<4.5%	3.8%	-	✓
Proportion of the population (75+) accessing hospital-level ARC services	A[Δ]	Total	6.0%	6.1%	E.6.0%	6.0%	-	✓
Proportion of the population (75+) accessing dementia ARC services	A[Δ]	Total	2.5%	2.7%	E. 2.5%	2.7%	-	✓
Proportion of the population (75+) accessing psychogeriatric ARC services	A[Δ]	Total	0.7%	0.7%	E. <1%	0.7%	-	✓
People entering ARC having had a clinical assessment using InterRAI	Q[64Δ]	Total	87%	90%	95%	90%	89%	↺

[63] The Canterbury region has higher ARC rates than national levels. 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 ageing of our population. Measures refer to people who accessed DHB funded ARC services and exclude people who chose to enter ARC privately or people living independently in retirement villages.

[64] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services. The DHB continues to work with ARC service providers to encourage the use of the InterRAI tool. Shortages in trained assessors impacted on performance against the national targets.

5. WHAKAHAERETIA Ā MĀTOU MAHI | MANAGING OUR BUSINESS

5.1 Te Whakaruruhau Rangatōpū | Corporate Governance

Statutory Information

This Annual Report presents Canterbury DHB's financial and non-financial performance for the year ended 30 June 2022 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

Board's Report & Statutory Disclosure

PRINCIPAL ACTIVITIES

Canterbury DHB was a New Zealand based District Health Board (DHB), which provided health and disability support services principally to the people within our region, and beyond for certain specialist tertiary services.

RESULTS

During the year, Canterbury DHB recorded a deficit of $222.307M, against a budget of $149.007M deficit (2020/21: deficit of $177.131M against the budgeted $145.006M deficit).

BOARD FEES

Board and Committee fees paid, or payable, to current Board and Committee Members for services as at 30 June 2022 were as follows:

	Board Fees $	Committee Fees $
Hon Sir John Hansen	63,522	2,500
Gabrielle Huria	39,698	2,000
Aaron Keown	31,759	1,250
Andrew Dickerson	31,759	4,000
Barry Bragg	31,759	4,125
Catherine Chu	31,759	1,500
Fiona Pimm	31,759	500
Gordon Boxall	-	750
Ingrid Taylor	31,759	3,500
James Gough	31,759	3,750
Jan Edwards	-	1,250
Jo Kane	31,759	4,750
Michelle Turrall	-	250
Naomi Marshall	31,759	2,313
Olive Webb	-	750
Peter Ballantyne	-	2,500
Rawa Karetai	-	1,000
Rochelle Faimalo	-	1,000
Rochelle Phipps	-	750
Steve Wakefield	-	2,500
Tom Callanan	-	750
Yvonne Palmer	-	1,000
Total	389,051	42,688

Total fees paid, or payable for the year were $431,739 (2020/21: $407,574).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	BOARD		QFARC		HAC		CPH&DSAC	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Sir John Hansen	11	12	10	11				
Gabrielle Huria	11	12	8	11				
Peter Ballantyne			10	11				
Gordon Boxall							3	4
Barry Bragg	12	12	11	11	4	5		
Tom Callanan							3	4
Catherine Chu	11	12			2	5	4	4
Andrew Dickerson	11	12	11	11	5	5		
Jan Edwards					5	5		
Rochelle Faimalo							4	4
James Gough	10	12	10	11	5	5		
Jo Kane	9	12	11	11	4	5	4	4
Rawa Karetai							4	4
Aaron Keown	12	12					4	4
Naomi Marshall	10	12			5	5	4	4
Yvonne Palmer							4	4
Rochelle Phipps					3	5		
Fiona Pimm	11	12					2	4
Ingrid Taylor	11	12	11	11	4	5		
Michelle Turrall					1	5	0	4
Steve Wakefield			10	11				
Olive Webb							3	4

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

DIRECTORS' FEES

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

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

DIRECTORS' FEES	2022 $'000	2021 $'000
Brian Wood	22	29
Claire Evans	16	12
Erin Black	1	11
Gail Gibson	11	8
Jane Cartwright	23	23
Kath Fox	2	11
Julie Hands	8	-
Paula Rose	-	1
Stella Ward	8	8
Steve Wakefield	37	33
Total	128	136

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD OR SUBSIDIARIES' INFORMATION

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

INFORMATION ON MINISTERIAL DIRECTIONS

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

ELIGIBILITY DIRECTION

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

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

AUTHENTICATION SERVICES DIRECTION

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

WHOLE OF GOVERNMENT APPROACH

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

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

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

COVID-19 RESPONSE DIRECTION

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

Several associated directives, epidemic notices and orders have since been issued by the Government to manage specific matters during the COVID-19 pandemic and the DHB worked in line with this national direction. The direction from the Minister of Health on COVID-19 Response 2020 issued on 17 March 2020 pursuant to Section 32 of the New Zealand Public Health and Disability Act 2000 and Section 103 of the Crown Entities Act 2004, applied for the year ended 30 June 2022.

5.2 Ā Mātou Hua Pūmau | Our Assets

Asset management and performance

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

The DHB had an Asset Management Plan that helped to inform our planning of capital requirements and investment decisions. This identified the condition of those assets and any planned refurbishment, upgrades or replacements. We aggregated our assets into three major portfolio areas that covered the majority of those assets considered significant (critical) to the delivery of core services.

ASSET PORTFOLIO	Asset Classes Within Portfolios	Asset Purpose	NET BOOK VALUE		
			2019/20	2020/21	2021/22
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	$737M	$1,337M	$1,457M
Clinical Equipment	Equipment	To enable the delivery of health services through diagnosis, monitoring or treatment	$53M	$95M	$99M
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of health services by aiding decision making at the point of care	$50M	$48M	$42M

The DHB developed a set of performance metrics, for use in internal management and decision-making processes, including relevant indicators of performance. These measures were reviewed annually as part of improving the maturity of the performance measures and to ensure currency and relevance.

PROPERTY PORTFOLIO					
Asset Performance Indicators	Indicator Class	2019/20	2020/21	2021/22 Standard	2021/22 Result
Percentage of the critical property portfolio with a National Building Standard at or greater than 34% [65]	Condition	84.0%	81.0%	90%	81.0%
Theatre Utilisation [66]	Utilisation	89.0%	88.1%	>85%	87.3%
Energy consumption per sqm (kWh/sqm) [67]	Other	412.70	350	<500	404

[65] All critical property, i.e. providing or supporting the provision of critical clinical services, should have a National Building Standard at or greater than 34%. The DHB was engaged in a significant redevelopment/remediation/repair programme following the earthquakes and had been progressively working to restore buildings to this standard. Some of the projects on this list are dependent on the masterplan, plans for regional development and completion of the new energy centre. In addition, there have been delays caused due to the COVID-19 pandemic.

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

[67] The Energy Consumption measure is based on the Code of Practice NZS4220: 1982 Energy Conservation standard which applies to non-residential buildings and specifies targets for existing buildings. This is an indicator of the functionality of assets implemented to help reduce energy consumption.

CLINICAL EQUIPMENT PORTFOLIO					
Asset Performance Indicators	Indicator Class	2019/20	2020/21	2021/22 Standard	2021/22 Result
Percentage of Linacs compliant with the requirements of the Radiation Safety Act	Condition	100%	100%	100%	100%
Percentage of CTs compliant with the requirements of the Radiation Safety Act	Condition	87.5%	75.0%	100%	100%
Percentage of X-Ray rooms compliant with requirements of the Radiation Safety Act [68]	Condition	95.0%	89.3%	100%	96.4%
Linacs - scheduled Radiation treatment hours as a percentage of available treatment hours [69]	Utilisation	90.4%	96.6%	>85%	93.8%
Percentage of diagnostic monitors meeting RANZCR QA requirements for primary monitors [70]	Functionality	100%	100%	>95%	100%
Percentage of MRI Scanners compliant with requirements of ACR annual quality checks [71]	Functionality	100%	100%	100%	100%
Percentage of Diagnostic Ultrasound machines meeting the IANZ specified industry accepted standards [72]	Functionality	100%	100%	100%	100%
Percentage of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first cancer treatment within 62 days of referral [73]	Other	96.0%	95%	>90%	90.8%

INFORMATION COMMUNICATION AND TECHNOLOGY (ICT) PORTFOLIO					
Asset Performance Indicators	Indicator Class	2019/20	2020/21	2021/22 Standard	2021/22 Result
Condition of servers to mitigate against cyber-attacks. Percentage of servers patched (not more than 15 patches outstanding) with critical and security updates	Condition	95.0%	95.2%	>95%	93.2%
HealthOne page views	Utilisation	96,681	119,257	>50,000	128,752
Security Penetration/Vulnerability Test - Internally Hosted Internet Facing Websites	Functionality	2.30	26.1	<11	14.3
Security Penetration/Vulnerability Test - Externally Hosted Internet Facing Websites	Functionality	-	24	<50	25.8
Percentage of ICT devices complaint with asset age replacement policy for Laptops, Tablet, PCs, Switches and Servers [74]	Condition	-	48.0%	>60%	61.0%
Network Bandwidth Capacity Usage [75]	Utilisation	-	0.5%	<30%	0.5%

[68] One failure from a fleet of 28 X-Ray rooms. The replacement equipment has been scheduled to be installed.

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

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

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

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

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

[74] The CDHB ICT asset replacement guidelines outline the recommended replacement age requirement for different ICT assets: PCs <5yrs, Laptops <4yrs, Tablets <3yrs, Servers <5yrs and Switches <5yrs. The asset age is calculated as an average age of all ICT assets.

[75] The Network Bandwidth Capacity Usage measures (as a percentage of time) the amount of time the ICT systems usage (through the Core Network Switches) is running at peak bandwidth usage. The peak bandwidth usage is set at 80% of the total Network bandwidth capacity.

5.3 Ā Mātou Tāngata | Our People

People at the heart of all we do

To work toward realising our vision for the Canterbury health system, and consistent with our organisational values, Canterbury DHB was committed to being a good employer and a great place to work and develop.

Fundamentally, healthcare is about people caring for people. To deliver high quality care to the community, the Canterbury health system put people – and their care – at the centre of all decisions. For this to happen a culture where we care for our people, as much as we care for our patients was essential.

Leadership, accountability and culture

Delivering on our commitment to care for our people and put them at the centre of all our decisions required leadership that was responsive and accountable to our people.

To implement a broad network of widely distributed clinical and operational leadership, the 20 DHBs committed to enabling a collective approach to talent management and leadership development that was underpinned by the Public Services Commission framework used by the core public sector. This approach allowed us to create transferable leadership skills across DHBs and the public sector.

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

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

The helmleaders.org website underwent an update and review to meet basic Web Content Accessibility Guidelines (WCAG) as part of our organisation signing the Ministry of Social Development's accessibility charter.

STAFF MIX BY AVERAGE AGE	
Medical	40
Nursing	44
Allied Health	43
Support	50
Management & Administration	49

STAFF MIX BY GENDER		
Female	9,444	80%
Male	2,317	20%
	11,761	

STAFF IDENTIFYING AS HAVING A DISABILITY[76]	
Yes	300

STAFF ETHNICITY[77]	
New Zealand European	4,903
Other European	1,275
Other Ethnicity	595
European	337
Other Asian	473
Southeast Asian	383
Māori	318
Indian	359
Chinese	269
African	57
Fijian	41
Samoan	60
Middle Eastern	31
Latin American	19
Tongan	17
Cook Islands Māori	16
Other Pacific Peoples	15
Unknown	2,593
Grand Total	11,761

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

[77] Source: Payroll as at 25 July 2022

Recruitment, selection and induction

Canterbury DHB was committed to a shared approach to talent acquisition and management including attracting, selecting and engaging people across the Canterbury health system, regionally and nationally for the needs of today and into the future. We continuously reviewed our workforce strategies to ensure that we could attract, source and identify top talent to meet our community's needs. Our primary objective was to support an integrated Canterbury health system by maximising opportunities that resulted in faster recruitment turnaround and more engaged employees; and ultimately improved the patient journey and outcomes throughout the Canterbury health system.

We were fully committed to enhancing our practices with respect to equity and diversity. There was a significant focus on ensuring our recruitment, selection and induction processes were equitable and embraced the development of a diverse workforce. Partnering with Mana Taurite we implemented a policy that ensured all Māori and Pacifica who meet job role requirements will go straight to interview. Along with implementing new recruitment campaigns specifically targeting these areas of the community we promoted the Canterbury health system as a rewarding career choice.

Workplace safety, health and wellbeing

We were committed to supporting and further developing a safe and healthy workplace. This focus was supported by professional leads in Wellbeing, Health and Safety. Our teams included experts in workplace safety, occupational health, rehabilitation, and employee mental health and wellbeing. In addition to working alongside our people and health and safety representatives, advice and support were provided to all levels of management.

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

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

- Promotion of a safe work environment and safe work practices;
- Critical risk management and injury prevention programmes;
- Workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training;
- Health monitoring programme which includes screening and immunisation;
- Free annual influenza vaccinations;
- An online hub, where wellbeing resources can be easily accessed by all staff;
- Development of new wellbeing resources to support our people with emerging needs;
- Provision of face to face wellbeing sessions for teams;
- Sharing our key resources nationally, so that all health staff can benefit from them;
- Facilitating connecting to care for our people if they need mental health support;
- Providing mental health expertise to our HR Advisory team and Injury Management Team, to help them better support our staff.

In response to feedback from our leaders, a trial of an alternative approach to staff welfare was started, whereby a welfare advisor was embedded in our Specialist Mental Health Service. Their role is to provide both proactive (e.g. wellbeing sessions) and reactive (e.g. supporting managers to look after their staff following an assault) wellbeing support for staff. The hope is that this approach will provide improved quality of support.

We enabled our people to be and stay well at work through our injury prevention programmes and actively support them to return to work following an injury, illness or other life event.

We did not tolerate any form of harassment, workplace bullying or discrimination. We were continually improving our policies, procedures and responses when issues of bullying, harassment or discrimination arise. This included a programme of work to improve our policies, a Code of Conduct, and enabling manager capability to address issues and integrate restorative workplace practises. We continued to improve our people's access to advice and resolution services when they were not having a positive experience at work.

Equal opportunities and positive behaviours

Canterbury DHB was committed to practices which minimised all forms of discrimination, bullying and harassment in the workplace, as well as barriers to the recruitment, retention, development and promotion of our employees. A newly established Equity, Diversity and Inclusion kapa (team) was created within our People and Capability function in August 2021. Over the past year this new workforce development kapa has led a number of key initiatives to better hire, support and grow our diverse workforce with a particular focus on our Māori workforce as well as Pacific peoples, tāngata with disabilities, our LGBTQIA+ workforce and other minority groups, thereby enabling us as an organisation to better reflect the community we serve. As part of our commitment to equity, diversity and inclusion, some of our key initiatives have included:

- Adopting new, fresh mana enhancing recruitment campaigns to attract Māori and Pasifika into our entry level career path opportunities;
- Creating a culture of authentic belonging for all our kaimahi (staff) by celebrating and honouring key dates and events in our calendar;
- Designing and implementing a growing Māori leaders programme, Tū Tangata Tū Rangatira, an in-depth programme that spans over nine-months;
- Supporting the implementation of the CDHB Disability Action Plan, including supporting Project Search, which provides internship opportunities for young people with intellectual disabilities.

We continued to review our processes and practices, deliver organisational initiatives and learning, and ensured we continued to review our talent acquisition and development practices to enable all people to be successful.

We also addressed poor behaviour and practices through informal and formal ER processes as appropriate.

Remuneration, recognition and conditions

Canterbury DHB was committed to applying fair and equitable remuneration and reward practices, taking into account our internal environment and external market relativities as well as the financial environment we operate within.

Most of our employees were on Multi Employer Collective Agreements that were negotiated nationally. Remuneration of employees on Individual Employment Agreements (IEA) that were not under union coverage were reviewed on an annual basis based on external market data.

Culture and engagement

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

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

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

Due to the pandemic and movement towards Te Whatu Ora Health New Zealand, follow up surveys were put on hold. We continued employee engagement and satisfaction with targeted workshop interventions when possible across the organisation.

Employee development and promotion

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

Our people had access to a broad range of leadership and managerial capability building. These development opportunities were structured to support effective transition between different roles and leadership contexts, which were supported through our leadership and management platform.

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

6. NGĀ MAHI AHUMONI | FINANCIAL PERFORMANCE

6.1 Ngā Wero Ahumoni | Meeting Our Financial Challenges

STATEMENT OF COMPREHENSIVE REVENUE & EXPENSE *for the year ended 30 June 2022*	Notes	Actual 2022 $'000	Budget 2022 $'000	Actual 2021 $'000
REVENUE				
Patient care revenue	2 [p47]	2,379,156	2,168,402	2,073,834
Other revenue	3 [p49]	83,803	63,305	52,203
Interest revenue		1,596	700	1,075
Total revenue		2,464,555	2,232,407	2,127,112
EXPENSE				
Employee benefit costs	4 [p49]	1,205,266	1,049,643	1,019,772
Treatment related costs		228,873	204,874	177,141
External service providers		953,155	851,785	844,188
Depreciation and amortisation		95,663	92,104	90,315
Finance costs		3,211	3,115	2,210
Other expenses	5 [p50]	146,778	125,944	130,746
Capital charge expense	6 [p51]	53,916	53,949	39,871
Total expense		2,686,862	2,381,414	2,304,243
Net Surplus/(deficit)		(222,307)	(149,007)	(177,131)
OTHER COMPREHENSIVE REVENUE & EXPENSE				
Revaluation of land and buildings	7,14 [pp51,57]	141,652	-	95,482
Total comprehensive revenue & expense	27[p74]	(80,655)	(149,007)	(81,649)

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY ***for the year ended 30 June 2022***	Notes	Actual 2022 $'000	Budget 2022 $'000	Actual 2021 $'000
Total equity at beginning of the year		1,124,844	1,125,762	490,730
Total comprehensive revenue & expense for the year		(80,655)	(149,007)	(81,649)
EQUITY INJECTIONS:				
Equity support	7 [p51]	80,000	153,000	180,000
Earthquake capital redrawn	7 [p51]	33,000	28,000	9,650
Mental Health facility drawdown	7 [p51]	30,373	69,357	1,435
Waipapa facility – Crown contribution	7 [p51]	-	-	525,050
Donated assets – Crown contribution	7 [p51]	-	-	1,489
EQUITY REPAYMENTS:				
Repayment of equity – annual depreciation funding		(1,861)	(1,861)	(1,861)
Total equity at end of the year	7 [p51]	1,185,701	1,225,251	1,124,844

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION *as at 30 June 2022*	Notes	Actual 2022 $'000	Budget 2022 $'000	Actual 2021 $'000
CROWN EQUITY				
Contributed capital	7 [p51]	1,267,934	1,374,917	1,126,422
Revaluation reserve	7 [p51]	656,485	518,818	514,833
Accumulated surplus / (deficit)	7 [p51]	(738,718)	(668,484)	(516,411)
Total equity		1,185,701	1,225,251	1,124,844
REPRESENTED BY:				
CURRENT ASSETS				
Cash and cash equivalents	8 [p52]	80,145	120,487	50,775
Trade and other receivables	9 [p53]	170,194	113,435	113,435
Inventories	10 [p54]	13,728	13,811	13,811
Restricted assets	18 [p64]	14,636	15,094	15,095
Investments	11 [p55]	2,750	750	750
Total current assets		281,453	263,577	193,866
CURRENT LIABILITIES				
Trade and other payables	12 [p55]	202,141	155,220	159,290
Employee benefit liabilities	13 [p56]	507,765	381,696	381,697
Restricted liabilities	18 [p64]	14,652	15,110	15,111
Borrowings	19[p65]	1,480	1,682	1,280
Total current liabilities		726,038	553,708	557,378
Net working capital		(444,585)	(290,131)	(363,512)
NON-CURRENT ASSETS				
Property, plant and equipment	14,16 [pp57,62]	1,650,103	1,529,834	1,493,358
Intangible assets	15, [p61]	40,037	37,865	50,310
Investment in joint venture	25, [p7061]	3,426	4,253	1,660
Restricted assets	18 [p64]	16	16	16
Total non-current assets		1,693,582	1,571,968	1,545,344
NON-CURRENT LIABILITIES				
Employee benefit liabilities	13 [p56]	8,013	7,544	7,544
Borrowings	19 [p65]	55,283	49,042	49,444
Total non-current liabilities		63,296	56,586	56,988
Net assets		1,185,701	1,225,251	1,124,844

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS ***for the year ended 30 June 2022***	Notes	Actual 2022 $'000	Budget 2022 $'000	Actual 2021 $'000
CASH FLOW FROM OPERATING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Receipts from Ministry of Health		2,233,913	2,091,407	2,009,011
Other receipts		168,142	140,300	123,138
Interest received		1,596	700	1,075
		2,403,651	2,232,407	2,133,224
CASH WAS APPLIED TO:				
Payments to employees		1,052,765	1,029,965	956,828
Payments to suppliers		1,321,879	1,202,281	1,168,032
Interest paid		3,210	7,448	2,210
Capital charge		53,916	49,616	52,397
GST – net		(6,215)	-	(369)
		2,425,555	2,289,310	2,179,098
Net cash inflow/ (outflow) from operating activities	20 [p66]	(21,904)	(56,903)	(45,874)
CASH FLOW FROM INVESTING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Sale of property, plant & equipment		241	-	2,736
Receipts from restricted assets & investments		11,506	-	14,597
		11,747	-	17,333
CASH WAS APPLIED TO:				
Purchase of investments & restricted assets		11,999		15,618
Purchase of property, plant & equipment		88,538	121,881	80,553
		100,537	121,881	96,171
Net cash inflow/ (outflow) from investing activities		(88,790)	(121,881)	(78,838)
CASH FLOW FROM FINANCING ACTIVITIES				
CASH WAS PROVIDED FROM:				
Earthquake repair capital redrawn	16 [p62]	33,000	28,000	-
Mental Health facility drawdown	7 [p51]	30,373	69,357	1,435
Equity support	7 [p51]	80,000	153,000	180,000
Proceeds from borrowings		-	-	3,141
		143,373	250,357	184,576
CASH WAS APPLIED TO:				
Annual depreciation funding repayment	7 [p51]	1,861	1,861	1,861
Repayment of finance leases		1,448	-	252
		3,309	1,861	2,113
Net cash inflow/ (outflow) from financing activities		140,064	248,496	182,463
Net increase/ (decrease) in cash and cash equivalents		29,370	69,712	57,751
Cash and cash equivalents at beginning of year		50,775	50,775	(6,976)
Cash & cash equivalents at end of year	8 [p52]	80,145	120,487	50,775

The accompanying notes form part of these financial statements.

RECONCILIATION OF LIABILITIES ARISING FROM FINANCING ACTIVITIES	Notes	Actual 2022 $'000	Actual 2021 $'000
FINANCE LEASE BORROWINGS			
Opening balance		50,724	26,757
Net financing cash flows		(1,343)	(252)
Non-cash charges		7,382	24,219
Closing Balance	19 [p44]	56,763	50,724

The accompanying notes form part of these financial statements.

6.2 Te Arataki ki Ngā Pūrongo Pūtea | Guide to Our Financial Reports

Notes to and forming part of the financial statements

1. STATEMENT OF ACCOUNTING POLICIES

Reporting entity and statutory base

Canterbury DHB was a District Health Board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB was a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

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

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

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

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

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

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

The financial statements of Canterbury DHB are for the year ended 30 June 2022.

Basis of Preparation

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Canterbury District Health Board's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

Operating and cash flow forecasts

Operating and cash flow forecasts indicated that Canterbury DHB would require additional funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements for the 2022/23 financial year.

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.

Breach of statutory reporting deadline

The 2021/22 annual report of Canterbury District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

Measurement basis

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

Functional and presentation currency

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

Changes in accounting policies

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

Significant Accounting Policies

Basis for consolidation

The purchase method was 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 were eliminated on consolidation.

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

Budget figures

The budget figures are those that were 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 was a Crown entity under the New Zealand Public Health and Disability Act 2000 and was exempt from income tax under section CW38 of the Income Tax Act 2007.

Goods and services tax

All amounts were shown exclusive of Goods and Services Tax (GST), except for receivables and payables that were stated inclusive of GST. Where GST was irrecoverable as an input tax, it was 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, was classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies were 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 were based on historical experience and various other factors that were 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 were not readily apparent from other sources. These estimates and assumptions may differ from the actual results. The estimates and underlying assumptions were reviewed on an ongoing basis.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are highlighted in notes 4, 13, 14, 15, and 19.

Standards issued but not yet effective and not early adopted

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

PBE IPSAS 41 Financial instruments

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

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

2. PATIENT CARE REVENUE	2022 $'000	2021 $'000
Ministry of Health population based funding	1,776,520	1,646,260
Inter-district flows	151,825	141,486
Ministry of Health other contracts	346,048	197,376
ACC revenue	52,170	37,061
Other patient related revenue	52,593	51,651
Total patient care revenue	2,379,156	2,073,834

Under the Public Finance Act 1989, Canterbury DHB was required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation, and the service performance measures[78] that report against the use of that funding.

The appropriation revenue received by Canterbury DHB for the 2021/22 financial year was $1,772.471M (2020/21: $1,645.803M) which equals the Government's actual expenses incurred in relation to the appropriation.

[78] The performance measures are set out in the Statement of Service Performance on pages 15-29

MINISTRY OF HEALTH APPROPRIATION REVENUE	Actual $'000	MOH Budget $'000
Crown funding appropriation	1,739,176	1,725,196
COVID-19 related adjustments	(3,174)	-
Additional funding for surge costs in both critical care and ward beds		2,700
Canterbury Earthquake Programme	751	6,150
Nursing and midwifery pay equity payments	33,019	47,726
Total appropriation revenue	1,769,772	1,781,772

The table above shows the actual and budget Ministry of Health appropriation figures.

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

ACCOUNTING POLICY

Revenue

Ministry of Health population based funding

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

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

Inter-district flows

Inter-district patient inflow revenue occurred when a patient treated within Canterbury DHB's district was domiciled outside of the district. Inter-district patient inflow revenue was recognised when eligible services were 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 was substantively linked to the provision of quantifiable units of service were treated as exchange contracts and revenue was recognised as Canterbury DHB provided the services.

Other contracts were treated as non-exchange and the total funding receivable under the contract was recognised as revenue immediately, unless there were substantive conditions in the contract. If there were substantive conditions, revenue was recognised when the conditions were 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 was not recognised where the contract contained substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which was assessed by considering factors such as the past practice of the Ministry of Health. Judgement was often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC revenue

ACC revenue was recognised as revenue when eligible services were provided, and any contract conditions had been fulfilled.

Other patient related revenue

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

3. OTHER REVENUE	2022 $'000	2021 $'000
Gain on sale of property, plant and equipment	875	1,653
Donations and bequests received	22,654	2,384
Pathology tests	29,796	20,848
Research & development	8,136	7,207
External rental revenue	1,252	985
Cafeteria sales	4,486	4,990
Other	16,604	14,136
Total other revenue	83,803	52,203

Donations include $18M of Covid protective equipment and test kits received from the Ministry at no cost. This revenue is offset by $18M of expenditure included in treatment related costs.

ACCOUNTING POLICY

Revenue

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

ESTIMATES AND ASSUMPTIONS

Non-government grants

Canterbury DHB needed to exercise judgement when recognising grant revenue to determine if conditions of the grant contract had been satisfied. This judgement was based on the facts and circumstances that were evident for each grant contract.

4. EMPLOYEE BENEFIT COSTS	2022 $'000	2021 $'000
Wages and salaries	1,083,771	949,274
Board members' fees	389	361
Directors' fees	128	136
Contributions to defined contribution plans[79]	32,641	29,508
Increase/(decrease) in Holidays Act compliance provision	46,329	20,421
Increase/(decrease) in employee benefit provisions	42,008	20,072
Total employee benefit costs	1,205,266	1,019,772

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

Holidays Act Compliance

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

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

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

The remediation programme associated with the MOU is a significant undertaking and work to assess, rectify and remediate all areas of non-compliance will continue through the 2022/23 financial year. At Canterbury DHB, the formal Review Phase, as set out in the MOU, was completed in March 2020 with all non-compliance issues identified. Efforts are now focused on rectifying payroll systems and processes to ensure ongoing compliance, as well as analysis, testing and remediating the results of retrospective areas of non-compliance for relevant individual employees.

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

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

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

If Te Whatu Ora Health New Zealand – Waitaha Canterbury is required to settle the holiday pay liability disclosed in note 13 prior to 1 July 2023, additional financial support would be needed from the Crown for this settlement.

5. OTHER EXPENSES	2022 $'000	2021 $'000
Financial statement audit fees	336	272
Loss on disposal of property, plant and equipment	108	4,336
Rental costs including operating leases	9,770	8,059
Facilities and infrastructure costs	70,801	59,933
Other non-clinical costs	65,763	58,146
Total other expenses	146,778	130,746

ACCOUNTING POLICY

Operating lease payments

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

6. CAPITAL CHARGE

Canterbury DHB paid a capital charge every six months to the Crown. This charge was based on actual closing equity as at the prior 30 June or 31 December, less an allowance for donated assets. For the year ended 30 June 2022 the rate was 5% (2020/21: 5%).

In July 2019, the Minister of Health announced that DHBs would be funded for capital charge on new facilities, with any deficit reducing the funding. The value of the relief funding for 2021/22 was $13.833M (2020/21: $6.916M). This has been accounted for through revenue.

7. EQUITY

	2022 $'000	2021 $'000
CONTRIBUTED CAPITAL		
Opening balance	1,126,422	410,659
Annual depreciation funding repayment	(1,861)	(1,861)
Equity support	80,000	180,000
Earthquake repair capital redrawn	33,000	9,650
Mental Health facility drawdown	30,373	1,435
Donated asset - Crown contribution	-	1,489
Waipapa facility - Crown contribution	-	525,050
Closing balance	1,267,934	1,126,422

The operating deficit for 2021 was $177.131M. The Ministry of Health provided $80M of equity support in January 2022.

ACCUMULATED SURPLUS/(DEFICIT)	2022 $'000	2021 $'000
Opening balance	(516,411)	(343,264)
Revaluation reserves transfer on disposal	-	3,984
Operating deficit	(222,307)	(177,131)
Closing balance	(738,718)	(516,411)
REPRESENTED BY:		
Accumulated surplus in parent and associates	(743,238)	(522,317)
Accumulated surplus in subsidiaries	4,520	5,906
Total accumulated surplus / (deficit)	(738,718)	(516,411)
REVALUATION RESERVE		
Opening balance	514,833	423,335
Transfer to accumulated surplus / (deficit on disposal)	-	(3,984)
Revaluation of land, buildings including fitout	141,652	95,482
Closing balance	656,485	514,833
REPRESENTED BY:		
Revaluation of land	123,787	99,150
Revaluation of buildings including fitout	532,698	415,683
Total revaluation reserve	656,485	514,833
Total equity	1,185,701	1,124,844

ACCOUNTING POLICY

Equity

Equity was 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 were recorded in contributed capital.

Revaluation reserve

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

8. CASH AND CASH EQUIVALENTS

	Credit rating	2022 $'000	2021 $'000
CURRENT ASSETS			
Bank balances and call deposits	AA-	80,106	50,738
Cash on hand		39	36
Total cash and cash equivalents		80,145	50,774

Bank facility

Canterbury DHB was a party to the "DHB Treasury Services Agreement" between NZ Health Partnerships Ltd (NZHPL) and the participating DHBs. This Agreement enabled NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provided for individual DHBs to have a debit balance with NZHPL, which incurred interest at a credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that was available to any DHB was the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and was defined as one-twelfth of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Canterbury DHB, that equated to $119.019M as at 30 June 2022 (2020/21: $88.808M).

While cash and cash equivalents at 30 June 2022 were subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance was recognised because the estimated loss allowance for credit losses was trivial.

Credit risk

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

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

The Board placed its cash and term investments with high quality financial institutions via a national DHB shared banking arrangement, facilitated by NZHPL. Restricted asset cash and term investments were placed with high quality financial institutions.

ACCOUNTING POLICY

Bank term deposits

Investments in bank term deposits were measured at the amount invested. A loss allowance for expected credit losses was recognised if the estimated loss allowance was not trivial.

Cash and cash equivalents

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

9. TRADE AND OTHER RECEIVABLES	2022 $'000	2021 $'000
Trade receivables	21,045	13,546
Receivable from the Ministry of Health	91,017	51,574
Prepayments	8,486	6,278
Other receivables	49,646	42,037
Total trade and other receivables	170,194	113,435
MOVEMENTS IN THE PROVISION FOR IMPAIRMENT OF RECEIVABLES ARE AS FOLLOWS:		
Balance at 1 July	1,639	1,336
Additional provisions made during the year	879	904
Receivables written-off during period	(1,181)	(601)
Balance at 30 June	1,337	1,639
THE AGEING OF THE IMPAIRMENT PROVISIONS ARE AS FOLLOWS:		
Current	-	8
< 6 months	1,080	623
6 months – 1 year	55	294
1 – 2 years	202	714
> 2 years	-	-
Balance at 30 June	1,337	1,639
THE NET AGEING OF RECEIVABLES, EXCLUDING PREPAYMENTS, IS:		
Current	130,179	104,180
< 6 months	30,600	2,864
6 months – 1 year	324	38
1 – 2 years	605	75
Balance at 30 June	161,708	107,157

Trade receivables and prepayments were from exchange transactions.

The value of trade receivables that were impaired on an individual basis total $0.555M, and the impairment on those accounts was $0.065M giving a net carrying value of $0.490M.

Other receivables and receivables from the Ministry of Health were a blend of both exchange and non-exchange transactions. The value of non-exchange balances in other receivables and in receivables from the Ministry of Health was $36.295M (2020/21: $25.404M).

Concentrations of credit risk from trade and other accounts receivable were limited due to the large number and variety of customers. The Ministry of Health was the largest single debtor. It was assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services. As at 30 June 2022, the Ministry of Health owed Canterbury DHB $91.017M (2020/21: $51.574M). See note 29 for the effects of COVID-19 on balance sheet items.

ACCOUNTING POLICY

Trade and other receivables

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

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

Trade and other receivables were written off when there was no reasonable expectation of recovery.

10. INVENTORIES	2022 $'000	2021 $'000
Pharmaceuticals	1,077	3,148
Surgical and medical supplies	9,602	7,890
Other supplies	3,700	3,812
	14,379	14,850
Provision for obsolescence	(651)	(1,039)
Total inventories	13,728	13,811

ACCOUNTING POLICY

Inventories

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

Inventories held for distribution, or consumption in the provision of services, that were not issued on a commercial basis were 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 were measured at fair value at the date of acquisition.

Other inventories were 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 was recognised in the surplus or deficit in the period of the write-down.

11. INVESTMENTS	Credit rating	2022 $'000	2021 $'000
Investments are represented by:			
Term deposits with maturities of 3-12 months	AA-	2,750	750
Total investments	AA-	2,750	750
Weighted average effective interest rates		1.48%	0.80%

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

Fair value interest rate risk

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

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

12. TRADE AND OTHER PAYABLES	2022 $'000	2021 $'000
Trade payables	14,775	19,714
Other payables	187,366	139,576
Total trade and other payables	202,141	159,290

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

Trade payables were from exchange transactions. The value of non-exchange balances in other payables was $66.314M (2020/21: $56.162M).

Trade and other payables were measured at fair value.

ACCOUNTING POLICY

Provisions

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

13. EMPLOYEE BENEFIT LIABILITIES	2022 $'000	2021 $'000
CURRENT LIABILITIES		
Annual, lieu and shift leave accruals	121,321	103,213
Holidays Act compliance provision	196,446	150,117
Unpaid days accruals	20,769	16,730
ACC accruals	5,294	4,737
Conference/sabbatical leave and expenses	52,229	48,482
Sick leave	8,861	7,037
Other	102,845	51,381
Total employee benefits - current	507,765	381,697
NON-CURRENT LIABILITIES		
Liability for long service leave	7,543	6,668
Liability for retirement gratuities	470	876
Total employee benefits – non-current	8,013	7,544

ACCOUNTING POLICY

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities was the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation was calculated using the projected unit credit method including a salary inflation factor and was discounted to its present value. The discount rate was the market yield on relevant New Zealand government bonds at the year-end date. The salary inflation factor was determined after considering historical salary inflation patterns and future movements. Canterbury DHB accrued the obligation for paid absences when the obligation both related to employees' past services and it accumulates. The sick leave amount was calculated based on the unused sick leave entitlement that could be carried forward at balance date to the extent Canterbury DHB anticipated it would 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 were short-term obligations and were 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 were classified as non-current liabilities; all other employee entitlements were classified as current liabilities.

ACC Partnership Programme

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

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

The liability for the ACC Partnership Programme was 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 was given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments were 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 depended on a number of factors that were 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 2022. 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 +/- $111,000.

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 +/- $105,000.

14. PROPERTY, PLANT AND EQUIPMENT

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

2021/22 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings & fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2021	142,266	1,105,803	349,259	64,942	52,477	1,714,747
Additions/transfers	-	22,792	35,778	12,578	32,779	103,930
Disposals/transfers	-	-	(30,868)	(784)	-	(31,648)
Revaluation	24,637	59,014	-	-	-	83,651
Balance at 30 June 2022	166,903	1,187,609	354,169	76,736	85,256	1,870,673
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2021	-	2,609	210,281	8,499	-	221,389
Depreciation	-	58,714	27,357	2,584	-	88,655
Disposals/transfers	-	258	(30,732)	(999)	-	(31,473)
Revaluation	-	(58,001)	-	-	-	(58,001)
Balance at 30 June 2022	-	3,580	206,906	10,084	-	220,570
CARRYING AMOUNT						
At 30 June 2022	166,903	1,184,029	147,263	66,652	85,256	1,650,103

2020/21 FINANCIAL YEAR	Freehold land $'000	Freehold buildings & fitout $'000	Plant, equipment & vehicles $'000	Leasehold buildings & fitout $'000	Work in progress $'000	Total $'000
COST OR VALUATION						
Balance at 1 July 2020	139,455	621,969	265,356	37,115	51,923	1,115,818
Additions/transfers	-	509,723	88,232	27,857	554	626,366
Disposals/transfers	(5,707)	-	(4,329)	(30)	-	(10,066)
Revaluation	8,518	(25,889)	-	-	-	(17,371)
Balance at 30 June 2021	142,266	1,105,803	349,259	64,942	52,477	1,714,747
DEPRECIATION & IMPAIRMENT LOSSES						
Balance at 1 July 2020	-	55,926	192,253	5,818	-	253,997
Depreciation	-	60,231	21,165	2,017	-	83,413
Disposals/transfers	-	(695)	(3,137)	664	-	(3,168)
Revaluation	-	(112,853)	-	-	-	(112,853)
Balance at 30 June 2021	-	2,609	210,281	8,499	-	221,389
CARRYING AMOUNT						
At 30 June 2021	142,266	1,103,194	138,978	56,443	52,477	1,493,358

Capital Work in Progress

Buildings in the course of construction total $68.239M (2020/21 $23.397M). Plant Equipment and Vehicles in progress total $17,017M (2020/21 $29.080M.

Finance leases

The net carrying amount of assets held under finance leases was $52.479M (2020/21: 50.724M).

Revaluation

Canterbury DHB revalued land, buildings and building fitout (excluding leased building fitout) at 30 June 2022. The revaluation was carried out by an independent registered valuer (TelferYoung (Canterbury) Ltd), which is consistent with PBE IPSAS 17 Property Plant & Equipment. Canterbury DHB previously revalued land, buildings and building fitout in the prior financial year (as at 30 June 2021). The 2022 revaluation was required to ensure that the carrying values did not differ materially from fair value.

Impairment

Canterbury DHB impaired buildings and building fitout at 30 June 2022 in relation to the costs of passive fire remediation required to be undertaken. The impairment was based on independent assessment and totals $47.3M across all campuses (2020/21: $41.7M). This has been reflected in the revaluation, where the movement has been recognised in other comprehensive revenue and expense.

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

ACCOUNTING POLICY

Property, plant and equipment

Owned assets

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

Additions

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

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

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

Subsequent costs

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

Disposal of property, plant and equipment

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

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

Depreciation

Depreciation was 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 were written off in the month of purchase. Land was not depreciated.

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

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

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

Revaluations

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

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

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

Impairment

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

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

When a decline in the fair value of an available-for-sale financial asset had been recognised directly in equity and there was objective evidence that the asset was impaired, the cumulative loss that had been recognised directly in equity was recognised in surplus or deficit even though the financial asset had not been derecognised. The amount of the cumulative loss that was recognised in surplus or deficit was 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 was calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration were not discounted.

Estimated recoverable amount of other assets was the greater of their fair value less costs to sell and value in use. The value in use was the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset were 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 was 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 was also recognised in other comprehensive revenue and expense.

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

Non-cash-generating assets

Property, plant, equipment and intangible assets held at cost that had a finite useful life were reviewed for impairment whenever events or changes in circumstances indicated that the carrying amount may not be recoverable. An impairment loss was recognised for the amount by which the asset's carrying amount exceeded 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 was 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 exceeded its recoverable service amount, the asset was regarded as impaired and the carrying amount was written-down to the recoverable amount. The total impairment loss was recognised in other comprehensive revenue and expense.

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

ESTIMATES AND ASSUMPTIONS

Useful lives and residual value

At each balance date Canterbury DHB reviewed 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 required Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, advance in medical technology, and expected disposal proceeds from the future sale of the assets. Any adjustments are disclosed within this note.

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

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

15. INTANGIBLE ASSETS	2022 $'000	2021 $'000
SOFTWARE		
COST		
Opening balance	91,494	89,003
Additions	6,250	4,846
Disposals	(11,285)	(2,355)
Closing balance	86,459	91,494
AMORTISATION AND IMPAIRMENT LOSSES		
Opening balance	50,957	45,914
Amortisation charge for the year	7,991	6,263
Disposals	(6,612)	(1,220)
Closing balance	52,336	50,957
Total Software	34,123	40,537
WORK IN PROGRESS - INTANGIBLES		
Opening balance	7,186	4,644
Additions / transfers	(3,498)	2,542
Closing balance	3,688	7,186
INVESTMENT IN NZ HEALTH PARTNERSHIPS LTD		
Opening balance	2,587	3,225
Amortisation charge for the year	(361)	(638)
Closing balance	2,226	2,587
Carrying amounts	40,037	50,310

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

NZ Health Partnerships Limited (NZHPL)

No impairment for the NZHPL Change Management and Supply Chain was recognised for the financial year ended 30 June 2022 (2020/21: Nil).

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

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

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

ACCOUNTING POLICY

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, was capitalised if the product or process was technically and operationally feasible and Canterbury DHB had 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 were recognised as an expense when incurred. Capitalised development expenditure was stated at cost less accumulated amortisation and impairment losses.

Expenditure relating to Software as a Service arrangements was treated in line with the latest Treasury guidance for configuration and customisation costs.

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

Amortisation

Amortisation was 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 were amortised from the date they were available for use. The estimated useful lives were as follows:

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

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

ESTIMATES AND ASSUMPTIONS

Estimating useful lives of software assets

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

- Period of time the software was 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 would affect the amortisation expense recognised in the surplus or deficit, and the carrying amount of the software assets in the statement of financial position.

16. THE CANTERBURY EARTHQUAKES 2010/2011

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

Agreement with Ministry of Health

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

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

DRAWDOWN	$M
Initial payment to Ministry of Health	290.00
Drawdown	(229.27)
Amount undrawn 30 June 2022	60.73

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

17. JOINTLY CONTROLLED OPERATIONS

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

	2022 $'000	2021 $'000
Canterbury DHB's result includes the following revenue and expenses as a result of the jointly controlled operations		
Sub tenant revenue	391	344
Manawa lease and facility costs	2,380	2,211

As at 30 June 2022, Canterbury DHB owed Ara Institute $10,673 (30 June 2021: $139,466); Ara Institute owed Canterbury DHB $39,036 (30 June 2021: $29,947).

18. RESTRICTED ASSETS & RESIDENTS' TRUST ACCOUNTS

RESTRICTED ASSETS

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

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

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

	2022 $'000	2021 $'000
FUNDS HELD DIRECTLY BY CANTERBURY DHB		
Balance at beginning of year	9,518	9,098
Interest received	(4)	148
Donations and funds received	458	954
Funds transferred to Māia Health Foundation	(6,140)	(84)
Funds spent	(672)	(598)
Balance at end of year	3,160	9,518
FUNDS HELD WITH MĀIA HEALTH FOUNDATION		
Balance at beginning of year	5,593	5,595
Interest earned on funds held with Māia Health Foundation	86	75
Transfers in from Canterbury DHB	6,140	84
Funds drawn down by Canterbury DHB	(327)	(161)
Balance at end of year	11,492	5,593
Total Restricted Assets	14,652	15,111
This balance is represented by:		
Current assets	14,636	15,095
Non-current assets	16	16
Total restricted assets	14,652	15,111
Weighted average effective interest rates	2.59%	0.71%

CREDIT QUALITY OF RESTRICTED ASSETS	Credit rating	2022 $'000	2021 $'000
Restricted assets:			
Bank balances	AA-	6,015	-
Term deposits with maturities of 3-12 months – Canterbury DHB	AA-	2,400	9,502
Term deposits with maturities of 3-12 months – Māia Health Foundation	AA-	6,221	5,593
Perpetual capital notes	BBB+	16	16
Total restricted assets		14,652	15,111

RESIDENTS' TRUST ACCOUNTS	2022 $'000	2021 $'000
Residents' trust account balance	1,126	1,105

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

19. BORROWINGS

	2022 $'000	2021 $'000
FINANCE LEASES		
Current portion	1,480	1,280
Non current portion	55,283	49,444
Total borrowings	56,763	50,724

Fair value

The fair value of finance leases was $56.763M (2020/21: $50.724M). Fair value has been determined using contractual cash flows discounted using the relevant rate to each finance lease.

ANALYSIS OF FINANCE LEASES	2022 $'000	2021 $'000
Minimum lease payments		
No later than one year	4,685	4,204
Later than one year and not later than five years	16,329	15,390
Later than five years	89,664	80,260
Total minimum Lease Payments	110,678	99,854
Future finance charges	(53,915)	(49,130)
Present value of minimum lease payments	56,763	50,724
Present value of minimum lease payments payable		
No later than one year	4,507	4,039
Later than one year and not later than five years	13,715	12,894
Later than five years	38,541	33,791
Total present value of minimum lease payments	56,763	50,724

Description of finance leasing arrangements

The group has entered into the following finance leases:

- Manawa building at 276 Antigua Street;
- Canterbury Linen Services Ltd premises at Dakota Park, 11 George Bellew Road, Yaldhurst;
- Canterbury Linen Services Ltd equipment;
- Selwyn Health Hub at 2/3 Norman Kirk Drive, Rolleston. COVID

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

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

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

ACCOUNTING POLICY

Liquidity risk

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

Borrowings

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

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

Finance leases

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

ESTIMATES AND ASSUMPTIONS

Leases classification

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

Judgement was 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 was recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset was recognised.

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

	2022 $'000	2021 $'000
Net (deficit)/ surplus before other comprehensive revenue and expense	(222,307)	(177,131)
Add back non-cash items:		
Depreciation and amortisation	95,663	90,315
Add back items classified as investing activities:		
Loss/(gain) on asset sale	(140)	(1,087)
Movement in term portion provisions/staff entitlements	469	1,240
MOVEMENTS IN WORKING CAPITAL:		
Decrease/(increase) in receivables & prepayments	(56,762)	(1,933)
Decrease/(increase) in stocks	85	738
Increase/(decrease) in creditors & other accruals	35,020	3,930
Increase/(decrease) in staff entitlements	126,068	38,054
Net cash inflow/(outflow) from operating activities	(21,904)	(45,874)

21. COMMITMENTS	2022 $'000	2021 $'000
CAPITAL COMMITMENTS		
Property	26,011	61,023
Intangible assets	1,516	2,977
Other capital commitments	9,744	8,489
Total capital commitments at balance date	37,271	72,489
NON-CANCELLABLE OPERATING LEASE COMMITMENTS		
Accommodation leases	35,468	30,433
Other leases	1,138	1,639
Total non-cancellable operating lease and supply commitments	36,606	32,072
FOR EXPENDITURE WITHIN:		
Not later than one year	7,148	6,665
Later than one year and not later than five years	17,139	14,893
Later than five years	12,319	10,514
Total non-cancellable operating lease and supply commitments	36,606	32,072

External service providers

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

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

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

Operating leases as lessee

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

ESTIMATES AND ASSUMPTIONS

Leases classification

Determining whether a lease agreement was a finance or an operating lease required judgement as to whether the agreement transferred substantially all the risks and rewards of ownership to Canterbury DHB.

Judgement was 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 was recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset was recognised.

22. CONTINGENCIES

Contingent assets

Canterbury DHB had no contingent assets as at 30 June 2022 (2020/21: Nil).

Contingent liabilities

Canterbury DHB had the following contingent liabilities as at 30 June 2022:

Outstanding legal proceedings

Canterbury DHB had no material outstanding legal proceedings as at 30 June 2022 (2020/21: Nil).

Canterbury earthquakes

In respect of the Canterbury earthquakes there are a number of repair costs yet to be determined and incurred, both of an operational and capital nature, which will be brought to account as they become quantifiable and a liability crystallises. See note 16 [p62] for further information.

Land and building contamination

Canterbury DHB owned land and buildings that are or may be potentially contaminated. Canterbury DHB was continually assessing the likelihood of actual contamination when it undertook repairs and maintenance activities. The uncertainty as to the actual contamination, and what associated costs of remediation are probable, means that the future liability cannot be reasonably estimated based on information currently available.

23. CONTRACTUAL MATURITY OF FINANCIAL ASSETS AND LIABILITIES

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

Contractual maturity analysis of financial liabilities	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000	More than 2 years $'000
2021/22 FINANCIAL YEAR					
Trade and other payables	198,741	198,741	198,741	-	-
Restricted funds	14,652	14,652	14,652	-	-
Finance leases	56,763	110,678	4,685	4,740	101,253
Total financial liabilities	270,156	324,071	218,078	4,740	101,253
2020/21 FINANCIAL YEAR					
Trade and other payables	159,290	159,290	159,290	-	-
Restricted funds	15,111	15,111	15,111	-	-
Finance leases	50,724	99,854	4,204	4,233	91,417
Total financial liabilities	225,125	274,255	178,605	4,233	91,417

Contractual maturity analysis of financial assets	Carrying amount $'000	Contractual cash flows $'000	Less than 1 year $'000	1-2 years $'000
2021/22 FINANCIAL YEAR				
Cash and cash equivalents	80,145	80,145	80,145	-
Trade and other receivables[80]	161,708	161,708	161,708	-
Term deposits (term > 3 months)	2,750	2,750	2,750	
Restricted assets	14,652	14,652	14,636	16
Total financial assets	259,255	259,255	259,255	16
2020/21 FINANCIAL YEAR				
Cash and cash equivalents	50,775	50,775	50,775	-
Trade and other receivables[81]	107,157	107,157	107,157	-
Term deposits (term > 3 months)	750	750	750	-
Restricted assets	15,111	15,111	15,095	16
Total financial assets	173,793	173,793	173,777	16

ACCOUNTING POLICY

Classification of financial instruments

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

Financial assets:

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

All financial liabilities were measured at amortised cost.

Sensitivity analysis

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

Canterbury DHB held NZD $345,439 of foreign currency accounts as at 30 June 2022 (2020/21: NZD $218,723).

	2022 $'000		2021 $'000	
FOREIGN EXCHANGE RISK	-10% Surplus	+10% Surplus	-10% Surplus	+10% Surplus
Financial assets				
Foreign currency	(35)	31	(22)	20
Total sensitivity	(35)	31	(22)	20

[80] Excludes prepayments

[81] Excludes prepayments

ACCOUNTING POLICY

Foreign currency

Transactions in foreign currencies were 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 were translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation were recognised in the surplus/deficit.

Derivative financial instruments

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

Derivatives were initially recognised at fair value on the date a derivative contract was entered into and were subsequently remeasured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit. Forward foreign exchange derivatives were classified as current if the contract was due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives was 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 were from independently sourced market parameters such as currency rates. Most market parameters were implied from forward foreign exchange contract prices.

24. CAPITAL MANAGEMENT

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

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

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

25. RELATED PARTIES

Canterbury DHB was a wholly owned entity of the Crown.

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

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

Canterbury Linen Services Ltd relocated to a new site in 2021. Canterbury DHB helped to fund the redevelopment through a loan facility charging the same interest rates that were applied to Canterbury DHB by NZ Health Partnerships Ltd and Treasury.

Significant transactions with government related entities

Canterbury DHB has received funding from the Crown, ACC, and other government entities of $2,242.159M to provide health services in the Canterbury area for the year ended 30 June 2022 (2020/21: $1,907.284M).

Revenue earned from other DHBs for the care of patients domiciled outside Canterbury DHB's district as well as services provided to other DHBs amounted to $166.029M for the year ended 30 June 2022 (2020/21: $156.961M).

Expenditure to other DHBs for the care of patients from Canterbury DHB's district and services provided from other DHBs amounted to $42.050M for the year ended 30 June 2022 (2020/21: $39.840M).

Other significant transactions with government-related entities

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

Canterbury DHB also purchased goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2022 totalled $24.286M (2020/21: $24.832M). These purchases included blood products from the New Zealand Blood Service, travel through Air New Zealand and services from NZ Health Partnerships Ltd.

ACCOUNTING POLICY

Subsidiaries

Subsidiaries are entities controlled by Canterbury DHB. Control existed when Canterbury DHB had 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 were exercisable or convertible were taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commenced until the date that control ceased.

Transactions eliminated on consolidation

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

Joint ventures

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

If the share of deficits of an associate equalled or exceeded the group's interest in the associate, Canterbury DHB discontinued recognising its share of further deficits. After Canterbury DHB's interest was reduced to zero, additional deficits were provided for, and a liability was recognised, only to the extent that Canterbury DHB had incurred legal or constructive obligations or made payments on behalf of the joint venture. If the joint venture subsequently reported surpluses, Canterbury DHB would resume recognising its share of those surpluses only after its share of the surpluses equalled the share of deficits not recognised.

Associates

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

Canterbury DHB subsidiaries

ENTITY	Interest held 2022	Balance Date
Canterbury Linen Services Ltd	100%	30 June
Brackenridge Services Ltd	100%	30 June
NZ Health Innovation Hub Management Ltd	100%	30 June

Canterbury Linen Services Ltd, Brackenridge Services Ltd and NZ Health Innovation Hub Management Ltd are incorporated in New Zealand. Canterbury Linen Services Ltd provides laundry services. Brackenridge Services Ltd provides residential accommodation and ongoing care for intellectually disabled persons. NZ Health Innovation Hub Management Ltd (NZHIH) works alongside public health system innovators to develop new products and services that have commercial potential, are based on intellectual property and improve health outcomes, and it also provides access to current information about the health landscape, market validation, potential investors and partners.

Canterbury DHB joint venture

ENTITY	Interest held 2022	Balance Date
HealthOne (2021) Limited Partnership	50%	30 June

Canterbury DHB held 50% interest in HealthOne (2021) Limited Partnership through its wholly owned subsidiary NZHIH with Pegasus Health (Charitable) Limited. HealthOne (2021) Limited Partnership is an unlisted limited partnership. Accordingly, there was no quoted market price for this investment. In 2021/22 the partnership made a loss of $1.015M.

Canterbury DHB associates

ENTITY	Interest held 2022	Balance Date
South Island Shared Service Agency Limited	47%	30 June

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

West Coast DHB

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

Canterbury DHB charged the West Coast DHB for these services. 2021/22 charges were $1.310M (2020/21: $1.291M). The amount owing by West Coast DHB relating to this agreement at balance date was Nil (2020/21: $0.247M).

Māia Health Foundation

Canterbury DHB provided accounting support, office space, and minor incidentals to the Māia Health Foundation at no charge, as well as assistance with seed funding of $0.250M (2020/21: $0.250M). Also refer note 18 [p64].

Burwood Orthopaedic Surgical Services

Canterbury DHB partnered with the Burwood Orthopaedic Surgical Services Group to provide ACC funded orthopaedic surgical and related anaesthesia services.

Key management personnel

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

26. EMPLOYEE REMUNERATION	2022 $'000	2021 $'000
COMPENSATION OF KEY MANAGEMENT PERSONNEL		
Salaries for executive management team	4,402	4,898
Board and Committee members fees	431	408
Total key management personnel compensation	4,833	5,306

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

KEY MANAGEMENT PERSONNEL FULL TIME EQUIVALENTS (FTE)	2022 FTE	2021 FTE
Full time equivalent Board and Committee members	1.24	1.24
Full time equivalent executive management team	12.59	11.87
Total key management personnel full time equivalents	13.83	13.11

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

Payments in respect of termination of employment

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

The total payments made by Canterbury DHB were $1,229,640 to 36 employees (2020/21: $1,937,172 to 32 employees) comprising negotiated settlements with the employees.

Remuneration of employees

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

SPECIFIED BANDS	2022	2021	SPECIFIED BANDS	2022	2021
100,000-109,999	698	555	360,000-369,999	12	15
110,000-119,999	506	338	370,000-379,999	14	13
120,000-129,999	392	208	380,000-389,999	10	5
130,000-139,999	215	140	390,000-399,999	11	10
140,000-149,999	152	116	400,000-409,999	10	7
150,000-159,999	107	83	410,000-419,999	7	4
160,000-169,999	90	68	420,000-429,999	9	11
170,000-179,999	63	62	430,000-439,999	7	3
180,000-189,999	53	36	440,000-449,999	6	3
190,000-199,999	39	42	450,000-459,999	3	2
200,000-209,999	43	46	460,000-469,999	-	4
210,000-219,999	39	24	470,000-479,999	2	4
220,000-229,999	38	35	480,000-489,999	-	5
230,000-239,999	40	26	490,000-499,999	4	5
240,000-249,999	30	32	510,000-519,999	1	1
250,000-259,999	29	29	520,000-529,999	1	-
260,000-269,999	27	32	530,000-539,999	-	1
270,000-279,999	34	29	540,000-549,999	-	2
280,000-289,999	18	22	550,000-559,999	-	1
290,000-299,999	29	30	580,000-589,999	1	-
300,000-309,999	28	23	610,000-619,999	-	1
310,000-319,999	27	20	630,000-639,999	-	1
320,000-329,999	28	23	640,000-649,999	-	1
330,000-339,999	15	20	770,000-779,999	-	1
340,000-349,999	12	12	790,000-799,999	1	-
350,000-359,999	16	12	1,060,000-1,069,999	-	1
			1,320,000-1,329,999	1	-
			Total employees	2,868	2,164

Of the positions identified above 2,575 positions (2020/21: 1,877) were predominantly clinical and 293 positions (2020/21: 287) were non-clinical.

27. MAJOR VARIANCES TO BUDGET

Canterbury DHB budgeted for a deficit of $149.007M as published in our 2021/22 Annual Plan approved in November 2021. Explanations for major variance from budget are as follows:

Statement of comprehensive revenue and expense

The key contributing factors to the revenue and expenses variances were the impact of COVID-19, Pay Equity, and donated Personal Protective Equipment (PPE) and Rapid Antigen Test kits (RATs) supplies from the Ministry

of Health, all of which have offsetting net variance effects, i.e. increased revenue matched by increased expenses, as outlined below. Please refer to note 29 for details of the impact of COVID-19.

Revenue

Total revenue was $232M favourable against budget, principally due to:

- $151M higher COVID-19 funding than planned;
- $54M of unbudgeted Pay Equity settlement funding for eligible nursing, support and clerical staff;
- $18M of donated PPE supplies and RATs test kits.

The balance of the revenue variance resulted from higher ACC and interest income offset by lower receipts from ineligible patients, cafeteria sales and laundry income, all of which were significantly impacted by the pandemic.

Expense

Total expenses were unfavourable against budget by $305M, made up of:

- $156M higher employee benefit costs, the main contributors being $36M higher COVID-19 cost than planned, $54M of unbudgeted Pay Equity expense, $31M uplift in the Holidays Act Remediation liability and $38M nurses interim pay settlement including lump sums and rate increases effective from March 2022. Offsetting these were lower staff numbers than planned due to recruitment difficulties as a result of the pandemic;
- $24M higher treatment related costs, of which $4M was COVID-19 related (e.g. testing consumables), $18M was donated PPE and RATs test kits, with the balance being higher clinical treatment supplies, such as blood products;
- $101M higher external service providers cost, due principally to $93M additional COVID-19 related expenses. The balance of the variance includes higher capitation and after hours and acute demand payments and additional spend in individual funding arrangements for complex patients;
- $3M higher depreciation and amortisation due mainly to depreciation associated with unbudgeted COVID-19 related assets;
- $21M higher other expenses, of which $15M was COVID-19 related, whilst higher utilities prices, compliance costs and information and technology related expense were the main contributing factors to the balance of the variance.

Other comprehensive revenue & expense

Canterbury DHB revalued land, buildings and building fitout (excluding leased building fitout) at 30 June 2022. The $141M other comprehensive revenue and expense variance relates to the increase in the value of assets arising from the revaluation process.

Statement of changes in equity

The closing Equity as at June 2022 ($1,186M) was $39M lower than budgeted ($1,225M) due to:

- $73M comprehensive revenue and expenses result favourable variance, principally resulting from the assets revaluation impact ($141M) offset by higher Holidays Act Remediation than budgeted ($31M) and nurses interim pay settlement increase ($38M);
- $5M higher Earthquake repair equity drawdown than budgeted;
- $73M lower equity support funding received than budgeted;
- $39M lower Mental Health facility drawdown than planned due to progress being impacted by the pandemic;
- $1M difference in the opening balance between actual audited and forecast budget amounts.

Statement of financial position

Cash and cash equivalents – refer statement of cash flows commentary below.

Receivables and payables closing balances were higher due mainly to the timing of payments.

Employee benefit liabilities variance includes impact of MECA and pay equity settlements on leave revaluations arising, unpaid days and other provisions.

Property, plant and equipment variance is primarily related to the asset revaluation impact offset by lower capital spend than planned e.g. Mental Health facility.

Statement of cash flows

The closing cash balance ($80M) was $40M lower than planned ($120M), primarily due to lower equity support funding received and Mental Health facility drawdown. This was offset by lower capital spend (e.g. Mental Health facility) and improved operating cashflow which included the timing difference between the receipt of some Ministry of Health funding and actual payments (e.g. clerical pay equity funding was received in June 2022, whilst payments were made after the balance date).

28. SUBSEQUENT EVENTS

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 200, and establishing Health New Zealand (Te Whatu Ora) and the Maori Health Authority (Te Aka Whai Ora). District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

29. THE EFFECTS OF COVID-19 ON CANTERBURY DHB

The effects of COVID-19 were present in the community in the 2021/22 financial year, largely due to the spread of the Omicron variant.

In December 2021 the Canterbury DHB set up the Care in the Community Hub to assist those who had tested positive for COVID-19 and required assistance for their treatment and recovery, including returning to work.

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

IMPACT OF COVID-19	2022 $'000	2021 $'000
Revenue	194,484	46,079
Employee benefit costs	50,659	17,814
Treatment related costs	27,123	8,465
External service providers	111,411	15,942
Other expenses	2,837	3,177
Total expense	192,030	45,398
Surplus/(Deficit)	2,454	681

In the 2020/21 year COVID-19 activity was centred around keeping COVID-19 out of the community.

During the 2021/22 year the Managed Isolation Quarantine Facilities (MIQF) and Border Control operations were in place for international travellers. These operations were scaled back towards the end of the financial year. Vaccination was at its height during the 2021/22 year with a large portion of the vaccinations administered. Swabbing and Labs Testing were significant as the number of cases and suspected cases increased, particularly around the peak of Omicron presence in the community. There was a significant impact on the hospital and wider health system with staff taking leave due to testing COVID-19 positive and many rescheduled appointments. All COVID-19 related activities were funded by the Ministry of Health.

The main impacts on the 2021/22 financial statements due to COVID-19 are explained below.

Government funding

The Ministry of Health provided funding of $194.5M in 2021/22 for the Canterbury DHB COVID-19 response as follows:

- $27.8M related to testing in the community;
- $68.3M related to the vaccination;

- $16.0M related to MIQF and border control;
- $39.7M related to care in the community;
- $7.7M related to Other Funded activities including the cost of staff sick with COVID;
- $22.0M related to Pathology;
- $17.5M related to MIQF;
- ($4.5M) of losses recognised for FY2021/22 were not funded by the Ministry of Health. These losses relate to revenue shortages in the Canterbury DHB owned and operated cafes and Canterbury Linen Services Ltd (100% owned subsidiary).

Operating expenses

As a result of COVID-19, Canterbury DHB has incurred additional expenditure of $192.0M as follows:

- Employee benefit costs $50.7M - the contributing additional costs include border screening and contact tracing, responsibility for oversight of the isolation hotels facilities, laboratory testing, care in the community, rolling over of the vaccination programme and additional staffing costs in the hospital and community due to staff leave due to COVID-19 or working additional hours to fill vacancies;
- Treatment related costs $27.1M - these additional costs are primarily associated with additional COVID-19 laboratory testing workload, as well as consumables to ensure that all DHB staff and patients had appropriate access to PPE;
- External provider costs $111.4M;
- Other expenses $2.8M.

The net revenue and expense was relatively neutral.

Balance sheet impacts

- At 30 June 2022, our trade and other receivables balance included $38.5M of Ministry of Health debt relating to COVID-19 response activities;
- Due to COVID-19 the number of ineligible patients presenting at the hospital dropped significantly, this affected our patient revenue numbers and the subsequent debtor balance, requiring a smaller doubtful debt provision;
- An impairment assessment has been completed for tangible and intangible assets. No impairments have been recognised as a result of the assessments due to COVID-19.

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

	Actual 2022 $'000	Budget 2022 $'000
Early detection & management	562,058	463,728
Intensive assessment & treatment	1,474,880	1,399,537
Prevention	106,038	47,844
Rehabilitation & support	321,579	321,298
Total revenue	2,464,555	2,232,407
Early detection & management	607,387	493,667
Intensive assessment & treatment	1,615,491	1,495,746
Prevention	107,949	49,927
Rehabilitation & support	356,035	342,074
Total expenditure	2,686,862	2,381,414
Deficit	(222,307)	(149,007)

7. KŌRERO TĀPIRI | SUPPLEMENTARY INFORMATION

7.1 Arataki | Directory

Board Members

Sir John Hansen KNZM – Chair
Gabrielle Huria – Deputy Chair
Barry Bragg
Catherine Chu
Andrew Dickerson
James Gough
Jo Kane
Aaron Keown
Naomi Marshall
Fiona Pimm
Ingrid Taylor

Chief Executive

Dr Peter Bramley

Corporate Office

Level 1
32 Oxford Terrace
Christchurch

New Zealand Business Number

9429000098045

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Bank of New Zealand

8. COVID-19 ADDITIONAL PERFORMANCE INFORMATION

The following information has been provided by the Ministry of Health.

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Canterbury DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[82]

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[83] (HSU 2021 vs HSU 2020)

Year[84]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	8.64%	9.17%
2021/2022	85.40%	90.64%
Total	94.04%	99.81%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 91%, compared with 85% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Canterbury DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

[82] **https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology**

[83] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.

[84] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year[85]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[86]
2020/21	63,189	42,448	1	0	105,638
2021/22	449,502	451,460	336,516	1,434	1,238,912
Total	512,691	493,908	336,517	1,434	1,344,550

By 30 June 2022, a total of 1,344,550 COVID-19 vaccinations had been administered, of which 92% were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[87]

Age group	Primary course				
(years)[88]	Dose 1	Dose 2	Booster 1	Booster 2	Total[89]
0 to 11	31,267	16,209	-	-	47,476
12 to 15	29,350	28,456	14	-	57,820
16 to 19	27,360	27,425	10,450	-	65,235
20 to 24	33,101	33,712	20,926	2	87,741
25 to 29	34,805	35,182	22,659	6	92,652
30 to 34	37,221	37,819	26,217	25	101,282
35 to 39	32,726	33,354	25,310	21	91,411
40 to 44	30,126	30,629	24,785	23	85,563

[85] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.

[86] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

[87] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.

[88] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.

[89] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

Age group	Primary course				
(years)[88]	Dose 1	Dose 2	Booster 1	Booster 2	Total[89]
45 to 49	30,944	31,613	27,411	46	90,014
50 to 54	31,934	32,924	30,389	82	95,329
55 to 59	29,277	30,594	30,150	158	90,179
60 to 64	27,140	28,666	29,944	173	85,923
65 to 69	23,398	25,302	25,997	262	74,959
70 to 74	21,181	23,040	23,344	270	67,835
75 to 79	13,642	15,936	16,679	208	46,465
80 to 84	9,225	11,112	11,742	103	32,182
85 to 89	4,581	5,959	6,412	42	16,994
90+	2,224	3,528	4,087	13	9,852
Total	449,502	451,460	336,516	1,434	1,238,912

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

COVID-19 people vaccinated by age group during 2021/22[90]

Age group[91] (years)	Partial [92]		Primary course [93]			Booster course		
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	26,817	32%	14,160	17%	-	0%	-	0%
12 to 15	25,620	87%	23,080	78%	-	0%	-	0%
16 to 19	27,039	95%	26,953	95%	5,888	52%	-	0%
20 to 24	33,646	86%	34,189	87%	20,673	57%	-	0%
25 to 29	34,041	79%	34,643	80%	22,145	58%	-	0%
30 to 34	37,814	81%	38,635	83%	25,995	61%	-	0%
35 to 39	33,764	83%	34,403	85%	25,415	67%	-	0%
40 to 44	31,007	84%	31,579	86%	24,982	72%	-	0%
45 to 49	30,021	79%	30,750	81%	26,364	77%	-	0%
50 to 54	32,595	82%	33,533	84%	30,367	80%	75	3%
55 to 59	29,312	78%	30,583	82%	29,858	85%	154	5%
60 to 64	28,101	79%	29,603	84%	30,451	89%	173	5%
65 to 69	24,198	81%	25,941	87%	26,605	92%	248	10%
70 to 74	21,296	82%	23,104	89%	23,555	95%	277	18%
75 to 79	15,749	88%	17,803	99%	18,100	96%	215	21%
80 to 84	10,337	82%	12,146	97%	12,383	98%	117	22%
85 to 89	5,391	78%	6,708	97%	7,018	101%	42	13%
90+	2,825	65%	4,047	93%	4,517	108%	17	6%
Total	449,573	75%	451,860	76%	334,316	76%	1,318	8%

[90] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.

[91] Age groupings in this table reflect age of the persons at end of financial year.

[92] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).

[93] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[94] administered by ethnicity[95] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	57,544	56,165	40,470	32	154,211
European/other	340,825	345,338	268,060	1,326	955,549
Māori	35,653	34,701	18,446	59	88,859
Pacific peoples	12,274	12,002	6,656	7	30,939
Unknown	3,206	3,254	2,884	10	9,354
Total	449,502	451,460	336,516	1,434	1,238,912

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[96]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated(12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster, 50+	Received second booster (% eligible, 50+)
Asian	52,660	84%	53,829	86%	40,361	73%	24	4%
Māori	32,685	82%	33,393	84%	18,308	60%	51	7%
European /other	322,703	82%	334,987	85%	266,016	79%	1,233	9%
Pacific peoples	11,221	81%	11,681	84%	6,632	60%	6	3%

[94] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.

[95] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.

[96] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

Unknown	3,487	85%	3,810	93%	2,999	61%	4	3%
Total	422,756	82%	437,700	85%	334,316	76%	1,318	8%

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	60,744	97%	60,205	96%	40,362	73%	24	4%
Māori	36,771	92%	35,718	90%	18,308	60%	51	7%
European /other	372,362	95%	368,287	94%	266,018	79%	1,233	9%
Pacific peoples	13,062	94%	12,741	92%	6,632	60%	6	3%
Unknown	5,130	125%	5,024	123%	3,000	61%	4	3%
Total	488,069	95%	481,975	94%	334,320	76%	1,318	8%

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)
Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)
Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)
Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)
50+ age determined as at 30-Jun-2022
Basis of population is HSU2021 for 12+ years old
All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :[97]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
    a. Official national and subnational projections
    b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [98]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

[97] **https://www.stats.govt.nz/methods/population-statistics-user-guide**.

[98] More information on the findings from the Stats NZ review of the HSU is available at: **stats.govt.nz/reports/review-of-health-service-user-population-methodology/**

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 596,162 health service users in the HSU 2021. This is an increase of 29,948 people from the HSU 2020 (an approximate 5% increase), and 9,762 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[99]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	53,249	59,700	6,451
Pacific peoples	18,090	17,700	-390
Asian	76,571	79,300	2,729
European/other	443,823	429,700	-14,123
Unknown	4,429	-	-4,429
Total (Note 1)	596,162	586,400	-9,762

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 596,162. This is 9,762 above the Stats NZ total projected population of 586,400 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[100]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	49,972	57,800	7,828
Pacific peoples	16,916	17,250	334
Asian	65,148	78,000	12,852

[99] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

[100] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

European/other	431,420	427,900	-3,520
Unknown	2,758	-	-2,758
Total (Note 1)	566,214	580,900	14,686

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 566,214. This is 14,686 below the Stats NZ total projected population of 580,900 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[101] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

> 'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Canterbury DHB by age group at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	1
20 to 29	0
30 to 39	0
40 to 49	2
50 to 59	2
60 to 69	13
70 to 79	42
80 to 89	66
90+	57
Total	183

[101] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Canterbury DHB by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	
Asian	5
European/other	163
Māori	11
Pacific peoples	4
Unknown[102]	0
Total	183

[102] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

9. KAIAROTAKE PŪTEA | INDEPENDENT AUDITOR'S REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Canterbury District Health Board's Group financial statements and performance information for the year ended 30 June 2022

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

Opinion

We have audited:

- the financial statements of the Group on pages 40 to 77 that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 4 to 29, 47, 78 and 80 to 89.

In our opinion:

- the financial statements of the Group on pages 40 to 77, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2022; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Group on pages 4 to 29, 47, 78 and 80 to 89:
    - presents fairly, in all material respects, the Group's performance for the year ended 30 June 2022, including:

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

o complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 6 March 2023. This is the date at which our opinion is expressed.

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

Emphasis of matters

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

The financial statements have been prepared on a disestablishment basis

Note 1 on page 45 outlines that the Group has prepared its financial statements on a disestablishment basis because the Group was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Group's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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

Note 4 on pages 49 and 50, outlines that the Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Group has estimated a provision of $196 million, as at 30 June 2022, to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

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

Footnote 28 on page 20, and pages 80 to 89 outline the information used by the Group to report on its Covid-19 vaccine coverage. The Group uses the Health Service User (HSU) population data rather than

the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 20. The information outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 29 on pages 76 and 77 to the financial statements and page 16 of the performance information outline the ongoing impact of Covid-19 on the Group.

Basis for our opinion

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

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

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

Responsibilities of the Board of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Group is the responsibility of Te Whatu Ora.

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

Up until 30 June 2022, the Group was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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

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

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

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

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

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

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

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

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

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

- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 3, 30 to 39, 79, 90 and 91 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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