South Canterbury
District Health Board

Annual Report

2019/2020

Including our Quality Accounts

E89

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

www.scdhb.health.nz

Message from the Chair

He aha te mea nui o te oa? He tangata, he tangata, he tangata

What is the most important thing in the world? It is the people, it is the people, it is the people

Welcome to the South Canterbury District Health Board Annual Report for July 2019 to June 2020.

2020 has seen a world changing pandemic, COVID-19, that continues to affect healthcare providers on an unprecedented scale. SCDHB responded quickly and effectively in a largely coordinated way to the threat of COVID-19. Our response cut through normal barriers to collaborative innovation, leading to a number of changes that were rapidly adopted and implemented. There is no doubt that COVID-19 affected services and we had to quickly adapt to an ever-changing new environment. 2020 will be a year that will change the world forever and have an impact on each and every person. During heightened alert levels, we saw a terrific effort made towards ensuring the safety of our communities and the staff who serve them. Risk management practices were effectively implemented and that is to be celebrated. Upon reflection of our 2019/20 year, we acknowledge that COVID-19 had a significant effect on District Health Board's across the country.

Me mahi tahi tatou mo te orange o te katoa – We must work together for the wellbeing of all

As a DHB we proudly stand by our vision of Every Moment Matters and we remain committed to this by continuously ensuring every voice matters, every person matters, every day matters and every dollar matters.

One of our many highlights for 2019/20 was the Timaru Hospital's future-proofing with the refurbishment of the emergency and outpatient department, resuscitation area and ambulance bay. This was followed by the front of hospital redevelopment which includes a new public and staff café, a new main entrance with an atrium, and an extension to the outpatient's department. The hospital has not undergone any refurbishments since 1999 and therefore these projects will see our hospital receive a much needed refresh and allow us to continue to provide quality healthcare to our South Canterbury community.

Our performance is measured through many indicators including community and patient satisfaction, government health targets, service levels, workforce and financial targets. Our success across all performance measures, whilst operating within our financial means, is always a challenge. We continue to collaborate nationally and regionally on projects that ensure the effective and efficient delivery of healthcare including representation on South Island Alliance Groups.

On behalf of the Board I would like to thank the staff and the community for their ongoing support. We are very proud of what we have collectively achieved and remain committed to ensuring that our community continues to benefit from the high level of quality health and disability services.

Ron Luxton, Chair

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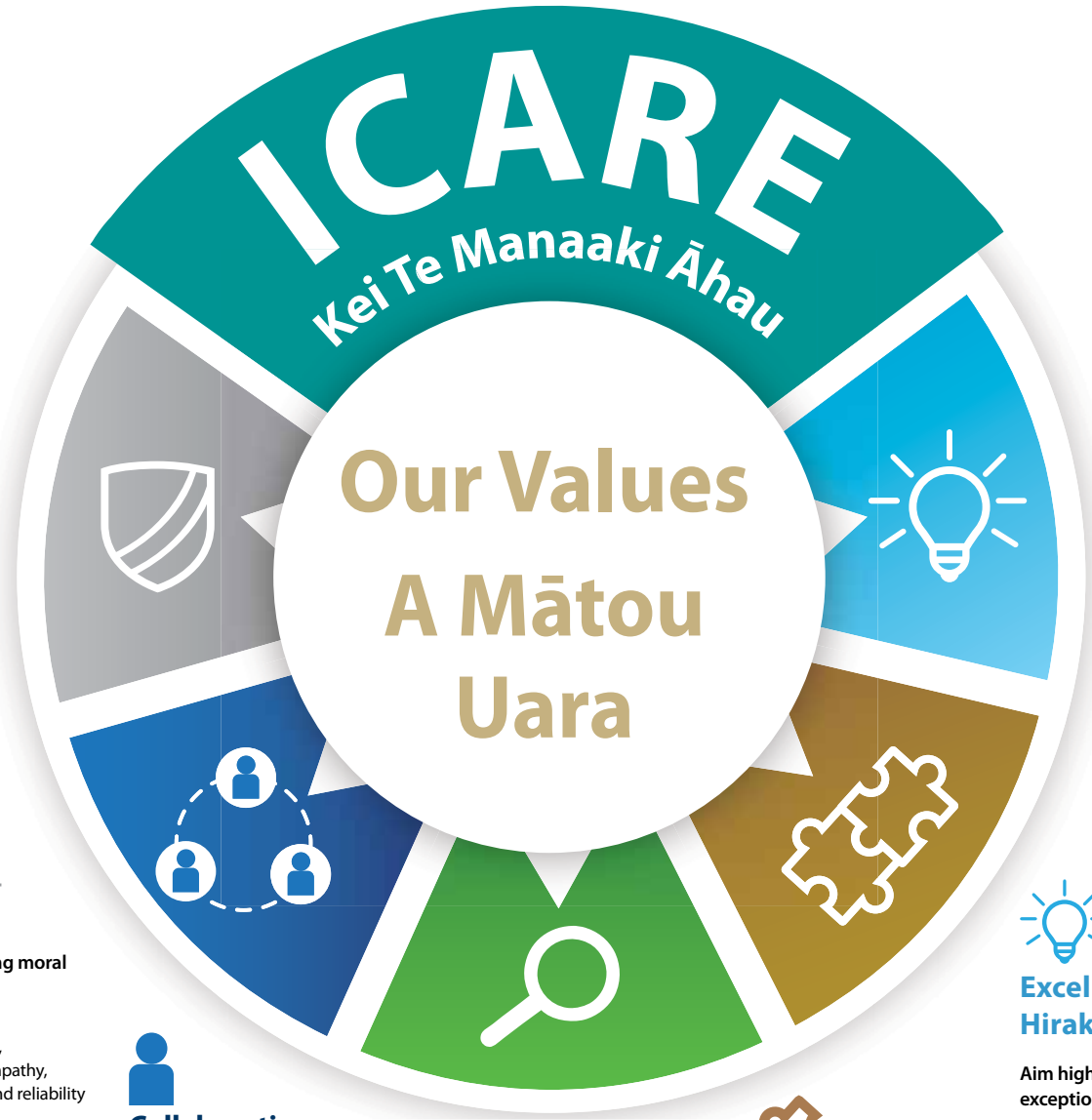
Our Vision, Mission and Values

Vision

Every moment matters

Mission

Enhancing the health and independence of the people of South Canterbury



Integrity – Pono

Honest and strong moral principles

This means I will:

- Act with honesty, transparency, empathy, confidentiality and reliability
- Uphold our professional culture
- Voice my concerns in the moment
- Accept responsibility for my actions and decisions

Collaboration – Mahi Tahi

Working together to make every moment matter

This means I will:

- Trust my colleagues across the system
- Provide colleagues with the skills, knowledge, and/or tools to engage
- Listen and contribute to communication ensuring it is clear, timely and transparent
- Seek partnership opportunities and decisions

Accountability – Whaiwhakaaro

Acknowledgement and assumption of responsibility

This means I will:

- Take responsibility for my behaviour
- Uphold commitments to others
- Continually seek to improve the outcomes of my work
- Reflect on and own errors and mistakes as an opportunity for improvement

Respect – Whakaute

Fostering inclusion and embracing diversity

This means I will:

- Be aware of my assumptions and biases
- Practice active listening
- Acknowledge thoughts, opinions and actions of others
- Invite participation from and value the role of others

Excellence – Hiraka

Aim high to deliver exceptional results

This means I will:

- Demonstrate high levels of professionalism
- Take pride in my work and my contribution to the organisation
- Use evidence-based practises to drive activity, continuous improvement and innovation

The South Canterbury DHB Strategy

Where do we want to go, and how do we get there?

Our strategic goals provide the vision for where we want to be while the priorities outline how we will achieve the goals over the coming years.

STRATEGIC GOALS	STRATEGIC PRIORITIES
PRODUCTIVE PARTNERSHIPS	■ Engaging the consumer's voice ■ Bolstering community collaboration ■ Strengthening regional relationships
INTEGRATED PERSON-CENTRED CARE	■ Improving health literacy ■ Designing sustainable models of care ■ Developing Primary Care Strategy
VALUING OUR PEOPLE	■ Enhancing the DHB culture ■ Equipping our staff for the future ■ Fostering innovation in the workplace
HEALTH EQUITY FOR ALL	■ Casting an equity lense over all that we do ■ Developing a Hauora Māori Strategy ■ Building cultural competency across the DHB
FIT FOR FUTURE	■ Progressing site development ■ Developing a local IT strategy ■ Obtaining value for money

Our Strategy is about change...

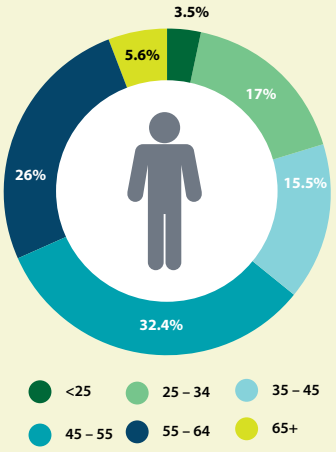
It is about being truly person centric, doing the best for the community we serve.

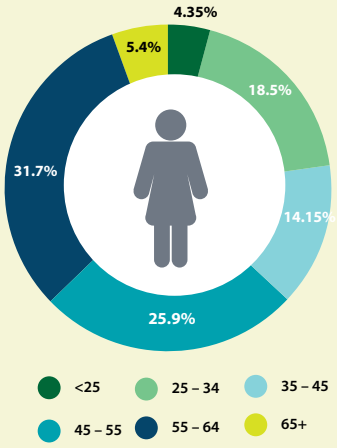
SNAPSHOT 2019/2020

876 EMPLOYEES

(Positions held 969 (multi-jobbed)) **15%** male **85%** female

Workforce Profile – by age bands





Employee Status

Casual **17%** Part time **56%** Full time **27%**

Figures sourced from Employee Report Data

TIMARU LAB RESULTS

319,326
COMMUNITY, OUTPATIENT AND HOME VISITS

137,097
EMERGENCY AND INPATIENT

(excludes all commercial and non-contract work and cervical smears)

5,956
Breast screens (50 – 69yrs)

11,575
Inpatient discharges

9,003
Mental Health community + outpatients visits

3,129 THEATRE EVENTS

38,402
District nursing visits

431,119
Primary Care Provider visits

23,134 Community visits by allied health services

227
Mental health admissions

624
Deaths in South Canterbury

561
Babies born in hospital

39,853 Radiology Exams

1,049 Chemotherapy attendances

25,330 Outpatient attendances

604
Number of 8 month olds immunised

561
B4 school checks

19,896 EMERGENCY DEPARTMENT PRESENTATIONS

Key Performance Indicators

These performance measures are specifically designed to improve the performance of health services. They provide a focus for action.

Shorter stays in emergency departments

Target **95%**

95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours.

Our Results

	2018/19	2019/20
Q1	96.3%	94.8%
Q2	96.8%	95.1%
Q3	97.3%	94.9%
Q4	95.9%	96.9%

Increased Immunisation

Target **95%**

95% of infants aged eight months will have completed their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

Our Results

	2018/19	2019/20
Q1	93%	91.1%
Q2	93.5%	92.7%
Q3	91.9%	96%
Q4	95%	96.2%

Better Help for Smokers to Quit

Target **90%**

90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

Our Results

	2018/19	2019/20
Q1	87.6%	81.1%
Q2	86.7%	82.4%
Q3	82.7%	86%
Q4	80.6%	82.6%

Raising Healthy Kids

Target **95%**

The target is that by December 2017, 95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Our Results

	2018/19	2019/20
Q1	86%	100%
Q2	93%	96%
Q3	94%	96.2%
Q4	100%	100%

Shorter Waits for Cancer Treatment

Target **90%**

90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Our Results

	2018/19	2019/20
Q1	73.8%	77.1%
Q2	93.9%	73.5%
Q3	93%	68.8%
Q4	87.8%	60.6%

Members of the Board and Committees

Ron Luxton

- Elected member South Canterbury District Health Board, Chair
- Community & Public Health and Disability Support Advisory Committee member
- Hospital Advisory Committee member
- Audit and Assurance Committee member

Phil Hope

- Appointed member South Canterbury District Health Board, Deputy Chair
- Audit and Assurance Committee Deputy Chair
- Community & Public Health and Disability Support Advisory Committee member
- Hospital Advisory Committee member

Paul Annear

- Elected member South Canterbury District Health Board
- Hospital Advisory Committee Chair
- Community & Public Health and Disability Support Advisory Committee member
- Audit and Assurance Committee member

Jo Goodhew

- Elected member South Canterbury District Health Board
- Community & Public Health and Disability Support Advisory Committee Chair
- Hospital Advisory Committee member
- Audit and Assurance Committee member

Bruce Small

- Elected member South Canterbury District Health Board
- Community & Public Health and Disability Support Advisory Committee member
- Hospital Advisory Committee member

Suran Dickson

- Appointed member South Canterbury District Health Board
- Hospital Advisory Committee Deputy Chair
- Community & Public Health and Disability Support Advisory Committee member

Karl Te Raki

- Appointed member South Canterbury District Health Board
- Community & Public Health and Disability Support Advisory Committee member
- Hospital Advisory Committee member

Rene Crawford

- Elected member South Canterbury District Health Board
- Community & Public Health and Disability Support Advisory Deputy Chair
- Hospital Advisory Committee member

Peter Binns

- Elected member South Canterbury District Health Board
- Community & Public Health and Disability Support Advisory Committee member
- Hospital Advisory Committee member

Raeleen de Joux

- Elected member South Canterbury District Health Board
- Community & Public Health and Disability Support Advisory Committee member
- Hospital Advisory Committee member

Mark Rogers

- Appointed member South Canterbury District Health Board
- Audit and Assurance Committee Chair
- Community & Public Health and Disability Support Advisory Committee member
- Hospital Advisory Committee member

Past Members of the Board

"Ehara toku toa i te toa takitahi. He toa takiitini toku toa" – My strength is not due to me alone, but due to the strength of many.

SCDHB would like to acknowledge our past Board Members, we thank you for your leadership and governance during your time on the Board.

Murray Cleverley

Edie Moke

Michael Boorer

Murray Roberts

Terry Kennedy

Māori Health Advisory Committee

Karl Te Raki	Chair
Raeleen de Joux	Deputy Chair
Ron Luxton	SCDHB Board Chair
Peter Binns	Board Member
Karin Thomas	Te Aitarakihi Trust Committee Member
Suzanne Eddington	Te Runanga o Waihao Committee Member
Juliette Stevenson	Te Runanga o Waihao Committee Member
Arahia Goldsmith	Te Aitarakihi Trust Committee Member
Elizabeth (Lisa) Stevenson	Te Runanga o Arowhenua – Committee Member
Pamela Manning	Te Runanga o Arowhenua – Committee Member

Quality accounts

The Health Quality and Safety Commission (HQSC) is driving improvement in the safety and quality of New Zealand health care through its quality improvement programmes. The set of quality and safety markers (QSM) help to evaluate the success of the programmes and determine whether the desired changes in practice and reductions in harm and costs have occurred. This is achieved through setting expected levels of improvement, public reporting of progress against these levels and supporting links to accountability mechanisms.

The markers are reported by calendar year and are a mix of process measures (ensuring a defined protocol is followed) and outcome measures (whether the protocol is having the desired effect based on clinical measures). The focus is on driving improvement for key safety priorities. The current markers are:

1. **Falls**
2. **Healthcare associated infections**
   a. Surgical Harm (safe surgery)
   b. Hand hygiene
   c. Surgical Site Infection (cardiac and orthopaedic – hip and knee arthroplasty) surgeries
3. **Medication safety**
4. **Deteriorating Patient Programme**
   a. Recognition and Response
   b. Korero Mai
   c. Shared Goals of Care

Falls

Falls are a leading cause of injuries to older people. One out of three older people have a fall each year. Underlying conditions or problems with balance, strength or mobility increase the risk of falling for older people. The national target requires that:

1. 90% of older inpatients are given a falls risk assessment. Our results over the 2019 year have been that between 89 and 98% of older inpatients (patients aged 75+ and Maori and Pacific peoples 55+) have received a falls risk assessment. This was on one occasion and was the first time since 2013 we have not met the 90% target.
2. 95% of older people assessed as at risk of falling receive an individualized care plan that addresses their falls risk. Our results have been between 77-83%.

Safe Surgery

The safe surgery programme aims to improve the perioperative care by encouraging operating theatre teams to consistently use safety checks on all patients to improve teamwork and communication. There are three national targets:

1. Safe surgery measures are the levels of teamwork and communication around the use of the three paperless surgical checklist parts: sign in, time out and sign out via direct observational audit. A minimum of 50 observational audits per part per quarter are required before the observation is included in the uptake and assessment. Due to our unique process for surgical checklist completion (which our clinical team all support as best practice), we discuss all elements before the surgery begins and the patient is included in this process. This makes our auditing process incompatible with all the national indicators.
2. 100% of audits where all components of the checklist were reviewed. Our results were: Sign in: insufficient observations; Time out: between insufficient observations – 100%; Sign out: between insufficient observations – 100%
3. 95% of audits where the staff engagement in the process was 5 or higher (on a scale of 1-7): our results were between insufficient observations – 97%

Our results show we have increased our compliance when we have recorded the minimum observational audits per quarter. There has been a change in staff and more auditors have been trained to increase out auditing capacity. There has been an increase in staff engagement compared to last year.

Hand Hygiene

Effective hand hygiene is the single most important strategy in preventing healthcare associated infections. Hand hygiene is a general term for washing hands with soap/solution and water or using a waterless antimicrobial gel on the hands. When performed correctly, hand hygiene results in a reduction of microorganisms on hands, helping to reduce the risk that infectious organisms will be spread between patients on the hands of healthcare workers. The 5 moments when hand hygiene should be performed are:

1. Before touching a patient
2. Before a procedure
3. After a procedure or body fluid exposure risk
4. After touching a patient
5. After touching a patient's surroundings

The national target requires 80% compliance with good hand hygiene practice (5 moments). Our results from November 2018 to October 2019 have been between 77 and 84%. These results have reflected the renewed focus on educating staff to improve their hand hygiene understanding and compliance. Our results continue to improve as we have rolled the auditing process out to more departments within the hospital.

Surgical Site Infection

Health care associated infections are a significant risk to patients and surgical site infections are among the highest proportion of these risks so this programme was established to provide a standardized approach for initially hip and knee replacement surgery that could be measured and compared nationally. There are two national targets for this marker:

1. 100% of the primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision. Our results over the last year have been between 93-100%. We continue to work on improving our performance.
2. The second marker is 95% of hip and knee (primary and secondary) replacement patients receive 2g or more of cefazolin or 1.5g or more of cefuroxime. Our results over the last year have been 94-100%. This is an improvement on last year.

Medication Safety

The QSM for medication safety focuses on medicine reconciliation. This is a process by which health professionals accurately document all medicines a patient is taking and their adverse reactions history (including allergy). The information is then used during the patient's journey across transitions in care. The national programme to roll out the electronic medicine reconciliation (eMR) process has so far been implemented in five DHBs and South Canterbury DHB is not one of these.

Deteriorating Patient Programme

HQSC introduced this QSM in 2018 to promote a nationally consistent approach to recognizing and responding to acute physical deterioration in adult patients. It consists of three work streams:

1. Recognition and Response: This included introducing a national vital signs chart which includes an early warning score (excluding maternity) and has the clinical escalation pathway. The QSM that are associated with this workstream is:
   a. 100% of eligible wards using the New Zealand early warning score. Our results are 50-75%
   b. 100% of early warning scores are calculated correctly. Our results are 62-94%
   c. 100% of patients that triggered an escalation of care and received appropriate response. Our results are 44-88%
2. Korero mai – patient, family and whānau escalation: Patients and family often recognize subtle signs of deterioration, even if vital signs are normal. The purpose of this HQSC led Korero Mai (Talk to Me), was to co-design a patient, family and whānau communication process to enable staff to establish whether family and whānau were concerned about a loved one's care. This workstream is still under development
3. Shared goals of care: this workstream is yet to be commenced and will begin when Korero Mai has been completed.

Being a good employer

Great health care for patients starts with great care for staff.

Leadership, Accountability and Culture

After the introduction of a new leadership structure in 2016, there has been a continued push to enable greater distributive leadership. This model has led to shared clinical and operational accountability and further shifts the authority to act and manage teams to the lowest levels; recognising that staff at the 'coalface' are best positioned to make the daily decisions affecting their areas. A review of the effectiveness of this model in 2018 led to a further refining/flattening out of the leadership structure, introducing self-directed teams and enabling front-line Managers and teams, to hold greater accountability and responsibility for their areas/services. This included for example the Clinical Directors being given direct responsibility for staffing of their Specialties along with operational management of the team and CNMs/CNSs to form clusters, which report direct to the Director of Nursing, Midwifery & Patient Services. At the same time, our HR, Learning Hub, and Quality & Risk Teams adopted a 'self-directed team' model.

Our original culture reset programme, stemmed from the 2016 Staff Engagement and Wellbeing Survey, that began a transition from largely hierarchical, control-based framework for decision making to a learning health system characterised by distributive leadership.

We have tracked our cultural progress through a biennial engagement and wellbeing survey which showed improvement across nearly all domains in the 2018 follow up. A key enabler for distributive leadership and our learning culture has been our bespoke leadership learning programme "Navigate". This has been available to any member of our health system ready to step into greater influence and leadership and most recently our Kaupapa Māori Waka – aimed at accelerating leadership capability and capacity among our Māori and Pacifika community was a resounding success creating new and meaningful connections across community support/social and health services for South Cantabrians.

South Canterbury DHB was also the first DHB to adopt High Performance High Engagement (HPHE); a partnership programme with some of our unions which empowers unions, staff and leaders to continually improve the sustainability of health provision in South Canterbury. The principles continue to build a sense of collaboration and partnership.

In addition, a refresh of our initial adoption of the 'Speaking up for Safety' and 'Promoting Professional Accountability' processes from the Cognitive Institute is helping to keep our cultural change expectations on track by providing staff with two proven tools to assist them to challenge behaviours seen as being undesirable/at odds with our culture.

Wellbeing

We have established a wellbeing committee and created a wellbeing framework for SCDHB against which we are now planning for strategies to support a resilient workforce that is supported and enabled to thrive. Our COVID-19 response demonstrated both our significant cultural strength and adaptability as well as clear opportunities to increase our investment in wellbeing initiatives. This is a major focus for the coming year with attention to the occupational health needs of our workforce that were highlighted during the pandemic response.

Recruitment, Selection and Induction

We recognise that to be successful in the sustainable delivery of high-quality health services locally, we need to be able to recruit and retain staff who reflect and are deeply connected to, our wider community. In particular we engage in health careers activities for young people, provide a family friendly approach to engagements wherever possible, and support the ongoing inclusion of an aging workforce. This year we have partnered with ARA and Kia ora Hauora to promote health careers to students and schools locally with a clear goal of inspiring the next generation of health professionals.

Our HR Team is actively liaising with our Director of Maori Health to cast a cultural lens over and inform our recruitment process in terms of further promoting diversity and addressing inequities in ethnic representation across our workforce.

As one of 20 District Health Boards we continue to collaborate at a regional and national level to improve recruitment efforts and to strengthen the public health employer brand. We successfully developed a comprehensive marketing campaign to rebrand Midwifery Services in wake of a new service delivery model (that included telling staff & client stories which were well received).

Comprehensive work has continued around developing our E-Recruitment platform which has reduced the paperwork burden for Hiring Managers and allowed more transparency and efficiency in the various recruitment process stages for both Managers and applicants. We reviewed our recruitment advertising supplier and in partnership with a new provider we have undertaken an employer of choice rebranding process which has resulted in the development of a new EVP and the creation of contemporary advertising resources (such as promotional videos).

Employee Development, Promotion and Exit

Our performance review process provides a means for two-way communication whereby all employees review their performance, engage in professional development planning and gain clear direction for the future. Managers are committed to the ongoing process of coaching, constructive feedback and formal appraisals which are linked to organisation goals and enable our organisation to move forward.

The current organisation-wide performance appraisal tool is future focused and explores our values in action and individual aspirations as much as reflecting on past performance. Our leadership learning programme 'Navigate' has created a community of learning and is growing exponentially through spin off smaller scale workshops such as monthly Leadership Matters forums and crucial conversations workshops for both teams and individuals. Further work has been put into obtaining increased compliance with Exit interview feedback requests and this

is now being tracked and managed by HR (along with Performance Appraisal rate compliance). A Monthly Leadership Training Schedule for Line Managers has been established by HR, where presenters are booked to deliver a presentation on various topics prioritised by our line managers. This is proving popular and has since been extended to run across the 2021 calendar.

Flexibility and Work Design

We know that in order for our staff to be able to provide top quality care for our community we need to first provide quality care to them. South Canterbury DHB recognises the importance of Family Friendly initiatives and where possible is keen to support alternative options for working. A Flexible Working Policy has recently been developed and implemented. The Workforce Governance Group aims to support a learning health care community delivering outstanding health care while ensuring sustainable work-life throughout our working lifespans. Our transition to retirement policy has started to be utilised by some staff to support dignified exit at the end stage of careers.

Remuneration, Recognition and Conditions

We endeavour to remunerate all staff fairly and consistently, ensuring that remuneration and conditions are equitable and in line with collective employment agreements.

We also participate in initiatives which focus on determining new salary structures. Significant national MECA Increases negotiated over recent times (e.g. Nursing, Allied Health, RMOs, SMOs) are starting to lead to an improvement in retention and attraction rates for our DHB.

SCDHB's Director of Allied Health has recently led the South Island DHB's work in establishing (together with the Union) an agreed Allied & Public Health Career Framework standard, tools and process, for the evaluation of Roles for remuneration setting. SCDHB's Director of Organisational Capability & Safety is the lead GM-HR for the National Pay Equity Claim for Administration staff.

Harassment and Bullying Prevention

South Canterbury DHB has engaged the Cognitive Institute to develop a training programme which is now embedded as part of orientation, to empower all staff to speak up in the moment when they are concerned for staff or patient safety. The Safety C.O.D.E. encourages people to increase the level of respect they convey alongside an increasing level of concern. Recognising colleagues as professionals and acknowledging that no-one comes to work to deliberately cause harm to patients or cause distress to colleagues has been received universally well. To support this culture shift changes have been made the Disciplinary Policy and Code of Behaviour document.

We know that culture doesn't change overnight, so while we continue developing these speaking up skills, the DHB has invested in Promoting Professional Accountability (PPA). PPA is an anonymous reporting tool that allows people to provide an anonymous nudge to a colleague that alerts them to the fact their behaviour is not representative of our values.

Our crucial conversations workshops and more intensive leadership learning programme, provided alternative models for effective professional reflection, learning and communication.

Safe and Healthy Environment

Creating a safe and healthy environment requires an organisation to effectively engage the whole team, empowering them to participate and innovate. For this reason, a major focus has been a thorough, consultative review of policies and procedures to ensure they are fit-for-purpose. An example being the focus on health monitoring which resulted in the creation of a comprehensive hearing conservation programme, with 'wellbeing' featuring in all of the work now being undertaken and the creation of a wellbeing group.

Creating a learning environment is vital when raising the understanding of hazards and controls, for this reason education sessions and workshops along with improved reporting of key indicators, occurs across all levels of the organisation on a monthly basis.

All hazard registers have been reviewed and this has helped inform a review of our risk register. We are particularly pleased with the production of our hazardous substances inventory [shared with Fire Safety NZ] and the associated learning package, which is mandatory for all staff and was included into the regional e-learning platform (HealthLearn).

Emergency preparedness took a major leap forward, with the introduction of a total evacuation and relocation procedure, introduction of vertical evacuation resources (with training for key staff) and the roll out of survival and casualty management packs. Regular reminders to staff about the need for personal planning for states of civil emergencies for families and home environments are undertaken along with offering key supplies for use in building personal emergency kits are offered for sale at modest prices.

The advent of COVID-19 Pandemic has helped test existing systems, identified gaps, but also demonstrated the adaptability and resilience of Teams and our service. Incident Management continues to be reviewed in the wake of those learnings and has led to the redevelopment of our Vaccinations Policy.

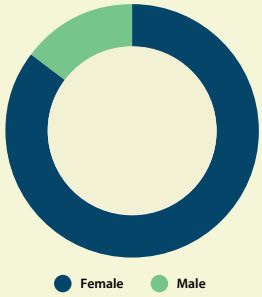
Our Employees

The principles of being a good employer are reflected in our employee mix. Our workforce is predominantly New Zealand European which is reflective of our South Canterbury community; however, we enjoy a multicultural workplace with representation from across the globe. The division of part-time versus full-time staff demonstrates our commitment to providing a flexible working environment. As with healthcare in New Zealand in general, we are a predominantly female driven workforce and we continue to keep an eye on the average age of our workforce ensuring sustainability over the coming years.

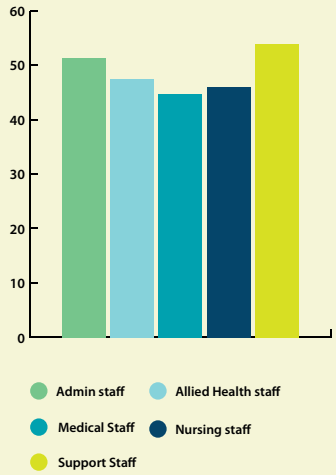
Distribution of employee ethnicity

Not Stated	38	Filipino	22	Other	1
Refused	6	German	3	Russian	1
African	1	Greek	1	S.East Asiannec	1
African Nec	1	Indian Nec	4	S.East Asiannfd	17
African Nfd	7	Indian Nfd	13	Samoan	1
American	8	Indian Tamil	1	Scottish	1
Asian Nfd	4	Irish	1	Sing. Chinese	1
Australian	11	Korean	1	Southeast Asian	2
British Nec	5	Lat Americanfd	1	Sri Lankan Nfd	1
British Nfd	36	Malay	1	Sth Af European	6
Canadian	5	Malay. Chinese	1	Swedish	1
Celtic Nfd	1	Maori	39	Swiss	2
Chinese	1	Mdl Eastern Nfd	4	Tongan	1
Chinese Nfd	4	Middle Eastern	1	Afrikaner	1
Dutch	3	Nepalese	2	Taiwanese	1
English	6	New Zealander	15	Sri Lankan Nec	1
European Nfd	45	Not Available	1	Bulgarian	1
European Undfin	28	Nz European	605	Grand Total	1007
Fijian	3	Nz Maori	1		

Gender



Average age by profession



Employment type

Casual **17.3%** Part time **55.7%** Full time **27%**

South Canterbury District Health Board - Median Hourly Rate Pay Gap Analysis

By Gender & Ethnicity, 1 October 2020

Occupational Group	Measure	Gender				Ethnicity					
		All	Female	Male	Pay Gap - Female	All	Maori	Pacific	Other	Pay Gap - Maori	Pay Gap - Pacific
Senior Medical	Median Hourly Rate	104.29	92.95	114.06	18.5%	104.29			104.29		
	Positions	71	24	47		71			71		
Junior Medical	Median Hourly Rate	50.70	49.28	52.38	5.9%	50.70		52.73	49.38		-6.8%
	Positions	26	14	12		26		2	24		
Nursing	Median Hourly Rate	37.10	37.10	37.10	0.0%	37.10	36.02	22.34	37.10	2.9%	39.8%
	Positions	510	480	30		510	25	3	482		
Allied Health	Median Hourly Rate	35.99	35.99	37.78	4.7%	35.99	35.99		35.99	0.0%	
	Positions	133	119	14		133	3		130		
Non Clinical Support	Median Hourly Rate	24.58	24.58	24.58	0.0%	24.58	28.38		24.58	-15.5%	
	Positions	41	27	14		41	4		37		
Management & Administration	Median Hourly Rate	25.00	25.00	34.24	27.0%	25.00	41.77		25.00	-67.1%	
	Positions	172	150	22		172	6		166		
All Staff	Median Hourly Rate	37.10	36.02	49.19	26.8%	37.10	36.00	37.10	37.10	3.0%	0.0%
	Positions	953	814	139		953	38	5	910		

Notes to Analysis

1. Pay gaps are calculated using the methodology recommended by the Human Rights Commission and Statistics New Zealand.
2. Pays gaps do not necessarily reflect different pay for identical work. Variation in occupation may be a factor.
3. Pay gaps signal gaps in the median hourly earnings between employees in each group.
4. Results where employee numbers are low in one or more categories may not be significant.

Financial Performance

In this section you will find:

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Independent Auditors Report	**16**
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Statement of Changes in Equity	**19**
Statement of Financial Position	**20**
Statement of Cashflows	**21**
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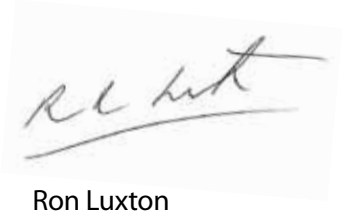
Statement of Responsibility

For the year ended 30 June 2020

1. The Board and management of South Canterbury District Health Board accept responsibility for the preparation of the annual financial statements and statement of service performance and the judgments used in them.

2. The Board and management of South Canterbury District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

3. In the opinion of the Board and management of South Canterbury District Health Board, the annual financial statements and statements of service performance for the year ended 30 June 2020 fairly reflect the financial position and operations of South Canterbury District Health Board.



Ron Luxton
Chair
14 December 2020

Nigel Trainor
Chief Executive
14 December 2020

Phil Hope
Deputy Chair
14 December 2020

Independent Auditors Report

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

The Auditor-General is the auditor of the South Canterbury District Health Board Group (the Group). The Auditor-General has appointed me, Rudie Tomlinson, 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 an appropriation, of the Group on his behalf.

We have audited:

- the financial statements of the Group on pages 18 to 50, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Group on pages 7, 51 and 53 to 70.

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the Basis for our qualified opinion section of our report, the financial statements of the Group on pages 18 to 50:

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

Unmodified opinion on the performance information

In our opinion, the performance information of the Group on pages 7 and 50 to 69:

- presents fairly, in all material respects, the Group's performance for the year ended 30 June 2020, including:
  - for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 14 December 2020. This is the date at which our opinion is expressed.

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

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

As outlined in note 15 on page 38, 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 provision for employee entitlements includes a provision of $14.7 million for the estimated amounts owed to current and past employees. Due to the complex nature of health employment arrangements, the Group's process is ongoing, and there is a high level of uncertainty over the amount of the provision. Because of the work that is yet to be completed, we have been unable to obtain sufficient appropriate audit evidence to determine if the amount of the provision is reasonable.

We were also unable to obtain sufficient appropriate audit evidence of the $14 million provision as at 30 June 2019. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

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 the basis for our qualified opinion on the financial statements and the basis for our opinion on the performance information.

Emphasis of matter

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

Impact of Covid-19

Note 29 on pages 49 to 50 outlines the impact of Covid-19 on the Group.

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

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

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

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

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

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Group's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the Group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 3 to 6, 8 to 15 and 71 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.

Rudie Tomlinson

Audit New Zealand

On behalf of the Auditor-General

Dunedin, New Zealand

Statement of Comprehensive Revenue and Expenses

for the year ended 30 June 2020
In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2020	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Patient Care Revenue	*2a*	209,700	219,281	205,226	220,450	205,327
Other Revenue	*2b*	2,015	2,450	2,554	1,652	2,429
Finance Revenue	*2c*	611	628	814	629	815
Total Revenue		212,326	222,359	208,594	222,731	208,571
Personnel Costs	*3*	70,593	74,581	82,881	74,358	82,688
Outsourced Services		9,086	10,212	10,653	10,357	10,779
Clinical supplies		11,421	11,190	9,970	11,216	9,997
Infrastructure and non-clinical expenses		9,845	10,875	11,366	11,010	11,446
Payments to non-DHB health providers		104,626	109,382	101,800	109,382	101,800
Depreciation and amortisation expense	*7&8*	4,424	4,348	4,424	4,362	4,436
Finance costs	*4*	-	-	4	2	6
Capital charge	*5*	2,304	1,648	2,389	1,648	2,389
Total Expenditure		212,299	222,236	223,487	222,335	223,541
SURPLUS/(DEFICIT)		27	124	(14,893)	396	(14,970)
Other Comprehensive Revenue and Expenses						
Item that will not be reclassified to surplus or (deficit)						
Gain on property revaluation		-	-	2,667	-	2,667
Total Other Comprehensive Revenue and Expenses		-	-	2,667	-	2,667
TOTAL COMPREHENSIVE REVENUE AND EXPENSES		27	124	(12,226)	396	(12,303)

Explanations of major variances against budget are provided in note 27.

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2020
In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2020	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Balance at 1 July		41,162	28,996	41,438	28,739	41,258
Comprehensive revenue/ (expense)						
Net Surplus/(Deficit) for the year	*9*	27	124	(14,893)	396	(14,970)
Other Comprehensive Revenue	*9*	-	-	2,667	-	2,667
Total comprehensive revenue		27	124	(12,226)	396	(12,303)
Capital Movements						
Repayment to Crown	*9*	(253)	(216)	(216)	(216)	(216)
Contribution from Crown	*9*	-	-	-	-	-
Total of Capital Movements		(253)	(216)	(216)	(216)	(216)
Balance at 30 June		40,936	28,904	28,996	28,919	28,739

The accompanying notes form part of these financial statements.

Statement of Financial Position

as at 30 June 2020
In thousands of New Zealand Dollars

		Parent			Group	
		Budget 2020	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Public Equity						
General Funds	9	16,264	15,969	16,184	15,969	16,184
Accumulated Surplus	9	10,353	(4,050)	(4,211)	(4,035)	(4,468)
Equity from Donated Assets	9	1,536	1,535	1,572	1,535	1,572
Revaluation Reserve	9	12,783	15,450	15,451	15,450	15,451
Total Equity		40,936	28,904	28,996	28,919	28,739
REPRESENTED BY:						
ASSETS						
Current Assets						
Cash and cash equivalents	10	4,203	9,770	7,639	10,050	7,671
Financial Assets	11	-	7,600	12,778	7,600	12,778
Debtors and other receivables	12	6,650	7,227	7,298	7,203	7,307
Inventories	13	1,170	1,436	1,242	1,436	1,242
Patient Trust Funds	10	-	2	2	2	2
Total Current Assets		12,023	26,035	28,959	26,291	29,000
Non Current Assets						
Financial Assets	11	13,925	5,525	347	5,178	-
Property, plant and equipment	7	40,812	40,232	38,594	40,282	38,636
Intangible assets	8	2,254	3,617	3,110	3,818	3,310
Total Non Current Assets		56,991	49,374	42,051	49,278	41,946
TOTAL ASSETS		69,014	75,409	71,010	75,569	70,946
LIABILITIES						
Current Liabilities						
Creditors and other payables	14	11,841	11,343	8,526	11,400	8,658
Employee entitlements	15	8,765	26,868	24,840	26,956	24,901
Borrowings	16	-	-	49	-	49
Finance Lease Liability	17	-	169	169	169	169
Patient Trust Funds	10	-	2	2	2	2
Total Current Liabilities		20,606	38,382	33,586	38,527	33,779
Non Current Liabilities						
Term Loans	16	16	-	-	-	-
Finance Lease Liability	17	506	169	337	169	337
Employee Entitlements	15	6,950	7,954	8,091	7,954	8,091
Total Non Current Liabilities		7,472	8,123	8,428	8,123	8,428
TOTAL LIABILITIES		28,078	46,505	42,014	46,649	42,207
NET ASSETS		40,936	28,904	28,996	28,919	28,739

The accompanying notes form part of these financial statements.

Statement of Cashflows

for the year ended 30 June 2020
In thousands of New Zealand Dollars

	Parent			Group	
	Budget 2020	**Actual 2020**	**Actual 2019**	**Actual 2020**	**Actual 2019**
CASH FROM OPERATING ACTIVITIES					
Cash was provided from:					
Receipts from Ministry of Health & Other Revenue	211,170	221,912	208,660	222,311	208,636
Interest Received	611	628	814	629	815
	211,781	222,540	209,474	222,941	209,451
Cash was applied to:					
Payments to suppliers & employees	205,654	212,615	201,205	212,737	201,178
Capital Charge	2,304	1,648	2,389	1,648	2,389
Interest Paid	-	-	4	2	6
GST (net)	-	(802)	48	(797)	27
	207,958	213,461	203,646	213,590	203,600
Net cash inflow/(outflow) from operating activities	3,823	9,079	5,828	9,350	5,851
CASH FROM INVESTING ACTIVITIES					
Cash was provided from:					
Proceeds from the sale of assets	-	114	27	114	27
Proceeds from Sale of Investment	-	-	-	-	-
Term Deposits Matured	-	12,778	2,000	12,778	2,000
Decrease in Special Funds	-	-	-	-	-
	-	12,892	2,027	12,892	2,027
Cash was applied to:					
Purchase of fixed assets	9,623	6,628	5,943	6,651	5,943
Purchase of Investments	-	12,778	2,122	12,778	2,122
Purchase of Goodwill	-	-	-	-	-
Term Deposits over 1 year	-	-	-	-	-
	9,623	19,406	8,065	19,429	8,065
Net cash inflow/(outflow) from investing activities	(9,623)	(6,514)	(6,038)	(6,537)	(6,038)
CASH FLOWS FROM FINANCING ACTIVITIES					
Cash was provided from:					
New Borrowings - MOH	-	-	-	-	-
New Borrowings - Energy Efficiency	-	-	-	-	-
New Finance Lease	-	-	-	-	-
Proceeds from Equity injections	-	-	-	-	-
	-	-	-	-	-

	Parent			Group	
	Budget 2020	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Cash was applied to:					
Finance Lease repayment	-	169	169	169	169
Repayment of Loans	-	49	66	49	66
Repayment of Equity	-	216	216	216	216
	-	434	451	434	451
Net cash inflow/(outflow) from financing activities	-	(434)	(451)	(434)	(451)
Net increase/(decrease) in cash held	(5,800)	2,131	(661)	2,379	(638)
Opening cash and cash equivalents	10,003	7,639	8,300	7,671	8,309
Closing cash and cash equivalents	4,203	9,770	7,639	10,050	7,671
Made up of:					
Balances at bank	4,203	9,770	7,639	10,050	7,671

The GST (net) component of operating activities reflects net GST paid and received with the Inland Revenue Department. The GST (net) component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statements purposes.

The notes form an integral part of and should be read in conjunction with these financial statements.

Reconciliation of net surplus/(deficit) to net cash flow from operating activities *In thousands of New Zealand Dollars*

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Net surplus/(deficit)	124	(14,893)	396	(14,970)
Add/(less) non-cash items:				
Depreciation and amortisation expense	4,348	4,424	4,362	4,436
Impairment of Investment	-	856	-	856
Total non cash items	4,348	5,280	4,362	5,292
Add/(less) item classified as investment activity:				
Increase (decrease)in investments	-	-	-	-
Total investing activity items	-	-	-	-
Add/(less) movements in working capital items:				
(Increase)/decrease in receivables and prepayments	71	920	103	916
(Increase)/decrease in inventories	(194)	(182)	(193)	(182)
Increase/(decrease) in payables and accruals	4,846	14,204	4,798	14,296
Increase/(decrease) in employee entitlements	(137)	526	(137)	526
Net working capital movement	4,586	15,468	4,571	15,556
Add/(less) movements in other items:				
Loss/(Gain) on sale of fixed assets	21	(27)	21	(27)
	21	(27)	21	(27)
Net cash (outflow)/inflow from operating activities	9,079	5,828	9,350	5,851

Notes to the Financial Statements

For the year ended 30 June 2020

1. Statement of Accounting Policies

Reporting entity

South Canterbury District Health Board (the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the Public Health and Disability Act 2000. The DHB's ultimate parent is the New Zealand Crown.

The group consists of the DHB and its subsidiary, South Canterbury Eye Clinic Limited. The DHB's subsidiary is incorporated and domiciled in New Zealand.

The group is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

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

The group's primary objective is to deliver health, disability, and mental health services to the community within its district. The group does not operate to make a financial return.

Funds administered on behalf of patients have been reported as a note to the financial statements.

The financial statements for the group for the year ended 30 June 2020 were approved by the Board on 14th December 2020.

Basis of preparation

The financial statements have been prepared on a going concern basis, using historical costs, except that land and buildings are stated at fair value. The accounting policies have been applied consistently throughout the year.

Statement of Compliance

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

The financial statements have been prepared in accordance with Tier 1 PBE Accounting Standards and comply with those standards.

Presentation currency and rounding

The financial statements are presented in New Zealand Dollars and all values are rounded to the nearest thousand dollars ($000), other than remuneration disclosed in Note 22 and related party transaction disclosures in Notes 21 and 28 , which are rounded to the nearest dollar.

Changes in accounting policies

There have been no changes in the group's accounting policies since the date of the last audited financial statements.

Standards issued and not yet effective and not early adopted

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

Financial instruments

In January 2017, the XRB issued PBE IFRS9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for financial years beginning on or after 1 January 2021, with earlier adoption permitted. The main changes under the standard relevant to the DHB are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The timing of the DHB adopting PBE IFRS 9 will be guided by the Treasury's decision on when the new standard for financial instruments will be included in the Financial Statements of the Government. The DHB has not yet assessed in detail the impact of the new standard. Based on an initial assessment, the DHB anticipates that the standard will not have a material effect on the DHB's financial statements.

Ministerial Directions

Section 151(1)(f) of the Crown Entities Act 2004 (the Act) states that the annual report must contain information on any new direction given to the DHB by a Minister in writing under any enactment during the financial year, as well as other such directions that remain current.

'Direction' is defined in the Act as "a direction given by a Minister under the Act or the entity's Act to an entity or to a member or employee or office holder of an entity (for example, a direction on government policy, a direction to perform an additional function [issued under section 112 of the Act], or a direction relating to the entity's statement of intent)".

The following have been identified as ministerial directions and, although referred to in the singular, the direction was issued to all DHBs:

- the 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.
- the requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act 004.
- the direction to support a whole of government approach, issued in April 2014 under s.107 of the Crown Entities Act 2004. The three directions cover procurement, ICT and property and the former two apply to DHBs.
- the direction on the use of authentication services, issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

for the year ended 30 June 2020
In thousands of New Zealand Dollars

Summary of Significant Accounting Policies

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ dollars (the functional currency) using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlements of such transactions and from the translation at year end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of the receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from, the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly no provision has been made for income tax.

Budget figures

The budget figures are derived from the 2019/20 Statement of Performance Expectations. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of these financial statements.

Cost allocation

The DHB has arrived at the net cost of service for each significant activity using the following cost allocation system.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specified output.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation.

Indirect costs are charged to output classes based on cost drivers and related activity/usage information. The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers, such as actual usage, staff numbers and floor area.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these financial statements, the Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

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

- Estimating the fair value of land and buildings - refer to Note 7.
- Measuring long service leave, retirement gratuities and other employee entitlements – refer to Note 15.

Critical Judgements in Applying Accounting Policies

Management has exercised the following critical judgements in applying accounting policies:

Classification of leases – refer to Note 17.

2. Revenue

Accounting policy

The specific accounting policies for significant revenue items are explained below.

MoH population-based revenue

The DHB receives anuual funding from the Ministry of Health (MoH), which is based on population levels within the South Canterbury DHB district.

MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

MoH contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as the number of screening tests or heart checks.

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

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

Inter-district flows

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

ACC contract revenue

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

Provision of other services

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

Rental revenue

Rental revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Interest revenue

Interest revenue is recognised using the effective interest rate method.

Donation and bequests

Donations and bequests to the DHB are dealt with by the Aoraki Foundation through the Health Endowment Fund.

Vested or donated physical assets

Where a physical asset is acquired for nil or nominal consideration the fair value of the asset received is recognised as revenue, unless there is a use or return condition attached to the assets.

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

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
2a. Patient Care Revenue				
MOH Population-based funding	210,475	196,072	210,723	196,039
MOH other contracts	1,418	1,451	1,418	1,451
Inter District Patient Inflows	4,088	3,637	4,088	3,637
	215,981	201,160	216,229	201,127
ACC Contracted Revenue	2,329	2,376	2,329	2,376
Patient and consumer sourced revenue	971	1,690	1,892	1,824
	219,281	205,226	220,449	205,327

Under the Public Finance Act, South Canterbury District Health Board is required to disclose the appropriation of the revenue provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of the funding. The appropriation revenue received by the DHB in the financial year 2020 is $202.84m (2019: $184.33m) with a budgeted figure of $189.26m (2019: $181.43m), which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the Statement of Service Performance.

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	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
2b. Other Revenue				
Gain/(loss) on sale of property, plant and equipment	198	27	198	27
Donations and bequests received	-	41	-	41
Rental Income	124	94	86	66
Other Revenue	2,128	2,392	1,368	2,295
	2,450	2,554	1,652	2,429
2c. Finance revenue				
Interest Revenue	628	814	628	815
	628	814	628	815

3. Personnel Costs

Accounting policy

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

Superannuation Schemes

Defined contribution schemes

Obligations for contributions to Kiwisaver, the Government Superannuation Fund and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

The DHB belongs to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

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

Breakdown of personnel costs				
Wages, salaries and outsourced personnel	70,887	66,259	70,628	66,042
Contributions to defined contribution plans	1,802	1,626	1,811	1,634
Increase /(decrease) in employee benefit provisions	1,892	14,996	1,919	15,012
	74,581	82,881	74,358	82,688

Employer contributions to defined contribution plans include contributions to Kiwisaver, State Sector Retirement Savings Scheme and the DPB Contributors Scheme

4. Finance costs

Accounting policy

Interest expense

Interest expense is accrued using the effective interest rate method. The effective interest rate exactly discounts estimated future cash payments through the expected life of the financial liability to that liability's net carrying amount. The method applies this rate to the principal outstanding to determine the interest expense each period.

Interest Expense	-	4	2	6
	-	4	2	6

5. Capital charge

Accounting policy

The capital charge is recognised as an expense in the financial year to which the charge relates.

Further information

The group pays a capital charge every six months to the Crown. The charge is based on the previous six month actual closing equity balance at 31 December and 30 June. The capital charge rate for the year ended 30 June 2020 was 6% (2019: 6%).

6. Other operating expenses

Accounting policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of lease expense over the lease term.

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Fees to Auditor:				
Audit fees for financial statement audit	140	138	154	152
Directors' fees and expenses	324	345	324	345
Impairment of receivables (bad & doubtful debts)	18	10	18	10
Impairment of Investment - NZ Health Partnership Limited ("B" Class Shares)	-	856	-	856
Write down of inventory	22	9	22	9
Operating Lease Expense	526	540	612	607
	1,030	1,898	1,130	1,979

Operating Leases

The DHB leases a number of residential buildings and equipment (including office and clinical equipment). The leases terms vary, typically from one to 5 years. None of the leases include contingent rentals.

7. Property, plant and equipment

Accounting policy

Property, plant and equipment consists of the following asset classes: land, buildings, plant and equipment, leased assets and motor vehicles.

Land is measured at fair value and buildings are measured at fair value less accumulated depreciation. Except for the assets vested from the hospital and health service (see below), all other asset classes are stated at cost, less accumulated depreciation and impairment costs.

Fixed assets vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Health South Canterbury Limited (a Hospital and Health Service) vested in the DHB on 1 January 2001. Accordingly, assets were transferred to the DHB at their net book values as recorded in the books of Health South Canterbury Limited. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of Health South Canterbury Limited. The vested assets will continue to be depreciated over their remaining useful lives.

Revaluations

Land and Buildings are revalued with sufficient regularity, and at least every three years, to ensure that the carrying amount at balance date is not materially different to fair value.

The carrying values of land and buildings are assessed annually by an independent registered valuer to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

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

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

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Additions

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

Work in progress is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to freehold buildings and/or plant and equipment on its completion and then depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at date of acquisition.

Costs incurred subsequent to initial acquisition are capitalised only it is probable that future economic benefits or service potential associated with the item will flow to the group and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Net gains and losses on disposals are reported in the surplus or deficit. When revalued assets are sold, the amounts included in the revaluation reserves in respect of those assets are transferred to accumulated surpluses/(deficits) in equity.

Depreciation

Depreciation is provided on a straight line basis on all property, plant and equipment, other than freehold land, at rates which will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as follows:

Land Improvements	8 to 33 years	3% – 13%
Buildings	14 to 65 years	1.5 -7.1%
Building Services	5 to 35 years	3 - 20%
Building Fitout	3 to 20 years	5 - 33%
Plant and equipment	2 to 20 years	5 - 50%
Information Technology	1.5 to 17 years	6 - 67%
Motor vehicles	3 to 7 years	13.5 - 33%
Leased plant and equipment	2 to 10 years	10 - 50%

Capital work in progress is not depreciated. The total cost of a project is transferred to freehold buildings and/or plant and equipment on its completion and then depreciated.

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year-end.

Impairment of Property, Plant and Equipment

The group does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash generating assets

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

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to its recoverable amount and an impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

Land and Buildings were valued to fair value as at 30 June 2019 by an independent registered valuer, John Dunckley, of Colliers International, a Fellow of the Property Institute and Institute of Valuers of New Zealand. The total fair value of land and buildings valued by the valuer amounted to $27,828,000 as at 30 June 2019. The valuation conforms to International valuation standards and was based on an optimised depreciated replacement cost methodology.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely.

Restrictions on the group's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions used in the valuation include:

- The replacement asset is based on the replacement with modern equivalent Assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For the group's earthquake prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost.
- The remaining useful life of the assets is estimated after considering factors such as the condition of the asset, DHB's future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates are applied to reflect market value. These valuations include adjustments for estimated building strengthening costs for earthquake prone buildings and the associated lost rental during the time to undertake the strengthening work.

7a. Property, plant and equipment – Group

	Land	Buildings	Plant & equipment	Information Technology*	Leased Assets	Motor vehicles	Work in Progress	TOTAL
Cost or Valuation								
Balance at 1 July 2018	3,338	24,375	31,754	3,416	1,686	2,320	1,749	68,639
Additions	-	1,236	2,972	287	-	88	431	5,014
Capitalisation of work in progress	-	878	158	-	-	-	(1,036)	-
Revaluations	332	(2,375)	-	-	-	-	-	(2,043)
Disposals	-	-	(420)	-	-	(275)	-	(695)
Balance at 30 June 2019	3,670	24,114	34,464	3,703	1,686	2,133	1,144	70,915
Balance at 1 July 2019	3,670	24,114	34,464	3,703	1,686	2,133	1,144	70,915
Additions	-	500	1,862	693	-	297	2,680	6,033
Transfers from WIP to PPE	-	2,921	307	-	-	-	(3,228)	-
Revaluations	-	-	-	-	-	-	-	-
Disposals	-	-	(21,008)	(2,322)	-	(510)	-	(23,840)
Balance at 30 June 2020	3,670	27,535	15,625	2,074	1,686	1,920	596	53,108
Accumulated depreciation and impairment losses								
Balance at 1 July 2018	-	3,092	24,785	2,924	856	1,854	-	33,510
Depreciation expense	-	1,619	2,005	229	169	151	-	4,174
Impairment losses	-	-	-	-	-	-	-	-
Disposals	-	-	(419)	-	-	(275)	-	(694)
Revaluations	-	(4,711)	-	-	-	-	-	(4,711)
Balance at 30 June 2019	-	-	26,371	3,153	1,025	1,730	-	32,279
Balance at 1 July 2019	-	-	26,371	3,153	1,025	1,730	-	32,279
Depreciation expense	-	1,685	2,075	175	169	146	-	4,249
Impairment losses	-	-	-	-	-	-	-	-
Disposals	-	-	(21,078)	(2,115)	-	(509)	-	(23,702)
Revaluations	-	-	-	-	-	-	-	-
Balance at 30 June 2020	-	1,685	7,368	1,213	1,194	1,367	-	12,826
Carrying amounts								
At 1 July 2018	3,338	21,283	6,969	493	830	466	1,749	35,129
At 30 June and 1 July 2019	3,670	24,114	8,093	550	661	403	1,144	38,636
At 30 June 2020	3,670	25,850	8,257	862	492	554	596	40,282

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7b. Property, plant and equipment – Parent

	Land	Buildings	Plant & equipment	Information Technology*	Leased Assets	Motor vehicles	Work in Progress	TOTAL
Cost or Valuation								
Balance at 1 July 2018	3,338	24,375	31,754	3,324	1,686	2,320	1,749	68,546
Additions	-	1,236	2,972	287	-	88	431	5,014
	-	878	158	-	-	-	(1,036)	-
Revaluations	332	(2,375)	-	-	-	-	-	(2,043)
Disposals	-	-	(420)	-	-	(275)	-	(695)
Balance at 30 June 2019	3,670	24,114	34,464	3,611	1,686	2,133	1,144	70,822
Balance at 1 July 2019	3,670	24,114	34,464	3,611	1,686	2,133	1,144	70,822
Additions	-	500	1,840	693	-	297	2,680	6,010
Transfers from WIP to PPE	-	2,921	2,061	-	-	-	(3,228)	-
Revaluations	-	-	-	-	-	-	-	-
Disposals	-	-	(21,008)	(2,322)	-	(510)	-	(23,840)
Balance at 30 June 2020	3,670	27,535	15,603	1,982	1,686	1,920	596	52,992
Accumulated depreciation and impairment losses								
Balance at 1 July 2018	-	3,091	24,784	2,886	856	1,854	-	33,472
Depreciation expense	-	1,620	2,004	218	169	151	-	4,161
Impairment losses	-	-	-	-	-	-	-	-
Disposals	-	-	(419)	-	-	(275)	-	(694)
Revaluations	-	(4,711)	-	-	-	-	-	(4,711)
Balance at 30 June 2019	-	-	26,369	3,104	1,025	1,730	-	32,228
Balance at 1 July 2019	-	-	26,369	3,104	1,025	1,730	-	32,228
Depreciation expense	-	1,685	2,061	175	169	146	-	4,234
Impairment losses	-	-	-	-	-	-	-	-
Disposals	-	-	(21,078)	(2,115)	-	(509)	-	(23,702)
Revaluations	-	-	-	-	-	-	-	-
Balance at 30 June 2020	-	1,685	7,352	1,164	1,194	1,367	-	12,760
Carrying amounts								
At 1 July 2018	3,338	21,284	6,968	436	830	466	1,749	35,074
At 30 June and 1 July 2019	3,670	24,114	8,095	507	661	403	1,144	38,594
At 30 June 2020	3,670	25,850	8,251	819	492	554	596	40,232

* Information Technology was not a separately disclosed PPE category in the previous financial years. Added for refinement in the 2020 financial year

Impairment

Impairment testing carried out has not revealed any assets requiring write-down due to impairment losses.

Restrictions on title

The group does not have full title to Crown land it occupies, but transfer is arranged if and when land is sold. Some of the group's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to the DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Waitangi Tribunal claims cannot be quantified and are therefore not reflected in the value of the land.

Capital work in progress

Buildings in the course of construction, including fitout and services total $492,000 (2019: $1.071 million).

Plant and equipment in progress total $104,000 (2019: $73,000)

8. Intangible Assets

Accounting policy

Software acquisition and development

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

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the costs of materials and services, employee costs, and any directly attributable overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with developing and maintaining the DHB's website are recognised as an expense when incurred.

Information technology shared services rights

The DHB has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the group's capital investment.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date the asset is derecognised. The amortisation charge for each year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates have been estimated as follows:

Software	2 to 10 years	10-50%

Impairment of Intangible Assets

Refer to the policy for impairment of property, plant and equipment above. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is an indication of impairment.

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	Software	Other	TOTAL
Cost			
Balance at 1 July 2018	4,845	200	5,045
Additions	929		929
Disposals	-	-	-
Balance at 30 June 2019	5,774	200	5,974
Balance at 1 July 2019	5,774	200	5,974
Additions	618	-	618
Disposals	(1,924)	-	(1,924)
Balance at 30 June 2020	4,468	200	4,668
Accumulated amortisation and impairment losses			
Balance at 1 July 2018	2,401	-	2,401
Amortisation expense	263	-	263
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2019	2,664	-	2,664
Balance at 1 July 2019	2,664	-	2,664
Amortisation expense	113	-	113
Disposals	(1,926)	-	(1,926)
Impairment losses	-	-	-
Balance at 30 June 2020	851	-	851
Carrying amounts			
At 1 July 2018	2,444	200	2,644
At 30 June and 1 July 2019	3,110	200	3,310
At 30 June 2020	3,617	200	3,817

Other intangible assets comprises goodwill paid on the purchase of the business of Timaru Eye Clinic Limited. The business has been incorporated into South Canterbury Eye Clinic Limited.

There are no restrictions over the title of the group's intangible assets, nor are any intangible assets pledged as security for liabilities.

9. Public equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- General Funds (contributed capital);
- Accumulated surplus/(deficit);
- Equity from donated assets; and
- Property revaluation reserves

Property revaluation reserves

These reserves relate to the revaluation of land and buildings to fair value.

9a) Movement in capital and reserves- Group

	General funds	Accumulated Surplus	Equity from donated assets	Revaluation reserve - land	Revaluation reserve - buildings	Total equity
Balance at 1 July 2018	16,401	10,465	1,609	2,960	9,823	41,258
Surplus/(deficit) - DHB		(14,893)				(14,893)
Surplus/(deficit) - Subsidiary		(77)				(77)
Subsidiary (prior year adjustment)						-
Transfer from accumulated surplus		37	(37)			-
Revaluation of land and buildings				312	2,355	2,667
Crown Debt to Equity						-
Repayment to the Crown	(216)					(216)
Repayment of equity						
Balance at 30 June 2019	16,185	(4,468)	1,572	3,272	12,178	28,739
Balance at 1 July 2019	16,185	(4,468)	1,572	3,272	12,178	28,739
Surplus/(deficit) - DHB		124				124
Surplus/(deficit) - Subsidiary		272				272
Transfer from accumulated surplus		37	(37)			-
Revaluation of land and buildings						-
Contribution from the Crown						-
Repayment of equity	(216)					(216)
Balance at 30 June 2020	15,969	(4,035)	1,535	3,272	12,178	28,919

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9b) Movement in capital and reserves- Parent

	General Funds	Accumulated Surplus	Equity from donated assets	Revaluation reserve – land	Revaluation reserve – buildings	Total equity
Balance at 1 July 2018	16,401	10,645	1,609	2,960	9,823	41,438
Surplus/(deficit)		(14,893)				(14,893)
Transfer from accumulated surplus		37	(37)			-
Revaluation of land and buildings				312	2,355	2,667
Crown Debt to equity transfer						-
Repayment to the Crown	(216)					(216)
Repayment of equity (Mental health ring-fence retained earnings)						-
Balance at 30 June 2019	16,185	(4,211)	1,572	3,272	12,178	28,996
Balance at 1 July 2019	16,185	(4,211)	1,572	3,272	12,178	28,996
Surplus/(deficit) - DHB		124				124
Transfer from accumulated surplus		37	(37)			-
Revaluation of land and buildings						-
Crown Debt to Equity transfer	-					-
Repayment of equity	(216)					(216)
Balance at 30 June 2020	15,969	(4,050)	1,535	3,272	12,178	28,904

The unspent mental health ring-fence portion of retained earnings increased to $0.319 million (30 June 2019: $0.285 million)

10. Cash and cash equivalents

Accounting policy

Cash and cash equivalents includes cash on hand, deposits held at call with banks, and other short-term highly liquid investments with original maturities of three months or less. "

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Cash on hand and at bank	(88)	(213)	192	(181)
Cash equivalents - term deposits	-	-	-	-
Other cash and cash equivalents	9,858	7,852	9,858	7,852
Total cash and cash equivalents	9,770	7,639	10,050	7,671

The carrying value of cash at bank and term deposits with maturity dates of three months or less approximates their fair value.

The DHB is party to a DHB Treasury Services Agreement between NZ Health Partnerships Limited (NZHPL) and participating DHBs. This agreement enables NZHPL to 'sweep' DHB bank accounts and invest surplus funds on their behalf.

SCDHB administers certain funds on behalf of patients. These funds are held in a separate bank account and total $2,054 (2019: $2,131)

11. Financial assets

Accounting policy

Bank Term Deposits

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

Equity investments

The DHB's investment in NZ Health Partnership Limited is stated at cost less impairment losses.

The DHB'S investment in the South Canterbury Eye Clinic is stated at cost.

	Parent		Group	
	Actual 2020	**Actual 2019**	**Actual 2020**	**Actual 2019**
Current investments are represented by:				
Term deposits	7,600	12,778	7,600	12,778
Total current portion	7,600	12,778	7,600	12,778
Non-current investments are represented by:				
Term deposits	5,178	-	5,178	-
Shares in NZ Health Partnership Limited	-	-	-	-
Investment in Subsidiary	347	347	-	-
Total non-current portion	5,525	347	5,178	-
Total Investments	13,125	13,125	12,778	12,778

Unlisted Shares

The DHB has an equity investment in NZ Health Partnership Limited ("HPL"). HPL proposes to implement finance, procurement and supply chain shared services on behalf of all New Zealand District Health Boards ("DHBs"). Capital contributions have been made to HPL by the DHBs by the issue of B Class shares. NZ Health Partnership Limited is an unlisted company. Accordingly, there are no published price quotations for this investment. Based on available information, the Board decided to fully impair the investment in the 2019 financial year.

Investment in Subsidiary

South Canterbury Eye Clinic Limited ("SCEC") is a wholly owned subsidiary company of the DHB. SCEC was incorporated on 6 August 2015 with an initial share capital of $10,000, for the purpose of taking over the business of an existing ophthamology practice. The share capital was increased to $100,000 in the 2018/19 financial year. There has been no change to the share capital in the 2019/20 financial year. The Company provides public and private ophthamology services in South Canterbury. The investment is valued at cost.

Maturity analysis and effective interest rates of term deposits

SCDHB maintains deposits on call with NZ Health Partnership Limited at variable rates of interest and these are measured at cost.

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

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12. Debtors and other receivables

Accounting policy

Short-term receivables are recorded at the amount due, less any provision for uncollectability.

A receivable is considered uncollectable when there is evidence that the group will not be able to collect the amount due. The amount that is uncollectable is the difference between the amount due of the receivable and the present value of the amounts expected to be collected.

Bad debts are written off to surplus or deficit during the period in which they are identified.

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Trade Debtors	1,270	1,276	1,245	1,284
Less: Provision for impairment	(12)	-	(12)	-
	1,258	1,276	1,233	1,284
Accrued Income	5,746	5,855	5,746	5,856
Prepayments	223	167	224	167
Total receivables & prepayments	7,227	7,298	7,203	7,307
Receivables from sale of goods and services (exchange transactions)	4,494	4,563	4,470	4,572
Receivables from grants (non-exchange transactions)	2,733	2,735	2,733	2,735

The carrying value of receivables approximates their fair value.

Trade debtors have been evaluated for impairment and, where impairment has been identified, provision has been made. Movements in the provision for impairment of receivables are as follows:

Balance at 1 July	-	(8)
Additional provisions made	(12)	-
Receivables written off	-	8
Recovery of amounts already provided	-	-
Balance at 30 June	(12)	-

13. Inventories

Accounting policy

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

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

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Pharmaceuticals	340	336	340	336
Theatre supplies	473	496	473	496
Central stores	520	307	520	307
Other supplies	103	103	103	103
Total inventories	1,436	1,242	1,436	1,242

The write-down of inventories held for distribution amounted to $21,682 (2019: $7,556). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities but some inventories are subject to retention of title clauses (Romalpa clauses).

14. Creditors and other payables

Accounting policy

Short term payables are recorded at their face value.

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Trade creditors	1,621	1,368	1,658	1,481
Capital Charge due	34	5	34	5
Income in advance	179	133	179	133
Accrued expenses	7,007	5,359	7,028	5,382
Taxes payable (GST and PAYE)	2,502	1,661	2,501	1,657
Total Payables and Accruals	11,343	8,526	11,400	8,658
Payables for goods and services (exchange transactions)	8,841	6,865	8,899	7,001
Payables for taxes payable (non-exchange transactions)	2,502	1,661	2,501	1,657

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of creditors and other payables approximates their fair value.

15. Employee entitlements

Accounting policy

Short term employee entitlements

e settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date and annual leave earned but not yet taken at balance date.

Entitlements for retirement gratuities, senior doctor conference and sabbatical leave, long service leave, sick leave and senior doctor costs that are expected to be settled within 12 months after balance date are calculated on an actuarial basis.

Long term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as retirement gratuities, senior doctor conference and sabbatical leave, long service leave, sick leave, and senior doctor study costs are calculated on an actuarial basis.

The actuarial calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlement information, and
- assumptions of discount rates, salary escalation rates, resignation rates and (for sabbatical leave) the take up rate.

Presentation of employee entitlements

Employee entitlements expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Critical accounting estimates and assumptions

Employee entitlements for retirement gratuities, senior doctor conference leave, senior doctor sabbatical leave, long service leave, sick leave and senior doctor study costs were actuarially revalued as at 30 June 2019 by Aon Consulting services NZ Ltd. The most important key assumptions used in calculating this liability include the discount rates, the salary escalation rate, resignation rates and (for sabbatical leave) the take up rate. Any changes to these assumptions will affect the carrying amount of the liability.

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Holidays Act 2003

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 has been ongoing since 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, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, nonstandard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated. The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2020/21 financial year. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

However, during the 2019/20 financial year the review process agreed as part of the MOU has rolled out in tranches to the DHBs and NZBS. DHB readiness and availability of resources (internal and external to the DHB) has determined when a DHB can commence the process.

SCDHB has assessed that further audit work is required to reach a reliable estimate of its historic non-compliance under the MOU.

Notwithstanding, as at 30 June 2020, in preparing these financial statements, the South Canterbury DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of noncompliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early 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 project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

Current employee entitlements are represented by:

	Parent		Group	
	Actual 2020	**Actual 2019**	**Actual 2020**	**Actual 2019**
Accrued salaries and wages	16,646	15,712	16,675	15,717
Annual Leave	7,971	6,658	8,012	6,692
Maternity Leave	-	-	-	-
Sick Leave	235	224	252	246
Retirement Gratuities	797	1,098	797	1,098
Senior Doctor Conference Leave	233	225	233	225
Senior Doctor Sabbatical Leave	27	41	27	41
Long Service Leave	535	433	535	433
Senior Doctor Study Costs	425	449	425	449
Restructuring Provision	-	-	-	-
Total current portion	26,869	24,840	26,956	24,901
Non-current employee entitlements are represented by:				
Sick Leave	275	311	275	311
Retirement Gratuities	4,453	4,314	4,453	4,314
Senior Doctor Conference Leave	467	899	467	899
Senior Doctor Sabbatical Leave	450	383	450	383
Long Service Leave	768	884	768	884
Senior Doctor Study Costs	850	450	850	450
Restructuring Provision	691	850	691	850
Total non-current portion	7,954	8,091	7,954	8,091
Total employee entitlements	34,823	32,931	34,910	32,992

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Restructuring provision				
Balance at 1 July	850	1,106	850	1,106
Additional provision made	-	-	-	-
Amounts used	(159)	(254)	(159)	(254)
Disused amounts reversed	-	(2)	-	(2)
Balance at 30 June	691	850	691	850

The restructuring provision represents the estimated cost for redundancy payments arising from the Talbot Park restructure.

16. Borrowings

Accounting policy

Borrowings are recognised initially at fair value plus transaction costs. Subsequent to initial recognition, all borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

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

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Current borrowings are represented by:				
Energy Efficiency and Conservation Authority (EECA)				
Current portion	-	49	-	49
Non current portion	-	-	-	-
	-	49	-	49
Repayable as follows:				
Not later than one year	-	49	-	49
Later than one, not later than two years	-	-	-	-
Later than two, not later than five years	-	-	-	-
Beyond five years	-	-	-	-
	-	49	-	49

Conversion of existing Crown loans to Crown equity

In September 2016, the Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. On the 15 February 2017, the DHB Crown loans of $12.778 million were converted into Crown equity. From that day onward, all Crown capital contributions would be made via Crown equity injections. The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

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17. Finance Lease Liability

Accounting policy

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and benefits incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the Statement of Financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the group will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term or its useful life.

Critical judgements in applying accounting policies

Leases classification

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

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

The DHB has exercised its judgement on the appropriate classification of the lease for the MRI scanner and has determined it to be a finance lease.

SCDHB has entered into a finance lease with Aoraki MRI Charitable Trust for the purchase of MRI scanner equipment. The lease is over a period of ten years from April 2013 and no interest or finance charges are payable.

Finance lease liabilities are payable as follows:

	Parent		Group	
	Actual 2020	Actual 2019	Actual 2020	Actual 2019
Not later than one year	169	169	169	169
Later than one year and not later than five years	168	337	168	337
Later than five years	-	-	-	-
Total present value of minimum lease payments	337	506	337	506
Current portion	169	169	169	169
Non current portion	168	337	168	337
Total present value of minimum lease payments	337	506	337	506

Finance Lease

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

18. Provisions

Accounting policy

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in "finance costs'.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

Restructuring

Details of the restructuring provision are shown in Note 15

Onerous contracts

The DHB has not identified any onerous contracts that require a provision.

19. Capital Commitments and Operating Leases

Accounting policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of lease expense over the lease term.

	Parent		Group	
	Actual 2020	**Actual 2019**	**Actual 2020**	**Actual 2019**
Capital Commitments				
Buildings	3,032	912	3,032	912
Plant and equipment	-	-	-	-
Information technology	2,262	2,665	2,262	2,665
Total Capital Commitments	5,294	3,577	5,294	3,577

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

Operating Leases as Lessee

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	Actual 2020	**Actual 2019**	**Actual 2020**	**Actual 2019**
Not later than one year	256	284	295	323
Later than one year and not later than five years	248	383	251	386
Later than five years	-	-	-	-
Total Non-cancellable Operating Leases	504	667	546	709

The DHB leases a number of buildings, vehicles and office equipment under operating leases.

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20. Contingencies

Contingent Liabilities

Superannuation Schemes

The group is a participating employer in the National Provident Fund's Defined Benefit Plan Contributors' Scheme (the scheme) which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the scheme, the DHB could be responsible for the entire deficit of the scheme. Similarly if a number of the employers ceased to participate in the scheme, the group could be responsible for an increased share of the deficit.

As at 31 March 2020, the Scheme had a past deficit of $2.773 million (exclusive of Employer Superannuation Contribution Tax) (2019: $1.791 million). This deficit was calculated using a discount rate equal to the expected return on net assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 25.

Contingent Assets

The DHB has no contingent assets (2019 $nil).

21. Related party transactions and key management personnel

The DHB is controlled by the Crown.

The group enters into transactions with Government departments, state-owned enterprises and other Crown entities. Those transactions that occur within a normal supplier or client relationship on terms no more or less favourable than those which it is reasonable to expect the group would have adopted if dealing with that entity at arm's length in the same circumstances have not been disclosed as related party transactions.

The following transactions were carried out with related parties other than those outlined above:

Shared Support Services

NZ Health Partnership Limited has been set up to implement Finance, Procurement and Supply Chain Services for all New Zealand District Health Boards. The programme will be funded by the District Health Boards making operating and capital contributions. The capital contributions are to be contributed by the issue of "B" Class shares. The "B" Class shares are fully impaired (see note 11).

During the year South Canterbury District Health Board paid NZ Health Partnership Limited $115,423 (2019: $226,746) as a contribution to operating expenditure. The balance outstanding at year end was $nil (2019: $nil).

Key management personnel

Key management personnel include all Board members, the Chief Executive, and the other eight members of the senior leadership team.

There have been no transactions between the members or senior leadership with the Board in any capacity other than that in which they are employed, except:

- Ron Luxton is the chairperson of Aoraki MRI Charitable Trust ("the Trust"). The Trust was established to raise funds for the provision of an MRI scanner, building and associated equipment for the benefit of the people of South Canterbury. In 2013 the Trust donated $1.2M to SCDHB for a building to house the MRI scanner, purchasing associated anaesthetic equipment and implementing the MRI service. The Trust also entered into a lease with the DHB for the provision of an MRI scanner. Details of the lease are disclosed in Note 17.
- Jo Goodhew is a Board Member of Presbyterian Support South Canterbury and Hospice South Canterbury. During the year the DHB paid Presbyterian Support $10,494 and Hospice South Canterbury $5,450 for meals on wheels. The DHB received $78,404 from Hospice South Canterbury for laundry and palliative care. All transactions were at arms length.

There are close family members of key management personnel employed by SCDHB. The terms and conditions of those arrangements are no more favourable than the DHB would have adopted if there were no relationship to key management personnel.

No provision has been required, nor any expense recognised for impairment of receivables from related parties (2019: nil).

Key management personnel compensation

	Actual 2020	Actual 2019
Board Members		
Remuneration	282	296
Full-time equivalent members	1.3	1.3
Leadership Team		
Remuneration	1,415	1,222
Full-time equivalent members	7.4	6.3
Total key management personnel remuneration	1,697	1,518
Total Full-time equivalent personnel	8.7	7.6

22. Board Member Remuneration and Committee Member Payments

Board Members Payments & Attendance

Member	Fees Paid	Attendance
Paul Annear (Deputy chairperson)	$18,945	10
Peter Binns	$16,905	10
Michael Boorer	$8,160	5
Murray Cleverley	$8,160	4
Rene Crawford	$16,905	10
Raeleen de Joux	$16,905	10
Suran Dickson	$8,745	6
Joanne Goodhew	$8,745	6
Phillip Hope (Deputy Chairperson)	$10,931	6
Terry Kennedy	$8,160	5
Ron Luxton (Chairperson)	$33,161	11
Edie Moke	$8,160	5
Murray Roberts	$8,160	4
Mark F Rogers	$17,003	11
Bruce Small	$8,745	6
Karl Te Raki	$8,745	6
TOTAL	$206,535	

The Board met 11 times in 2019/20

Committee Members Payments

Member	Fees Paid
Paul Annear	$8,125
Peter Binns	$6,458
Michael Boorer	$2,500
Wendy Buchanan	$1,591
Murray Cleverley	$2,813
Rene Crawford	$5,000
Jane Cullimore	$2,582
Raeleen de Joux	$6,875
Suran Dickson	$2,135
Kylie Douglas	$179
Suzanne Eddington	$4,092
Sally Feely	$1,667
Gareth Ford	$833
Joanne Goodhew	$4,583
Arahia Goldsmith	$2,084
Shannon Hanson	$894
Suzanne Harrex	$1,250
Suzanne Hollick	$1,250
Phillip Hope	$3,333
Nicola Hornsey	$1,818
Rebecca Jackson	$1,667
John Keenan	$1,250
Karen Kennedy	$1,136
Terry Kennedy	$2,500
Neil Kiddey	$2,679
Lik Loh	$682
Ron Luxton	$11,458
Anne-Marie McRae	$2,194
Edie Moke	$4,062
Maria Parish	$909
Vania Pirini	$833
Murray Roberts	$3,854
Mark F Rogers	$6,302
Mark A Rogers	$666
Bruce Small	$2,083
Juliette Stevenson	$2,500
Joy Sylvia	$276
Karl Te Raki	$3,542
Deborah Whatuira	$1,250
Katrina Whiu	$962
Ngaire Whytock	$833
TOTAL	$111,700

Member Liability Insurance

SCDHB has effected Directors and Officers Liability, General Liability, Employers Liability and Professional Indemnity insurance cover during the financial year, in respect of the liability or costs of Board members and employees.

Termination Benefits

During the year ended 30 June 2020, no Board members received compensation or other benefits in relation to cessation of employment (2019: nil).

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23. Employee remuneration

Range	Actual 2020	Actual 2019
$670,001 - $680,000	1	
$430,001 - $440,000	1	
$400,001 - $410,000	1	1
$390,001 - $400,000	1	
$380,001 - $390,000	1	2
$370,001 - $380,000		
$360,001 - $370,000	1	1
$350,001 - $360,000	1	1
$340,001 - $350,000	3	2
$330,001 - $340,000	6	2
$320,001 - $330,000	4	3
$310,001 - $320,000	5	2
$300,001 - $310,000		5
$290,001 - $300,000	2	1
$280,001 - $290,000		3
$270,001 - $280,000	3	2
$260,001 - $270,000	3	6
$250,001 - $260,000	2	4
$240,001 - $250,000	1	4
$230,001 - $240,000	5	2
$220,001 - $230,000	3	1
$210,001 - $220,000	1	4
$200,001 - $210,000	3	
$190,001 - $200,000	1	1
$180,001 - $190,000	4	3
$170,001 - $180,000		5
$160,001 - $170,000	3	1
$150,001 - $160,000	4	3
$140,001 - $150,000	6	3
$130,001 - $140,000	5	3
$120,001 - $130,000	14	5
$110,001 - $120,000	22	16
$100,001 - $110,000	31	30
TOTAL	138	116

The Chief Executive's current salary is in the $350,001 to $360,000 range.

Termination Benefits (IPSAS 25)

During the year ended 30 June 2020, 17 employees (2019: 8) were paid or were payable compensation and other benefits in relation to the cessation of their employment to the value of $250,890 (2019: $265,038).

24. Financial instrument risks

South Canterbury District Health Board is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, trade creditors and loans.

The Board has a series of policies providing risk management for interest rates, operating and capital expenditures denominated in a foreign currency, and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury activities. Its policies do not allow any transactions which are speculative in nature to be entered into.

Market risk

Price Risk

Price risk is the risk that the value of the financial instrument will fluctuate as a result of changes in market prices. The group has no financial instruments that give rise to price risk.

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. SCDHB's exposure to fair value interest rate risk is limited to its bank deposits and borrowings which are held at fixed rates of interest.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of a change in market interest rates. Investments and borrowings issued at variable interest rates expose SCDHB to cash flow interest rate risk.

SCDHB's treasury policy requires a spread of investment and borrowing maturity dates and a limit on variable rate percentages of total investments or borrowings. SCDHB currently has no variable interest rate investments or borrowings.

SCDHB's treasury policy is conservative and as such tends not to adopt a view as to interest rate outlook. Interest rate derivates are thus not used to manage interest rate risk.

Sensitivity analysis

As at 30 June 2020, if the 90 day bank bill rate had been 50 basis points higher or lower, with all other variables held constant, the surplus for the year would have been $15,000 (2019 $64,000) higher or lower. This movement is attributable to increased or decreased interest revenue on cash at bank and short term bank deposits. Borrowings and longer term deposits are at fixed rates.

Foreign currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. SCDHB's Treasury policy allows for exchange hedging. However, there were no foreign currency forward exchange contracts (or option agreements) in place as at 30 June 2020 (30 June 2019 Nil), nor were any hedged transactions undertaken during the course of the last two financial years.

Credit Risk:

Credit risk is the risk that a third party will default on its obligation to the Board, causing the Board to incur a loss.

Financial instruments which potentially subject the group to concentrations of risk consist principally of cash and short term investments, and trade receivables. The maximum exposure to credit risk exposure for each class of financial instrument is as follows:

	Parent		Group	
	Actual 2020	**Actual 2019**	**Actual 2020**	**Actual 2019**
Cash at bank and term deposits	17,372	20,419	17,652	20,451
Debtors and Other Receivables	7,227	7,298	7,203	7,307
	24,599	27,717	24,855	27,758

The Board invests in high quality financial institutions, local and government stock and limits the amount of credit exposure to any one financial institution. Accordingly, the Board does not require any collateral or security to support financial instruments with organisations it deals with.

Concentration of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health for 96% (2019: 96%) of South Canterbury District Health Board's revenue. However the Ministry of Health is a high credit quality entity, being the Government-funded purchaser of health and disability support services.

Credit Quality of Financial Assets:

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates.

	Parent		Group	
	Actual 2020	**Actual 2019**	**Actual 2020**	**Actual 2019**
COUNTERPARTIES WITH CREDIT RATINGS				
Cash at bank and term deposits				
AA - rating	17,372	20,419	17,652	20,451
Total cash at bank and term deposits	17,372	20,419	17,652	20,451

The status of trade receivables at the reporting date is as follows:

	Parent			
	Gross Receivables 2020	**Impairment 2020**	**Gross Receivables 2019**	**Impairment 2019**
Trade receivables				
Not past due	755	-	1,080	-
Past due 0-30 days	313	-	32	-
Past due 31-120 days	202	(12)	164	-
Past due more than 1 year				
Total	1,270	(12)	1,276	-

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In thousands of New Zealand Dollars

	Group			
	Gross Receivables 2020	Impairment 2020	Gross Receivables 2019	Impairment 2019
Trade receivables				
Not past due	718	-	1,077	-
Past due 0-30 days	316	-	34	-
Past due 31-120 days	211	(12)	173	-
Past due more than 1 year				
Total	1,245	(12)	1,284	-

All impairments stated above have been calculated on individual accounts. No collective impairments have been included.

Liquidity risk
Liquidity risk represents the SCDHB's ability to meet its contractual obligations. The DHB evaluates its liquidity requirements on an ongoing basis. In general the DHB generates sufficient cash flows from its operating activities to meet its obligations arising from its financial liabilities and has cash equivalent balances and credit lines in place sufficient to cover potential shortfalls.

Contractual maturity analysis of financial liabilities

	Parent			
	Carrying Amount	Contractual Cash Flows	Less than 1 Year	More than 1 Year
2020				
Creditors and other payables (excluding deferred revenue and taxes)	8,662	8,662	8,662	-
Borrowings	-	-	-	-
Finance Leases	337	337	169	168
Total	8,999	8,999	8,831	168
2019				
Creditors and other payables	8,526	8,526	8,526	-
Borrowings	49	49	49	-
Finance Leases	506	506	169	337
Total	9,081	9,081	8,744	337

	Group			
	Carrying Amount	Contractual Cash Flows	Less than 1 Year	More than 1 Year
2020				
Creditors and other payables (excluding deferred revenue and taxes)	8,720	8,720	8,720	-
Borrowings	-	-	-	-
Finance Leases	337	337	169	168
Total	9,057	9,057	8,889	168
2019				
Creditors and other payables	8,658	8,658	8,658	-
Borrowings	49	49	49	-
Finance Leases	506	506	169	337
Total	9,213	9,213	8,876	337

Classification and fair values

The classification and fair values together with the carrying amounts shown in the statement of financial position are as follows:

		Parent			
	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
2020					
Financial Assets					
Cash and cash equivalents	10	9,770		9,770	9,770
Term Deposits >3 <12 months	11	7,600		7,600	7,600
Term Deposits >12 months	11	5,178		5,178	5,178
Trade and other receivables	12	7,227		7,227	7,227
Patient Trust Funds	10	2		2	2
Equity investments	11	347	-	347	347
		30,124	-	30,124	30,124
Financial Liabilities					
Trade and other payables (excluding deferred revenue and taxes)	14	8,662		8,662	8,662
Patient Trust Funds	10	2		2	2
Borrowings	16	-		-	-
Finance Lease Liability	17	337		337	337
		9,001	-	9,001	9,001

	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
2019					
Financial Assets					
Cash and cash equivalents	10	7,639		7,639	7,639
Term Deposits >3 <12 months	11	12,778		12,778	12,778
Term Deposits >12 months	11	-		-	-
Trade and other receivables	12	7,298		7,298	7,298
Patient Trust Funds	10	2		2	2
Equity investments	11	347	-	347	347
		28,064	-	28,064	28,064
Financial Liabilities					
Trade and other payables	14	8,526		8,526	8,526
Patient Trust Funds	10	2		2	2
Borrowings	16	49		49	49
Finance Lease Liability	17	506		506	506
		9,083	-	9,083	9,083

for the year ended 30 June 2020
In thousands of New Zealand Dollars

		Group			
	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
2020					
Financial Assets					
Cash and cash equivalents	10	10,050		10,050	10,050
Term Deposits >3 <12 months	11	7,600		7,600	7,600
Term Deposits >12 months	11	5,178		5,178	5,178
Trade and other receivables	12	7,203		7,203	7,203
Patient Trust Funds	10	2		2	2
Equity investments	11	-	-	-	-
		30,033	-	30,033	30,033
Financial Liabilities					
Trade and other payables (excluding deferred revenue and taxes)	14	8,720		8,720	8,720
Patient Trust Funds	10	2		2	2
Borrowings	16	-		-	-
Finance Lease Liability	17	337	-	337	337
		9,059	-	9,059	9,059

	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
2019					
Financial Assets					
Cash and cash equivalents	10	7,671		7,671	7,671
Term Deposits >3 <12 months	11	12,778		12,778	12,778
Term Deposits >12 months	11	-		-	-
Trade and other receivables	12	7,307		7,307	7,307
Patient Trust Funds	10	2		2	2
Equity investments	11	-	-	-	-
		27,758	-	27,758	27,758
Financial Liabilities					
Trade and other payables	14	8,658		8,658	8,658
Patient Trust Funds	10	2		2	2
Borrowings	16	49		49	49
Finance Lease Liability	17	506		506	506
		9,215	-	9,215	9,215

25. Capital management

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

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

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

26. Post balance date events

There have been no significant post balance date events.

27. Explanation of significant variances against budget

Explanations for significant variations from SCDHB's budgeted figures in the Statement of Intent are as follows:

Total revenue was greater than budget by $10.033m. MOH additional Funding advise and variations to the funding package received after the budget close off was a primary driver of the favourable to budget revenue variance.

The most significant variances to budget are as follows:

- Funding for COVID-19 for the 2019/20 financial year of $1.830m.
- Primary Care additional funding of $2.4m mainly driven by unbudgeted Community Service Card Funding $1.9m and additional GP funding $0.5m. The additional funding for Primary Care was off set by additional expenditure.
- Personal Services additional funding of $2.4m mainly driven by additional Elective Funding $1.1m, MECA Funding $0.9m and individual MOH agreement funding $0.4m all to support additional expenditure. The additional funding for Personal services was off set by additional expenditure.
- Disability Support additional funding of $2.6m was mainly driven by Home Based Support travel reimbursement funding $1.7m and additional Pay Equity Funding $0.9m. Additional Home Based Travel and Pay Equity funding was off set by additional expenditure in these areas.
- Additional to budget IDF revenue of $0.4m.

Total Expenditure was $9.937m greater than budget.

- Overall personnel costs were $3.973m greater than budget, including $3.335m for nurses salaries driven by the patient acuity and safe staffing requirements, $0.732m for senior medical salaries driven by additional MECA costs and one off costs and $0.318m for management and administration salaries driven by additional hours worked compared to budget. Support salaries were $0.389m less than budget driven by the closure of the laundry. The laundry wage reduction was offset by Outsourced Laundry costs.
- Outsourced services were $1.126m greater than budget. Treatment Service expenditure was $0.741m greater than budget driven by the outsourcing of Orthopaedic joints to Bidwill Hospital. Blood service expenditure was $0.206m greater than budget driven by demand.
- Clinical supply expenditure was $0.554, greater than budget which was primarily driven by hospital pharmaceutical demand.
- Infrastructure and non-clinical supply expenditure was $0.486m greater than budget driven by the unbudgeted Outsourcing of the Laundry Operation $0.347m, Outsourced Maintenance $0.130m and Cleaning costs $0.125m. The over budget expenditure was offset by under budget expenditure in Patient Transport by $0.120m, driven by demand.
- Payments to Non-DHB Providers were $4.756m more than budget (including inter-district flows).The main expenses more than budget were: Primary Practice Services $1.465m, $1.3m of which being GP swabbing expenditure as a result of COVID-19. Other significant variances are due to demand driven services for Home support of $3.711m.
- The Capital charge was $777k less than budget due to the reduction in net assets in the 2018/19 financial year, as a result of the Holidays Act 2003 compliance requirements.

28. South Canterbury Eye Clinic Limited

The South Canterbury Eye Clinic was purchased by SCDHB in 2015 and is a wholly owned subsidiary of the DHB. At 30 June 2020, the directors of South Canterbury Eye Clinic Limited were Ron Luxton and Mark Rogers.

The South Canterbury Eye Clinic's financial results for 2019/20 and 2018/19 have been consolidated into the SCDHB financial accounts and form part of the disclosure. For the year ended 30 June 2020, the South Canterbury Eye Clinic had total revenue of $2.428m (2019: $1.382m) and total expenditure of $2.156m (2019: $1.458m) which resulted in a net surplus of $272k (2019: deficit $76k). South Canterbury Eye Clinic Limited had assets of $360k (2019: $104k) and liabilities of $197k (2019: $213k) as at 30 June 2020.

Related party disclosure

During the financial year 2019/20, South Canterbury Eye Clinic received clinical services revenue from the SCDHB of $1,493,917 (2019: $1,216,619). The balance outstanding from the DHB at year end was $nil (2019: $nil).

South Canterbury Eye Clinic paid the DHB for personnel, supplies and services during the year at a cost of $809,433 (2019: $133,770). The balance due to the DHB at year end was $52,446 (2019: $8,300).

29. Impact of COVID-19

On 11 March 2020, the World Health Organisation declared the outbreak of COVID-19 a pandemic. The New Zealand Government declared a state of National Emergency on 25 March 2020.

The Country was put into Alert Level 4 lockdown from 26 March to 27 April, then remained in lockdown Alert level 3 until 13 May.

The DHB remained open and continued to provide healthcare as an essential service throughout the lockdown period.

Employees in non-essential roles who were able to work from home did so during the Level 4 lockdown. Non-essential workers were non clinical, clerical administration workers.

All staff returned to work at Alert Level 3, with those who were able to work from home continuing to do so. The key focus for the DHB was the health and safety and the immediate retention of staff.

The known financial effects of COVID-19 on our 2019/20 operations is reflected in these financial statements.

The forecasted long-term impact of COVID-19 is uncertain and dependent on factors impacting variable revenue and expenditure streams such as:

- Electives; IDFs; ACC, and the costs associated with these
- Outsourcing required as a result of resources dedicated to standard health care performance being diverted to COVID-19 testing, prevention, and care

Main impacts on the 2019/20 financial statements due to COVID-19:

Additional funding

In 2019/20 the Ministry of Health provided funding of $1.831M for the South Canterbury District Health Board COVID-19 response, recognised as follows:

GP Funding	$0.928M
Pharmaceuticals	$0.541M
Aged Residential Care	$0.361M

Offsetting this additional funding was the COVID-19 expenditure incurred in 2019/20 of $1.759M.

This was primarily the result of clinical supplies and personnel costs such as test kits and consumables, staffing for the testing clinic, COVID-19 ward nursing, and additional Resident Medical Officer shifts.

The pandemic presented unique challenges for staffing and roster modelling to ensure both staff and patient safety.

Non-Financial impacts of COVID-19
Restrictions as a result of lockdown procedures, as well as staff diversions to the COVID-19 response effort, have had a negative impact on several areas of the non-financial performance of the DHB.

For additional detail, refer to the Statement of Service Performance output classes included in this annual report.

SSP impacts per the financial statements
Prevention services where the DHB's role is to encourage uptake of services, often through promotional events, was impacted negatively by COVID-19. This included a decrease in cervical and breast screening, as well as immunisations during the 2020 financial year.

Early detection and management services were impacted with the DHB managing throughput during the lockdown levels in line with guidance from the Ministry of Health. This resulted in a decrease in MRI and CT scans within six weeks against their respective targets.

Intensive assessment and treatment services were also impacted by COVID-19, with surgical discharges for planned care interventions falling below target, as well as faster cancer treatments.

Rehabilitation and support services, which often require in-person meetings, were restricted as a result of lockdown procedures.

COVID-19 increased patient waiting lists across SCDHB specialities. Plans for recovery were implemented post-lockdown and remained underway into the 20/21 financial year. For example, cervical screening required close coordination with the primary providers of the service. For breast screening, this has been a national initiative under the national contract via Breast-screening Aotearoa. For immunisations, the Public Health Nursing team continue to work toward existing immunisation targets.

Planned Care recovery plans have involved the provision of additional clinics and theatre sessions. Specialties such as Otorhinolaryngology (Ear, Nose Throat) and Dental were most severely impacted. Specialist waiting lists have been brought back under control by Sep-20. Waiting lists for Theatre were also improved significantly, to pre-COVID-19 levels by Sep-20

The DHB has assessed there to be no significant impact on its asset values as a result of COVID-19.

Assets continued to be utilised during lockdown as a result of essential healthcare services.

The DHB continues to monitor the COVID-19 situation and is working closely with relevant parties to ensure the appropriate actions are taken as required and ensuring that health, safety and wellbeing continues to be a primary area of focus.

30. Crown Entities Act 2004: Statement of Performance Expectations

The Statement of Performance Expectations (SPE) requirements of the Crown Entities Act 2004 (CEA) apply to all DHBs. These requirements are separate to those in the Public Health and Disability (Planning) Regulations 2011 that require each DHB to prepare an Annual Plan and agree that Plan with the Minister of Health. In developing the SPE, the DHB is required to provide the draft SPE to the Minister of Health by 30 April each year and the Minister of Health has 15 working days from receipt to provide comments to the DHB on the SPE. The DHB then considers the comments to the draft SPE and must provide the completed SPE to the Minister of Health before the start of the financial year, which is 1 July each year, and publish it on the DHB's website as soon as is practicable once it has been provided to the Minister of Health. The SPE is completed when it includes the information required by section 149E of the CEA (such as forecast financial statements and forecast financial information) and is signed and dated by two board members of the DHB. If the SPE is not completed by 1 July each year, this is a breach of section 149C of the CEA.

In the 2019/20 financial year, the Minister of Health granted an extension for the SPE under the Crown Entities Act 2004: 149CA due to the COVID-19 pandemic. As a result of this, the SPE was required to be completed by the DHB and provided to the Minister of Heath by 15 August 2020.

Whilst SCDHB met all timelines and expectations of the Ministry of Health (MOH), it has made a technical breach of section 149C of the Crown Entities Act 2004 by not submitting a completed SPE by 15 August 2020. The SPE 20/21 was adopted by the SCDHB Board and submitted to the MOH on the 28 August 2020.

Cost of Services

	Budget 2019/20	Actual 2019/20
REVENUE	**TOTAL $**	**TOTAL $**
Prevention	8,367,833	10,077,333
Early detection and management	47,875,850	48,924,055
Intensive assessment and treatment	120,363,465	123,948,951
Support and rehabilitation	35,718,853	39,780,661
Grand Total	**212,326,000**	**222,731,000**
EXPENDITURE	**TOTAL $'000**	**TOTAL $'000**
Prevention	8,367,833	9,877,333
Early detection and management	47,875,850	48,924,055
Intensive assessment and treatment	120,336,465	123,752,951
Support and rehabilitation	35,718,853	39,780,661
Grand Total	**212,299,000**	**222,335,000**
Surplus/(Deficit)	**27,000**	**396,000**

Statement of **Service Performance**

In this section you will find:

Improving Health Outcomes for our Population 53

Measuring our Non-Financial Performance 61

Improving Health Outcomes for our Population

What are we trying to achieve?

DHBs are expected to deliver against the national health sector outcomes: 'All New Zealanders lead longer, healthier and more independent lives' and 'The health system is cost effective and supports a productive economy' and to meet their objectives under the New Zealand Public Health and Disability Act to "improve, promote and protect the health of people and communities'.

The mission statement of the South Canterbury District Health Board (SCDHB) is "enhancing the health and independence of the people of South Canterbury". Over the long term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in South Canterbury, the decisions we make about which services will be delivered have a significant impact on our population and, if coordinated and planned well, improve the efficiency and effectiveness of the whole South Canterbury health system.

This section presents an overview of how we are succeeding in meeting those commitments and improving the health and wellbeing of our population. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service access indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing its strategic framework, the South Island DHBs identified three shared strategic high-level outcome goals where collectively we can change and deliver on the expectations of Government, our communities and our patients by making a positive change in the health of our populations.

Alongside these outcome goals are a number of associated outcomes indicators, which will demonstrate success over time. These are long-term outcome indicators (5-10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target.

- **Outcome Goal 1: People are healthier and take greater responsibility for their own health.**

  A reduction in smoking rates.

  A reduction in obesity rates.

- **Outcome Goal 2: People stay well in their own homes and communities.**

  A reduction in the rate of acute admissions to hospital.

  An increase in the proportion of people living in their own homes.

- **Outcome Goal 3: People with complex illnesses have improved health outcomes.**

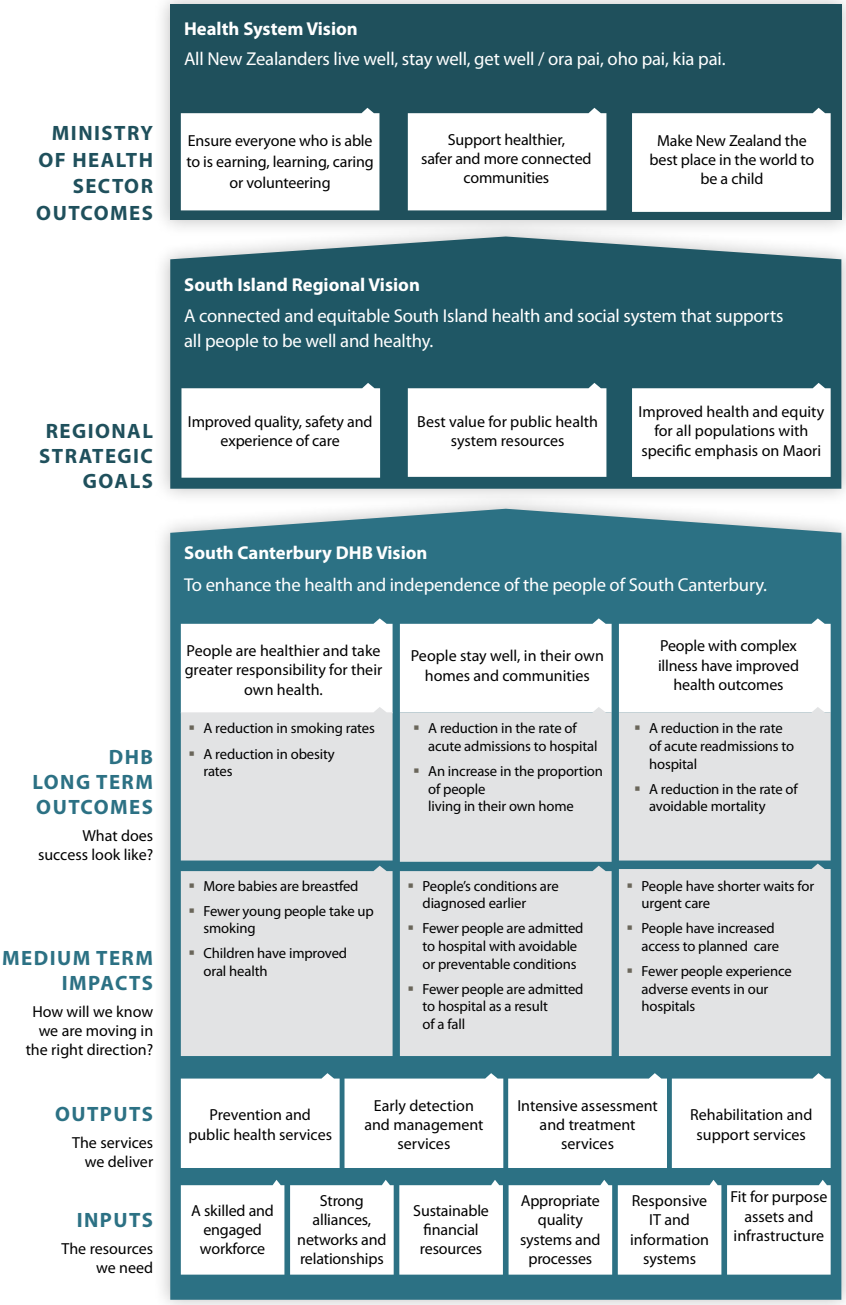
  A reduction in the rate of acute readmission to hospital.

  A reduction in rate of avoidable mortality.

South Island Intervention Logic Framework

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) will have an impact on the health of their population and result in the achievement of desired longer-term regional outcomes and the expectations and priorities of Government.

Overarching intervention logic



Te Tiriti O Waitangi

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

How have we performed?

STRATEGIC OUTCOME GOAL 1: people are healthier and take greater responsibility for their own health

Outcome: A reduction in smoking rates.

Comment

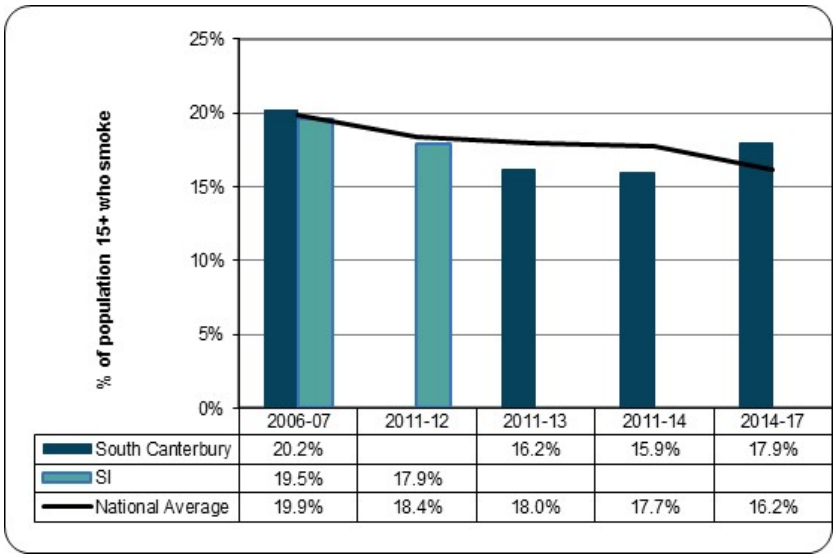
Smoking and exposure to second-hand smoke causes an estimated 4,627 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

The South Canterbury result for the period 2014-17 is 1.7% higher than the national average and 2% up on the previous period. However, it is important to note that the NZHS data collection is sample based and that this sample size is very small.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequalities in health status between population groups.

Data sourced from the National Health Survey (NZHS).

Outcome Measure Long Term (5 – 10 years): The percentage of the population (15+) who smoke.



	2006-07	2011-12	2011-13	2011-14	2014-17
South Canterbury	20.2%		16.2%	15.9%	17.9%
SI	19.5%	17.9%			
National Average	19.9%	18.4%	18.0%	17.7%	16.2%

Outcome: A reduction in obesity rates.

Comment

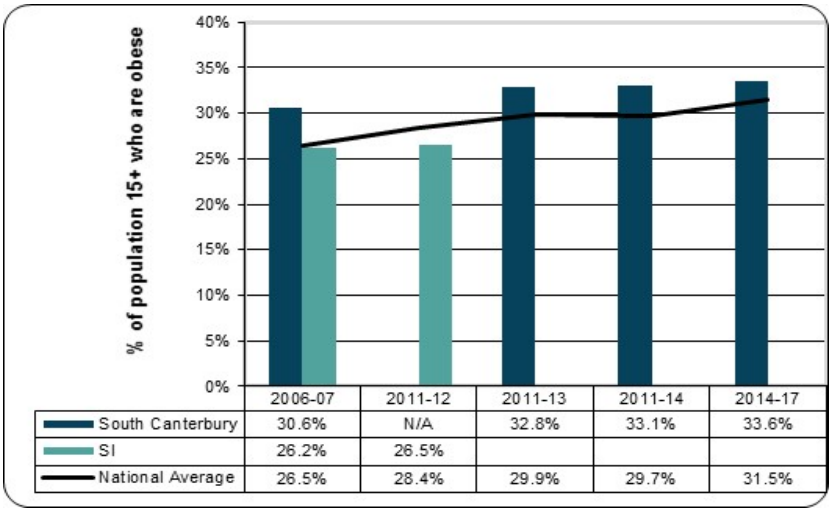
There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicities. Obesity is set to overtake tobacco as the leading risk to health and the most recent NZ Health Survey found 32% of all adults and 12% of children were obese.

The South Canterbury result for the period 2014-17 is 1.7% higher than the national average and 2% up on the previous period. However, it is important to note that the NZHS data collection is sample based and that this sample size is very small.

Supporting people to achieve a healthier body weight is fundamental to improving people's wellbeing and to preventing poor health and disability at all ages.

Data sourced from the National Health Survey (NZHS).

Outcome Measure Long Term (5 – 10 years): The percentage of the population (15+) who are obese.



	2006-07	2011-12	2011-13	2011-14	2014-17
South Canterbury	30.6%	N/A	32.8%	33.1%	33.6%
SI	26.2%	26.5%			
National Average	26.5%	28.4%	29.9%	29.7%	31.5%

STRATEGIC OUTCOME GOAL 2: people stay well in their own homes and communities

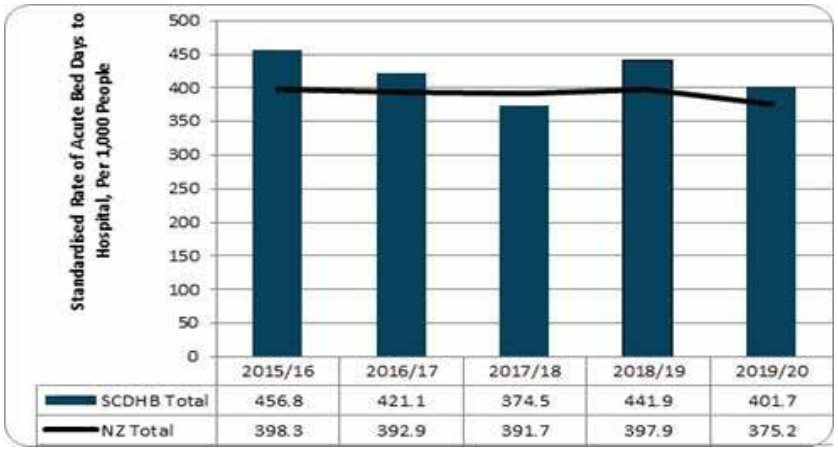
Outcome: A reduction in acute hospital bed days.

Comment

The result shows an increase on 2018/19. A discharge planning project commenced in 2019/20 to identify opportunities for improvements in this area.

Data sourced from the South Island Alliance Programme Office.

Outcome Measure Long Term (5 – 10 years): The rate of standardised acute hospital bed days per 1,000 population



Outcome: An increase in the proportion of the population living in their own home.

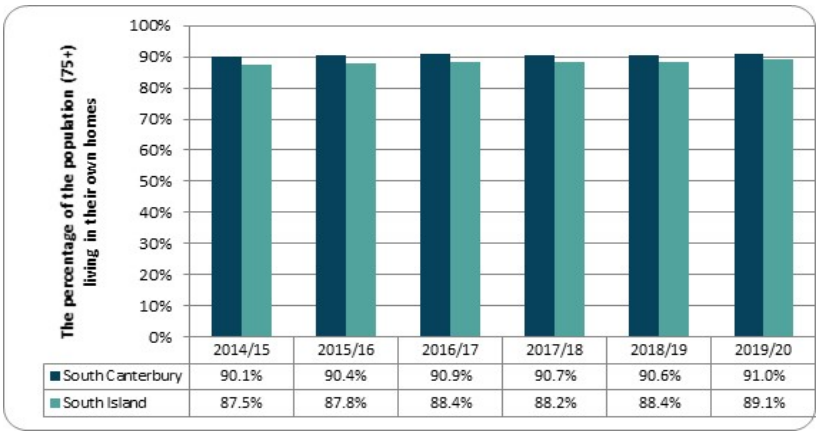
Comment

SCDHB's result for 2019/20 is slightly higher than previous years and remains above the South Island rate.

This reflects the continued focus across the sector to view home as the First Choice ensuring timely support services are put in place to reduce admissions to aged care facilities.

Data sourced from the South Island Alliance Programme Office.

Outcome Measure Long Term (5 – 10 years): The percentage of the population (75+) living in their own homes.



STRATEGIC OUTCOME GOAL 3: people with complex illness have improved health outcomes

Outcome: A reduction in acute readmissions.

Comment

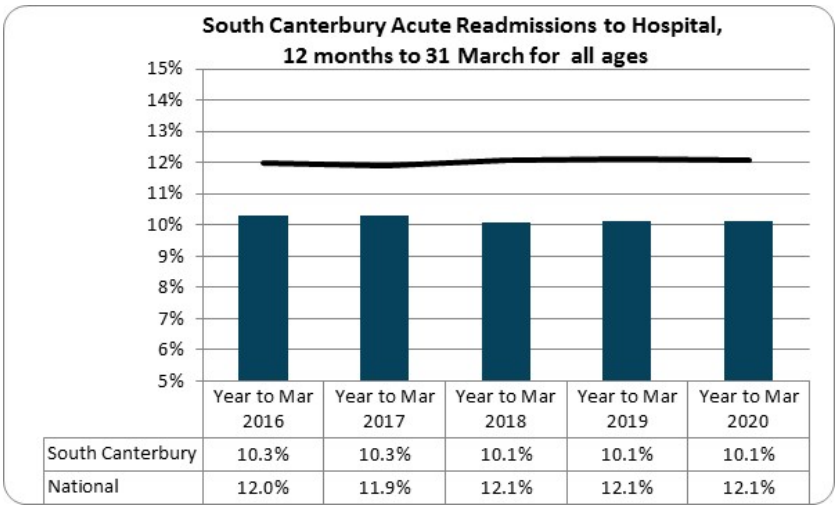
SCDHB's result for the year to March 2020 is comparable with previous years and remains below the national result.

Key factors in reducing acute readmissions include patient safety and quality standards, discharge planning and care coordination at the interface between services. Ensuring people receive effective treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided, and the integration between service providers. These rates are also a good balancing-measure to productivity measures such as reductions in lengths of stay.

Data sourced from the Ministry of Health.

Outcome Measure Long Term (5 – 10 years): The standardised rate of acute readmissions to hospital within 28 days of discharge.



	Year to Mar 2016	Year to Mar 2017	Year to Mar 2018	Year to Mar 2019	Year to Mar 2020
South Canterbury	10.3%	10.3%	10.1%	10.1%	10.1%
National	12.0%	11.9%	12.1%	12.1%	12.1%

Outcome: A reduction in mortality rates.

Comment

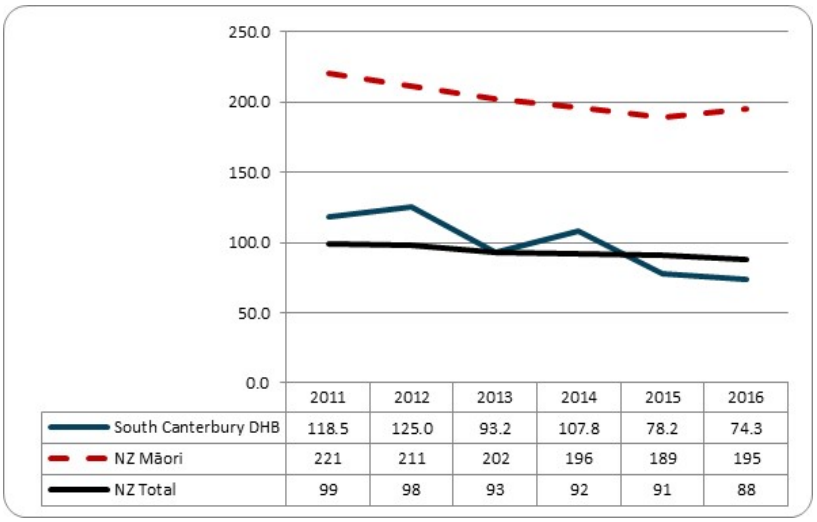
Mortality rates were last published in 2016. Results are presented for the South Island population rather than at DHB level. Rates for South Island Māori sit below NZ Māori.

Premature mortality (death before age 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition the more harmful impacts and complications of a number of complex illnesses can be reduced.

A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.

Data sourced from the South Island Alliance Programme Office.

Outcome Measure Long Term (5 – 10 years): The rate of all-cause mortality for people aged under 65 (age standardised per 100,000).



	2011	2012	2013	2014	2015	2016
South Canterbury DHB	118.5	125.0	93.2	107.8	78.2	74.3
NZ Māori	221	211	202	196	189	195
NZ Total	99	98	93	92	91	88

What difference have we made for our population?

Nine impact measures (3-5 years) supporting the three strategic goals demonstrate where we have made a measurable contribution to the longer-term outcomes we are seeking. Chosen impacts reflect areas of activity where the DHB can influence change and corresponding impact measures help demonstrate the difference we are making in the health of the South Canterbury population. Targets have been set against these impact measures in order to evaluate the impact of service delivery over a three-year period. This section provides an update on our progress.

STRATEGIC OUTCOME GOAL 1: people are healthier and take greater responsibility for their own health

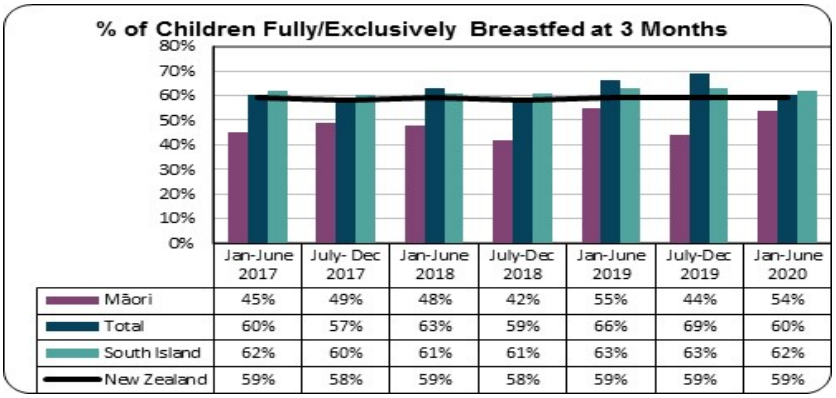
Impact: More babies are breastfed.

Comment

The South Island rates remain comparable with previous years and are slightly higher than the national result.

An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.

Impact Measure Medium Term (3-5 years): The percentage of babies fully/exclusively breastfed at three months.



	Jan-June 2017	July- Dec 2017	Jan-June 2018	July-Dec 2018	Jan-June 2019	July-Dec 2019	Jan-June 2020
Māori	45%	49%	48%	42%	55%	44%	54%
Total	60%	57%	63%	59%	66%	69%	60%
South Island	62%	60%	61%	61%	63%	63%	62%
New Zealand	59%	58%	59%	58%	59%	59%	59%

Impact: Children have improved oral health.

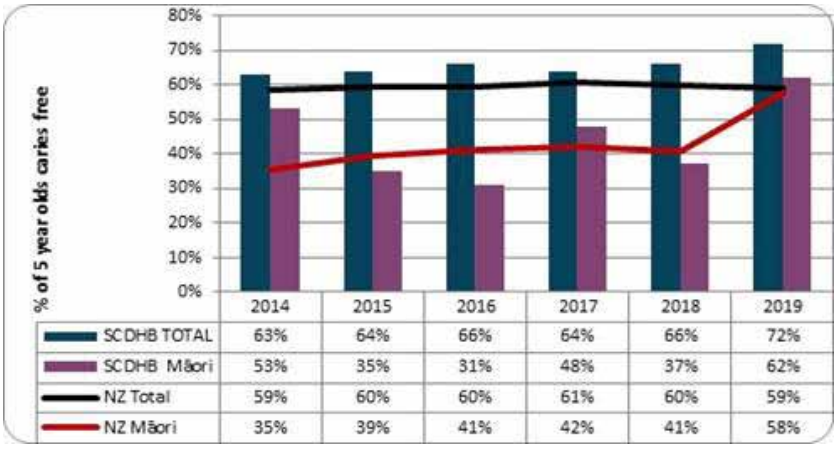
Comment

SCDHB's result for 2019 has improved on the previous year's result. There has been a significant improvement for Māori in 2019.

Good oral health not only reduces unnecessary complications and hospital admissions, it also signals a reduction in a number of risk factors such as poor diet, which has lasting benefits in terms of improved nutrition – helping to keep people well.

Data sourced from Ministry of Health.

Impact Measure Medium Term (3-5 years): The percentage of children caries-free at age 5 (no holes or fillings).



	2014	2015	2016	2017	2018	2019
SCDHB TOTAL	63%	64%	66%	64%	66%	72%
SCDHB Māori	53%	35%	31%	48%	37%	62%
NZ Total	59%	60%	60%	61%	60%	59%
NZ Māori	35%	39%	41%	42%	41%	58%

Impact: Fewer young people take up tobacco smoking.

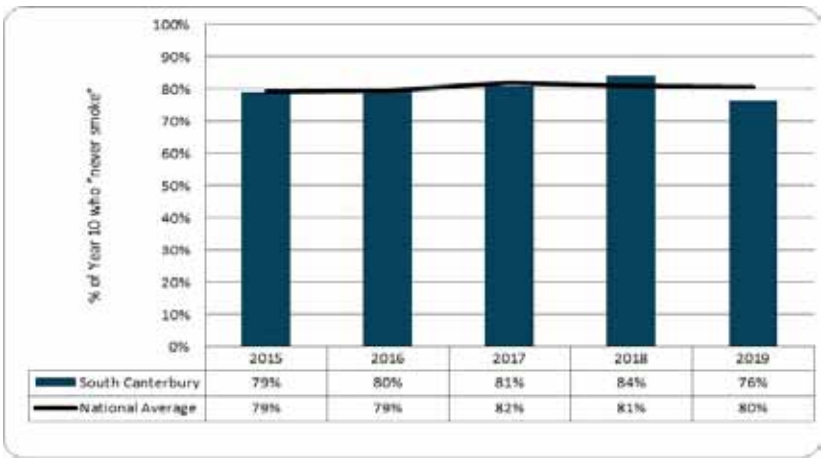
Comment

The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. Run by Action on Smoking & Health, the survey has been used to monitor student smoking since 1999 and provides valuable insights into tobacco use trends amongst young people. For more detail see www.ash.org.nz.

Results fluctuate year on year dependent on the sample composition and size.

Data sourced from ASH NZ Year 10 Survey

Impact Measure Medium Term (3-5 years): The percentage of 'never smokers' among Year 10 students.



	2015	2016	2017	2018	2019
South Canterbury	79%	80%	81%	84%	76%
National Average	79%	79%	82%	81%	80%

STRATEGIC OUTCOME GOAL 2: People stay well in their own homes and communities

Impact: People receive timely access to diagnostics.

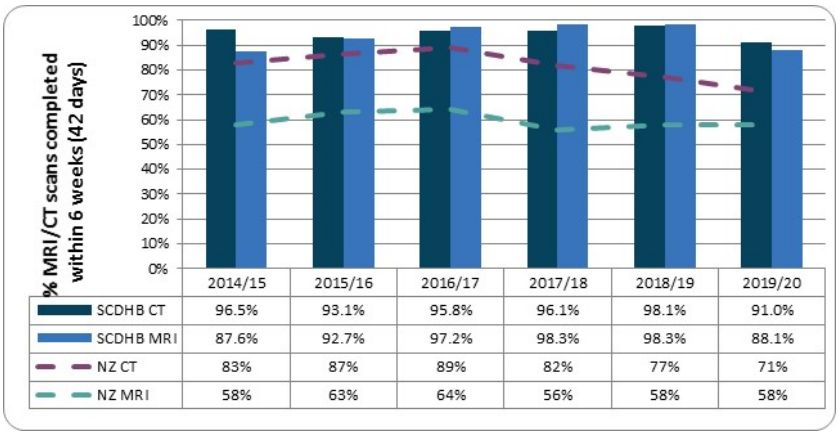
Comment

SCDHB's CT and MRI results each year have consistently met the Ministry's 95% and 90% target, respectively. However in 2019/20 these results were impacted due to COVID-19 Alert Levels.

Timely access to diagnostics avoids unnecessary delays for referrers making decisions on treatment options in conjunction with their patients.

Data sourced from the Ministry of Health.

Impact Measure Medium Term (3-5 years): The percentage of people waiting no more than six weeks for their CT or MRI Scan



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
SCDHB CT	96.5%	93.1%	95.8%	96.1%	98.1%	91.0%
SCDHB MRI	87.6%	92.7%	97.2%	98.3%	98.3%	88.1%
NZ CT	83%	87%	89%	82%	77%	71%
NZ MRI	58%	63%	64%	56%	58%	58%

Impact: Fewer people are admitted to hospital with conditions considered 'avoidable' or preventable.

Comment

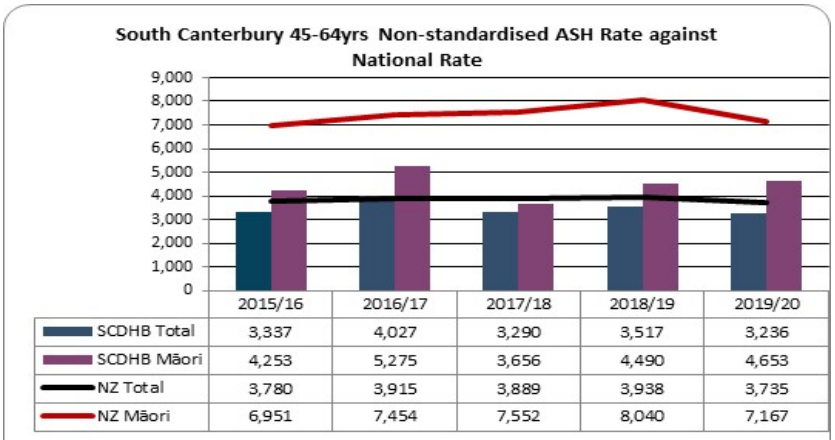
SCDHB's result for 2019/20 seen a positive result for avoidable hospital admissions for our populations aged 45-64 years and our result remains lover than the national rate.

A number of admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.

These admissions provide an indication of the quality of early detection, intervention and disease management services. A reduction would indicate improvements in care and would also free up hospital resources for more complex and urgent cases.

Data sourced from the Ministry of Health.

Impact Measure Medium Term (3-5 years): The non-standardised rate of avoidable hospital admissions for the population aged 45-64 years (per 100,000).



	2015/16	2016/17	2017/18	2018/19	2019/20
SCDHB Total	3,337	4,027	3,290	3,517	3,236
SCDHB Māori	4,253	5,275	3,656	4,490	4,653
NZ Total	3,780	3,915	3,889	3,938	3,735
NZ Māori	6,951	7,454	7,552	8,040	7,167

Impact: Fewer people are admitted to hospital as a result of a fall.

Comment

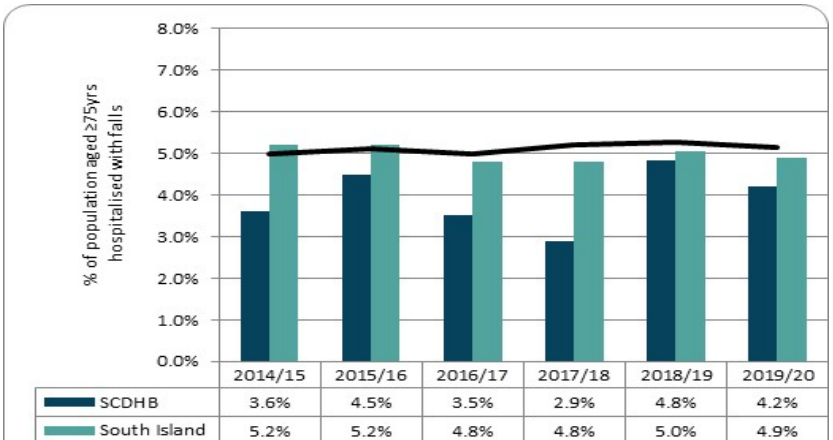
The 2019/20 result shows a decrease when compared to 2018/19 and is lower than both South Island and national results.

This is a reflection of the SCDHB philosophy of people staying in their home longer, and the aged population moving from old to very old, and the associated fragility of people. SCDHB has 5% more people per population in the over 75 year bracket compared to the National Data.

Living stronger for longer campaign will continue to be a major focus in 2020/21, to ensure the promotion of ACC approved strength and balance programmes in the community or at home.

Data sourced from the South Island Alliance Programme Office.

Impact Measure Medium Term (3-5 years): The percentage of the population (75+) admitted to hospital as a result of a fall.



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
SCDHB	3.6%	4.5%	3.5%	2.9%	4.8%	4.2%
South Island	5.2%	5.2%	4.8%	4.8%	5.0%	4.9%
New Zealand	5.0%	5.1%	5.0%	5.2%	5.3%	5.2%

STRATEGIC OUTCOME GOAL 3: People with complex illness have improved health outcomes

Impact: People have shorter waits for treatment.

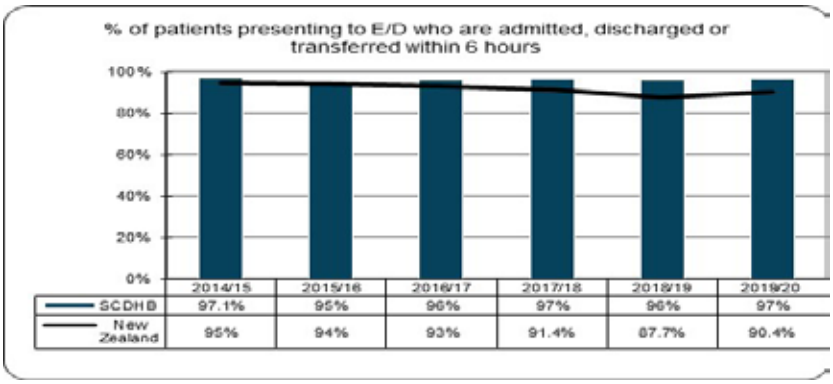
Comment

SCDHB continues to consistently meet this target and remain above the national target.

Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

Data sourced from SCDHB.

Impact Measure Medium Term (3-5 years): The percentage of people presenting at ED who are admitted, discharged or transferred within six hours.



Impact: People have increased access to elective services.

Comment

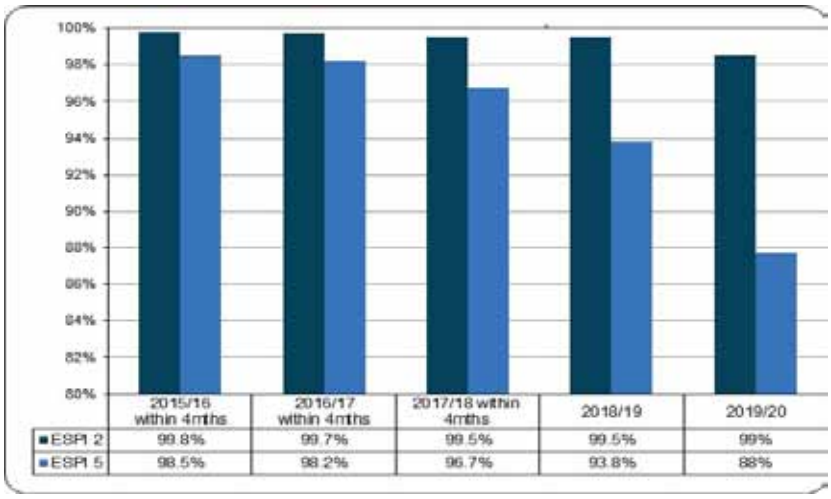
Elective Service Performance Indicator 2 relates to the percentage of patients provided with a First Specialist Appointment within 4 months of referral. The 2019/20 result remains close to target.

Elective Service Performance Indicator 5 relates to the percentage of patients given a commitment to treatment within 4 months. The DHB result for 2019/20 was impacted by COVID-19 Alert Levels.

Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is indicative of how responsive the system is to the needs of the population.

Data sourced from SCDHB.

Impact Measures Medium Term (3-5 years): The percentage of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in under four months.



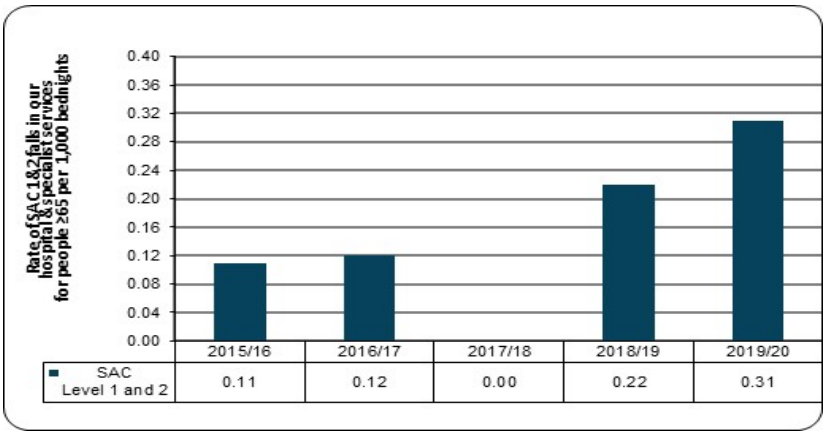
Impact: People stay safe in hospital.

Comment

Increasing number of people who have significant cognitive impairment has contributed to the increase in serious falls in hospital. Education to staff regarding delirium and the management of people who have dementia will continue to be a focus.

Data sourced from SCDHB.

Impact Measure Medium Term (3-5 years): The rate of SAC level 1 and 2 falls in hospital (per 1,000 inpatient bed-days)



Measuring Our Non-Financial Performance

Over the long-term, we aim to make positive changes in the health status of our population. As part of evaluating our performance, we provide an annual forecast of the services we plan to deliver and report actual delivery against that forecast at the end of each year. The following section presents our actual performance against the forecast outputs presented in our Statement of Performance for 2019/2020.

Identifying a set of appropriate measures is difficult. We cannot not simply measure 'volumes' as the number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'.

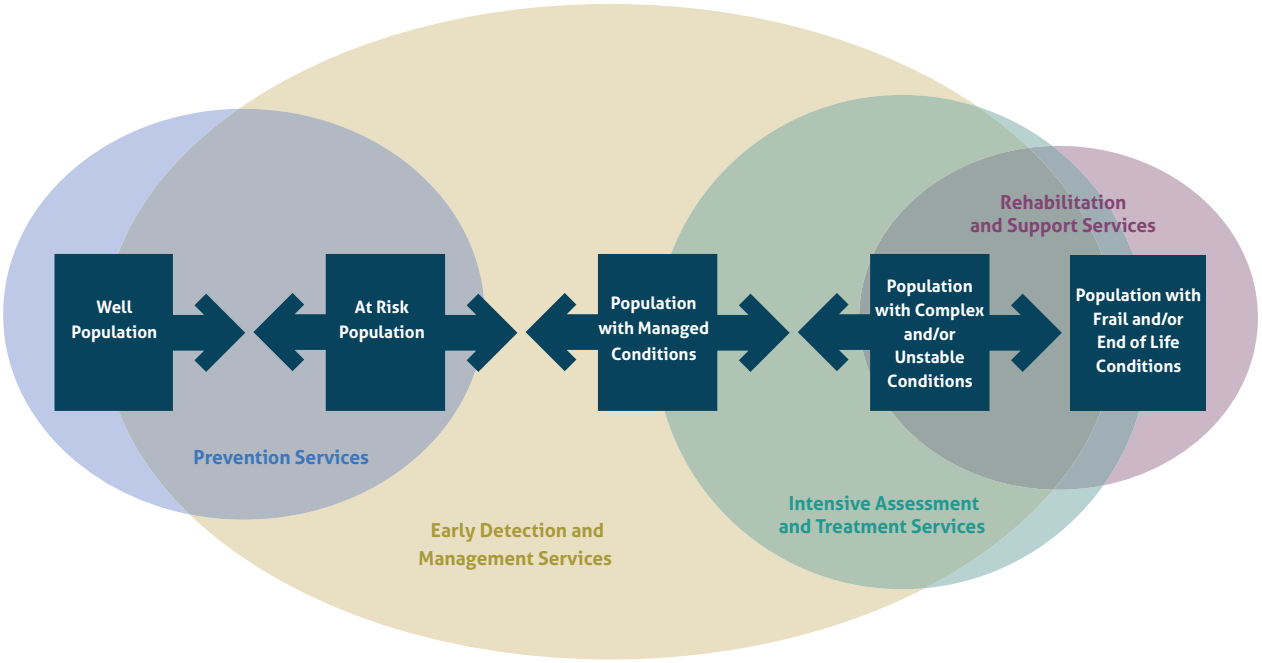
The output measures chosen are those activities which reflect a reasonable picture of activity across the whole of the South Canterbury health system and have the potential to make the greatest contribution to the health and wellbeing of our population in the shorter term and to the health outcomes we are seeking over the longer term.

We have used a mix of measures of Quantity (V), Quality (Q), Coverage (C) and Timeliness (T) – all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected. Quantity measures demonstrate capacity and 'how much' of a service we are delivering. Quality measures demonstrate 'how well' we are delivering the service. Coverage demonstrates the scope and scale of services provided and Timeliness measures demonstrate where services are delivered within recommended timeframes.

Where appropriate we have set targets for output measures to demonstrate the expected standard. Where available we have included prior year's baseline data to support evaluation of our performance over time as well as national results for 2019/20 to give context in terms of what we are trying to achieve.

In order to present a representative picture of performance, outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum of care and are applicable to all DHBs: Prevention Services, Early Detection and Management Services, Intensive Assessment and Treatment Services, and Rehabilitation and Support Services.

Output grouping set against the continuum of care for our population



Some data is collected on calendar rather than financial years and where this occurs is indicated as such. Results are based on data available at the time of producing this report and may be subject to change as additional coding and invoicing is completed. Any other irregularities have been footnoted.

What have we delivered – performance results

Where the targets set out in the following tables has been achieved this has been indicated with a ✔ in the status column. For those measures where target has not been achieved these results have been indicated with an ✘ and a comment explaining variance to target has been included as a footnote.

Output class – prevention services

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

By improving environments and raising awareness, these services support people to make healthier choices, reducing the major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. High need and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population.

Output measures

Health Promotion and Education Services

These services inform people about risks and support them to be healthy. Success is measured by greater awareness and engagement, reinforced by programmes that support people to maintain wellness, change personal behaviours and make healthier choices.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age.	*C, Q1.*	*60%	*63%	64.2%	70%	58.7%	✘
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months.	*C2.***	92.6%	80.6%	82.6%	90%	80%	✘
Percentage of pregnant women who identify as smokers upon registration with a DHB employed midwife or LMC offered brief advice and support to quit smoking.	*C*+	89%	100%	98%	90%	92.3%	✔

*Result updated to a 12 month period.

**Result as at Quarter 4 for previous 15 months.

+ 2019/20 data covers Quarter 1, Quarter 2 and Quarter 4 only. Due to COVID-19 Alert Levels no Quarter 3 data was available.

1. Increase in result compared to previous years, continuing to promote locally the benefits of breast feeding.
2. Increase in result compared to 2018/19. The SCDHB continue to support practices to use tools and processes to give brief advice as part of their business as usual service.

Population Based Screening

These services are mostly funded and provided through the National Screening Unit and help identify people at risk of illness earlier. They include breast and cervical screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years.	*T1.*	77%	73.8%	70.2%	80%	69.5%	✘
Percentage of Māori enrolled women aged 25 – 69 years who have had a cervical screen in the last three years.	*T1.*	65.3%	62.4%	59.2%	80%	61.5%	✘
Percentage of enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years.	*T2.*	76.2%	75.8%	68.6%	70%	66.8%	✘
Percentage of Māori enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years.	*T2.*	67.3%	62.6%	60.4%	70%	60.3%	✘
Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.	*T*	87% (12 months to 31 May 18)	96% (12 months to 31 May 19)	98% (12 months to 31 May 20)	95%	96% (12 months to 31 May 20)	✔

1. Completion of cervical screening and planned promotional events have been impacted by COVID-19 Alert Levels.
2. Completion of breast screening and planned promotional events have been impacted by COVID-19 Alert Levels.

Immunisation

These services reduce the transmission and impact of vaccine-preventable diseases including unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of infants aged 8 months who have completed their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	*T, C1.**	93%	93%	94%	95%	91%	✘
Percentage of 2-year olds fully immunised on time.	*T, C1.**	94%	93%	93%	95%	91%	✘
Percentage of 5-year olds fully immunised on time.	*T, C1.**	91%	91%	93%	95%	89%	✘
Percentage of the eligible population receiving the flu vaccination.	*C2.*	60% (1 March - 30 September 2017)	60% (1 March - 30 September 2018)	61% (1 March - 30 September 2019)	75%	57% (1 March - 30 September 2019)	✘
Percentage of eligible girls fully immunised with HPV vaccine.	*V3.*	44%	40%	51.3%	75%	60.6%	✘

*Result updated to a 12 month period.

1. 2019/20 result was close to target, activity influenced by COVID-19 Alert Level.
2. Significant effort and promotional activities were undertaken. This remains an area of interest for the DHB.
3. Target has not been met however there has been a 11% increase compared to last year. This continues to be an area of focus for the DHB.

Output class – early detection & management

Early detection and management services maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated – particularly where people have multiple conditions requiring ongoing interventions or support.

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include primary care, Māori health services, radiology and diagnostic services and child oral health services.

By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes.

Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services. Increases in access to diagnostics and agreed referral pathways and reductions in avoidable hospital admissions also reflect improvement.

Primary Health Care These services are offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.	**Notes**	**2017/18 Result**	**2018/19 Result**	**2019/20 Result**	**Target/ Estimated Delivery 2019/20**	**Current National Result**	**Achievement Against Target**
Percentage of ethnicity reported accurately in PHO registers.	*C*	99.64%	99.7%	99.9%	99%	N/A	✔
Percentage of Māori enrolled in a general practice.	*C1.*	83%	84%	82%	90%	87%	✘
Avoidable Hospital Admission (ASH) 0 – 4 years (Total) rate.	*Q*	*3,868	*3,925	4,065	≤4,195	5,397	✔
Avoidable Hospital Admission (ASH) 45 - 64 years (Total) rate.	*Q*	*3,290	*3,517	3,236	≤3,331	3,735	✔

* Result updated to a 12 month period.

1. Māori enrolments have been increasing due to good links between our Māori health provider and General Practice.

Long Term Conditions Programme

These services are targeted at people with high needs due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention, self-management strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of people assessed as high risk who have received an annual review.	*C*	NEW	NEW	N/A	NEW*	N/A	N/A

* The 2019/20 Target / Estimated Delivery is yet to be established.

Oral Health

These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.

	Notes	2017 Result	2018 Result	2019 Result	Target/ Estimated Delivery 2019	Current National Result	Achievement Against Target
Percentage of children under five years enrolled in DHB funded dental services.	*C1.*	73.5%	69.6%	77.1%	≥ 95%	95.1%	✘
Percentage of adolescents accessing DHB funded oral health services.	*C2.*	84%	80.7%	78.1%	≥ 85%	68.3%	✘
Percentage of children caries free at five years of age.		64%	67%	72%	≥ 66%	58.8%	✔
Oral Health Decayed, Missing and Filled Teeth score at year eight.		0.82	0.82	0.81	≤ 0.77	N/A	✔
Percentage of enrolled preschool and primary school children overdue for their scheduled examination.		14%	11%	9%	≤10%	22.4%	✔

1. Whilst the target was not met we are working on an electronic enrolment system which should show improvements.
2. Whilst the target was not met, the current result is lower than the previous years. This improvement is partly due to the number of new graduates recruited.

Community Referred Tests and Diagnostic Services

These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as, radiographers. To improve performance, we will target improved primary care access to diagnostics without the need for a hospital appointment to improve clinical referral processes and decision making.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of accepted referrals for a MRI scan receive their scan within six weeks.	*T1.*	98.3%	98.3%	88.1%	95%	58%	✘
Percentage of accepted referrals for a CT scan receive their scan within six weeks.	*T1.*	96.1%	98.1%	91%	95%	71%	✘
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 calendar days.	*T*	96.2%	95.4%	97.7%	90%	90%	✔
Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within six weeks.	*T*	47.2%	50.9%	85.6%	70%	53%	✔
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date.	*T*	76.5%	61.9%	90.4%	70%	56%	✔

All of the results included in this table have been updated to a 12 month period.

1. This 2019/20 result was impacted by COVID-19 Alert Levels..

Output class – intensive assessment and treatment services

Intensive assessment and treatment services are usually complex services provided by specialists and other health care professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services and emergency or urgent care services.

We provide an extensive range of intensive treatment and complex specialist services to our population and we also fund some intensive assessment and treatment services for our population that are provided by other DHBs. A proportion of these services are driven by demand which we must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or through corrective action. Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed.

As an owner and provider of these services, we are also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and / or maximise their quality of life.

Success is defined by a reduction in acute demand, increased access to services and timely treatment and increased access to less complex care in the community setting.

Acute Services

These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly creating an urgent need for care. For more complex acute conditions, hospital-based services include emergency services, acute medical and surgical services and intensive care services.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of patients admitted, discharged or transferred from ED within 6 hours.	*T**	97.1%	96.6%	95.4%	95%	87.1%	✔
Standardised acute hospital stays bed days per 1,000 population.	*V1.*	*374.5	*441.9	401.7	<384	375.2	✘
Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	*T2.*	85.3%	88.6%	69%	90%	87.2%	✘
Percentage of older patients assessed as at risk of falling.	*Q*	97%*	95%*	97%[+]	95%	N/A	✔

*Result updated to a 12 month period.

[+]Results are only for Quarter 1 and Quarter 2 due to the impact of COVID-19 Alert Levels.

1. The result shows an increase on 2018/19. A discharge planning project commenced in 2019/20 to identify improvements in this area.
2. Capacity constraints continue to have an impact on the ability to meet this target, inclusive of networking with our referral centre to assist us in meeting compliance. This result was impacted by COVID-19 Alert Levels.

Planned Care

These are the services (which incorporate elective services) for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes surgery and specialist assessments. National Elective Services Patient Flow Indication (ESPIs) are indicative of a successful and responsive service, addressing population need.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
No. inpatient surgical discharges (planned care interventions).	*Q1.*	NEW	NEW	2,773	3, 129	N/A	✘

1. The definition for this measure and been revised again in 2019, as such it is not comparable with previous years. Delivery of target was impacted by COVID-19 Alert Levels.

Specialist Mental Health Services

These are services for the most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services.	*C*	5.75% (12 months - 31 March 2018)	5.9% (12 months - 31 March 2019)	5.9% (12 months - 31 March 2020)	5%	4% (12 months - 31 March 2020)	✔
Access rates to Primary Mental Health Brief Intervention – 12-19 Years.	*T*	4.5%	4.6%	6%	4.7%	N/A	✔
Access rates to Primary Mental Health Brief Intervention – 20+ Years.	*T1.*	2.5%	3.5%	2.5%	2.8%	N/A	✘
Rate of Māori per 100,000 under the Mental Health (Compulsory Assessment and Treatment) Act 1992: section 29 community treatment orders relative to other ethnicities.	*Q2.*	Māori *133 Non-Māori *102	Māori *169 Non-Māori *91	Māori 160 Non-Māori 89	Māori 120 Non-Māori 92	Māori 301 Non-Māori 95	✘

* Result updated to a 12 month period.

1. The 2019/20 results are close to target. Access and equity are a key focus of the mental health and addiction review implementation.
2. Presented results relate to a very small number of Māori and the 2019/20 results are close to target. The DHB continues to engage clients with the Hauora Māori team at the earliest point of contact with the service.

Output class – rehabilitation and support services

Rehabilitation and support services provide people with the support and assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered following a clinical 'needs assessment' process and include: domestic support, personal care, community nursing, community services provided in people's own homes and places of residence, day care, respite and residential care services. Services are mostly for older people, mental health clients and for personal health clients with complex health conditions.

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admissions or readmission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

Needs Assessment and Support

These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.

	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of residents who have had a subsequent InterRAI long term care facility assessment completed within 230 days of the previous assessment.	*T*	89%	93%	95%	90%	N/A	✔
Percentage of clients who have been admitted to an Aged Related Care (ARC) facility from the community who have been assessed using the InterRAI Home Assessment Tool within six months of admission to the ARC facility.	*Q1.*	94%	91%	91%	95%	N/A	✘

All of the results included in this table are for a 12 month period.

1. Single point of entry for all community referrals established in May 2019 allows for people to be prioritised and seen sooner. Early indications demonstrate an improved performance against target. This result was impacted by COVID-19 Alert Levels.

Rehabilitation	Notes	2017/18 Result	2018/19 Result	2019/20 Result	Target/ Estimated Delivery 2019/20	Current National Result	Achievement Against Target
Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	*T*	85%	*74.5%	84.1%	80%	N/A	✔
Percentage of patients referred for community rehabilitation seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	*Q*	*80%	63%	71%	60%	N/A	✔
Percentage of mental health and addiction clients with a transition (discharge) plan.	*C1.*	NEW	NEW	81%	95%	N/A	✘

*Result updated due to a data entry error.

1. The transition to wellness plan is currently being updated to make it more user friendly. Delivery of the wellness plan was impacted by COVID-19 Alert Levels.

Your feedback

In order to continue to improve on the information we provide to you, we welcome your feedback on this document.

Annual Report Feedback

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Alternatively, you can email your feedback to:

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