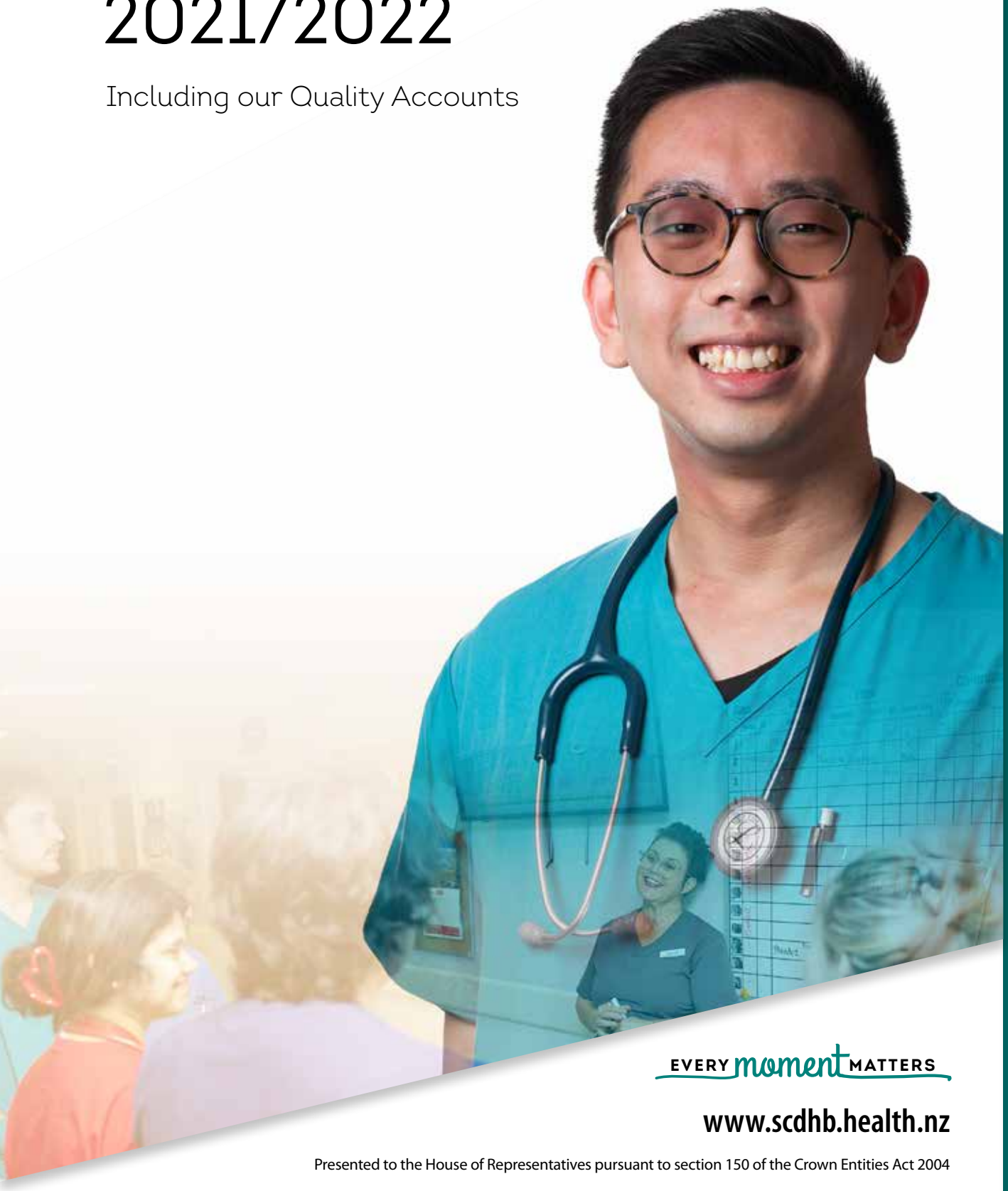
South Canterbury
District Health Board

Annual Report

2021/2022

Including our Quality Accounts



EVERY moment MATTERS

www.scdhb.health.nz

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

What's inside?

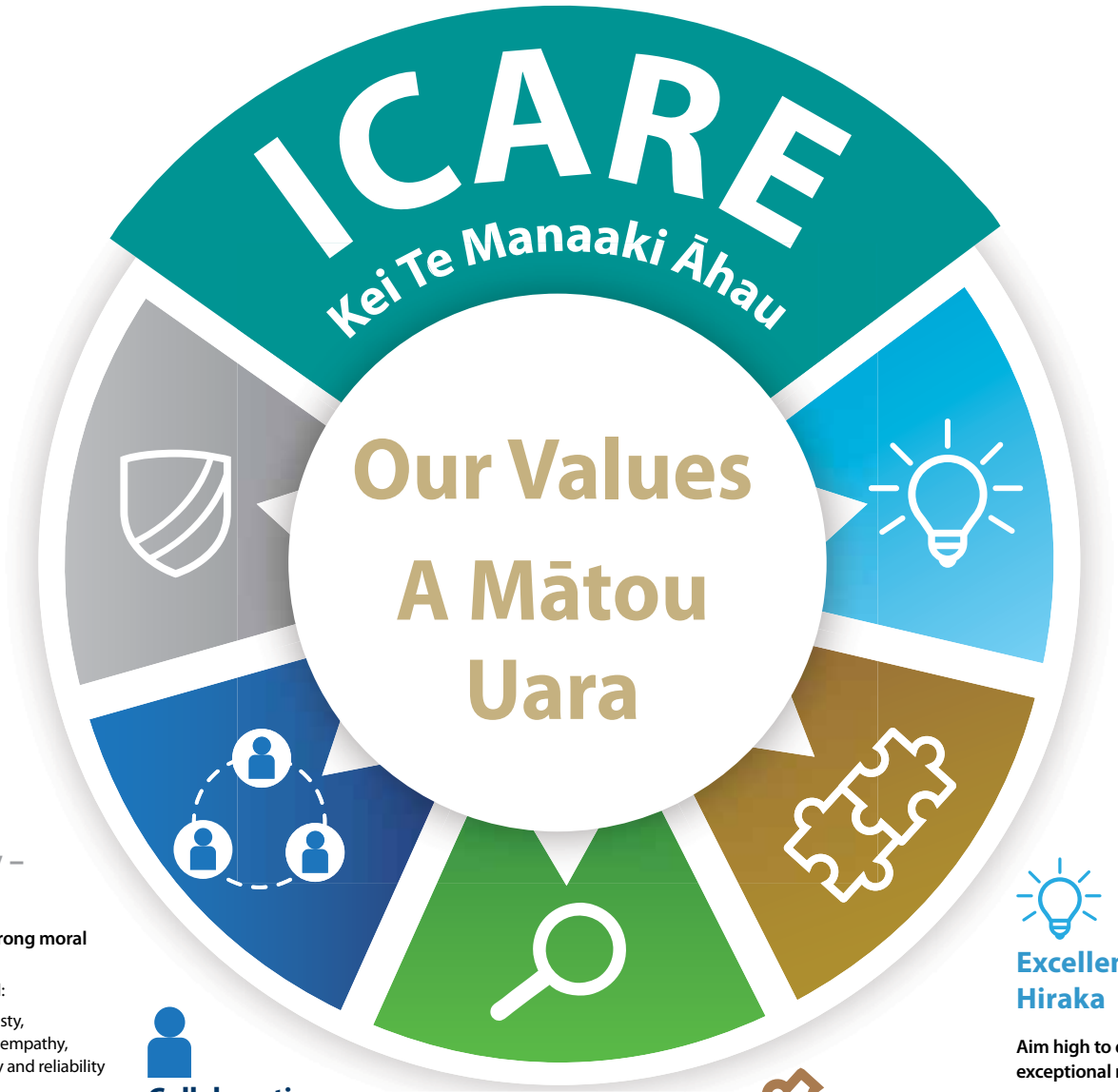
Our Vision, Mission and Values

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

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

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.

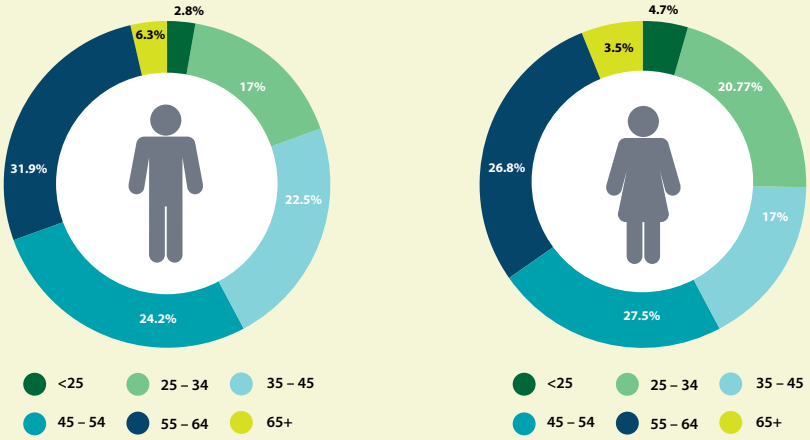
STRATEGIC GOALS	STRATEGIC PRIORITIES
PRODUCTIVE PARTNERSHIPS	■ Engaging the consumer's voice ■ Bolstering community collaboration ■ Strengthening regional relationships
INTEGRATED PERSON-CENTRED CARE	■ Improving health literacy ■ Designing sustainable models of care ■ Developing Primary Care Strategy
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 lens 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

SNAPSHOT 2021/2022

994 EMPLOYEES

14% male **86%** female

Workforce Profile – by age bands



Employee Status

Casual **13%** Part time **57%** Full time **30%**

Figures sourced from Employee Report Data

TIMARU LAB RESULTS

353,438
COMMUNITY, OUTPATIENT AND HOME VISITS

170,034
EMERGENCY AND INPATIENT

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

8,113
Breast screening (45 – 69yrs)
Women Screened Previous 2 Years

11,536
Hospital discharges

9,375
Mental Health Community + Outpatient Contacts

3,372 THEATRE EVENTS

35,512
District nursing visits

347,022
Primary Care Provider visits

22,925 Allied Health Community + Outpatient Contacts

237
Mental Health Hospital Discharges

639
Deaths in South Canterbury

547
Babies born in hospital

38,956 Radiology Attendances

1,262 Chemotherapy attendances

30,818 Specialist Outpatient attendances

609
Number of 8 month olds immunised

582
B4 school checks

20,347 **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

	2020/21	2021/22
Q1	95.3%	95.4%
Q2	94.9%	94.1%
Q3	94.4%	94.3%
Q4	96%	93.6%

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

	2020/21	2021/22
Q1	95.9%	93.4%
Q2	96.6%	95.4%
Q3	93.9%	93%
Q4	92.8%	91.3%

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

	2020/21	2021/22
Q1	80%	77.5%
Q2	78.8%	74.4%
Q3	76.5%	70.2%
Q4	74.4%	67%

Raising Healthy Kids

Target 95%

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

	2020/21	2021/22
Q1	96.9%	100%
Q2	98.1%	100%
Q3	100%	100%
Q4	100%	96%

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

	2020/21	2021/22
Q1	79.3%	87.5%
Q2	82.1%	74.2%
Q3	93.9%	66.7%
Q4	88.5%	68.8%

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

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
- Resigned December 2022

Murray Roberts

- Audit and Assurance Committee member

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
Tania Kemp	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. Due to COVID-19, the ability of our district to collect and submit data has been impacted. The markers discussed here 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
5. **Safe Use of opioids**
6. **Pressure Injury Prevention**

1. 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. This marker is now in a sustainability phase and no longer reported.

2a Safe Surgery

The safe surgery programme was introduced to improve perioperative care by encouraging operating theatre teams to consistently use safety checks on all patients to improve teamwork and communication.

Safe surgery measures 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. These measure continue however are not now reported as this has become normal and expected practice on every theatre list.

2b 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). Manual auditing was suspended from March to June due to COVID-19. However our results for the period November 2021 to October 2022 have been between 79 and 89%. We have continued to increase the number of auditors within the hospital.

2c 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 standardised approach for initially hip and knee replacement surgery that could be measured and compared nationally. Cardiac surgery is not undertaken at SCDHB. In October 2020 we commenced light surveillance which means we only collect process data when a surgical site infection has occurred and then a full investigation is undertaken into the event.

3. 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, South Canterbury is not one of these.

4. Deteriorating Patient Programme

This national patient deterioration programme aims to reduce harm by recognising and responding to acute physical deterioration for adult inpatients. It consists of three work streams:

a. **Recognition and Response:** This included introducing a national vital signs chart which contains an early warning score (excluding maternity) and has a clinical escalation pathway. The QSMs that are associated with this work stream are manually collected and have been affected by COVID-19. The targets are:
   i. 100% of eligible wards using the New Zealand early warning score. Our results are 100%
   ii. 100% of early warning scores are calculated correctly. Our results are 100%
   iii. 100% of patients that triggered an escalation of care and received appropriate response. Our results are 100%.

b. Kōrero mai: is patient, family and whānau escalation: Patients and family often recognise subtle signs of deterioration, even if vital signs are normal. The purpose of this HQSC led Kōrero 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.

c. Shared goals of care: was designed to proceed once the Kōrero mai had been established. Patients, whānau and clinicians discuss the patient's values, their care and treatment options available and agree the goals of care for the current admission and if the patient deteriorates. This work stream was rolled out at the end of this year.

5. Safe Use of Opioid

Opioid medicines (morphine, oxycodone, fentanyl, methadone, tramadol and codeine) are high-alert medicines, which are excellent at controlling pain also have a number of unintended side-effects (eg constipation, nausea, vomiting and urinary retention). This QSM has specific audit criteria: an inpatient on a surgical ward, (general surgery, orthopaedic and urology patients, including those surgical patients admitted to the surgical ward who do not receive surgical interventions), 18 years and older and having been administered an opioid. The outcome measure is taken form the districts national minimum dataset data. This is derived from district coding data. This marker has now moved to a sustainability phase.

6. Pressure Injury Prevention

Pressure Injuries are an indicator of the quality of care patients receive. They are often avoidable, have significant negative impacts on patients' lives and increase hospital length of stay. SCDHB partnered with Accident Compensation Corporation to employ a project nurse until February 2023 to educate primary, community and aged related services on prevention and identification of pressure injuries. This surveillance was introduced to promote a consistent practice and to monitor the effectiveness of improvement activities to reduce pressure injuries. The QSM measures are:

1. Percentage of patients with a documented and current pressure injury assessment. Our results were: 100%
2. Percentage of at-risk patients with a documented and current individualised care plan. Our results were: no results available
3. Percentage of patient with a hospital-acquired pressure injury. Our results were: 0.0 – 10.8.

In addition our results show an increase in the number of non-hospital acquired pressure injuries identified, which reflects a national trend. This is a manually collected marker and has been affected by COVID-19.

Being a good employer

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

Leadership, Accountability and Culture

Since establishing a flattened leadership structure, there has been a continued focus on enabling greater distributive leadership, a model that 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). With the subsequent introduction of self-directed teams and enabling front-line Managers and teams, to hold greater accountability and responsibility for their areas/services, feedback/discussions held with a range of managers in various forums has continued to emphasised how much people appreciate feeling more empowered and 'in charge of their own areas" with a strong indication expressed that staff would not want to see a return to the old top down hierarchical management approach. Our Clinical Directors for example hold direct responsibility for staffing of their specialties along with operational management of the team and CNM's/ CNS's have formed clusters, which report directly to the Director of Nursing, Midwifery & Patient Services. Similarly, our HR, Learning Hub, Health & Safety, and Quality & Risk Teams all successfully operate a 'self-directed team' model approach.

It is our belief that since implementing a culture reset programme, as a result of a 2016 Staff Engagement and Wellbeing Survey, we have been successful in transitioning from a largely hierarchical, control-based framework for decision making, to a learning health system, (characterised by a distributive leadership model that has become imbedded practice).

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

With the introduction of a three-day cultural awareness programme (Kia Tika te Ara) we are witnessing an increase in staff understanding of māori health inequity and history. Feedback from those attending our programme (including members of SLT) has been extremely positive.

This has led many staff into furthering their cultural competence and understanding of te reo through personal commitments to ongoing education options locally.

In addition, a refresh of our initial adoption of the 'Speaking up for Safety' and 'Promoting Professional Accountability' processes from the Cognitive Institute has helped 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 against which we are now planning specific actions and priorities, 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. We continue to partner 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 in conjunction with our Director of Māori Health had cast a cultural lens over our recruitment process in terms of further promoting diversity and addressing inequities in ethnic representation across our workforce. This resulted in a commitment to always interview applicants who identify as Māori where said applicant holds the minimum skill requirements for the role, as well as inserting a number of mandatory cultural focused questions into every interview, along with the practice of starting each interview with a brief mihi (ideally in te reo).

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).

Work continues in further developing our E-Recruitment platform, as well as a project underway to implement M-Files electronic personnel records system and associated workflow tracking/automation, which would reduce the paperwork burden for hiring managers and allow more transparency and efficiency in the various recruitment process stages for managers and applicants alike. Since changing our recruitment advertising supplier we undertook an extensive rebranding process which has resulted in the creation of contemporary advertising resources (such as promotional videos).

Employee Development, Promotion and Exit

Our performance review process provides an avenue 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 tools are future focused and explore our values in action and individual aspirations as much as reflecting on past performance. Our leadership learning programme 'Navigate' created a community of learning with spin off, smaller scale workshops to support 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 was established, where presenters were booked to deliver a presentation on various leadership and process topics as prioritised by our line managers. This was proving popular until COVID-19 struck and has now been discontinued due to risk associated with hosting large groups from across multiple clinical services in a confined venue. Some alternative learning modules have since been developed or identified on HealthLearn as an alternative supported leadership training option for those who may be interested.

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. In South Canterbury we recognise the importance of family friendly initiatives and where possible are keen to support alternative options for working. A flexible working policy has been 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 is being 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) have assisted in retention rates.

Our Director of Allied Health 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. These have now been enacted resulting in increases for a number of Allied Health Clinical Leader roles across the organisation.

Our Director of Organisational Capability & Safety has been the lead GM-HR for the National Pay Equity Claim for administration staff which has been implemented, resulting in significant boosts to pay rates for our admin staff (a predominantly female dominated workforce).

Similar Pay Equity claims are now underway nationally for Nursing, Midwifery and Allied Health professional staff, for which we will be actively involved.

Harassment and Bullying Prevention

South Canterbury engaged the Cognitive Institute to develop a training programme which is now embedded as part of organisational 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 were also made the Disciplinary Policy and Code of Behaviour document. This approach seems to be used by staff across services with increasing confidence.

We know that culture doesn't change overnight, so while we continue developing these speaking up skills, we also adopted 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. We have continue to support this process through the training of new Key Messengers.

Our crucial conversations workshops and more intensive leadership learning programme, provides 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, thorough and consultative reviews of policy and procedure continues to ensure they are fit-for-purpose. We introduced an occupational health nurse to strengthen health monitoring and wider wellbeing related activity.

Creating a learning environment is vital when increasing the understanding of hazards and controls, for this reason education sessions and workshops along with improved reporting of key indicators is an on-going activity.

Hazard registers are regularly reviewed and this has helped inform decision making at the newly formed Risk, Health & Safety Management meetings.

Emergency preparedness is continually developing, including a current initiative to improve the operational quality of local Business Continuity Plans. Increased regional networking is also strengthening capability amongst the local emergency management community.

We have introduced a contracted security guard service and raised awareness across the organisation, particularly in the field of protective security.

Our COVID-19 pandemic response has helped to refine infection, prevention, control practices, along with employee support and contractor management.

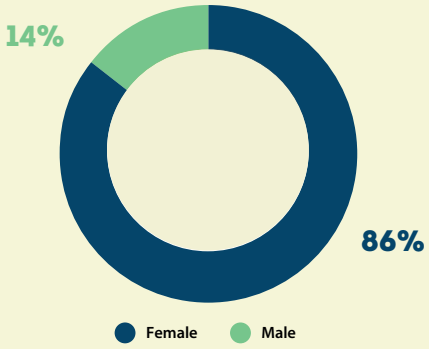
Our Employees

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 with a focus on ensuring sustainability over the coming years while also supporting nationally lead recruitment initiatives and the concept of 'NZ Inc' as a single entity particularly as we transition into Te Whatu Ora – a Team of Teams.

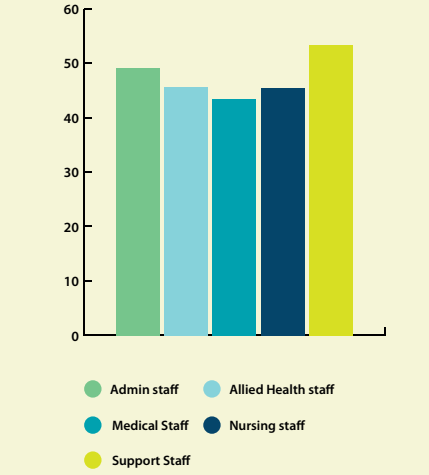
Distribution of employee ethnicity

Not Stated	19	Canadian	6	French	1
refused	4	Celtic NFD	1	German	2
African	1	Chinese NFD	12	Indian NEC	10
African NEC	2	Cook Is Maori	1	Indian NFD	35
African NFD	12	Dutch	2	Indian Tamil	1
American	10	English	7	Irish	2
Asian NEC	1	European NFD	46	Lat Americanec	1
Asian NFD	3	European Undfin	20	Malay	2
Australian	8	Fijian	3	Maori	46
British NEC	9	Fijian Indian	1	Mdl Eastern NFD	3
British NFD	33	Filipino	23	**Grand Total**	**994**
Bulgarian	1				

Gender



Average age by profession



Employment type

Casual **13%** Part time **57%** Full time **30%**

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

By Gender & Ethnicity, 15 December 2022

Occupational Group	Measure	Gender				Ethnicity					
		All	Female	Male	Pay Gap - Female	All	Māori	Pacific	Other	Pay Gap - Māori	Pay Gap - Pacific
Senior Medical	Median Hourly Rate	105.83	99.01	107.96	8.3%	105.3		94.11	107.17		12.2%
	Positions	72	29	43		72					
Junior Medical	Median Hourly Rate	49.19	49.19	49.47	0.6%	49.19		50.05	49.19		-1.7%
	Positions	31	20	11		31					
Nursing	Median Hourly Rate	39.88	39.88	39.88	0.0%	39.88	39.88	22.14	39.88	0.0%	44.5%
	Positions	523	485	38		523					
Allied Health	Median Hourly Rate	39.80	39.80	41.22	3.4%	39.80	31.58		39.80	20.7%	
	Positions	150	134	16		150					
Non Clinical Support	Median Hourly Rate	28.18	28.18	28.18	0.0%	28.18	28.24		28.18	-0.2%	
	Positions	44	26	18		44					
Management & Administration	Median Hourly Rate	32.76	32.76	39.15	16.3%	32.76	32.50	24.59	32.76	0.8%	24.9%
	Positions	179	154	25		179					
All Staff	Median Hourly Rate	39.88	39.88	43.96	9.3%	39.88	37.40	24.59	39.88	6.2%	38.3%
	Positions	999	848	151		999					

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:

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022. As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the South Canterbury DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

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

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

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

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

Signed on behalf of the Te Whatu Ora Board

Naomi Ferguson
Acting Chair
Dated: 3 May 2023

Hon Amy Adams
Board member
Dated: 3 May 2023

Independent Auditor's Report

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

The Auditor-General is the auditor of 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 appropriations, of the Group on his behalf.

Opinion

We have audited:

- the financial statements of the Group on pages 19 to 52, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Group on pages 7 and 53 to 79.

In our opinion:

- the financial statements of the Group on pages 19 to 52, which have been prepared on the disestablishment basis:
  - present fairly, in all material respects:
- its financial position as at 30 June 2022; and
- its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Group on pages 7 and 53 to 79:
  - present fairly, in all material respects, the Group's performance for the year ended 30 June 2022, including:
- for each class of reportable inputs:
  - 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 9 May 2023. This is the date at which our opinion is expressed.

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

Emphasis of matters

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

The financial statements have been prepared on a disestablishment basis

Note 1 on page 24 outlines that the Group has prepared its financial statements on a disestablishment basis because the Group was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Group's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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

Note 15 on page 41 and page 42 outlines that the Group has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Group has estimated a provision of $20.7 million, as at 30 June 2022, to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

Covid-19 Impact

Note 27 on page 52 to the financial statements and pages 57, 61 to 62 and 64 to 72 of the performance information outline the ongoing impact of Covid-19 on the Group.

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

Additional performance information in page 73 to 79 outlines the information used by the Group to report on its Covid-19 vaccine coverage. The Group uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the

reasons set out on page 77. The information outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Group has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Basis of our opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 6, 8 to 15 and 81 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

Christchurch, New Zealand

Statement of Comprehensive Revenue and Expense

for the year ended 30 June 2022

In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2022	Actual 2022	Actual 2021	Actual 2022	Actual 2021
Patient Care Revenue	2a	238,360	254,820	231,757	255,945	232,840
Other Revenue	2b	2,015	3,183	3,659	2,164	2,625
Finance Revenue	2c	136	354	365	359	366
Total Revenue		**240,511**	**258,357**	**235,781**	258,468	235,830
Personnel Costs	3	78,085	94,627	77,895	94,361	77,674
Outsourced Services		10,531	11,886	11,842	11,671	11,712
Clinical supplies		12,792	13,865	12,956	13,900	12,985
Infrastructure and non-clinical expenses		12,270	14,609	12,102	14,768	12,228
Payments to non-DHB health providers		120,370	122,229	114,146	122,229	114,146
Depreciation and amortisation expense	7&8	5,000	5,560	5,169	5,593	5,186
Finance costs	4	0	0	0	0	1
Capital charge	5	1,368	1,875	1,363	1,875	1,363
Total Expenditure		**240,416**	**264,651**	**235,471**	**264,398**	**235,294**
SURPLUS/(DEFICIT)		95	(6,294)	310	(5,930)	536
Other Comprehensive Revenue and Expenses						
Item that will not be reclassified to surplus or (deficit)						
Gain on property revaluation	9	-	17,188	-	17,188	-
Total Other Comprehensive Revenue and Expenses		-	17,188	-	17,188	-
TOTAL COMPREHENSIVE REVENUE AND EXPENSES		95	10,894	310	11,258	536

Explanations of major variances against budget are provided in note 25.

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2022

In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2022	Actual 2022	Actual 2021	Actual 2022	Actual 2021
Balance at 1 July		29,091	29,331	28,904	29,573	28,919
Comprehensive revenue/(expense)						
Net Surplus/(Deficit) for the year	9	95	(6,294)	310	(5,930)	536
Other Comprehensive Revenue	9	-	17,188	0	17,188	0
Total comprehensive revenue		95	10,894	310	11,258	536
Capital Movements						
Repayment to Crown	9	(217)	(217)	(217)	(217)	(217)
Contribution from Crown	9	7,000	6,864	334	6,864	334
Total of Capital Movements		6,783	6,648	117	6,648	117
Balance at 30 June		35,969	46,874	29,331	47,479	29,573

The accompanying notes form part of these financial statements.

Statement of Financial Position

as at 30 June 2022

In thousands of New Zealand Dollars

		Parent			Group	
		Budget 2022	Actual 2022	Actual 2021	Actual 2022	Actual 2021
Public Equity						
General Funds	9	22,666	22,734	16,086	22,734	16,086
Accumulated Surplus	9	(3,882)	(10,221)	(4,011)	(9,616)	(3,770)
Equity from Donated Assets	9	1,735	1,722	1,806	1,722	1,806
Revaluation Reserve	9	15,450	32,639	15,450	32,639	15,450
Total Equity		35,969	46,874	29,332	47,479	29,573
REPRESENTED BY:						
ASSETS						
Current Assets						
Cash and cash equivalents	10	2,739	19,568	9,704	20,402	10,319
Financial Assets	11	-	2,100	11,378	2,100	11,378
Debtors and other receivables	12	7,215	10,698	9,233	10,739	9,207
Inventories	13	1,380	1,749	1,605	1,749	1,605
Patient Trust Funds	10	-	0	2	0	2
Total Current Assets		11,334	34,114	31,923	34,989	32,512
Non Current Assets						
Financial Assets	11	2,379	347	1,747	0	1,400
Property, plant and equipment	7	67,689	71,655	43,996	71,746	44,046
Intangible assets	8	5,104	4,463	4,111	4,663	4,311
Total Non Current Assets		75,172	76,466	49,854	76,409	49,757
TOTAL ASSETS		86,506	110,580	81,777	111,399	82,269
LIABILITIES						
Current Liabilities						
Creditors and other payables	14	17,411	17,290	15,506	17,373	15,657
Employee entitlements	15	25,693	38,581	29,022	38,711	29,122
Borrowings	16	-	0	0	0	0
Finance Lease Liability	17	-	0	169	0	169
Patient Trust Funds	10	-	0	2	0	2
Total Current Liabilities		43,104	55,871	44,699	56,084	44,950
Non Current Liabilities						
Term Loans	16	-	0	-	0	-
Finance Lease Liability	17	169	0	0	0	0
Employee Entitlements	15	7,264	7,836	7,746	7,836	7,746
Total Non Current Liabilities		7,433	7,836	7,746	7,836	7,746
TOTAL LIABILITIES		50,537	63,707	52,445	63,920	52,697
NET ASSETS		35,969	46,873	29,332	47,478	29,573

The accompanying notes form part of these financial statements.

Statement of Cashflows

for the year ended 30 June 2022
In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2022	Actual 2022	Actual 2021	Actual 2022	Actual 2021
CASH FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health & Other Revenue		240,239	258,260	234,153	258,311	234,209
Interest Received		136	354	365	359	366
		240,375	258,615	234,518	258,670	234,574
Cash was applied to:						
Payments to suppliers & employees		221,514	248,367	222,696	248,113	222,417
Capital Charge		1,368	1,875	1,363	1,875	1,363
Interest Paid		-	-	0	(0)	1
GST (net)		-	(440)	1,048	(425)	1,032
		222,882	249,802	225,107	249,564	224,812
Net cash inflow/(outflow) from operating activities		17,493	8,812	9,412	9,107	9,763
CASH FROM INVESTING ACTIVITIES						
Cash was provided from:						
Proceeds from the sale of assets		-	64	-	64	-
Reclassify term deposits <3 months		-	-	-	-	-
Term Deposits Matured		-	10,678	7,600	10,678	7,600
Decrease in Special Funds		-	-	-	-	-
		-	10,742	7,600	10,742	7,600
Cash was applied to:						
Purchase of fixed assets		25,235	16,169	9,426	16,244	9,443
Purchase of Investments		-	-	7,600	-	7,600
Purchase of Goodwill		-	-	-	-	-
Term Deposits over 1 year		-	-	-	-	-
		25,235	16,169	17,026	16,244	17,043
Net cash inflow/(outflow) from investing activities		(25,235)	(5,427)	(9,426)	(5,502)	(9,443)
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
New Borrowings - MOH		-	-	-	-	-
New Borrowings - Energy Efficiency		-	-	-	-	-
New Finance Lease		-	-	-	-	-
Equity injections		-	6,864	334	6,864	334
		-	6,864	334	6,864	334
Cash was applied to:						
Finance Lease repayment		-	169	169	168	169
Repayment of Loans		-	-	-	-	-
Repayment of Equity		217	217	217	217	217
		217	385	385	385	385
Net cash inflow/(outflow) from financing activities		(217)	6,479	(51)	6,480	(51)

Net increase/(decrease) in cash held	(7,959)	9,864	(66)	10,084	269
Opening cash and cash equivalents	10,698	9,704	9,770	10,319	10,050
Closing cash and cash equivalents	2,739	19,568	9,704	20,403	10,319
Made up of:					
Balances at bank	2,739	19,568	9,704	20,402	10,319

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 2022	**Actual 2021**	**Actual 2022**	**Actual 2021**
Net surplus/(deficit)	(6,294)	310	(5,930)	536
Add/(less) non-cash items:				
Depreciation and amortisation expense	5,560	5,169	5,593	5,186
Impairment of Investment	-	-	-	0
Total non cash items	5,560	5,169	5,593	5,186
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	(1,465)	(2,006)	(1,531)	(2,005)
(Increase)/decrease in inventories	(143)	(170)	(143)	(170)
Increase/(decrease) in payables and accruals	11,343	6,317	11,305	6,424
Increase/(decrease) in employee entitlements	90	(208)	90	(208)
Net working capital movement	9,824	3,932	9,720	4,041
Add/(less) movements in other items:				
Loss/(Gain) on sale of fixed assets	(277)	0	(277)	0
	(277)	0	(277)	0
Net cash (outflow)/inflow from operating activities	8,812	9,412	9,106	9,763

Notes to the Financial Statements

For the year ended 30 June 2022

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 2022 and through the use of performance measures and indicators, highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same act.

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 2022 were approved by Health New Zealand on 3 May 2023.

Basis of preparation

Health Sector Reforms

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown Entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

The Pae Ora (Healthy futures) Act 2022 disestablishes the DHB on 1 July 2022. Health NZ takes over the assets, liabilities, and responsibilities of the DHB from 1 July 2022. Therefore, the financial statements have been prepared on a disestablishment basis.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in Note15 prior to 1 July 2022, additional financial support would be needed from the Crown.

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 3 and related party transaction disclosures in Note 26, 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:

PBE IPSAS 41 - Financial instruments

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

PBE FRS 48 - Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ended 30 June 2023, with earlier adoption permitted. The group has not yet determined how the application of PBE FRS 48 will affect its statement of performance. It does not plan to early adopt the standard.

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.

Basis of consolidation

The group financial statements are prepared by adding together like items of assets, liabilities, equity, revenue, expenses and cash flowsof entities in the group on a line-by-line basis. All intra-group balances, transactions, revenue, and expenses are eliminated on consolidation.

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

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 2021/22 Annual Plan. 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 the liabilities for Holidays Act 2003 remediation, 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.

In thousands of New Zealand Dollars

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

Provision of other services

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

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 2022	Actual 2021	Actual 2022	Actual 2021
2a. Patient Care Revenue				
MOH Population-based revenue	245,587	221,804	245,902	222,042
MOH other contracts	2,003	2,464	2,003	2,464
Inter District Patient Inflows	4,616	4,328	4,616	4,328
	252,206	228,596	252,521	228,835
ACC Contracted Revenue	2,035	2,201	2,035	2,201
Patient and consumer sourced revenue	578	960	1,389	1,804
	254,820	231,757	255,945	232,840

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 2022 is $232.72m (2021: $209.41m) with a budgeted figure of $202.37m (2021: $204.41m), 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.

	Parent		Group	
	Actual 2022	Actual 2021	Actual 2022	Actual 2021
2b. Other Revenue				
Gain/(loss) on sale of property, plant and equipment	87	(137)	87	(137)
Donations and bequests received	-	-	-	-
Rental Income	151	147	53	49
Other Revenue	2,945	3,649	2,024	2,713
	3,183	3,659	2,164	2,625
2c. Finance revenue				
Interest Revenue	354	365	359	366
	354	365	359	366

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 Plan Contributors Scheme

The group makes employer contributions 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.

The funding arrangements for the scheme are governed by section 44 of the National Provident Fund Restructuring Act 1990 and by a Trust Deed.

This Act requires that any increase or decrease to the employer contribution rate should result in contributions being at a level which, on reasonable assumptions, is likely to achieve neither a surplus or a deficit in the trust fund of the scheme at the time that the last contributor to that scheme ceases to contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

In practice, at present, a single contribution rate is determined for all employers, which is expressed as a multiple of the contributions of members of the scheme who are employees of that employer. The current employer contribution rate is three times contributor contributions, inclusive of Employer Contribution Withholding Tax. The actuary has recommended a stepped approach to changing the employer contribution rate as follows:

- 1 April 2021 - 31 March 2022: Four times contributor contributions
- From 1 April 2022: Five times contributor contributions

There is no minimum funding requirement.

As at 31 March 2022, the scheme had a past service deficit of $595,000. (2021: Surplus $1.26 million). This amount is exclusive of Employer Superannuation Contribution Tax. The deficit/surplus was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 39 Employee Benefits.

The scheme had 64 members at 31 March 2022.

for the year ended 30 June 2022
In thousands of New Zealand Dollars

	Parent		Group	
	Actual 2022	Actual 2021	Actual 2022	Actual 2021
Breakdown of personnel costs				
Wages, salaries and outsourced personnel	84,749	74,035	84,458	73,796
Contributions to defined contribution plans	2,145	1,915	2,156	1,925
Increase /(decrease) in employee benefit provisions	7,733	1,945	7,747	1,952
	94,627	77,895	94,361	77,674

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

Employee remuneration

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within $10,000 bands were as follows:

Range	Actual 2022	Actual 2021
$460,001 - $470,000	1	-
$450,001 - $460,000	2	1
$440,001 - $450,000	2	-
$430,001 - $440,000	-	1
$400,001 - $410,000	1	3
$390,001 - $400,000	-	1
$380,001 - $390,000	-	-
$370,001 - $380,000	1	2
$360,001 - $370,000	-	1
$350,001 - $360,000	-	1
$340,001 - $350,000	6	-
$330,001 - $340,000	5	5
$320,001 - $330,000	1	4
$310,001 - $320,000	-	2
$300,001 - $310,000	2	2
$290,001 - $300,000	3	3
$280,001 - $290,000	5	2
$270,001 - $280,000	3	6
$260,001 - $270,000	4	4
$250,001 - $260,000	5	5
$240,001 - $250,000	2	3
$230,001 - $240,000	2	1
$220,001 - $230,000	1	1
$210,001 - $220,000	2	3
$200,001 - $210,000	-	-
$190,001 - $200,000	2	4
$180,001 - $190,000	4	-
$170,001 - $180,000	3	1
$160,001 - $170,000	5	2
$150,001 - $160,000	10	6
$140,001 - $150,000	8	4
$130,001 - $140,000	15	11
$120,001 - $130,000	30	15
$110,001 - $120,000	42	29
$100,001 - $110,000	58	43
TOTAL	225	166

The Chief Executive's current salary is in the $330,001 to $340,000 range.

Termination Benefits (IPSAS 25)

During the year ended 30 June 2022, no employees (2021: 24) were paid or were payable compensation and other benefits in relation to the cessation of their employment to the value of $nil (2021: $428,113).

Board and Committee Member Remuneration

Board Members payments

Included in infrastructure and non-clinical expenses.

Member	Fees Paid 2022	Fees Paid 2021
Ron Luxton (Chairperson)	$34,647	$34,166
Phillip Hope (Deputy chairperson)	$21,862	$21,862
Paul Annear (Deputy Chairperson prior year)	$17,490	$17,490
Peter Binns	$17,490	$17,490
Rene Crawford	$17,490	$17,490
Raeleen de Joux	$17,490	$17,490
Suran Dickson	$17,490	$17,490
Joanne Goodhew	$17,490	$17,490
Mark F Rogers	$5,830	$17,490
Bruce Small	$17,490	$17,490
Karl Te Raki	$17,490	$17,490
TOTAL	$202,259	$213,438

Committee Member Payments

Included in infrastructure and non-clinical expenses.

Member	Fees Paid 2022	Fees Paid 2021
Paul Annear	$6,104	$6,604
Peter Binns	$6,250	$5,250
Wendy Buchanan	$0	$227
Rene Crawford	$5,000	$5,000
Jane Cullimore	$1,591	$1,818
Raeleen de Joux	$5,750	$6,000
Suran Dickson	$4,000	$4,500
Kylie Douglas	$146	$1,284
Bridget Duff	$504	$1,300
Suzanne Eddington	$1,205	$2,136
Dominique Enright	$504	$0
Gareth Ford	$504	$1,137
Joanne Goodhew	$6,104	$6,604
Arahia Goldsmith	$0	$250
Shannon Hanson	$0	$2,828
Phillip Hope	$6,021	$6,500
Nicola Hornsey	$227	$682
Andrew Humphrey	$601	$1,300
Karen Kennedy	$909	$1,591
Neil Kiddey	$1,672	$2,923
Ron Luxton	$7,000	$7,250
Anne-Marie McRae	$0	$179
Pamela Manning	$1,250	$1,000
Jillian Merritt	$634	$1,430
Julie Paterson	$406	$1,300
Murray Roberts	$1,000	$1,500
Mark A Rogers	$0	$1,349
Mark F Rogers	$3,773	$6,823
Bruce Small	$5,000	$5,000
Elizabeth Stevenson	$1,000	$1,000
Juliette Stevenson	$750	$1,000
Joy Sylvia	$634	$3,315
Karl Te Raki	$5,802	$6,042
Karin Thomas	$1,000	$750
Katrina Whiu	$0	$569
	$75,341	$96,441

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 2022, no Board members received compensation or other benefits in relation to cessation of employment (2021: nil).

In thousands of New Zealand Dollars

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.

	Parent		Group	
	Actual 2022	Actual 2021	Actual 2022	Actual 2021
Interest Expense	0	0	0	1
	0	0	0	1

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 2022 was 5% (2021: 5%).

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 2022	Actual 2021	Actual 2022	Actual 2021
Fees to Auditor:				
Audit fees for financial statement audit	152	143	168	158
Board members fees and expenses	299	317	307	322
Impairment of receivables (bad & doubtful debts)	12	4	12	4
Write down of inventory	60	5	60	5
Operating Lease Expense	627	427	682	478
	1,150	896	1,230	967

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.

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% to 13%
Buildings	14 to 65 years	1.5% - 7.1%
Building Services	5 to 35 years	3% - 21%
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% to 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 2022 by an independent registered valuer, Praveen Menon, of Colliers International, a Member 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 $48,728,000 as at 30 June 2022. 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 2020	3,670	27,535	15,625	2,074	1,686	1,920	596	53,108
Additions	-	194	1,958	215	-	493	5,782	8,643
Transfers from WIP to PPE	-	418	0	0	-	0	(418)	-
Revaluations	-	-	0	-	-	-	-	0
Disposals	-	-	(97)	(0)	-	(523)	-	(620)
Balance at 30 June 2021	3,670	28,147	17,486	2,290	1,686	1,891	5,959	61,131
Balance at 1 July 2021	3,670	28,147	17,486	2,290	1,686	1,891	5,959	61,131
Additions	-	153	2,267	464	-	-	13,093	15,977
Transfers from WIP to PPE	-	5,115	90	-	-	-	(5,205)	-
Revaluations	2,853	8,803	-	-	-	-	-	11,656
Disposals	-	(13)	(1,067)	(2)	-	(3)	-	(1,085)
Balance at 30 June 2022	6,523	42,206	18,776	2,752	1,686	1,888	13,847	87,679
Accumulated depreciation and impairment losses								
Balance at 1 July 2020	-	1,685	7,368	1,213	1,194	1,367	-	12,827
Depreciation expense	-	1,828	2,198	346	169	264	-	4,805
Impairment losses	-	-	-	-	-	-	-	-
Disposals	-	-	(23)	0	-	(523)	-	(546)
Revaluations	-	-	-	-	-	-	-	0
Balance at 30 June 2021	-	3,513	9,543	1,559	1,362	1,108	-	17,086
Balance at 1 July 2021	-	3,513	9,543	1,559	1,362	1,108	-	17,086
Depreciation expense	-	2,021	2,321	473	169	268	-	5,252
Impairment losses	-	-	-	-	-	-	-	-
Disposals	-	(2)	(866)	0	-	(3)	-	(871)
Revaluations	-	(5,532)	0	-	-	-	-	(5,532)
Balance at 30 June 2022	-	0	10,998	2,033	1,531	1,372	-	15,935
Carrying amounts								
At 1 July 2020	3,670	25,850	8,257	862	492	554	596	40,282
At 30 June and 1 July 2021	3,670	24,634	7,942	731	324	783	5,959	44,045
At 30 June 2022	6,523	42,206	7,778	719	155	515	13,847	71,745

In thousands of New Zealand Dollars

7b. Property, plant and equipment – Parent

	Land	Buildings	Plant & equipment	Information Technology	Leased Assets	Motor vehicles	Work in Progress	TOTAL
Balance at 1 July 2020	3,670	27,535	15,603	1,982	1,686	1,920	596	52,992
Additions	-	194	1,933	215	-	493	5,782	8,617
Capitalisation of Work in Progress	-	418	0	0	-	-	(418)	-
Revaluations	-	-	-	-	-	-	-	-
Disposals		-	(65)	0	-	(523)	-	(588)
Balance at 30 June 2021	3,670	28,147	17,471	2,198	1,686	1,891	5,959	61,022
Balance at 1 July 2021	3,670	28,147	17,471	2,198	1,686	1,891	5,959	61,022
Additions	-	153	2,192	464	-	0	13,093	15,903
Capitalisation of Work in Progress	-	5,115	90	0	-	-	(5,205)	-
Revaluations	2,853	8,803	0	0	-	-	-	11,656
Disposals	-	(13)	(1,067)	(2)	-	(3)	-	(1,085)
Balance at 30 June 2022	6,523	42,206	18,686	2,660	1,686	1,888	13,847	87,496
Accumulated depreciation and impairment losses								
Balance at 1 July 2020	-	1,685	7,352	1,164	1,194	1,367	-	12,760
Depreciation expense	-	1,828	2,182	346	169	264	-	4,788
Impairment losses	-	-	-	-	-	-	-	-
Disposals	-	-	0	0	-	(523)	-	(523)
Revaluations	-	-	-	-	-	-	-	0
Balance at 30 June 2021	-	3,513	9,534	1,510	1,362	1,108	-	17,026
Balance at 1 July 2021	-	3,513	9,534	1,510	1,362	1,108	-	17,026
Depreciation expense	-	2,021	2,287	473	169	268	-	5,218
Impairment losses	-	-	-	-	-	-		0
Disposals	-	(2)	(866)	0	-	(3)	-	(871)
Revaluations	-	(5,532)	-	-	-	-	-	(5,532)
Balance at 30 June 2022	-	0	10,955	1,983	1,531	1,372	-	15,840
Carrying amounts								
At 1 July 2020	3,670	25,850	8,251	819	492	554	596	40,232
At 30 June and 1 July 2021	3,670	24,634	7,937	687	324	783	5,959	43,996
At 30 June 2022	6,523	42,206	7,731	676	155	515	13,847	71,655

Impairment

The values of buildings identified as earthquake prone have been adjusted by the valuer through the application of an obsolescence factor. Impairment testing carried out has not revealed any other 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 $13.679 million (2021: $5.766 million).

Plant and equipment in progress total $168K (2021: $193K)

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 - 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.

	Software	Other	TOTAL
Cost			
Balance at 1 July 2020	4,468	200	4,669
Additions	875		875
Disposals	0	-	-
Balance at 30 June 2021	5,343	200	5,543
Balance at 1 July 2021	5,343	200	5,544
Additions	693	-	693
Disposals	-	-	-
Balance at 30 June 2022	6,036	200	6,237

In thousands of New Zealand Dollars

Accumulated amortisation and impairment losses			
Balance at 1 July 2020	851	-	851
Amortisation expense	381	-	381
Disposals	0	-	-
Impairment losses	-	-	-
Balance at 30 June 2021	1,232	-	1,232
Balance at 1 July 2021	1,232	-	1,232
Amortisation expense	342	-	342
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2022	1,574	-	1,574
Carrying amounts			
At 1 July 2020	3,617	200	3,817
At 30 June and 1 July 2021	4,111	200	4,311
At 30 June 2022	4,463	200	4,663

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 2020	15,969	(4,035)	1,535	3,272	12,178	28,919
Surplus/(deficit) - DHB		310				310
Surplus/(deficit) - Subsidiary		226				226
Subsidiary (prior year adjustment)						0
Transfer from accumulated surplus		(271)	271			-
Revaluation of land and buildings				0	0	-
Contribution from the Crown	334					334
Repayment of Equity	(217)					(217)
Balance at 30 June 2021	16,086	(3,770)	1,806	3,272	12,178	29,573
Balance at 1 July 2021	16,086	(3,770)	1,806	3,272	12,178	29,573
Surplus/(deficit) - DHB		(6,294)				(6,294)
Surplus/(deficit) - Subsidiary		364				364
Transfer from accumulated surplus		84	(84)			0
Revaluation of land and buildings				2,853	14,335	17,188
Contribution from the Crown	6,864					6,864
Repayment of equity	(217)					(217)
Balance at 30 June 2022	22,734	(9,616)	1,722	6,125	26,514	47,479

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 2020	15,969	(4,050)	1,535	3,272	12,178	28,904
Surplus/(deficit)		310				310
Transfer from accumulated surplus		(271)	271			-
Revaluation of land and buildings						-
Contribution from the Crown	334					334
Repayment of Equity	(217)					(217)
Balance at 30 June 2021	16,086	(4,011)	1,806	3,272	12,178	29,331
Balance at 1 July 2021	16,086	(4,011)	1,806	3,272	12,178	29,331
Surplus/(deficit) - DHB		(6,294)				(6,294)
Transfer from accumulated surplus		84	(84)			0
Revaluation of land and buildings				2,853	14,335	17,188
Contribution from Crown	6,864					6,864
Repayment of equity	(217)					(217)
Balance at 30 June 2022	22,734	(10,221)	1,722	6,125	26,514	46,874

In thousands of New Zealand Dollars

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 2022	Actual 2021	Actual 2022	Actual 2021
Cash on hand and at bank	(306)	1	528	616
Cash equivalents - term deposits	-	-	-	-
Other cash and cash equivalents	19,874	9,703	19,874	9,703
Total cash and cash equivalents	19,568	9,704	20,402	10,319

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

The group is party to a 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. The DHB Treasury Services Agreement provides for individual DHBs to have a negative balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL, plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST.

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

SCDHB administers certain funds on behalf of patients. These funds are held in a separate bank account and total $nil (2021: $2,148).

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 2022	Actual 2021	Actual 2022	Actual 2021
Current investments are represented by:				
Term deposits	2,100	11,378	2,100	11,378
Total current portion	2,100	11,378	2,100	11,378
Non-current investments are represented by:				
Term deposits	-	1,400	-	1,400
Shares in NZ Health Partnership Limited	-	-	-	-
Investment in Subsidiary	347	347	-	-
Total non-current portion	347	1,747	-	1,400
Total Investments	2,447	13,125	2,100	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 currently available information the Board have 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 on 31 July 2019. There has been no change to the share capital in the 2021/22 financial year. The Company provides public and private ophthamology and midwifery services in South Canterbury.

South Canterbury Eye Clinic Limited is an unlisted company. Accordingly, there is no quoted market price for this investment and it 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.

12. Debtors and other receivables

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses.

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 2022	Actual 2021	Actual 2022	Actual 2021
Trade Debtors	3,617	2,711	3,650	2,679
Less: Provision for impairment	0	0	0	0
	3,617	2,711	3,650	2,679
Accrued Income	6,844	6,178	6,845	6,179
Prepayments	237	343	245	351
Total receivables & prepayments	10,698	9,233	10,739	9,208
Receivables from sale of goods and services (exchange transactions)	6,908	5,815	6,949	5,790
Receivables from grants (non-exchange transactions)	3,790	3,418	3,790	3,418

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

In thousands of New Zealand Dollars

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 2022	Actual 2021	Actual 2022	Actual 2021
Pharmaceuticals	379	281	379	281
Theatre supplies	513	535	513	535
Central stores	733	664	733	664
Other supplies	124	126	124	126
Total inventories	1,749	1,605	1,749	1,605

The write-down of inventories held for distribution amounted to $59,788 (2021: $4,795). 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 2022	Actual 2021	Actual 2022	Actual 2021
Trade creditors	2,103	1,203	2,141	1,336
Capital Charge due	0	0	0	0
Income in advance	2,591	602	2,591	602
Accrued expenses	10,221	11,893	10,241	11,914
Taxes payable (GST and PAYE)	2,375	1,808	2,400	1,805
Total Payables and Accruals	17,290	15,506	17,373	15,657
Payables for goods and services (exchange transactions)	14,915	13,698	14,974	13,852
Payables for taxes payable (non-exchange transactions)	2,375	1,808	2,400	1,805

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

Employee entitlements that are due to be 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 2022 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.

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

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

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

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

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

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

If Te Whatu Ora Health New Zealand – South Canterbury is required to settle the holiday pay liability disclosed in note 15 prior to 1 July 2023, additional financial support would be needed from the Crown for this settlement.

for the year ended 30 June 2022
In thousands of New Zealand Dollars

Current employee entitlements are represented by:

	Parent		Group	
	Actual 2022	**Actual 2021**	**Actual 2022**	**Actual 2021**
Accrued salaries and wages	6,079	3,173	6,131	3,207
Annual Leave	9,279	8,062	9,339	8,110
Holidays Act 2003 remediation	20,703	15,135	20,703	15,135
Maternity Leave	(0)	-	0	-
Sick Leave	182	263	200	280
Retirement Gratuities	882	858	882	858
Senior Doctor Conference Leave	332	364	332	364
Senior Doctor Sabbatical Leave	33	19	33	19
Long Service Leave	525	566	525	566
Senior Doctor Study Costs	565	583	565	583
Restructuring Provision	-	-	-	-
Total current portion	38,581	29,022	38,711	29,122

Non-current employee entitlements are represented by:

Sick Leave	366	329	366	329
Retirement Gratuities	4,191	4,113	4,191	4,113
Senior Doctor Conference Leave	664	729	664	729
Senior Doctor Sabbatical Leave	535	550	535	550
Long Service Leave	866	775	866	775
Senior Doctor Study Costs	1,131	1,167	1,131	1,167
Restructuring Provision	83	83	83	83
Total non-current portion	7,836	7,746	7,836	7,746
Total employee entitlements	46,417	36,768	46,547	36,868

	Parent		Group	
	Actual 2022	**Actual 2021**	**Actual 2022**	**Actual 2021**
Restructuring provision				
Balance at 1July	83	691	83	691
Additional provision made	-	-	-	-
Amounts used	-	(448)	-	(448)
Disused amounts reversed	-	(160)	-	(160)
Balance at 30 June	83	83	83	83

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 2022	Actual 2021	Actual 2022	Actual 2021
Current portion	-	-	-	-
Non current portion	-	-	-	-
	-	-	-	-

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

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.

In thousands of New Zealand Dollars

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 2022	**Actual 2021**	**Actual 2022**	**Actual 2021**
Not later than one year	-	169	-	169
Later than one year and not later than five years	-	-	-	-
Later than five years	-	-	-	-
Total present value of minimum lease payments	-	169	-	169
Current portion	-	169	-	169
Non current portion	-	-	-	-
Total present value of minimum lease payments	-	169	-	169

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 2022	Actual 2021	Actual 2022	Actual 2021
Capital Commitments				
Buildings	8,295	4,633	8,295	4,633
Plant and equipment	-	-	-	-
Information technology	1,626	2,104	1,626	2,104
Total Capital Commitments	9,921	6,737	9,921	6,737

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 2022	Actual 2021	Actual 2022	Actual 2021
Not later than one year	353	363	401	411
Later than one year and not later than five years	457	149	570	310
Later than five years	-	-	-	-
Total Non-cancellable Operating Leases	810	511	971	721

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

20. Contingencies

Contingent Liabilities

The DHB has no significant contingent liabilities (2021 $nil).

Contingent Assets

The DHB has no contingent assets (2021 $nil).

21. Related party transactions and key management personnel

The DHB is controlled by the Crown.

Related party disclosures have not been made for transactions with related parties, including associates, that are:

– within a normal supplier or client/recipient relationship; and

– on terms and conditions no more or less favourable than those that it is reasonable to expect that the group would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies.

Related party transactions required to be disclosed

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).

In thousands of New Zealand Dollars

Key management personnel

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

- 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.

No provision has been required, nor any expense recognised for impairment of receivables from related parties (2021: nil).

Key management personnel compensation

	Actual 2022	Actual 2021
Board Members		
Remuneration	261	277
Full-time equivalent members	1.3	1.3
Leadership Team		
Remuneration	1,377	1,554
Full-time equivalent members	5.5	6.5
Total key management personnel remuneration	1,638	1,831
Total Full-time equivalent personnel	6.8	7.8

22. 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 2022, 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 $73,000 (2021 $49,000) 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 2022 (30 June 2021 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 2022	**Actual 2021**	**Actual 2022**	**Actual 2021**
Cash at bank and term deposits	21,668	21,084	22,502	21,699
Debtors and Other Receivables	10,698	9,233	10,739	9,207
	32,366	30,317	33,241	30,9076

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 97% (2021: 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 2022	**Actual 2021**	**Actual 2022**	**Actual 2021**
COUNTERPARTIES WITH CREDIT RATINGS				
Cash at bank and term deposits				
AA - rating	21,668	21,084	22,502	21,699
Total cash at bank and term deposits	21,668	21,084	22,502	21,699

for the year ended 30 June 2022
In thousands of New Zealand Dollars

	Parent			
	Gross Receivables 2022	**Impairment 2022**	**Gross Receivables 2021**	**Impairment 2021**
Trade receivables				
Not past due	2,996	-	1,626	-
Past due 0-30 days	143	-	212	-
Past due 31-120 days	478	-	873	-
Past due more than 1 year				
Total	3,617	-	2,711	-

	Group			
	Gross Receivables 2021	**Impairment 2021**	**Gross Receivables 2020**	**Impairment 2020**
Trade receivables				
Not past due	3,004	-	1,579	-
Past due 0-30 days	146	-	215	-
Past due 31-120 days	500	-	885	-
Past due more than 1 year				
Total	3,650	-	2,679	-

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**
2022				
Creditors and other payables (excluding deferred revenue and taxes)	12,324	12,324	12,324	-
Borrowings	-	-	-	-
Finance Leases	0	0	0	-
Total	12,324	12,324	12,324	-
2021				
Creditors and other payables (excluding deferred revenue and taxes)	13,097	13,097	13,097	-
Borrowings	-	-	-	-
Finance Leases	169	169	169	0
Total	13,266	13,266	13,266	0

	Group			
	Carrying Amount	Contractual Cash Flows	Less than 1 Year	More than 1 Year
2022				
Creditors and other payables (excluding deferred revenue and taxes)	12,383	12,383	12,383	-
Borrowings	-	-	-	-
Finance Leases	0	0	0	-
Total	12,383	12,383	12,383	-
2021				
Creditors and other payables (excluding deferred revenue and taxes)	13,250	13,250	13,250	-
Borrowings	-	-	-	-
Finance Leases	169	169	169	0
Total	13,419	13,419	13,419	0

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
2022					
Financial Assets					
Cash and cash equivalents	10	19,568		19,568	19,568
Term Deposits >3 <12 months	11	2,100		2,100	2,100
Term Deposits >12 months	11	-		-	-
Trade and other receivables	12	10,698		10,698	10,698
Patient Trust Funds	10	0		0	0
Equity investments	11	347	-	347	347
		32,713	-	32,713	32,713
Financial Liabilities					
Trade and other payables (excluding deferred revenue and taxes)	14	12,324		12,324	12,324
Patient Trust Funds	10	0		0	0
Borrowings	16	0		0	0
Finance Lease Liability	17	0		0	0
		12,324	-	12,324	12,324

for the year ended 30 June 2022
In thousands of New Zealand Dollars

	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
2021					
Financial Assets					
Cash and cash equivalents	10	9,704		9,704	9,704
Term Deposits >3 <12 months	11	11,378		11,378	11,378
Term Deposits >12 months	11	1,400		1,400	1,400
Trade and other receivables	12	9,233		9,233	9,233
Patient Trust Funds	10	2		2	2
Equity investments	11	347	-	347	347
		32,064	-	32,064	32,064
Financial Liabilities					
Trade and other payables (excluding deferred revenue and taxes)	14	13,097		13,097	13,097
Patient Trust Funds	10	2		2	2
Borrowings	16	0		0	0
Finance Lease Liability	17	169		169	169
		13,268	-	13,268	13,268

		Group			
	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
2022					
Financial Assets					
Cash and cash equivalents	10	20,402		20,402	20,402
Term Deposits >3 <12 months	11	2,100		2,100	2,100
Term Deposits >12 months	11	-		-	-
Trade and other receivables	12	10,739		10,739	10,739
Patient Trust Funds	10	0		0	0
Equity investments	11	-	-	-	-
		33,241	-	33,241	33,241
Financial Liabilities					
Trade and other payables (excluding deferred revenue and taxes)	14	12,383		12,383	12,383
Patient Trust Funds	10	0		0	0
Borrowings	16	0		0	0
Finance Lease Liability	17	0		0	0
		12,383	-	12,383	12,383

	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
2021					
Financial Assets					
Cash and cash equivalents	10	10,319		10,319	10,319
Term Deposits >3 <12 months	11	11,378		11,378	11,378
Term Deposits >12 months	11	1,400		1,400	1,400
Trade and other receivables	12	9,208		9,208	9,208
Patient Trust Funds	10	2		2	2
Equity investments	11	-	-	-	-
		32,307	-	32,307	32,307
Financial Liabilities					
Trade and other payables (excluding deferred revenue and taxes)	14	13,250		13,250	13,250
Patient Trust Funds	10	2		2	2
Borrowings	16	0		0	0
Finance Lease Liability	17	169		169	169
		13,420	-	13,420	13,420

23. Capital management

SCDHB's capital is it's 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.

24. Post balance date events

On 1 July 2022, South Canterbury District Health Board was disestablished and the assets and liabilities were transferred to Health New Zealand. Further details on the basis of preparation of the financial statements are in the Statement of Accounting Policies (Note 1).

Subsequent to year end, the shares in SCECL were transferred to Te Whatu Ora.

On 14 December 2022, the Employment Relations Authority (ERA) agreed to Te Whatu Ora's request to fix pay rates for our nursing workforce while the ERA undertakes the process of determining pay equity rates.

The ERA interim order means Te Whatu Ora must:
- implement the pay equity rates at the level of the Agreement in Principle, specified in the Order.
- make 7 March 2022 the effective date for the increased rates
- pay a lump sum payment of $10,000 to each employee, less the $7,000 advance payment already made to NZNO members.

These payments are due by the end of February 2023.

25. Explanation of significant variances against budget

Explanations for significant variations from SCDHB's budgeted figures in the 2021/2022 Annual Plan are as follows:

Total revenue was greater than budget by $17.846m. The main variances were: MoH sourced revenue was $16.460m greater than budget; Non DHB health contract revenue was $1.386m greater than budget.
Significant variances were the result of Government initiatives, including funding for Covid cost recovery revenue $10.9m; Funding for nurses pay equity payments: $3.7m and additional planned care: $1.3m

Total Expenditure was $24.235m greater than budget.

- Overall personnel costs were $16.542m greater than budget. The main variances were: increase in the Holiday Act Remediation $5.6m; pay equity payments for nurses: $3.7m; increase in permanent and casual staff relating to impacts of Covid: $3.8m
- Outsourced services were $1.355m greater than budget, including an increase in orthopaedic procedures: $0.5m; NZ blood - demand driven $0.3m and demand driven Ophthalmology & Midwifery services $0.3m
- Clinical supply expenditure was $1.073m higher than budget as a result of more orthopaedic procedures being undertaken $0.7m, and an increase in the cost of medical supplies $0.3m

- Infrastructure and non clinical supply expenditure was $2.339m higher than budget. The main variances were: including professional fees and services increase of $0.7m including Covid, security, and surgical bus hire costs. Unbudgeted IT licensing costs in the current year of $0.5m. Additional rents and leases driven by Covid $0.2m
- Payments to Non-DHB Providers were $1.859m higher than budget. This was the result of increased GP swabbing costs and health vaccination costs.
- Depreciation was $0.56m greater than budget, including $0.3m for intangible software.

26. 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 2022, the directors of South Canterbury Eye Clinic Limited were Ron Luxton, Raelene De Joux and Paul Annear.

The South Canterbury Eye Clinic's financial results for 2021/22 and 2020/21 have been consolidated into the SCDHB financial accounts and form part of the disclosure. For the year ended 30 June 2022, the South Canterbury Eye Clinic had total revenue of $2.880m (2021: $2.675m) and total expenditure of $2.516m (2021: $2.450m) which resulted in a net surplus of $364k (2021: surplus $226k). South Canterbury Eye Clinic Limited had assets of $972k (2021: $692k) and liabilities of $219k (2021: $303k) as at 30 June 2022.

Related party disclosure

During the financial year 2020/21, South Canterbury Eye Clinic received clinical services revenue from the SCDHB of $1,796,960 (2021: $1,591,333). The balance outstanding from the DHB at year end was $nil (2021: $nil).

South Canterbury Eye Clinic paid the DHB for personnel, supplies and services during the year at a cost of $1,018,546 (2021: $1,034,814). The balance due to the DHB at year end was $6,413 (2021: $92,536).

27. Impact of COVID-19 on the DHB

The South Canterbury area started the year at Alert Level 1. In August 2021, New Zealand moved to Alert Level 4 and the area then moved through Alert Levels 3 and 2 until the introduction of the COVID-19 Protection Framework, in December 2021. Initially, the district was at the Orange Setting but moved to the Red Setting, along with the rest of the country, in January 2022. In April 2022, the area moved to the Orange Setting, where it has remained.

At Alert Levels 2, 3 and 4 and in the Red Setting, the operating capacity of the DHB was reduced. At Alert Level 1 and in the Orange Setting, the DHB resumed normal business activity and in some instances at a higher level. This was because planned care that was delayed during the more restrictive Alert Levels and Settings was rescheduled.

Government Funding

The MOH approved funding of $4.449 million for the DHB to assist with the COVID-19 resonse. In addition, the MOH announced additional funding of $6.412 million to support community health providers impacted by the COVID-19 lockdowns. This funding was distributed through the DHB to general practitioners, pharmacists, and aged care providers.

Personnel Expenses

Personnel expenses have increased by $3.753 million due to an increase in permanent and casual staff. Also, staff have taken less leave since the pandemic declaration.

Other Expenses

There was an increase in clinical and infrastructure and non-clinical supply costs of $7.131 million, mainly driven by the administration of the COVID-19 vaccine roll out such as leasing additional premises, hygienic and sanitation supplies, pharmaceutical, patient transport, security management, advertising and building alteration costs to ensure safer access to the hospital site for the community and staff.

Valuation of Land and Buildings

Overall, the DHB does not consider there to be any material impacts on the value of land and buildings at 30 June 2022.

28. Breach of statutory reporting deadline

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

This timeframe was not met because Audit New Zealand was unable to complete the audit within this timeframe due to an auditor shortage and the consequential effects of Covid-19, including lockdowns.

Cost of Services

	Budget 2021/22	Actual 2021/22
REVENUE	**TOTAL $'000**	**TOTAL $'000**
Prevention	5,023	5,880
Early detection and management	56,051	59,864
Intensive assessment and treatment	129,795	139,537
Support and rehabilitation	49,642	53,077
Grand Total	**240,511**	**258,357**
EXPENDITURE	TOTAL $'000	TOTAL $'000
Prevention	5,023	12,706
Early detection and management	56,051	56,539
Intensive assessment and treatment	129,700	144,474
Support and rehabilitation	49,642	50,932
Grand Total	**240,416**	**264,651**
Surplus/(Deficit)	95	(6,294)

Statement of **Service Performance**

In this section you will find:

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.**

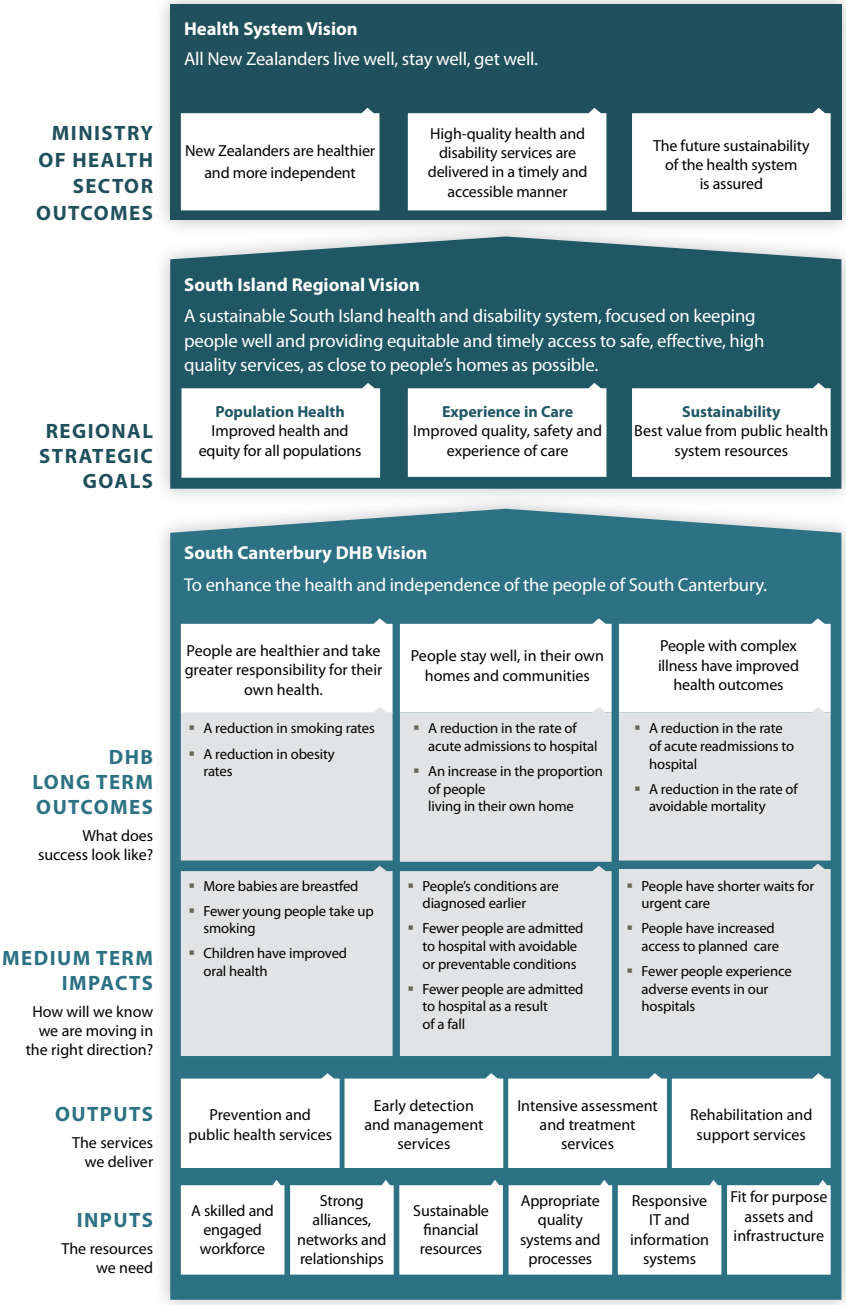
  A reduction in the rate of acute readmission to hospital.

  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

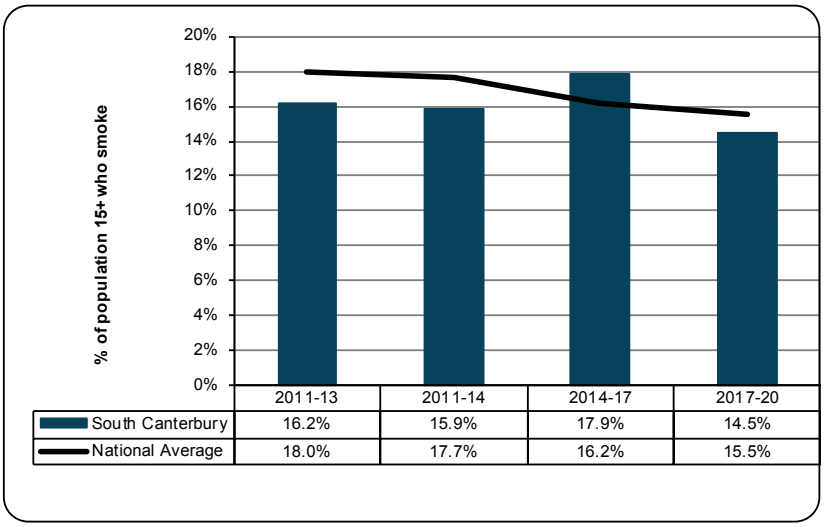
The smoking data published is an average over 3 years. The next smoking data will be 2021-2023. Smoking and exposure to second-hand smoke causes an estimated 4,627 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

The South Canterbury result for the period 2017-20 is 1% lower than the national average and 3.4% down 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.



	2011-13	2011-14	2014-17	2017-20
South Canterbury	16.2%	15.9%	17.9%	14.5%
National Average	18.0%	17.7%	16.2%	15.5%

Outcome: A reduction in obesity rates.

Comment

The obesity data published is an average over 3 years. The next obesity data will be 2021-2023. There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicities.

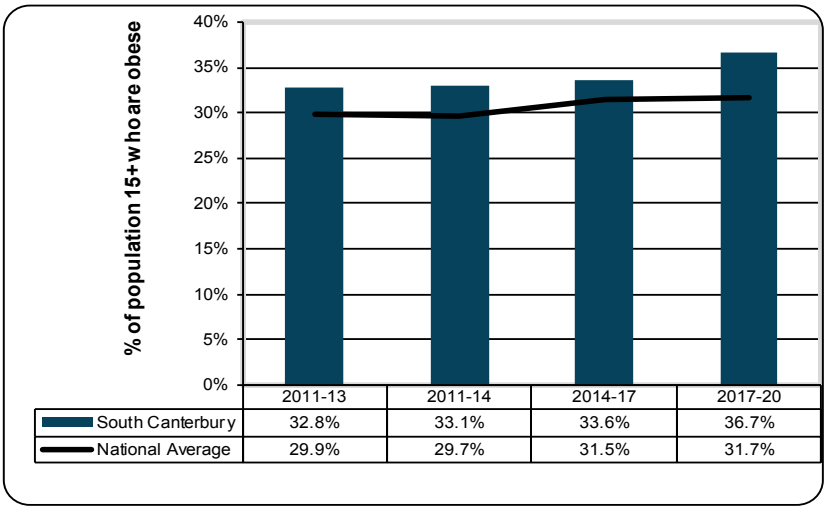
Obesity is set to overtake tobacco as the leading risk to health and the most recent NZ Health Survey found 32% of all adults and 12% of children were obese.

The South Canterbury result for the period 2017-20 is 5% higher than the national average and 3.1% 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.



	2011-13	2011-14	2014-17	2017-20
South Canterbury	32.8%	33.1%	33.6%	36.7%
National Average	29.9%	29.7%	31.5%	31.7%

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

Outcome: A reduction in acute hospital bed days.

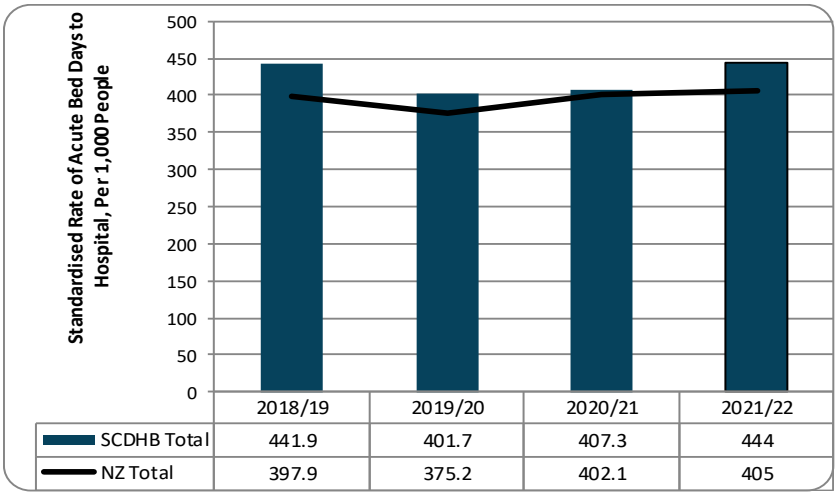
Comment

SCDHB's result for 2021/22 is higher than the previous year due to the high prevalence of COVID-19 cases. This meant planned care was deferred and it deterred people from seeking hospital care.

The 2021/22 result remains above the national result for the same period.

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



	2018/19	2019/20	2020/21	2021/22
SCDHB Total	441.9	401.7	407.3	444
NZ Total	397.9	375.2	402.1	405

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

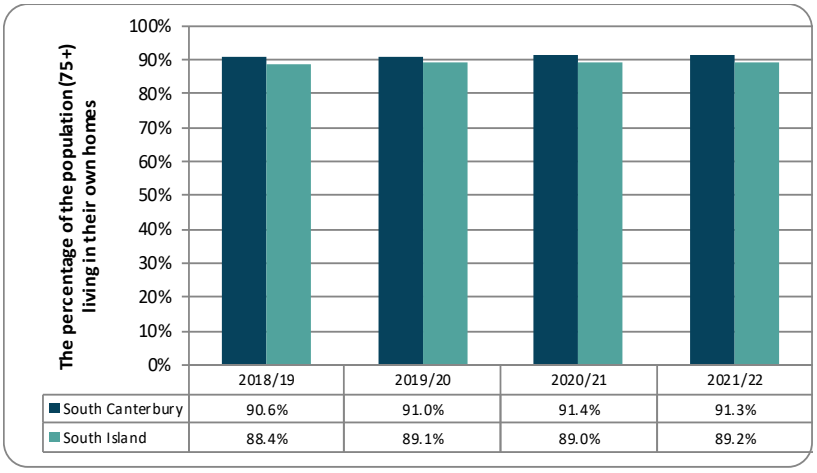
Comment

SCDHB's result for 2021/22 is slightly lower 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.



	2018/19	2019/20	2020/21	2021/22
South Canterbury	90.6%	91.0%	91.4%	91.3%
South Island	88.4%	89.1%	89.0%	89.2%

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

Outcome: A reduction in acute readmissions.

Comment

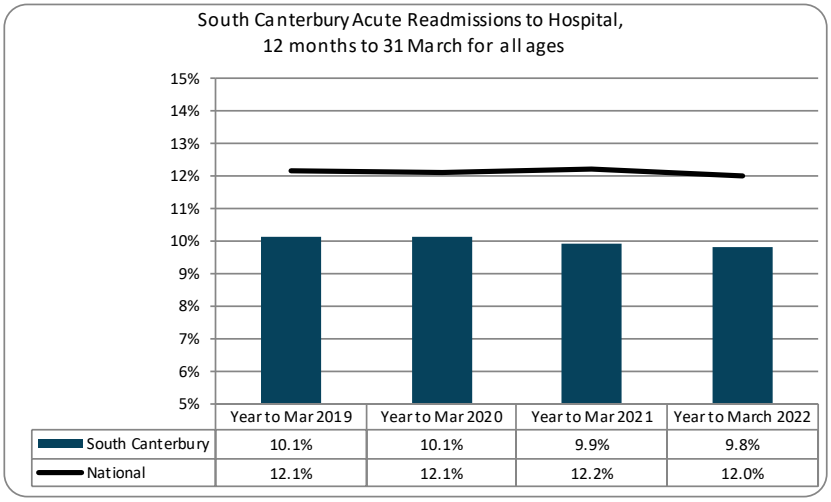
SCDHB's result for the year to March 2022 is comparable with previous years and remains below the national result.

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 2019	Year to Mar 2020	Year to Mar 2021	Year to March 2022
South Canterbury	10.1%	10.1%	9.9%	9.8%
National	12.1%	12.1%	12.2%	12.0%

Outcome: A reduction in mortality rates.

Comment

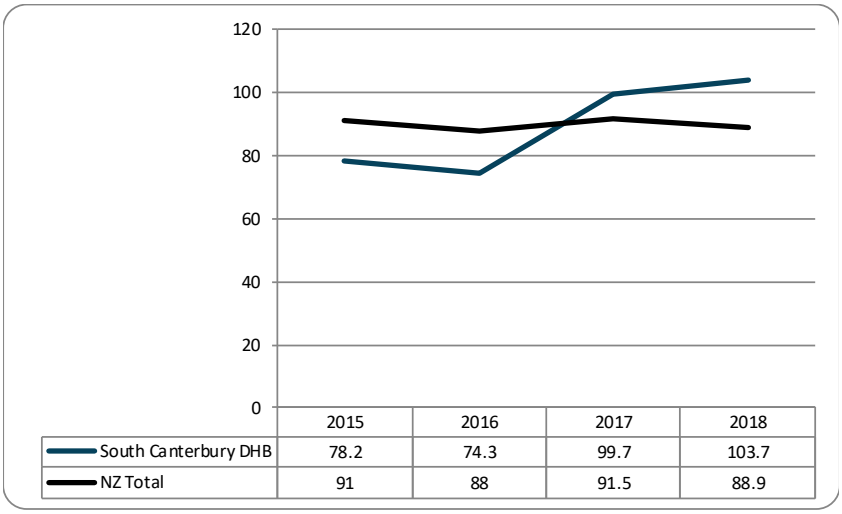
Mortality rates were last published in 2018. Results are presented for the South Island population rather than at DHB level.

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).



	2015	2016	2017	2018
South Canterbury DHB	78.2	74.3	99.7	103.7
NZ Total	91	88	91.5	88.9

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.

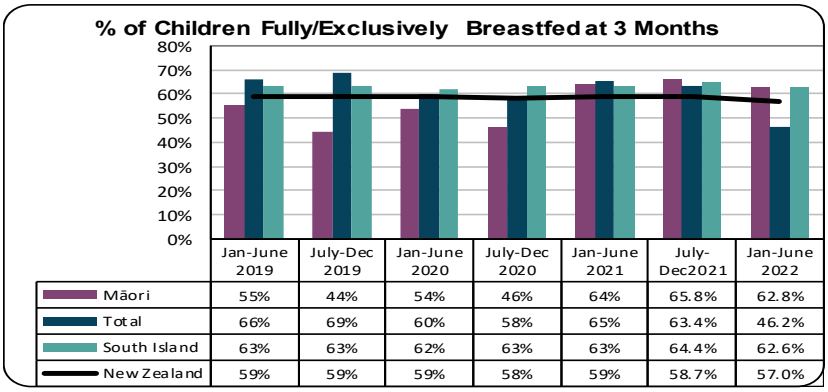
Comment

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

The total rates have decreased in the January - June 2022 period compared with previous years.

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 2019	July-Dec 2019	Jan-June 2020	July-Dec 2020	Jan-June 2021	July-Dec2021	Jan-June 2022
Māori	55%	44%	54%	46%	64%	65.8%	62.8%
Total	66%	69%	60%	58%	65%	63.4%	46.2%
South Island	63%	63%	62%	63%	63%	64.4%	62.6%
New Zealand	59%	59%	59%	58%	59%	58.7%	57.0%

Impact: Children have improved oral health.

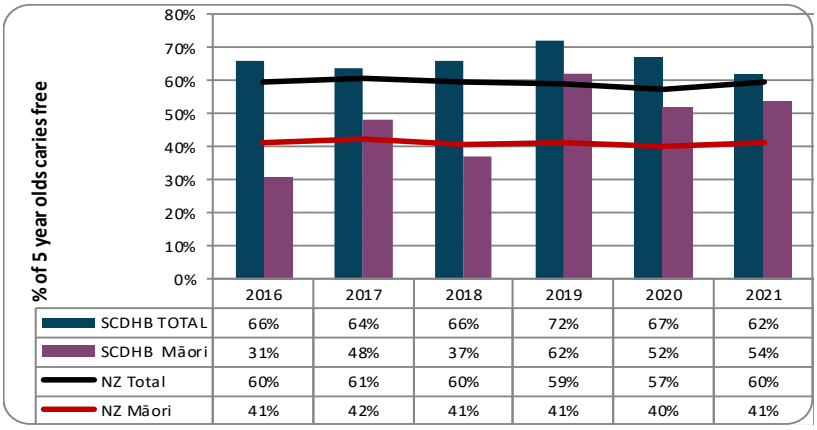
Comment

The oral health data is reported by calendar year. The 2022 data is not yet available. SCDHB's result for 2021 has decreased on the previous year's result, however the result remains comparable with the previous years. Our result is slightly higher than the national result.

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).



	2016	2017	2018	2019	2020	2021
SCDHB TOTAL	66%	64%	66%	72%	67%	62%
SCDHB Māori	31%	48%	37%	62%	52%	54%
NZ Total	60%	61%	60%	59%	57%	60%
NZ Māori	41%	42%	41%	41%	40%	41%

Impact: Fewer young people take up tobacco smoking.

Comment

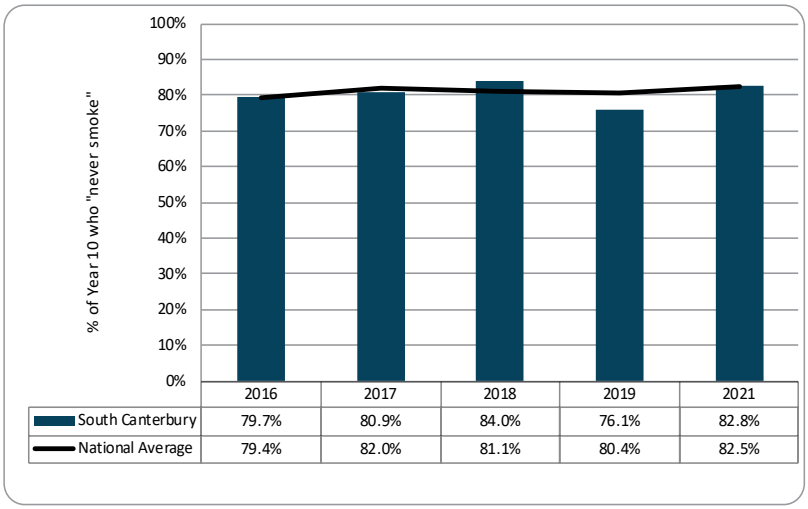
The ASH Survey is reported by calendar year. The 2022 data is not yet available. The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. The survey is run by Action on Smoking & Health, has been used to monitor student smoking since 1999 and provides valuable insights 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.



	2016	2017	2018	2019	2021
South Canterbury	79.7%	80.9%	84.0%	76.1%	82.8%
National Average	79.4%	82.0%	81.1%	80.4%	82.5%

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

Impact: People receive timely access to diagnostics.

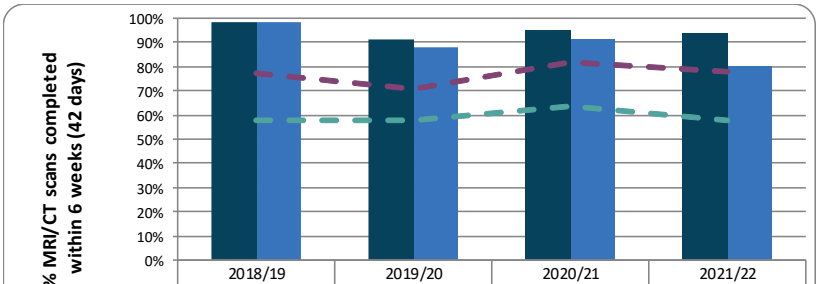
Comment

SCDHB's CT and MRI results in 2018/19 and 2020/21 met the Ministry's 95% and 90% targets. However in 2019/20 and 2021/22 these results were impacted due to the high prevalence of COVID-19 cases and COVID-19 Alert Levels. The results remain above the national average.

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



	2018/19	2019/20	2020/21	2021/22
SCDHB CT	98.1%	91.0%	95%	93.8%
SCDHB MRI	98.3%	88.1%	91%	80.4%
NZ CT	77%	71%	82%	78%
NZ MRI	58%	58%	64%	58%

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

Comment

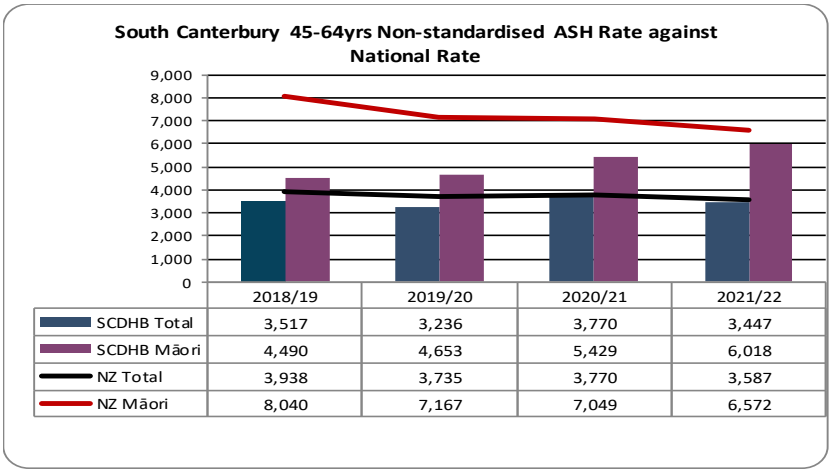
SCDHB's result for 2021/22 has decreased on the previous year. Our result remains lower than the national average.

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 standardised rate of avoidable hospital admissions for the population aged 45-64 years (per 100,000).



	2018/19	2019/20	2020/21	2021/22
SCDHB Total	3,517	3,236	3,770	3,447
SCDHB Māori	4,490	4,653	5,429	6,018
NZ Total	3,938	3,735	3,770	3,587
NZ Māori	8,040	7,167	7,049	6,572

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

Comment

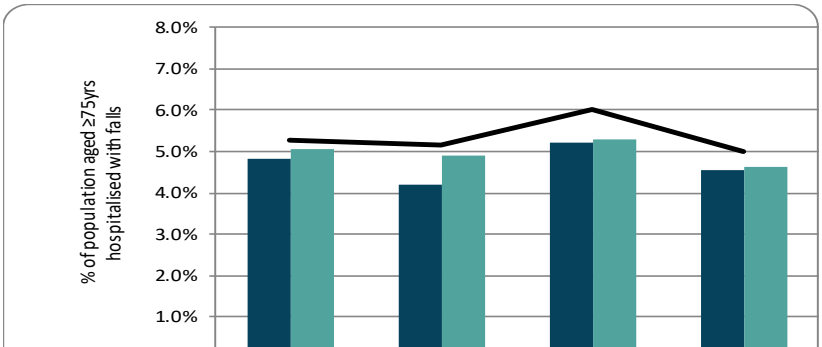
The 2021/22 result shows a decrease compared with 2020/21 and our result remains lower than both South Island and national results.

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, 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.



	2018/19	2019/20	2020/21	2021/22
SCDHB	4.8%	4.2%	5.2%	4.5%
South Island	5.0%	4.9%	5.3%	4.6%
New Zealand	5.3%	5.2%	6.0%	5.0%

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

Impact: People have shorter waits for treatment.

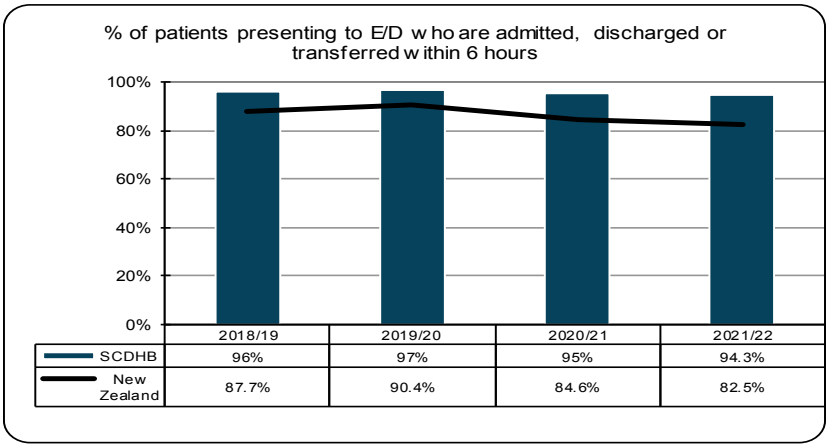
Comment

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

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

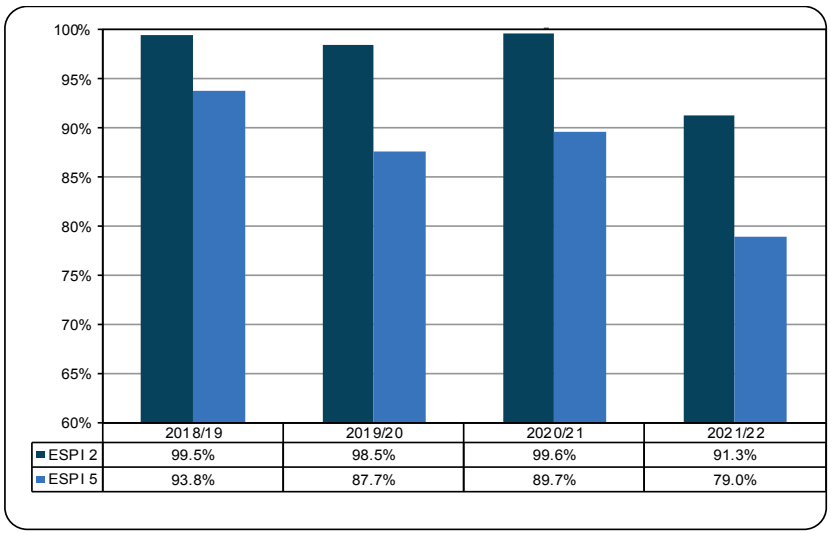
Elective Service Performance Indicator 2 relates to the percentage of patients provided with a First Specialist Appointment within 4 months of referral.

Elective Service Performance Indicator 5 relates to the percentage of patients given a commitment to treatment within 4 months.

The 2021/22 ESPI 2 and ESPI 5 results were both impacted by the high prevalence of COVID-19 cases.

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.

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.

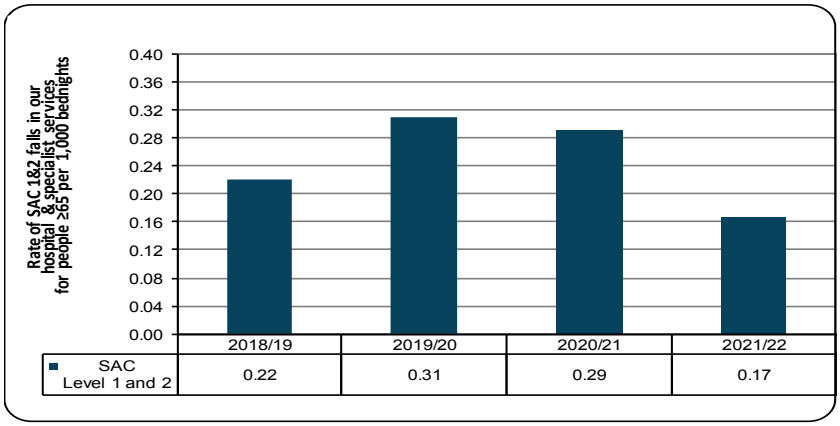
Comment

The 2021/22 result has decreased in comparison to the previous years.

The increasing number of people who have significant cognitive impairment contributed to the increase of serious falls in hospital during 2019/20 and 2020/21.

Education to staff regarding delirium and the management of people who have dementia continues to be a focus.

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 2021/2022.

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'.

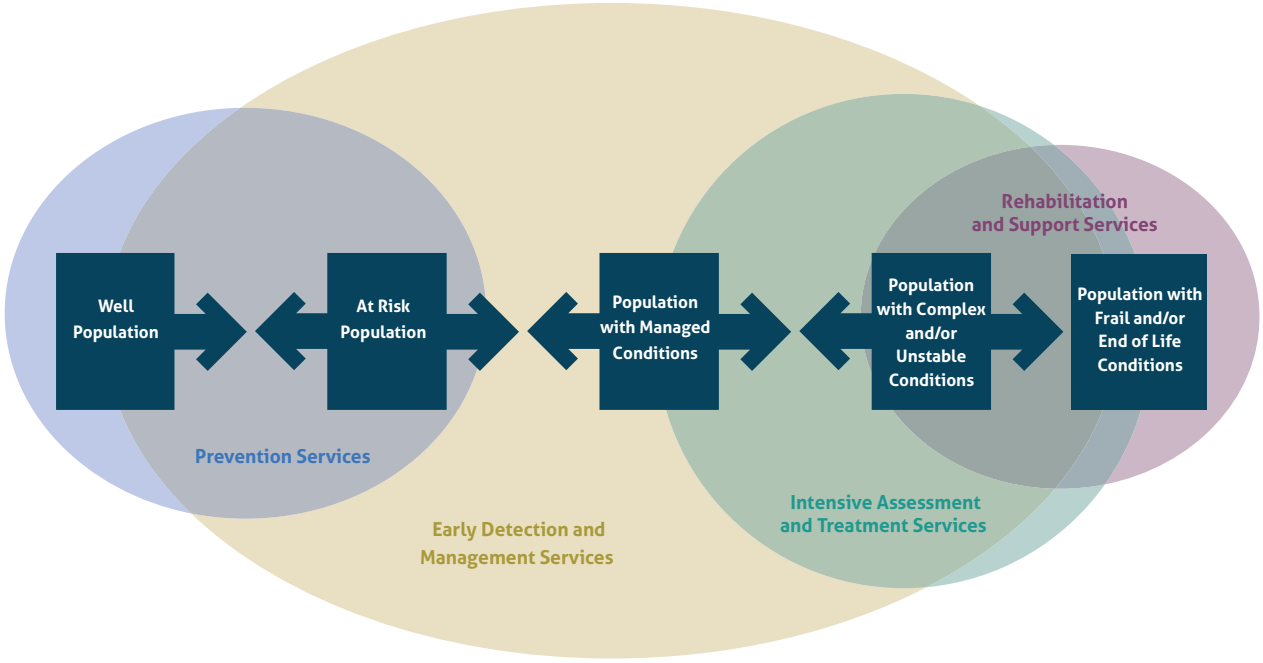
The output measures chosen are those activities which reflect a reasonable picture of activity across the whole of the South Canterbury health system and have the potential to make the greatest contribution to the health and wellbeing of our population in the shorter term and to the health outcomes we 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 2021/22 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.

Our outputs cover the full 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 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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age.	*C, Q, 1*	64.2%	62%	63.1%	70%	57.9%	✗
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.	*C, 2*	82.6%	74.4%	67%	90%	67.3%	✗
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*	98%	95%	92.5%	90%	N/A	✓

1. Increase in result compared to previous years, continuing to promote locally the benefits of breast feeding.
2. Decrease in result compared previous years due to the reprioritisation of primary care services to the COVID-19 response. 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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years.	*T, 1*	70.2%	72%	70.6%	80%	67.2%	✗
Percentage of Māori enrolled women aged 25 – 69 years who have had a cervical screen in the last three years.	*T, 1*	59.2%	59.3%	58.8%	80%	54.9%	✗
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.	*T*	68.6%	69.9%	75.9%	70%	66.1%	✓
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.	*T, 2*	60.4%	60%	64%	70%	59.2%	✗
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*	98% (12 months to 31 May 20)	98.9% (12 months to 31 May 21)	98.2% (12 months to 31 May 22)	95%	92.7% (12 months to 31 May 2022)	✓

1. Completion of cervical screening and planned promotional events have been impacted by the high prevalence of COVID-19 cases and COVID-19 Alert Levels.
2. Completion of breast screening and planned promotional events have been impacted by the high prevalence of COVID-19 cases and 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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of 8 months old fully immunised on time	*T, C, 1*	94%	94%	93.4%	95%	88.3%	×
Percentage of 2 years old fully immunised on time.	*T, C, 1*	93%	91.6%	91.8%	95%	84.8%	×
Percentage of 5 years old fully immunised on time.	*T, C, 1*	93%	91.2%	89.6%	95%	80.2%	×
Percentage of the eligible population receiving the flu vaccination	*C, 2*	61% (Sept 2019)	68.2% (2020)	66.9% (2021)	75%	63.4% (2021)	×
Percentage of eligible girls and boys (from 2019/20) fully immunised with HPV vaccine.	*V, 3*	51.3%	59.9%	63.1%	75%	54%	×

1. The 2021/22 results were close to target, these results were impacted by the high prevalence of COVID-19 cases and COVID-19 Alert Levels. Our results remain above the national average.
2. The 2021 result has decreased slightly on the previous year, however this result remains higher than the national average. These results may have been impacted by the borders being closed due to COVID-19 and with international travellers required to stay in MIQ for 14 days it meant the prevalence of influenza was significantly reduce in 2021. Significant effort and promotional activities were undertaken. This remains an area of focus.
3. The target has not been met, however there has been an 3.2% increase compared to last year. This continues to be an area of focus.

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. By promoting regular engagement with primary and community services people are better supported to manage their long term conditions, stay well, identify issues earlier and reduce complications, acute illness and crises resulting in unnecessary hospital admissions. Reducing the diversion of critical resources into managing acute demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions. The integration of services presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home.

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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of ethnicity reported accurately in PHO registers.	*C*	99.9%	99.95%	99.97%	>95%	N/A	✓
Percentage of Māori enrolled in a general practice.	*C, 1*	82%	80%	80%	95%	83%	✗
Avoidable Hospital Admission (ASH) 0 – 4 years (Total) rate.	*Q, 2*	4,065	3,166	4,525	≤2,611	5,618	✗
Avoidable Hospital Admission (ASH) 45 - 64 years (Total) rate.	*Q, 3*	3,236	3,594	3,447	≤3,265	3,587	✗

1. The 2021/22 Māori enrolments remained the same as the previous year. Our Māori health provider has good links with the General Practices and increasing Māori enrolments remains an area of focus.
2. The 2021/22 result has increased compared to the previous year, however this result is well below the national average. This may have been due to the increased prevalence of winter illnesses with the international borders being opened in 2022. There was a reduction in winter illnesses in 2021 due to the COVID-19 lockdown and this contributed to reduced ASH rates in 2020/21.
3. The 2020/21 result has decreased compared to the previous year and is below the national average. This may have been due to the increased prevalence of winter illnesses with the international borders being opened in 2022.

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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of people who receive an annual diabetes review with an HbA1c<64mmols.	*C*	60.2%	63.1%	63.9%	60%	N/A	✓

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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of children under five years enrolled in DHB funded dental services.	*C, 1*	77.1%	81.8%	78.4%	>95%	N/A	✗
Percentage of adolescents accessing DHB funded oral health services.	*C, 2*	78.1%	76%	70%	>85%	59.6%	✗
Percentage of children caries free at five years of age.	*C, 3*	72%	67%	62%	68.8%	59.7%	✗
Oral Health Decayed, Missing and Filled Teeth score at year eight.	*C*	0.81	0.78	0.83	0.73	0.79	✓
Percentage of enrolled preschool and primary school children overdue for their scheduled examination.	*T, 4*	9%	9%	23%	≤10%	N/A	✗

1. The 2021/22 result has decreased compared to the previous year. This result has been impacted by the high prevalence of COVID-19 cases.
2. Whilst this target has not been met, our result is above the national average. The 2021/22 result has been impacted by the high prevalence of COVID-19 cases and staff shortages in the community dental service.
3. Whilst this target has not been met, our result is above the national average but the 2021/22 result is lower than previous years.
4. The 2021/22 result has been impacted by the high prevalence of COVID-19 cases and staff shortages in the community dental service.

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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of accepted referrals for a MRI scan receive their scan within six weeks.	*T, 1*	88.1%	91%	80.4%	90%	58.1%	✗
Percentage of accepted referrals for a CT scan receive their scan within six weeks.	*T, 1*	91%	95.1%	93.8%	95%	78.1%	✗
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 calendar days.	*T*	97.7%	96.9%	96.8%	90%	89.6%	✓
Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within six weeks.	*T*	85.6%	88%	93.2%	70%	50.8%	✓
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date.	*T*	90.4%	92.8%	94.6%	70%	58.7%	✓

1. The 2021/22 results were impacted by the high prevalence of COVID-19 cases and COVID-19 Alert Levels changes. Our results remain well above the national average.

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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of patients discharged or transferred from ED within 6 hours	*T, 1*	87.1%	95.2%	94.3%	95%	82.5%	✗
Standardised acute hospital bed days per 1,000 population.	*V, 2*	401.7	407	444	<318	405	✗
Percentage of patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	*T, 3*	69%	87.3%	71.4%	90%	84.8%	✗
Percentage of older patients assessed as at risk of falling.	*Q*	97%	98%	96%	95%	N/A	✓

1. The 2021/22 result has decreased slightly on the previous year and has not met target by 0.7%. This target has been impacted by the high prevalence of COVID-19 cases. The hospital inpatient capacity created delays in moving patients out of ED at times during surge of winter illnesses and COVID-19 cases.
2. The 2021/22 result has been impacted by the high prevalence of COVID-19 cases, RSV and other winter respiratory illnesses.
3. The result shows an increase on the 2019/20 result. The result was impacted by the high prevalence of COVID-19 cases and staffing shortages.

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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
No. inpatient surgical discharges	*Q, 1*	2,773	3,178	3,045	3,124	N/A	✗

1. The 2021/22 result was impacted by the high prevalence of COVID-19 cases and staffing shortages.

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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	Achievement Against Target
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services. Ref MH01.	*C*	5.9% (12 months to Mar 20)	6.2% (12 months to Mar 21)	6.7% (12 months to Mar 22)	5%	3.8% (12 months to Mar 22)	✓
Access rates to Primary Mental Health Brief Intervention – 12-19 years	*T, 1*	6%	8.5%	4.4%	4.7%	N/A	✗
Access rates to Primary Mental Health Brief Intervention 20+	*T, 1*	2.5%	2.6%	1.4%	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	*Q, 2*	Māori 160 Non-Māori 89	Māori 255 Non-Māori 94	Māori 268 Non-Māori 106	Māori 173.7 Non-Māori 86.4	Māori 298 Non-Māori 96	✗

1. The 2020/21 results were impacted by the high prevalence of COVID-19 cases. Access and equity are a key focus of the mental health and addiction review implementation. A reduction in Brief Intervention referrals has been reported since the introduction of Health Improvement Practitioners (HIPs) and Wellness Coaches into Primary Care in March 2022.
2. Presented results relate to a very small number of Māori. 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	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	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, 1*	95%	97%	89%	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.	*Q*	91%	95%	97%	95%	N/A	✓

1. The 2021/22 result was impacted by the high prevalence of COVID-19 cases and staffing shortages.

Rehabilitation	Notes	2019/20 Result	2020/21 Result	2021/22 Result	Target/ Estimated Delivery 2021/22	Current National Average	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, 1*	84.1%	88.4%	67.7%	80%	N/A	✗
Percentage 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, 2*	71%	66%	58%	60%	N/A	✗
Percentage of mental health & addiction clients with a transition (discharge) plan.	*C*	81%	79%	99.5%	95%	N/A	✓

1. The 2021/22 result was impacted by the high prevalence of COVID-19 cases. The main portion of the inpatient rehabilitation unit was utilised as a COVID-19 ward. Therefore the number of rehabilitation beds within the impatient ward was significantly reduced and the patients were admitted to the medical or surgical ward.
2. The 2021/22 result was impacted by the high prevalence of COVID-19 cases and staffing shortages.

Additional performance information: COVID-19 vaccinations and mortality

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

COVID-19 vaccinations

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

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

HSU 2021

People are included if they were:

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

HSU 2020

People are included if they were:

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

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

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

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

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

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

To determine the coverage of the COVID-19 vaccine across the population of SCDHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[1]

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[2] (HSU 2021 vs HSU 2020)

Year	HSU 2021	HSU 2020
	Percentage of the eligible population who have completed their primary course	Percentage of the eligible population who have completed their primary course
2020/2021	14.00%	14.45%
2021/2022	76.91%	79.39%
Total	**90.91%**	**93.84%**

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 90.91%, compared with 93.84% using HSU 2020 as at 30 June 2022.

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

1 https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

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

COVID-19 vaccine doses administered by dose type and year

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

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

Year	Primary Course				
	Dose 1	Dose 2	Booster 1	Booster 2	**Total**
2020/21	11,155	7,777	0	0	**18,932**
2021/22	41,541	42,782	34,358	164	**118,845**
Total	**52,696**	**50,559**	**34,358**	**164**	**137,777**

By 30 June 2022, a total of 137,777 COVID-19 vaccinations had been administered, of which 118,845 were administered in 2021/22.

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

COVID-19 vaccine doses administered by age group

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

COVID-19 vaccine doses administered by age group[3]

Age group	Primary course				
(years)	Dose 1	Dose 2	Booster 1	Booster 2	Total
0 to 11	2846	1219	0	0	4065
12 to 15	3018	2910	1	0	5929
16 to 19	2261	2281	643	0	5185
20 to 24	2501	2519	1230	0	6250
25 to 29	3011	3004	1552	0	7567
30 to 34	3169	3170	1863	0	8202
35 to 39	2814	2826	1966	1	7607
40 to 44	2733	2753	2118	0	7604
45 to 49	3028	3090	2563	5	8686
50 to 54	3263	3359	3029	7	9658
55 to 59	3410	3583	3439	10	10442
60 to 64	3284	3509	3673	13	10479
65 to 69	2533	3036	3415	24	9008
70 to 74	2215	2756	3307	34	8312
75 to 79	675	1283	2385	31	4374
80 to 84	417	821	1744	23	3005
85 to 89	260	482	941	14	1697
90+	103	181	489	2	775
Total	**41541**	**42782**	**34358**	**164**	**118845**

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

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

COVID-19 people vaccinated by age group

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

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

COVID-19 people vaccinated by age group during 2021/22[4]

Age group (years)	Partial		Primary Course				Booster course	
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	2409	29%	1051	12%	0	0%	0	0%
12 to 15	2605	84%	2305	74%	0	0%	0	0%
16 to 19	2488	91%	2470	90%	357	41%	0	0%
20 to 24	2484	80%	2517	81%	1199	45%	0	0%
25 to 29	2906	75%	2913	75%	1495	47%	0	0%
30 to 34	3240	81%	3260	81%	1846	52%	0	0%
35 to 39	2910	83%	2918	83%	1947	61%	0	0%
40 to 44	2681	78%	2720	80%	2055	69%	0	0%
45 to 49	2921	77%	2970	78%	2413	73%	0	0%
50 to 54	3270	79%	3368	81%	3002	78%	6	2%
55 to 59	3293	74%	3471	78%	3341	83%	12	3%
60 to 64	3375	77%	3580	81%	3675	88%	14	3%
65 to 69	2657	67%	3066	78%	3429	92%	20	4%
70 to 74	2328	63%	2842	77%	3302	95%	34	8%
75 to 79	1033	40%	1626	63%	2579	98%	32	7%
80 to 84	502	26%	960	50%	1863	100%	23	5%
85 to 89	269	26%	518	51%	1004	102%	16	6%
90+	133	24%	244	45%	567	105%	2	1%
Total	**41504**	**66%**	**42799**	**68%**	**34074**	**76%**	**159**	**5%**

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

COVID-19 vaccine doses administered by ethnicity

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

COVID-19 vaccine doses[5] administered by ethnicity[6] (1 July 2021 – 30 June 2022)

Ethnicity (Note a1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asia	2554	2495	1918	1	6968
European/other	34658	36290	30326	158	101432
Māori	3058	2839	1474	5	7376
Pacific peoples	1052	959	483	-	2494
Unknown	219	199	157	-	575
Total	**41541**	**42782**	**34358**	**164**	**118845**

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

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

COVID-19 people vaccinated by ethnicity

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

COVID-19 people vaccinated by ethnicity during 2021/22[7]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated (12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster(18+)	Received first booster (18+) (% eligible)	Received second booster,50+	Received second booster (% eligible, 50+)
Asian	2361	80%	2428	82%	1914	77%	1	3%
Māori	2766	76%	2742	75%	1462	55%	5	2%
European /other	32782	71%	35372	76%	30056	78%	153	5%
Pacific peoples	943	92%	957	94%	484	53%	0	0%
Unknown	243	124%	249	127%	158	56%	0	0%
Total	**39095**	**72%**	**41748**	**77%**	**34074**	**76%**	**159**	**5%**

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

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

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

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

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

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	2735	93%	2711	92%	1914	77%	1	3%
Māori	3269	89%	3141	86%	1462	55%	5	2%
European /other	42721	92%	42179	91%	30057	78%	153	5%
Pacific peoples	1064	104%	1032	101%	485	53%	0	0%
Unknown	310	158%	283	144%	158	56%	0	0%
Total	**50099**	**92%**	**49346**	**91%**	**34076**	**76%**	**159**	**5%**

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

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)

Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)

Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)

Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

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

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

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

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

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ[8] :

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

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

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

8 https://www.stats.govt.nz/methods/population-statistics-user-guide.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.'[9]

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

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

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

- age
- ethnicity
- DHB
- gender

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

Comparison of HSU 2021 to the Stats NZ projected resident population

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

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

As at 31 December 2021, there is an estimated 62,718 health service users in the HSU 2021. This is an increase of 1,497 people from the HSU 2020 (an approximate 2.4% increase), and 518 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison.

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	5021	5890	869
Pacific peoples	1411	1070	-341
Asian	3603	3640	37
European/other	52484	51600	-884
Unknown	199	0	-199
Total (Note 1)	**62718**	**62200**	**-518**

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 62,718. This is 518 above the Stats NZ total projected population of 62,200 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[11]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	4785	5720	935
Pacific peoples	1200	1030	-170
Asian	3048	3590	542
European/other	52136	51700	-436
Unknown	52	0	-52
Total (Note 1)	**61221**	**62000**	**779**

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 61,221. This is 779 below the Stats NZ total projected population of 62,000 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

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

10 HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

11 HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[12] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

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

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

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

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

COVID-19 Deaths by age group

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

Age group (years)	
<10	0
10 to 19	0
20 to 29	0
30 to 39	0
40 to 49	0
50 to 59	0
60 to 69	2
70 to 79	2
80 to 89	3
90+	4
Total	**11**

COVID-19 deaths by ethnicity

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

Ethnicity	
Asian	0
European/other	9
Māori	1
Pacific peoples	1
Unknown	0
Total	**11**

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

Getting Better

Our Annual Report 2021/2022

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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