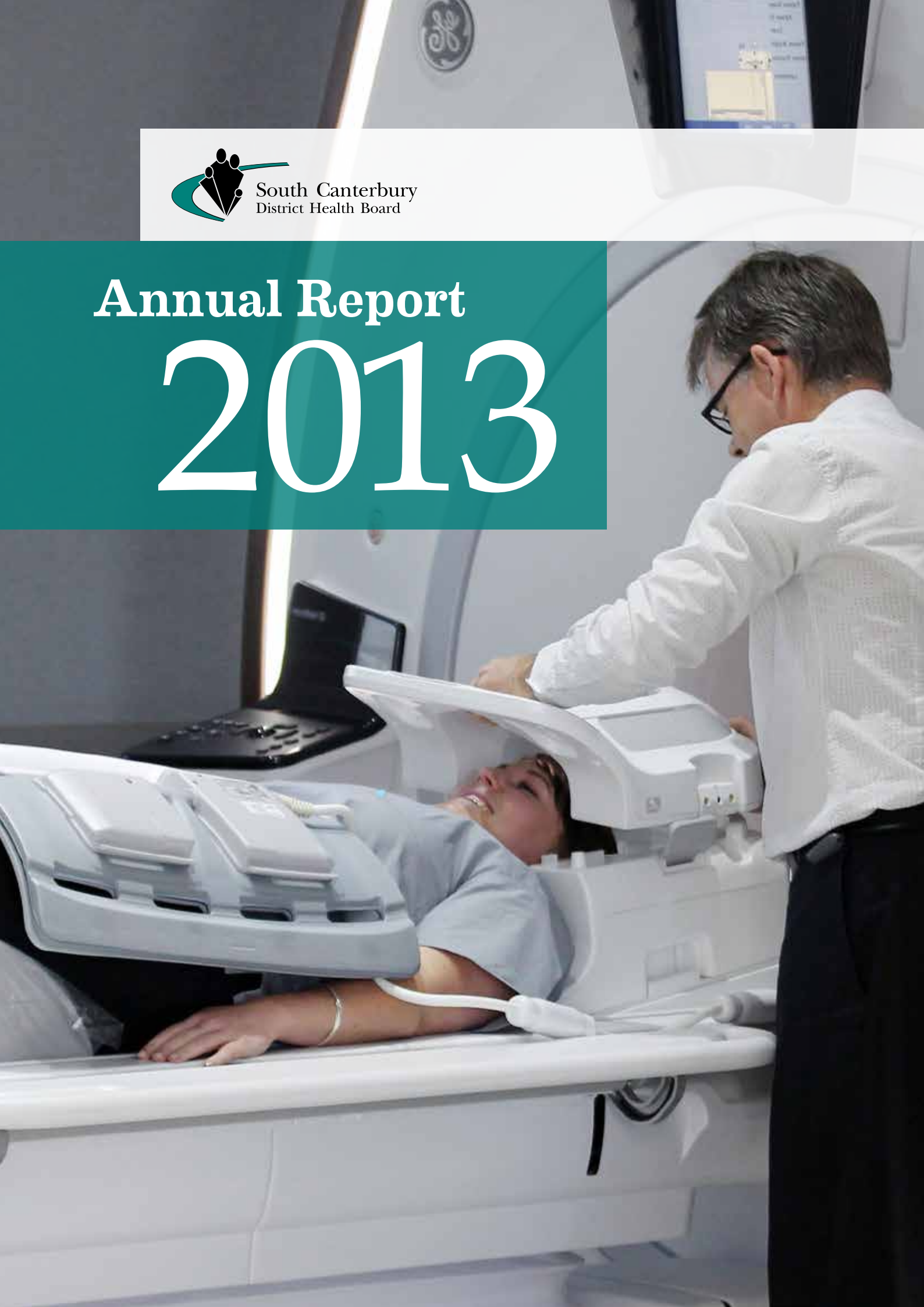

South Canterbury
District Health Board

Annual Report 2013

A Snapshot

A year in health in South Canterbury

Summary of statistics from 1 July 2012 to 30 June 2013

18,252
emergency department presentations

11,348
inpatient discharges

207,601
lab tests at Timaru Hospital

29,043
specialist outpatients appointments

183
Major joint replacement procedures at Timaru Hospital

34,252
meals on wheels

319
mental health admissions

33,200
radiology examinations

33,345
district nurse community visits

1,074
chemotheraphy attendances

621
births at Timaru Hospital

12,481
mental health face to face patient contacts

3,621
surgical operations

2,689
elective operations (1863 as day surgery)

25,792
allied health professional patient contacts

100,984
patient meals at Timaru Hospital

Contents

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Auditor

Audit New Zealand

on behalf of the Auditor General

Bankers

Westpac Bank

Solicitors

Gresson Dorman & Co

PO Box 244, Timaru

Our Mission

To enhance the health and independence of the people of South Canterbury.

From the Board

The South Canterbury District Health Board's (SCDHB) mission is to enhance the health and independence of the people of South Canterbury. We pride ourselves on being the best little DHB with a track record of excellent performance.

Therefore, it is with pleasure we present this report detailing our positive performance and progress for 2012/13.

The SCDHB has seen continued strengthening of its performance with some exciting additions and developments to our DHB. Our performance is measured through many indicators including community and patient satisfaction, government health targets, service levels, workforce, and financial targets.

Individually these factors are important and a challenge to achieve, therefore our success across all performance measures, whilst operating within our financial means, is a proud achievement. We continue to collaborate nationally and regionally on projects that ensure the effective and efficient delivery of healthcare, including representation on South Island Alliance groups.

A selection of projects are detailed below.

MRI Scanner

The culmination of a major community fundraising effort saw South Canterbury's MRI Scanner installed, officially opened and up and running at Timaru Hospital. This project is a prime example of working collaboratively with the community to achieve a better health outcome for all. The machine will save up to 1400 trips to Christchurch each year to access this service. The MRI machine is owned by Aoraki Charitable Trust, a special purpose trust whose sole purpose is to own a MRI and lease it to South Canterbury District Health Board.

Clinical Board

Established in late 2012, the Clinical Board covers Primary, Community and Secondary care and was developed into a single Clinical Board from two previous groups that covered Primary and Community, and Secondary care separately. The Clinical Board has strong consumer representation from our community and in an exciting development we are the first DHB in the country to appoint a consumer, David Sibley, as the independent chair of our Clinical Board. The Clinical Board has already shown that it is effective in bringing together clinical professionals and consumers to guide the quality and patient safety agenda for the DHB.

Strategic assessment of the Timaru Hospital redevelopment sign off

Planning is underway to strengthen and refurbish existing buildings and make improvements to functionality, suitability and climate within our Clinical Services building and Garden's Block.

Technology in health

As a largely rural community South Canterbury DHB understands it must make use of technology and innovation to ensure accessible health services that are better, sooner and more convenient across our whole district. Electronic referrals or e-referrals are in the first stages of being introduced. GP practices will have access to software that enables them to refer patients directly to hospital, where previously it was done by post.

Aoraki HealthPathways

Primary Care are working together with hospital, community and general practice clinicians to continue creating "Aoraki HealthPathways". These pathways give clear guidance to clinical people for assessing and managing a wide variety of conditions. Where a hospital specialist consultation is being considered, the HealthPathway gives up-to-date guidance about what information the specialist needs to receive, and what tests may be required.

Thank you

On behalf of the Board we would like to acknowledge the effort put in by staff, volunteers, and contracted providers both within the hospital and the wider South Canterbury health system. We appreciate and thank you all for the vital roles played by all providers including General Practice, Community Pharmacies, Aged Care Providers, Primary Mental Health Providers, Arowhenua Whanau Services, Medlab South, Christchurch Radiology Group, and many other Non-Government Organisations. Your contribution is critical to the ongoing success and stability of health and disability services within the South Canterbury community.

The community and all the team should be very proud of the collective results our DHB has once again delivered.

For and on behalf of the South Canterbury District Health Board.



Murray Cleverley
Chair

Ron Luxton
Deputy Chair

Nigel Trainor
Chief Executive

South Canterbury District Health Board (SCDHB)

South Canterbury District Health Board is governed by a 10-member board, 6 members publicly elected and four appointed by the Minister of Health. The Board concentrates on setting policy, approving strategy and monitoring progress towards meeting objectives. Management implements the Board's policy and strategies.

The Board's responsibilities include:

- Communicating with the Minister of Health and other stakeholders to ensure their views are reflected in SCDHB's planning.
- Defining specific objectives and delegating responsibility for their achievement to the Chief Executive.
- Monitoring organisational performance toward achieving stated objectives.
- Reporting to stakeholders on plans and progress towards achieving set objectives.
- Maintaining effective systems of internal control.

The Board maintains an interest register and ensures members are aware of their obligations to declare potential conflicts of interest.

Board meetings are held monthly at the Timaru Hospital Education Centre in Timaru. Members of the public are encouraged to attend.

BOARD MEMBERS

Murray Cleverley, chair (elected)
Ron Luxton, deputy chair (elected)
Paul Annear (elected)
Peter Binns (elected)
Rene Crawford (elected)
Terry Kennedy (elected)
Ngaire Whytock (elected)
Nicola Hornsey (appointed)
Warwick Isaacs (appointed)
Peter Lyman (appointed)

Murray Cleverley
Chair

Ron Luxton
Deputy Chair

Peter Lyman

Rene Crawford

Peter Binns

Nicola Hornsey

Warwick Isaacs

Ngaire Whytock

Paul Annear

Terry Kennedy

Board Committees

South Canterbury DHB has three statutory advisory committees and three other non-statutory committees. Committees do not involve themselves in operational matters. Rather, their role is to advise the Board on policies and to monitor progress towards meeting SCDHB objectives.

Hospital Advisory Committee (HAC)
HAC monitors the financial and operational performance of Timaru and Talbot Hospitals and assesses strategic issues related to the provision of hospital services.

MEMBERS
Nicola Hornsey, chair
Terry Kennedy, deputy chair
Paul Annear
Warwick Isaacs
Chris Miller (community representative)
Peter Dalziel (community representative)
David Sibley (community representative)
Raeleen de Joux (Māori representative)
Koriana Waller (Māori representative)

Disability Support Services Advisory Committee (DSAC)
DSAC advises on the disability support service (DSS) needs of the people of South Canterbury and on the priorities for the use of DSS funding. DSS includes assessment, treatment, rehabilitation, community-based services aimed at helping the disabled retain independence, and residential care.

MEMBERS
Ngaire Whytock, chair
Paul Annear, deputy chair
Terry Kennedy
Rene Crawford
Tony Gilchrist (community representative)
Kathy Wright (community representative)
Diane Nutsford (community representative)
Wendy Heath (Māori representative)

Audit and Assurance Committee (AAC) - non-statutory
AAC ensures the Board appropriately discharges its responsibilities relative to financial reporting, regulatory compliance and risk management.

MEMBERS
Warwick Isaacs, chair
Ron Luxton
Murray Cleverley
Nicola Hornsey
John Christie (Independent)

CEO Remuneration Committee - non-statutory
This committee advises the Board on the performance and level of remuneration of the DHB's chief executive.

MEMBERS
Murray Cleverley, chair
Ron Luxton, deputy chair
Warwick Isaacs

Māori Health Advisory Group - non-statutory
The Māori Health Advisory Group advises the Board on issues related to Māori health.

MEMBERS
Peter Lyman, chair
Peter Binns, deputy chair
Koriana Waller (Arowhenua)
Suzanne Eddington (Waihao)
Raeleen De Joux (Te Aitarakihi)
Wendy Heath (Arowhenua)
Viv Wood (Waihao)
Jan Beck-Manawatu (Te Aitarakihi) Resigned February 2013

Disclosure of Board Members Interests

Paul Annear
Elected member
Physiotherapist in private practice (Timaru & Ashburton); married to Janie Annear, Mayor of Timaru District; daughter employed by SCDHB as an occupational therapist
Chief Financial Officer/shareholder: Opihi Vineyard
Shareholder/director: FAIM Holdings – Family Company, Timaru Holdings, Westhills Forestry Ltd
Director: McLeod Building, Invercargill
Treasurer: So Kan Ju Judo Club

Peter Binns MB, BChir, FRCS
Elected member
Retired medical practitioner
Committee member: Timaru Greypower Trustee, Line Trust SC

Murray Cleverley MBA, FEcD, AFNZIM
Elected member, Board Chair
Principal Officer: Trust Aoraki
Managing Director: Business Class Ltd
Chairman: Opihi Vineyard Ltd
Director: Canterbury Economic Development Co. Ltd, NZ Petfoods Ltd, Shoe Shield Ltd, Animal Care Solutions, Sky Solar Holdings Ltd, District Health Boards New Zealand, South Island Neurosurgical Services Board, KCL Properties, Warbirds over Wanaka
Director and Employee: Canterbury Earthquake Recovery Authority
Deputy Chair: 20 District Health Boards
Partner: Cleverley Holdings Partnership

Nicola Hornsey BA LLB
Appointed member
Resource management and employment law consultant; sister is a Registered Nurse and casual employee of SCDHB
Limited Statutory Manager: Omarama School
Board member: Presbyterian Support South Canterbury Inc

Warwick Isaacs
Appointed member
General Manager, Operations, for the Canterbury Earthquake Recovery Authority
Trustee: Isaacs Family Trust

Terry Kennedy
Elected member
Councillor: Timaru District Council

Ron Luxton MPS, ANZCP, JP
Elected member, Board Deputy Chair
Locum Pharmacist
Chairman: Aoraki MRI Charitable Trust
Trustee: Aoraki Foundation, Green-gables Trust

Peter Lyman MCM (Hons) (Finance and Strategic Management)
Appointed member
Senior Business Analyst – Te Runanga o Ngai Tahu
Trustee: Linwood Intermediate School
Member: Arowhenua Runanga

Ngaire Whytock
Elected member
Registered Nurse
Member: Alzheimers SC Inc.
Residents Advocate for Presbyterian Support South Canterbury

Rene Crawford
Elected member
Employed by University of Otago School of Physiotherapy as a Professional Practice Fellow (University of Otago School of Physiotherapy has a contract with SCDHB).
Employed by SCDHB occasionally as a casual physiotherapist
Brother employed by SCDHB as a Consultant Orthopaedic Surgeon
Member: Physiotherapy New Zealand Education Group Executive Committee, Physiotherapy New Zealand South Canterbury Branch, Physiotherapy New Zealand Canterbury Branch committee.
Trustee: Board of Trustees at Cannington Primary School,Temford Family Trust

The Year in Review

South Canterbury's MRI Scanner

SOUTH CANTERBURY'S MRI SCANNER UP AND RUNNING

A Magnetic Resonance Imaging (MRI) Scanner uses a large powerful magnet, safe low-energy radio waves and a computer to produce extremely detailed pictures of the inside of the body. It increases a clinician's ability to provide timely diagnosis for patients with serious heart, brain, cancer and muscle/bone conditions. Patients previously travelled to Christchurch or Dunedin for MRI scans.

On December 20 last year, only 16 months since community fundraising began, a crane maneuvered the 6.5 tonne MRI Scanner out of its box and onto rollers. The scanner was then rolled into an opening in the side of the new purpose-built MRI building.

Two medical radiation technologists have been employed to operate the scanner, which will save about 1400 patient trips to Christchurch each year to access the services that were not previously available here.

OFFICIAL OPENING

The official opening of the MRI Scanner was held on Friday, 15 March. More than 90 invited guests attended the launch, including former South Canterbury District Health Board Chief Executive Chris Fleming, Rangitata MP Jo Goodhew and hospital chaplain the Rev Alan Cummings.

All guest speakers spoke of the efforts made by the community and the people who worked behind the scenes to make the district's MRI dream a reality.

The ceremony was followed by a guided tour of the MRI suite and the was also open to a public tour the following day for people to see the fruitions of their contributions and have the chance to ask questions of staff.

COMMUNITY CONTRIBUTION

In an 18 month fundraising campaign, a culmination of a major community fundraising effort, with contributions from businesses, trusts, a range of community groups, and many ordinary South Cantabrians reached a total of $3m. $1.59m went towards the machine, $800,000 towards the building and $200,000 for an anaesthetic machine.

A further $200,000 went toward training staff to operate the MRI. Remaining money will be kept in the Aoraki MRI Charitable Trust for ongoing maintenance costs and future replacement of the machine, which has a life expectancy of 10 years.

Strong Clinical Leadership

ESTABLISHMENT OF THE CLINICAL BOARD

Clinical Governance is a way of developing an environment that encourages and supports everyone to be involved in organising and delivering care to improve the quality of services we provide. Put simply, Clinical Governance allows all staff to be involved in managing and improving our clinical activities. Quality is everybody's responsibility and staff get a say in how things could be done better.

Established last year, the Clinical Board covers Primary Community and Secondary care and was developed into a single Clinical Board from two previous groups that covered Primary and Community, and Secondary care separately. The Clinical Board has strong consumer representation from our community, and in an exciting development, we are the first DHB in the country to appoint a consumer, David Sibley, as the independent chair of our Clinical Board.

The Clinical Board has already shown that it is effective in bringing together clinical professionals and consumers to guide the quality and patient safety agenda for the DHB.

Who makes up the Clinical Board?

Members of the Clinical Board include representatives from clinical groups across the organisation including Secondary and Primary and Community, consumer representatives, nursing, allied health, pharmacy, medical, and cultural representatives.

Our Clinical Board is unique in NZ in that it has an independent chair (not a clinician), who is also a consumer.

What is the purpose of the Clinical Board?

The role of the Clinical board is to give expert advice and exhibit leadership on clinical matters.

The Clinical Board is the key Patient Safety body for South Canterbury District Health Board, and as such has direct links with senior operational management and reports directly to the Board.

The Clinical Board monitors clinical practice and patient safety initiatives across the organisation, identifies areas where an improvement focus is required. The board also receives, and where appropriate, support new initiatives that will improve clinical practice and patient safety.

Left to Right. Back row: Bruce Wikitoa, Sue Eddington, David Sibley (Chair), Chris Eccleston, Mike Cotton, Jane Brosnahan, Neil Savage, Nicki Youngson, Jill Pope, Gayle Borman, Nigel Trainor

Left to Right. Front row: Sonya Veale, Mr Steve Earnshaw, Dr Richard Johnson, Jan Bell, Judy Hines, Dr Bruce Small. Absent: Dr Vince Lambourne, Dr Daniel Williams, Dr Tim Gardner.

The Year in Review

Change in Leadership

In 2012/13 three key roles changed within SCDHB.

It is a credit to the organisation that not only did several internal applicants apply, but all three successful appointments were internal candidates.

In April 2013, Nigel Trainor was appointed Chief Executive Officer following the departure of Chris Fleming who left to become CEO of Nelson and Malborough DHB. Nigel's previous role at SCDHB was the General Manager of Finance, IT and Commercial.

Richard Johnson, commenced his role as Chief Medical Officer in November 2012. His previous role was as a Consultant Anaesthetist at SCDHB.

Jane Brosnahan began as the Director of Nursing, Midwifery and Allied Health in October 2012 progressing from her previous role as Nurse Advisor, Primary Care.

Nigel Trainor
Chief Executive Officer

Richard Johnson
Chief Medical Officer

Jane Brosnahan
Director of Nursing, Midwifery & Allied Health

Working Together

The integration of primary and secondary health services was a focus in the 2012/13 year with many initiatives that saw community providers working more closely with their hospital colleagues, and other staff working across the whole health continuum.

AORAKI HEALTHPATHWAYS

Based on a model of working together, hospital, community and general practice clinicians are continuing to work together to create "Aoraki HealthPathways". These give clear guidance for clinical people to assess and manage a wide variety of conditions. Where a hospital specialist consultation is being considered, the HealthPathway gives up-to-date guidance about what information the specialist needs to receive, and how long it will to be before a person would see a specialist.

SOUTH ISLAND ALLIANCE

The South Island Alliance is a collaboration of five DHBs working regionally to improve health services, ensuring consistent, quality, timely care across the South Island. By using our combined resources to jointly solve problems, we are better positioned to respond to changes in the technology and demographics that will have a significant impact on the health sector in the coming years.

Some of the successes of the Alliance so far have been the development of a South Island wide early intervention eating disorder service; a regional training hub to recruit and train staff for the South Island, particularly rural health professionals; Major projects that are underway include the regional rollout of information systems for example, electronic referrals; and a single patient administration system across the South Island. Work has also begun on the Faster Cancer Treatment Plan to ensure patients' journey from diagnosis to treatment is as streamlined and quick as possible.

SOUTH ISLAND ALLIANCE
best for patients, best for system

Attracting and Retaining Staff

Initiatives to look after current staff, create new clinical roles to meet the needs of the community, and attract young people into a health career all featured in 2012/13.

STAFF FORUMS

Quarterly staff forums have been reintroduced for all staff and on site contractors. The purpose of the forum is for all staff to find out more about what is going on in the organisation and for staff to feedback and ask questions. The format has some formal presentations in the beginning then open the floor for questions, answers and discussions to increase communications and an open environment for staff to ask questions and voice opinions.

INCUBATOR PROGRAMME VISITS HIGH SCHOOLS

Senior high school students gained a unique perspective on working in the health sector through "Programme Incubator" in 2013. The programme offers students a "hands on" experience of working in health through a variety of activities that are fun and educational in the school and hospital setting. These activities are delivered by real health professionals who also share their "stories" to engage and inspire the students. There are currently six high schools and over 120 students taking part.

Attracting and Retaining Staff

ATTRACTING GP GRADUATES TO SOUTH CANTERBURY

South Canterbury's general practice workforce is aging and there is a nationwide shortage of GPs (not enough doctors are training to become GPs) meaning it is getting more difficult to recruit and retain GP registrars in South Canterbury.

To offset these challenges South Canterbury District Health Board is being supported by Health Work Force New Zealand (HWNZ), to demonstrate a new approach to GP training in the South Canterbury region. It aims to increase the number of GP registrar opportunities in South Canterbury, attract vocationally trained GPs to South Canterbury and encourage them to stay after registration to create a sustainable GP workforce in South Canterbury.

The GP training pilot programme is both hospital and rotation based training within a number of GP practices. This enables stronger bonds to be formed between GP, community and hospital services as well as providing GP registrars with opportunities to develop a flexible skill set for a career in general practice.

SCDHB offers support for travel cost and tops up the registrars salaries to be on par with house surgeons/registrars employed in a hospital based training programme; disparity in employment conditions between GP registrars and their hospital counterparts has been identified as one of the barriers to GP recruitment. SCDHB is the only DHB currently funded by HWNZ to offer this top up. In 2012/13 three GP registrars took up this opportunity.

GP registrars Maria Patu and Tahir Ayub and Timaru Doctor and accredited GP registrar teacher Mary McSherry (centre)

A Focus on Facilities

The importance of health facilities to the community was highlighted with the Canterbury earthquakes. With this in mind, SCDHB placed considerable focus on facility development and improvements in 2012/13.

FACILITY STRATEGIC ASSESSMENT

The South Canterbury District Health Board has signed off a strategic assessment of the Timaru Hospital redevelopment. The accepted strategic assessment includes the following projects:

1. The Gardens Block will be strengthened and refurbished to accommodate management and administration staff along with Senior Medical Officers and some clinical staff. Planning for the gardens block project is well underway.
2. Improvements to the regulation of the temperature within the Clinical Services Building
3. A new Emergency Department including refurbishment, extension of out-patients, refit to include day patient services and a revision of the layout of the medical and surgical wards.

REGULAR SWIMMING FOR YOUR HEALTH

Jessica is a double amputee but is determined not to give up on exercise. Her GP thought swimming would be a good option and referred her to the S.W.I.M programme.

Jessica and her husband swim at CBay three times a week. They have lots of laughs with the other swimmers and she loves the feeling of freedom that the water gives her.

After six months of swimming Jessica's strength and fitness have improved remarkably, including her cardiac health. She is doing well. She is no longer experiencing angina.

"Even if I haven't got legs, I'm using every muscle in my body to swim, and they (instructors) teach you to breathe properly as well. I'm very grateful for all the help I've had."

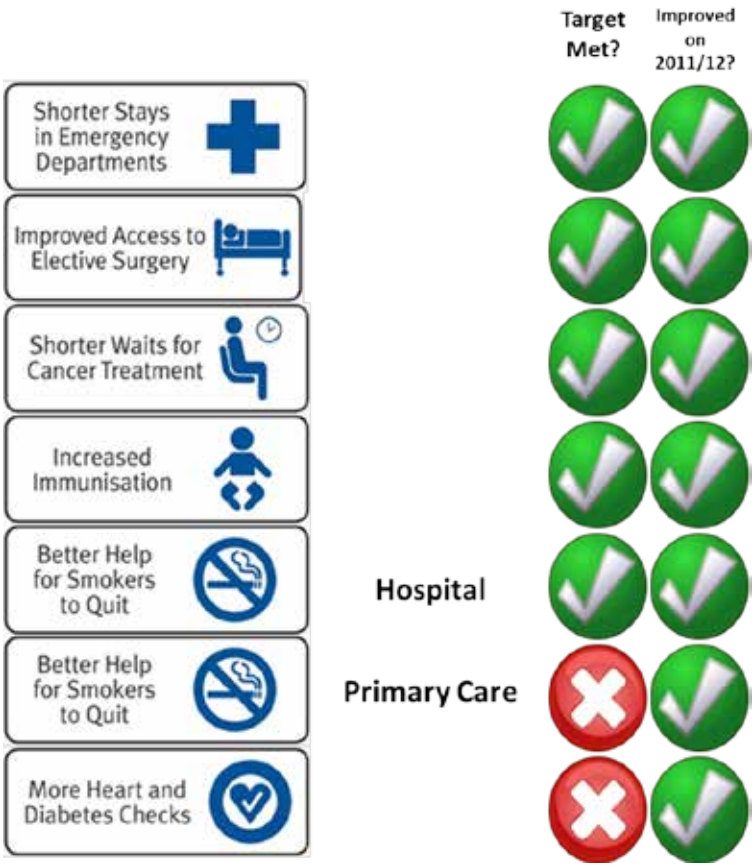
Jessica says swimming is great for people who are self conscious about exercise because nobody can see what shape and size you are under the water. "Nobody judges you."

Meeting the Health Targets

The Minister of Health set seven health targets for all district health boards to work towards in the 2012/13 year, challenging health professionals working in both the community and the hospital.

	Target 2012/13	Result 2011/12	Result 2012/13	Did we meet target?
Percentage of patients admitted, discharged or transferred from the Emergency Department within six hours	95%	98%	96%	yes
Percentage of agreed elective surgery provided to patients	100%	104%	106%	yes
Percentage of cancer patients ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.	100%	96%	100%	yes
Percentage of eight- month-olds fully immunised	85%	96%	88%	yes
Percentage of hospitalised smokers provided with advice and help to quit smoking - In hospitals	95%	97%	99%	yes
Percentage of smokers provided with advice and help to quit smoking - In Primary Care	90%	Not measured	76%	no*
Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years.	75%	42%	64%	no

* New target in 2012/13.



Centre of Excellence for the Health of Older People

The development of the Centre of Excellence for Older People in South Canterbury began in 2013.

The Centre of Excellence for Older People is not bricks and mortar – it is a project that aims to make South Canterbury the place of best practice for the health of older people in New Zealand. South Canterbury has the highest proportion of over 65s in the country with a large increase in the number of elderly patients predicted in the near future. South Canterbury's size means it is easier for the collaboration and communication that develops best practice to occur.

The ongoing project commenced with well attended public forums to gain feedback and engage with patients, their families, community and experts including academic, clinical and service providers to ensure a wide range of perspective on the health of older people.

The project will continue into 2013/14 with the development of a high level plan and pilot projects. Changes to practices and protocols will be implemented during the process of analysis if deemed suitable.

The Whole Experience

Public confidence in the services provided at Timaru Hospital has always been strong. The hospital continued to make improvements to the quality, safety and efficiency of services in 2012/13.

ACCREDITATION AND CERTIFICATION

A certification/accreditation surveillance visit of SCDHB took place in June 2013. Certification is a mandatory requirement of the Ministry of Health and ensures the organisation meets health and disability sector standards. Accreditation is about looking at all aspects of an organisation's performance and comparing it with contemporary standards of client rights, standards of care, management and safety.

The surveillance visit takes place between full certification and accreditation surveys, and is used to assess progress against recommendations for improvement identified during the full survey. The surveillance visit was split into two due to bad weather, and was conducted by a group of surveyors from the DAA Group. They met with staff, patients and patient's family / whanau. The DHB was found to be making good progress at putting improvements in place against the previous recommendations.

CLINICAL NURSE SPECIALIST GASTRO – INTESTINAL/COLORECTAL

Jill Keys commenced in this newly developed clinical nurse specialist role in early March 2013 following a growing need for colorectal patients in particular to be able to access specialist nursing care. The role provides support, expert education, advice and follow up for patients with colorectal cancers and other bowel disorders. Such a role enhances those of the surgeons/endoscopists and ensures that patients receive timely treatment. Jill works closely with all of the general surgeons, the recently appointed cancer nurse co-ordinator, and multidisciplinary teams.

The GI/colorectal role also includes Colorectal cancer follow up and weekly Endoscopy histology reviews, and with a background in stomal therapy, Jill works closely to support two training Stomal Therapists in the surgical ward and community.

Future involvement with inflammatory bowel patients is planned in the future.

ELECTRONIC REQUEST MANAGEMENT SYSTEM (ERMS)

ERMS is a platform for making electronic referrals from primary care to secondary care.

This has now been implemented in all GP practices within South Canterbury and enables general practitioners to refer patients to both Timaru Hospital and private specialists electronically. The ERMS platform works with the practice management systems, Medtech, and helps referrers make referrals quickly and easily by having many of the field's auto-populating.

The Year in Review

We are Open for Better Care

The Health, Quality and Safety Commission's national patient safety campaign 'Open for Better Care' challenges health workers to be open to working closely with patients and consumers, open to change, improvement and innovation and open to acknowledging mistakes and learning from them. It is an exciting opportunity for us all to make a real difference to patient safety.

There are a number of focus areas covered:

- Falls prevention and reducing harm from falls
- Preventing harm from healthcare associated infections
- Preventing harm caused by surgery

To celebrate and show commitment to the campaign, SCDHB held a morning tea launch, signing of the pledge by officials and a large pledge for staff to sign at the Timaru Hospital cafe on June 20.

The launch was attended by Hon Jo Goodhew, board chairman, staff and management who gave examples of what better care means to them. A falls prevention Giant Jenga game was also available to play.

FALLS PREVENTION

In SCDHB, the key area for improvement highlighted from our Serious and Sentinel events report is patient falls.

Significant focus has been placed on reducing the rate of falls that we see within the hospital. Wards monitor their rate of falls, and target actions to prevent them. These include:

- Introduction of "Care Calling." Staff regularly check with each patient to see how they are feeling, and whether they need anything
- Trialling of falls mats and other alarm devices that warn staff if a patient is getting up
- Review of the falls risk assessment and action planning process to make sure we are delivering the right support to each individual patient

QUALITY ACCOUNT

South Canterbury District Health Board's first Quality Account was produced this year, which highlights just some of the work done over the last year to improve services and outcomes for our community for example the updated early warning system which utilises a track and trigger system to help nurses identify possible signs of clinical deterioration so they can get medical help early. This Quality Account covers the year from July 2012 to June 2013 and is available from November 2013 as an e-book at www.scdhb.health.nz.

Open for Better Care launch at Timaru Hospital's cafe.

Out in our Community

A large proportion of DHB funding is spent on health services in the community, including the subsidising of patient GP visits and prescriptions, the provision of public health programmes and the promotion of good nutrition and physical activity.

MULTI-CONDITION REHABILITATION (MCR)

MCR is a Primary and Community funded project for the support of patients with multiple long -term conditions. It is a short course of exercise and education classes to encourage and empower self-management and run by the Community Health Team, of clinical nurse specialists, a dietitian, physiotherapists and Smoke-Free facilitators. The programme has been running for 12 months and is a successful and widely supported initiative. Not only does the programme encourage and motivate exercise, it is also good for social engagement for attendees to meet others dealing with similar health issues.

HPV VACCINATION RE-OFFERED IN SCHOOLS

The Immunisation and Public Health Nursing teams have completed the second dose of HPV in the 2013 School Based Programme – parents throughout South Canterbury have given the teams consent to vaccinate Year 8 students and any other female students 12 years or older who have not yet commenced vaccination.

HPV (Gardasil) vaccination protects against many forms of cervical cancers and offers at least 10 years confirmed immunity against Human Papilloma Virus.

The school based programme has been well received and the teams offer an outreach service and assistance to link in with GPs if this is the student's preference.

The vaccine is also provided by general practices.

IMMUNISATIONS

Patients who have had a diagnosis of Pneumonia and are aged 65 years or older are being followed up by the Primary Care Team after discharge from hospital and offered to be vaccinated with Pnemovax23. The uptake of the vaccination offer has been high, the target population is appreciative of the offer for increased protection and research supports a decreased readmission rate.

SCDHB is regularly achieving the 95% fully immunised target for two year olds and the 85% target for fully immunised 8 month olds for childhood immunisations. Successful vaccination campaigns are the result of a collaborative approach and close work with all Primary providers to maintain historical and current success rates with Ministry of Health immunisation targets.

A Waimate Multi - Condition Rehabilitation participant enjoying her exercise circuit.

The Year in Review

Māori and High Needs Populations

South Canterbury DHB serves all people living in South Canterbury. Our boundaries are the Rangitata River in the north, the Waitaki River in the south and Aoraki/Mount Cook in the west. The area has a resident population of 55,260 (1.28% of the national population). The Ngai Tahu Iwi through their Runaka at Arowhenua (Temuka) and Waihao (Morven) are the mana whenua of South Canterbury.

As an agent of the Crown, the Board is committed to the principles of the Treaty of Waitangi, in particular Māori participation and partnership in health planning and services, and protection of Māori well-being.

GP PRACTICE ENROLLED POPULATION

AGE GROUP	Māori	%	TOTAL POPULATION
0 - 5 years	430	11%	3893
6 - 17 years	799	9%	8442
18 - 24 years	392	8%	4672
25 - 44 years	749	6%	12060
45 - 64 years	551	3%	16001
65+ years	171	2%	11204

CONSULTATIONS AND ADMISSIONS

	MEASURE	Māori	NON-Māori
GP Consultations	number	7477	172,626
	per patient	2.60	3.0
Nurse Consultations	number	1,485	38,101
	per patient	0.50	0.7
Ambulatory Sensitive Hospitalisation rates per 100,000 (30/6/13)	0-74 age group 0-4 age group 45-64 age group	1911 4038 1900	1907 3509 2051
Elective Surgery (30/06/12)	rate per 10,000 population	302	316
Cancer treatment starting within four weeks	percentage of patients	100%	100%

HEALTH SCORECARD FOR Māori AND HIGH NEEDS POPULATION

AREA OF PERFORMANCE	INDICATOR	Māori	TOTAL POPULATION	TARGET	TREND
Screening Programmes	8 month old childhood immunisation	91%	88%	85%	▸
	2 year old childhood immunisation	92%	94%	95%	▸
	HPV immunisation for girls 12+ years (1999 cohort)	47%	41%	65%	▲
	Flu vaccine for 65 years+	40%	68%	75%	▲
	Breast screening for women 45 - 69 years	72%	80%	75%	▼
	Cervical screening for women 20 -69 years	70%	76%	75%	▼
	Cardiovascular risk assessment 5 yearly 35+ years	58%	64%	90%	▲
	Diabetes detection	100%	100%	90%	▲
	Smoking status recorded	77%	78%	90%	▲
Patient Review/Advice	Diabetes annual review	42%	41%	72%	▼
	Diabetes management less than 65mmol/mol HbA1c	67%	60%	83%	▲
	Brief advice & cessation support given in primary care	81%	76%	90%	▲
	Brief advice & cessation support given in secondary care	99%	98%	95%	▲
Mental Health	Access rates 0 - 19	3.64%	5.29%	2.93%	▸
	Access rates 20 - 64	7.44%	3.58%	6.41%	▸
	Access rates 65+	0.38%	0.45%	1%	▲
	Service users with crises intervention plan adult 20+ (excluding addictions)	75%	79%	95%	▼
	Service users with crises intervention plan adult 20+ (addictions only)	100%	98%	95%	▲

Statement of Financial Responsibility

FOR YEAR ENDED 30 JUNE 2013

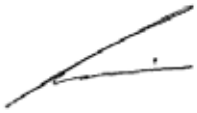
1. The Board and management of South Canterbury District Health Board accept responsibility for the preparation of the annual financial statements and the statement of service performance and for the judgements used in them.

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

3. In the opinion of the Board and management of South Canterbury District Health Board, the annual financial statements and the statement of service performance for the year ended 30 June 2013 fairly reflect the financial position and operations of South Canterbury District Health Board.

Murray Cleverley
Chair
25 October 2013

Ron Luxton
Deputy Chair
25 October 2013



Nigel Trainor
Chief Executive
25 October 2013

South Canterbury
District Health Board

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of South Canterbury District Health Board's financial statements and performance information for the year ended 30 June 2013

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

We have audited:

- the financial statements of the Health Board on pages 22 to 45, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of movements in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board that comprises the statement of service performance on pages 48 to 70.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 22 to 45:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers.

The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 48 to 70:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 25 October 2013. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health Board's preparation of the financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control 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 Health Board's internal control.

Our audit of the financial statements involved evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board's framework for reporting performance;
- the material performance measures, including the national health targets; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board's financial position, financial performance and cash flows; and
- fairly reflect its service performance achievements and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

3/14

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

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

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

Statement of Significant Accounting Policies

FOR YEAR ENDED 30 JUNE 2013

Reporting Entity

South Canterbury District Health Board (SCDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. SCDHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. SCDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

SCDHB is a public benefit entity, as defined under NZIAS 1.

SCDHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

Reporting period

The reporting period for these financial statements is for the year ended 30 June 2013.

Statement of Compliance

The financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These Financial Statements have been authorised for issue by the Board of SCDHB on 25 October 2013. The Board and management are responsible for ensuring that the Financial Statements are prepared using appropriate assumptions and that all disclosure requirements have been met.

Basis of Preparation

The financial statements are prepared on the historical cost basis except that land and buildings are stated at their fair value. The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars. The functional currency of SCDHB is New Zealand dollars.

Critical Accounting Estimates and Assumptions

The preparation of financial statements in conformity with NZIFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates. The present value of the retirement, long service leave, sick leave, senior doctors conference leave, sabbatical leave and senior doctors study cost obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating the liability include the discount rate and the salary inflation factor. Any changes in these assumptions will impact on the carrying amount of the liability.

Basis for Consolidation

SCDHB is required under the Crown Entities Act 2004 (the "Act") to prepare consolidated financial statements in relation to the group for each financial year. Consolidated financial statements for the group have not been prepared using the acquisition method due to the small size of its subsidiary, HSC Charitable Trust, which means that the parent and the group amounts are not materially different. Information relating to HSC Charitable Trust is separately disclosed in the notes to the financial statements.

Accounting Policies

The following particular accounting policies which materially affect the measurement of financial results and financial position have been applied consistently in preparing these Financial Statements:

1. Budget Figures

The budget figures are those approved by the Board and published in its Statement of Intent, which is the external accountability document prepared by SCDHB under the Crown Entities Act 2004. 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 the financial statements.

2. Goods and Services Tax

All items in the financial statements are 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.

3. Taxation

SCDHB is exempt from income tax as it is a public authority.

4. Donations and Bequest Funds

Donations and bequests to SCDHB are recognised as revenue when control over assets is obtained. A liability, rather than revenue, is recognised where fulfilment of any restrictions attached to those assets is not probable. Those donations and bequests with restrictive conditions are appropriated from retained earnings to the special funds component of equity. When expenditure is subsequently incurred in respect of these funds it is recognised in the Statement of Comprehensive Income and an equivalent amount is transferred from the special funds component of equity to retained earnings under the separate heading of "Equity from Donated Assets". The balance of that account does not attract a capital charge under new rules adopted in 2006 by the Ministry of Health.

5. Trade and Other Receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

6. Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis is measured at the lower of cost and current replacement cost.

The cost of purchased inventory held for distribution is determined using the weighted average cost formula.

Any write down from cost to current replacement cost, or reversal of such a write down, is recognised in the Statement of Comprehensive Income.

7. Cash and Cash Equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of SCDHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

8. Property, Plant and Equipment

Classes of Property, Plant and Equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- plant, equipment and vehicles
- fixture and fittings
- work in progress

Owned Assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads. Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

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

When an asset is acquired for nil or nominal consideration the asset will be recognised initially at fair value, where fair value can be reliably determined, with the fair value of the asset received, less costs incurred to acquire the asset, also recognised as revenue in the Statement of Comprehensive Income.

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 South Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to South Canterbury DHB at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

9. Revaluation of Land and Buildings

Land and Buildings are revalued with sufficient regularity, and at least every five years, to ensure that the carrying amount at balance date is not materially different to fair value. If there is evidence supporting a material difference, then the asset class will be revalued. Revaluation movements are accounted for on a class-of-asset basis. The results of any revaluing are credited or debited to an asset revaluation reserve for that class of asset. Where this results in a debit balance in the asset revaluation reserve, this balance is expensed in the Statement of Comprehensive Income. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the Statement of Comprehensive Income will be recognised first in the Statement of Comprehensive Income up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

Additions to land and buildings between valuations are recorded at cost.

10. Disposal of Fixed Assets

When a fixed asset is disposed of, any gains and losses are reported net in the Statement of Comprehensive Income and are calculated as the difference between the sale price and the carrying value of the fixed asset.

11. Depreciation of Fixed Assets

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

Buildings	33 to 65 years	1.5 – 3.0%
Building Fit-outs	3.5 to 20 years	5 – 28.6%
Plant and Equipment	2 to 10 years	10 – 50%
Motor Vehicles	3 to 5 years	20 – 33.3%

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.

12. Leases

Finance Leases

Leases which effectively transfer to SCDHB substantially all the risks and benefits incident to ownership of the leased items are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments. The leased assets and corresponding lease liabilities are recognised in the Statement of Financial Position. The leased assets are depreciated over the period SCDHB is expected to benefit from their use.

Operating Leases

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

13. Intangible Assets

Software

Computer software that is acquired by SCDHB is stated at cost less accumulated amortisation and impairment losses. Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is charged to the Statement of Comprehensive Income on a straight-line basis over the estimated useful lives of intangible assets from the date they are available for use. The estimated useful lives are as follows:

Software	2 to 10 years	10-50%

14. Impairment

The carrying amounts of SCDHB's assets are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the Statement of Comprehensive Income.

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

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognized on a class basis.

A provision for impairment of receivables is established when there is objective evidence that SCDHB will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the effective interest method. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the Statement of Comprehensive Income.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

15. Investments in Equity Securities

SCDHB's investments in equity securities are classified as available-for-sale financial assets and are stated at fair value, with any resultant gain or loss, expect for impairment losses, recognised directly in equity. When these assets are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the Statement of Comprehensive Income.

Statement of Significant Accounting Policies

16. Employee Benefits

Long Service Leave, Sick Leave, Sabbatical Leave, Medical Education Leave and Retirement Gratuities

SCDHB's net obligation in respect of long service leave, sick leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The entitlement is calculated by discounting the obligation to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date. Note 15 provides an analysis of the expenditure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities

Annual Leave

Annual leave is a short-term obligation and is calculated on an actual basis at the amount SCDHB expects to pay. SCDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Superannuation Schemes

Defined contribution schemes

Obligations for contributions to defined contribution superannuation schemes are recognised as an expense in the Statement of Comprehensive Income as incurred.

Defined benefit schemes

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

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

17. Revenue

Crown Funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Goods Sold and Services Rendered

Revenue from goods sold is recognised when SCDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and SCDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to SCDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by SCDHB.

Revenue relating to Service Contracts

SCDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or SCDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Interest Revenue

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

Donated or Subsidised Assets

Where a physical asset is acquired for nil or nominal consideration the fair value of the asset received is recognised as revenue in the Statement of Comprehensive Income.

18. Interest Expenditure

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.

19. Cost Allocation

SCDHB has arrived at the net cost of service for each significant activity using the following cost allocation system. Direct costs are charged directly to output classes. 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.

20. Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the Statement of Comprehensive Income over the period of the borrowings on an effective interest basis.

21. Trade and Other Payables

Trade and other payables are stated at amortised cost using the effective interest rate.

22. Other Liabilities and Provisions

Other liabilities and provisions are recorded at the best estimate of the expenditure required to settle the obligation. Liabilities and provisions to be settled beyond 12 months are recorded at their present value.

23. Financial Instruments

Financial Assets

Financial assets held for trading and financial assets designated at fair value through profit and loss are recorded at fair value with any realised and unrealised gains or losses recognised in the Statement of Comprehensive Income. A financial asset is designated at fair value through profit and loss if acquired principally for the purpose of selling in the short term. It may also be designated into this category if the accounting treatment results in more relevant information because it either significantly reduces an accounting mismatch with related liabilities or is part of a group of financial assets that is managed and evaluated to fair value basis. Gains or losses from interest, foreign exchange and fair value movements are separately reported in the Statement of Comprehensive Income...

Available-for-sale financial assets are stated at fair value, with any resultant gain or loss, expected for impairment losses, recognised directly in equity. When these assets are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Loans and receivables are recognised initially at fair value plus transaction costs and subsequently measured at amortised cost using the effective interest rate method. Loans and receivables issued with duration less than 12 months are recognised at their nominal value, unless the effect of discounting is material. Allowances for estimated recoverable amounts are recognised when there is objective evidence that the asset is impaired. Interest, impairment losses and foreign exchange gains and losses are recognised in the Statement of Comprehensive Income.

Statement of Significant Accounting Policies

24. Standards issued but not yet effective

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

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, South Canterbury DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means South Canterbury DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, South Canterbury DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

25. Changes in Accounting Policies

There have been no changes in accounting policies during the financial year.

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2013
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	Budget 2013	Actual 2013	Actual 2012
Revenue	*1*	172,396	173,207	170,227
Other Operating Income	*2*	3,320	3,219	2,536
Finance Income	*4a*	1,363	1,530	1,331
Total Income		177,079	177,956	174,094
Employee Benefit Costs	*3*	56,808	55,121	54,786
Outsourced personnel and other services		7,908	9,247	9,122
Clinical supplies		8,851	9,163	8,983
Infrastructure and non-clinical expenses		11,543	11,445	10,811
Payments to non-DHB health providers		61,653	60,150	59,737
IDF Outflows		24,041	25,348	24,003
Depreciation and amortisation expense	*7*	3,388	3,069	3,190
Finance costs	*4b*	466	321	302
Capital charge	*5*	1,810	1,950	1,681
Other operating expenses	*6*	1,111	1,406	1,175
Total Expenses		177,579	177,220	173,790
NET SURPLUS (DEFICIT)		(500)	736	304
Other Comprehensive Income *Item that will not be reclassified to surplus/(deficit)*				
Revaluation of land and buildings		-	-	-
Fair value through other comprehensive income financial assets		-	-	-
Total Other Comprehensive Income		-	-	-
TOTAL COMPREHENSIVE INCOME		(500)	736	304

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

STATEMENT OF MOVEMENTS IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2013
IN THOUSANDS OF NEW ZEALAND DOLLARS

		Budget 2013	Actual 2013	Actual 2012
Balance at 1 July 2012		25,815	25,616	25,511
Comprehensive income/(expense)				
Net Surplus/(Deficit) for the period	9	(500)	736	304
Other Comprehensive Income	9	-	-	-
Total comprehensive income		(500)	736	304
Capital Movements				
Repayment to Crown	9	(205)	(216)	(217)
Contribution from Crown	9	-	-	18
Movement in Special Funds	9	(30)	-	-
Total of Capital Movements		(235)	(216)	(199)
Balance at 30 June 2013		25,080	26,136	25,616

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

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2013
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	Budget 2013	Actual 2013	Actual 2012
Public Equity				
General Funds	9	4,710	4,705	4,921
Retained Earnings	9	9,574	11,324	9,931
Equity from Donated Assets	9	995	861	963
Revaluation Reserve	9	9,246	9,246	9,246
		24,525	26,136	25,061
Special Funds	9	555	-	555
Total Equity		25,080	26,136	25,616
REPRESENTED BY:				
ASSETS				
Current Assets				
Cash and cash equivalents	10	1,267	19,292	12,613
Financial Assets	11	6,000	-	5,000
Debtors and other receivables	12	5,470	4,807	5,156
Inventories	13	943	920	924
Patient Trust Funds	10	25	31	25
Special Fund Assets	9	555	-	556
Total Current Assets		14,260	25,050	24,274
Non Current Assets				
Financial Assets	11	12,781	12,778	12,781
Property, plant and equipment	7	38,659	31,839	28,220
Intangible assets	8	1,395	532	600
Total Non Current Assets		52,835	45,149	41,601
TOTAL ASSETS		67,095	70,198	65,875
LIABILITIES				
Current Liabilities				
Creditors and other payables	14	12,988	12,985	11,342
Employee entitlements	15	10,029	10,265	9,659
Borrowings	16	12,778	-	-
Finance Lease Liability	17	-	169	-
Patient Trust Funds	10	25	31	25
Total Current Liabilities		35,820	23,450	21,026
Non Current Liabilities				
Term Loans	16	-	12,778	12,778
Finance Lease Liability	17	-	1,350	-
Employee Entitlements	15	6,195	6,485	6,455
Total Non Current Liabilities		6,195	20,613	19,233
TOTAL LIABILITIES		42,015	44,063	40,259
NET ASSETS		25,080	26,136	25,616

STATEMENT OF CASHFLOWS
FOR THE YEAR ENDED 30 JUNE 2013
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	Budget 2013	Actual 2013	Actual 2012
CASH FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Ministry of Health & Other		175,976	176,490	174,434
Interest Received		951	1,530	1,331
		176,927	178,020	175,765
Cash was applied to:				
Payments to suppliers & employees		170,756	169,464	169,980
Capital Charge		1,950	1,950	1,681
Interest Paid		316	321	302
GST (net)		-	(153)	159
		173,022	171,582	172,122
Net cash inflow/(outflow) from operating activities	*17*	3,905	6,438	3,643
CASH FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from the sale of assets		-	25	11
Proceeds from Sale of Investment			4	-
Term Deposits over 3 months		7,000	5,000	10,000
Decrease in Special Funds		-	555	-
		7,000	5,584	10,011
Cash was applied to:				
Purchase of fixed assets		12,437	4,958	2,350
Term Deposits over 3 months			-	17,778
Increase in Special Funds		-	-	3
		12,437	4,958	20,131
Net cash inflow/(outflow) from investing activities		(5,437)	626	(10,120)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
New Borrowings - CHFA		-	-	12,796
New Finance Lease		-	-	-
Proceeds from Equity injections		-	-	-
		-	-	12,796
Cash was applied to:				
Repayment of loans		-	-	10,000
Finance Lease repayment		-	169	-
Repayment of Equity		205	216	217
		205	385	10,217
Net cash inflow/(outflow) from financing activities		(205)	(385)	2,579
Net increase/(decrease) in cash held		(1,737)	6,679	(3,898)
Opening cash and cash equivalents		3,004	12,613	16,511
Closing cash and cash equivalents	10	1,267	19,292	12,613
Made up of:				
Balances at bank		1,267	19,292	12,613

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.

NOTES TO THE FINANCIAL STATEMENTS
AS AT 30 JUNE 2013
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Actual 2013	Actual 2012
1. Revenue		
Health & Disability Services (MoH contracted Revenue)	164,712	161,237
ACC Contracted Revenue	1,602	1,732
Inter District Patient Inflows	4,352	4,770
Other Health Revenue	2,541	2,488
	173,207	170,227
2. Other Operating Income		
Gain on sale of property, plant and equipment	1	17
Donations and bequests received	1,245	1
Rental Income	134	163
Other Non-health Revenue	1,839	2,355
	3,219	2,536
3. Employee benefit costs		
Wages and salaries	53,613	52,389
Contributions to defined contribution plans	872	897
Increase /(decrease) in employee benefit provisions	636	1,500
	55,121	54,786

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

4a Finance income		
Interest Income	1,530	1,331
	1,530	1,331
4b Finance costs		
Interest Expense	321	302
	321	302

5. Capital charge

South Canterbury DHB pays a monthly capital charge to the Crown based on the greater of its actual or planned closing equity balance for the month. An annual washup adjustment is done after 30 June each year. The capital charge rate for the year ended 30 June 2013 was 8% (2012: 8%).

6. Other operating expenses

Fees to Auditor:		
Audit fees for financial statement audit	110	105
Directors' fees and expenses	311	284
Impairment of receivables (bad & doubtful debts)	23	14
Write down of inventory	69	85
Operating Lease Expense	893	687
	1,406	1,175

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.

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2013

IN THOUSANDS OF NEW ZEALAND DOLLARS EXCEPT WHERE OTHERWISE INDICATED

7. Property, plant and equipment

	Land	Buildings	Plant & equipment	Leased Assets	Motor vehicles	Work in Progress	TOTAL
Cost or Valuation							
Balance at 1 July 2011	2,463	21,660	22,723	-	1,530	402	48,778
Additions	-	100	1,893	-	113	(393)	1,713
Revaluations	-	-	-	-	-	-	-
Disposals	-	-	(317)	-	-	-	(317)
Balance at 30 June 2012	2,463	21,760	24,299	-	1,643	9	50,174
Balance at 1 July 2012	2,463	21,760	24,299	-	1,643	9	50,174
Additions	-	1,595	3,144	1,686	173	(9)	6,589
Revaluations	-	-	-	-	-	-	-
Disposals	-	(0)	(0)	-	(48)	-	(48)
Balance at 30 June 2013	2,463	23,355	27,443	1,686	1,768	-	56,715
Accumulated depreciation and impairment losses							
Balance at 1 July 2011	-	-	17,941	-	1,362	-	19,303
Depreciation expense	-	1,235	1,645	-	80	-	2,960
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	(309)	-	-	-	(309)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2012	-	1,235	19,277	-	1,442	-	21,954
Balance at 1 July 2012	-	1,235	19,277	-	1,442	-	21,954
Depreciation expense	-	1,267	1,558	42	77	-	2,944
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	-	-	(23)	-	(23)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2013	-	2,502	20,835	42	1,496	-	24,875
Carrying amounts							
At 1 July 2011	2,463	21,660	4,782	-	168	402	29,475
At 30 June and 1 July 2012	2,463	20,525	5,022	-	201	9	28,220
At 30 June 2013	2,463	20,853	6,607	1,644	272	-	31,839

Impairment

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

A seismic assessment of the land and buildings was obtained in February 2012. Further information is being sought on the costs of bringing the DHB's buildiings up to current standards. Crighton Anderson, who are qualified property infrastucture valuers, advise that a current valuation of the land and buildings is not materially different from the valuation carried out in 2011 and that no further adjustment for impairment is required in 2013.

Valuation

Land and Buildings were valued to fair value as at 30 June 2011 by an independent registered valuer, John Dunckley, of Darroch Ltd a Fellow of the Property Institute and Institute of Valuers of New Zealand. The total fair value of land and buildings valued by the valuer amounted to $24,122,652 as at 30 June 2011. The valuation conforms to International valuation standards and was based on an optimised depreciation 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 nagative effect on the value of the land where an owner is unable to use the land more intensely.

Restrictions on the DHB'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 value 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 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 DHB'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.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specilised 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.

Restrictions on title

South Canterbury District Health Board does not have full title to Crown land it occupies, but transfer is arranged if and when land is sold. Some of the Board'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 SCDHB 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 Treaty of Waitangi Act 1975 cannot be quantified.

8. Intangible Assets

	Software	Other	TOTAL
Cost			
Balance at 1 July 2011	892	-	892
Additions	667	-	667
Disposals	-	-	-
Balance at 30 June 2012	1,559	-	1,559
Balance at 1 July 2012	1,559	-	1,559
Additions	57	-	57
Disposals	-	-	-
Balance at 30 June 2013	1,616	-	1,616
Accumulated amortisation and impairment losses			
Balance at 1 July 2011	729	-	729
Amortisation expense	230	-	230
Disposals	-	-	0
Impairment losses	-	-	0
Balance at 30 June 2012	959	-	959
Balance at 1 July 2012	959	-	959
Amortisation expense	125	-	125
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2013	1,084	-	1,084
Carrying amounts			
At 1 July 2011	163	-	163
At 30 June and 1 July 2012	600	-	600
At 30 June 2013	532	-	532

There are no restrictions over the title of SCDHB's intangible assets, nor are any intangible assets pledged as security for liabilities. All software has been purchased.

9. Public equity

Reconciliation of movement in capital and reserves

	General funds	Retained earnings	Equity from donated assets	Revaluation reserve - land	Revaluation reserve - buildings	Special funds	Total equity
Balance at 1 July 2011	5,120	9,563	1,031	2,085	7,161	551	25,511
Surplus/(deficit)		304					304
Transfer from retained earnings		64	(68)			4	-
Revaluation of land and buildings							-
Contribution from the Crown	18						18
Repayment to the Crown	(217)						(217)
Balance at 30 June 2012	4,921	9,931	963	2,085	7,161	555	25,616
Balance at 1 July 2012	4,921	9,931	963	2,085	7,161	555	25,616
Surplus/(deficit)		736					736
Transfer from retained earnings		657	(102)			(555)	-
Revaluation of land and buildings					-		-
Contribution from the Crown	-						-
Repayment of equity	(216)						(216)
Balance at 30 June 2013	4,705	11,324	861	2,085	7,161	(0)	26,136

The unspent mental health ring-fence portion of retained earnings decreased to $0.375 million (30 June 2012: $0.492 million)

Special funds

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the Surplus/deficit. The transfers to and from Retained Earnings reflect these transactions.

All special funds are held in a bank account that is separate from SCDHB's normal banking facilities.

	2013 Actual	2012 Actual
Opening Balance	555	551
Transfer from Retained Earnings in respect of:		
Funds Received		
- Interest Received	12	4
- Donations and Other	1,245	1
Transfer to Retained Earnings in respect of:		
- Funds spent	(1,812)	(1)
Closing Balance 30 June	-	555

10. Cash and cash equivalents

	Actual 2013	Actual 2012
Cash on hand and at bank	19,292	613
Cash equivalents - term deposits	0	12,000
Total cash and cash equivalents	19,292	12,613

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

SCDHB administers certain funds on behalf of patients. These funds are held in a separate bank account and total $31,000 (2012: $25,000)

11. Investments

Current investments are represented by:

Term deposits	0	5,000
Total current portion	0	5,000

Non-current investments are represented by:

Term deposits	12,778	12,778
Equity investment - SISSAL Share Capital	0	3
Total non-current portion	12,778	12,781
Total Investments	12,778	17,781

There were no impairment provisions for investments.

The DHB had an equity investment in South Island Shared Service Agency Limited (SISSAL). During the year SISSAL completed a buy back of 50% of it's shares. The resultant gain is recognised in the Statement of Comprehensive Income. SISSAL has ceased to be active and the remaining shares are deemed to have no value.

Maturity analysis and effective interest rates of term deposits
SCDHB maintains deposits on call with Health Benefits Limited at variable rates of interest and these are measured at cost.

Two term deposits have been taken for a term longer than 12 months. The deposits mature on 8 June 2015 and have an effective average interest rate of 5.01%.

The carrying amounts of call and term deposits approximate their fair value.

12. Debtors and other receivables

	Actual 2013	Actual 2012
Trade Debtors	1,077	1,090
Less: Provision for impairment	(29)	(13)
	1,048	1,077
Accrued Income	3,565	3,844
Prepayments	194	235
Total receivables & prepayments	4,807	5,156

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	(13)	(2)
Additional provisions made	(29)	(13)
Receivables written off	0	0
Recovery of amounts already provided	13	2
Balance at 30 June	(29)	(13)

13. Inventories

Pharmaceuticals	389	372
Theatre supplies	427	451
Central stores	29	32
Other supplies	75	69
Total inventories	920	924

The write-down of inventories held for distribution amounted to $68,000 (2012: $84,000). 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

Trade creditors	2,221	1,099
Capital Charge due	70	44
Income in advance	170	395
Accrued expenses	10,524	9,804
Total Payables and Accruals	12,985	11,342

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

Current employee entitlements are represented by:

Accrued salaries and wages	2,852	2,702
Annual Leave	5,871	5,414
Maternity Leave	0	0
Sick Leave	139	117
Retirement Gratuities	661	735
Senior Doctor Conference Leave	144	108
Senior Doctor Sabbatical Leave	54	32
Long Service Leave	247	265
Senior Doctor Study Costs	297	286
Total current portion	10,265	9,659

Non-current employee entitlements are represented by:

Sick Leave	319	330
Retirement Gratuities	3,772	3,795
Senior Doctor Conference Leave	288	215
Senior Doctor Sabbatical Leave	556	575
Long Service Leave	956	968
Senior Doctor Study Costs	594	572
Total non-current portion	6,485	6,455
Total employee entitlements	16,750	16,114

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 2013 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.

16. Borrowings

	Actual 2013	Actual 2012
Current borrowings are represented by:		
Secured loan - Crown Health Financing Agency (CHFA)	0	12,778
Total current portion	0	12,778
Current portion	-	-
Non current portion	12,778	12,778
	12,778	12,778
Repayable as follows:		
Not later than one year	-	-
Later than one, not later than two years	-	-
Later than two, not later than five years	12,778	12,778
Beyond five years	-	-
	12,778	12,778
Interest rates:		
Crown Health Financing Agency interest rates	2.50%	2.50%

The CHFA received a negative pledge from SCDHB. Without the CHFA's prior written consent, SCDHB cannot perform the following actions:

a. Security Interest: Create any security interest over its assets except in certain defined circumstances or

b. Loans and Guarantees: Lend money to another person (except in the ordinary course of business and then only on commercial terms), or give a guarantee, or

c. Change of Business: Make a substantial change in the nature or scope of its business as presently conducted, or

d. Disposals: Dispose of any of its assets except disposals made in the course of its ordinary business or disposals for full year value.

Borrowing facilities:

SCDHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan, inclusive of GST. For SCDHB that equates to $13.4M.

17. Finance Lease Liability

Finance lease liabilities are payable as follows:

	Actual 2013	Actual 2012
Not later than one year	169	-
Later than one year and not later than five years	675	-
Later than five years	675	-
Total present value of minimum lease payments	1,519	-
Current portion	169	-
Non current portion	1,350	-
Total present value of minimum lease payments	1,519	-

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

Description of finance lease arrangements
The DHB has entered into a lease with Aoraki MRI Charitable Trust for the provision on an MRI scanner. The lease is for a period of ten years from April 2013 and no interest or finance charges are payable.

18. Reconciliation of net surplus/(deficit) to net cash from operating activities

	Actual 2013	Actual 2012
Net surplus/(deficit)	736	304
Add/(less) non-cash items:		
Depreciation and amortisation expense	3,069	3,169
Total non cash items	3,069	3,169
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	348	328
(Increase)/decrease in inventories	4	(53)
Increase/(decrease) in payables and accruals	1,645	(1,591)
Increase/(decrease) in employee entitlements	636	1,497
Net working capital movement	2,633	181
Add/(less) movements in other items:		
Gain(Loss) on sale of fixed assets	-	(11)
	-	(11)
Net cash (outflow)/inflow from operating activities	6,438	3,643

19. Capital Commitments and Operating Leases

	Actual 2013	Actual 2012
Capital Commitments		
Property, plant and equipment	-	267
Intangible assets	-	-
Total Capital Commitments	-	267

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 2013	Actual 2012
Not later than one year	631	719
Later than one year and not later than five years	1,073	1,004
Later than five years	172	378
Total Non-cancellable Operating Leases	1,876	2,101

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

20. Contingencies

Contingent Liabilities

Superannuation Schemes

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

As at 31 March 2012, the Scheme had a past surplus of $19.833 million (exclusive of Employer Superannuation Contribution Tax). This surplus was calculated using a discount rate equal to the expected return on net assets, but otherwise the assumptions and methodology were consistent with the requirements of NZ IAS 19.

The actuary of the Scheme has recommended that the employer contributions be suspended with effect from 1 April 2013.

Lawsuits against the DHB

There were outstanding legal claims against the DHB at year end. The DHB disputes these claims by third parties and there is uncertainty as to what any legal judgement may be. The DHB believes that any court award will be met by its insurers.

Contingent Assets

The DHB has no contingent assets (2012 $nil).

21. HSC Charitable Trust

SCDHB's predecessor was the settlor of HSC Charitable Trust (the "Trust") and the Board has the right to appoint one of four trustees. The Trust is therefore deemed to be controlled by SCDHB in accordance with NZ IAS 27. The purposes of the Trust are:

- To purchase and maintain facilities and equipment for use in the Timaru and Talbot Hospitals.
- To actively foster, promote, encourage and develop the continuing education of health professionals working at or from Timaru or Talbot Hospitals in whatever area and in whichever manner the trustees may time to time decide.
- To fund, foster, promote and encourage medical research and clinical quality assurance by health professionals at Timaru and Talbot Hospitals.

The Trust has not been consolidated. For the year ended 30 June 2013, the Trust had total revenue of $12,020 (2012 $19,477) and a net deficit of $68,969 (2012 net surplus $3,069). The Trust had assets of $159,044 (2012 $233,009) and liabilities of $2,924 (2012 $7,198) as at 30 June 2013.

22. Related party transactions and key management personnel

South Canterbury District Health Board is a wholly owned entity of the Crown. The Government significantly influences the role of the Board as well as being its major source of revenue.

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

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

Shared Support Services

South Island Shared Services Agency Limited has been set up by all South Island DHBs to provide shared support services to funder operations.

South Canterbury District Health Board did not make any payments to South Island Shared Services Agency Limited during the year (2012 $52,103). The balance outstanding at year end was $nil (2012 $nil).

HSC Charitable Trust

During the year ended 30 June 2013 the DHB invoiced the Trust a total of $1,154 (2012 $3,262) for costs associated with research trials. The balance outstanding at year end was $nil (2012 $nil).

Key management personnel

Key management personnel include all Board members, the Chief executive, and the other five members of the management team.

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

- Murray Cleverley is a director of DHBNZ which had provided annual plan and project management services to SCDHB. During the year there were no transactions (2012; $19,330).

- 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. During the year 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.

- Nicola Hornsey is a board member of Presbyterian Support. Presbyterian Support South Canterbury Inc provide aged care, home support, meals on wheels and other services to the SCDHB to the value of $7.02 million (2012 $6.68million).

- Rene Crawford was employed by SCDHB as a casual staff physiotherapist on terms and conditions that were no more favourable than the DHB would have adopted if she was not a member of the Board.

- The wife of Paul Annear, a Board member, is the incumbent Mayor of Timaru District. During the year SCDHB paid Timaru District Council for rates and other municipal services to the value of $116,412 (2012 $108,770)

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

No provision has been required, nor any expense recognised for impairment of receivables from related parties (2012 nil).

Key management personnel compensation

	Actual 2013	Actual 2012
Salaries and other short-term employee benefits	2,099	1,879
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	-
Total key management personnel compensation	2,099	1,879

23. Board Member Remuneration and Committee Member Payments

Board Members Payments & Attendance

Member	Fees Paid	Attendance
Paul Annear	$16,000	9
Peter Binns	$16,000	11
Murray Cleverley (chairperson)	$32,000	10
Rene Crawford	$16,000	11
Nicola Hornsey	$16,000	10
Warwick Isaacs	$16,000	6
Terry Kennedy	$16,000	11
Ron Luxton (deputy chair)	$20,000	11
Peter Lyman	$16,000	11
Ngaire Whytock	$16,000	11
TOTAL	$180,000	

The Board met 11 times in 2012/13.

Committee Members Payments

Member	Fees Paid
Paul Annear	$5,000
Jan Beck-Manawatu	$417
Peter Binns	$5,000
John Christie	$6,000
Murray Cleverley	$12,500
Michael Cotton	$2,083
Rene Crawford	$5,000
Peter Dalziel	$2,083
Raeleen De Joux	$2,500
Suzanne Eddington	$3,333
Janet Gilbert	$1,667
Tony Gilchrist	$1,667
Nicola Hornsey	$5,625
Warwick Isaacs	$5,625
David Jack	$2,083
Terence Kennedy	$5,000
Ronald Luxton	$5,625
Peter Lyman	$5,625
Christine Miller	$2,500
Diane Nutsford	$1,667
David Sibley	$13,216
Koriana Waller	$3,750
Ngaire Whytock	$3,125
Vivien Wood	$1,667
Kathleen Wright	$1,250
	$104,008

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 Payments

During the year ended 30 June 2013, one employee (2012: nil) received compensation and other benefits in relation to the cessation of their employment. No Board members received compensation or other benefits in relation to cessation of employment (2012: nil).

24. Employee remuneration

Range	Actual 2013	Actual 2012
$350,001 - $360,000	1	
$340,001 - $350,000		1
$330,001 - $340,000	1	3
$320,001 - $330,000	3	1
$310,001 - $320,000	1	2
$300,001 - $310,000	6	2
$290,001 - $300,000	1	5
$280,001 - $290,000	4	2
$270,001 - $280,000	2	1
$260,001 - $270,000	3	2
$250,001 - $260,000	1	3
$240,001 - $250,000	3	2
$230,001 - $240,000	5	5
$220,001 - $230,000		4
$210,001 - $220,000	3	1
$200,001 - $210,000	1	
$190,001 - $200,000	1	
$180,001 - $190,000	3	3
$170,001 - $180,000	1	1
$160,001 - $170,000		1
$150,001 - $160,000		
$140,001 - $150,000	3	
$130,001 - $140,000	3	1
$120,001 - $130,000	2	9
$110,001 - $120,000	4	1
$100,001 - $110,000	18	16
TOTAL	70	66
Clinical staff	56	52
Management and other staff	14	14

The current Chief Executive's salary is in the $290,001 to $300,000 range.

25. 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 activites. Its policies do not allow any transactions which are speculative in nature to be entered into.

Market risk

The interest rates on SCDHB's cash and investments are disclosed in notes 10 and 11. Interest rates on borrowings are disclosed in note 16.

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 2013, 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 $92,000 (2012 $60,000) 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. The sensitivity is higher in 2013 than 2012 because of overall higher interest rates receivable on consolidation of funds..

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 2013 (30 June 2012 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 Board 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:

	2013	2012
Cash at bank and term deposits	19,323	18,193
Debtors and Other Receivables	4,807	5,156
	24,130	23,349

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 95% (2012: 95%) 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.

	2013	2012
Cash at bank and term deposits		
Counterparties with Credit Ratings		
AA rating	-	18,193
Counterparties without Credit Ratings	19,323	-
Total cash at bank and term deposits	19,323	18,193

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

	Gross Receivables 2013	Impairment 2013	Gross Receivables 2012	Impairment 2012
Trade receivables				
Not past due	923		767	
Past due 0-30 days	88		110	
Past due 31-120 days	66	29	213	13
Past due 121-365 days				
Past due more than 1 year				
Total	1,077	29	1,090	13

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

	Carrying amount	Contractual cash flows	Less than 1 year	More than 1 year
2013				
Creditors and other payables	12,985	12,985	12,985	0
Borrowings	12,778	12,778	0	12,778
Total	25,763	25,763	12,985	12,778
2012				
Creditors and other payables	11,342	11,342	11,342	0
Borrowings	12,778	12,778	0	12,778
Total	24,120	24,120	11,342	12,778

Classification and fair values

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

2013	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
Financial Assets					
Cash and cash equivalents	10	19,292		19,292	19,292
Term Deposits >3 <12 months	11	0		0	0
Term Deposits >12 months	11	12,778		12,778	12,778
Trade and other receivables	12	4,807		4,807	4,807
Special Funds	9	0		0	0
Patient Trust Funds	10	31		31	31
Equity investments	11	-	0	0	0
		36,908	0	36,908	36,908
Financial Liabilities					
Trade and other payables	14	12,985		12,985	12,985
Patient Trust Funds	10	31		31	31
Loan from CHFA	16	12,778		12,778	12,778
Finance Lease Liability	17	1,519		1,519	1,519
		27,313	0	27,313	27,313

2012	Note	Amortised Cost	Available for sale	Carrying amount Actual	Fair Value Actual
Financial Assets					
Cash and cash equivalents	10	12,613		12,613	12,613
Term Deposits >3 <12 months	11	5,000		5,000	5,000
Term Deposits >12 months	11	12,778		12,778	12,778
Trade and other receivables	12	5,156		5,156	5,156
Special Funds	9	555		555	555
Patient Trust Funds	10	25		25	25
Equity investments	11	-	3	3	3
		36,127	3	36,130	36,130
Financial Liabilities					
Trade and other payables	14	11,342		11,342	11,342
Patient Trust Funds	10	25		25	25
Loan from CHFA	16	12,778		12,778	12,778
		24,145	0	24,145	24,145

26. 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.

27. Post balance date events

There were no significant post balance day events of which the Board is aware.

28. Explanation of significant variances against budget
Explanations for significant variations from SCDHB's budgeted figures in the Statement of Intent are as follows:

Revenue was greater than budgeted by $877K due to additional revenue input from the Ministry of Health. Significant increases include, including Personal General Practitioners ($612K) and Personal Pharmaceuticals $258K).

Employee benefit costs were less than budget by $1.687M. Outsourced Personnel were $1.339M over budget which partially off set the employee benefit under budget costs.

Outsourced Personnel were $1.339M over budget, including $579K Senior Medical Officers and $194K for Junior Medical Staff. There were also expenses over budget for Community Workers ($126K), Treatment Services ($192K) and Diagnostic Services ($214K).

Clinical supplies were $312K greater than budget. Patient Transport costs were $342K greater than budget due to demand.

Payments to non-DHB Health Providers were $1.530M lower than budget, including Pharmaceuticals ($817K), Home Support ($524K), Mental Health ($252K) and Miscellaneous Services ($646K). Amounts greater than budget included Primary Practice Services ($745K), Alchohol and Drug ($352K) and Residential Care ($433K).

Inter District (IDF) Outflows were $1.307M greater than budget.
Other Operating Costs were $295K greater than budget largely due to increased lease costs of property and equipment.

SUMMARY OF REVENUE AND EXPENSES BY OUTPUT CLASS 2012/2013

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Management		Treatment		Prevention		Support & Rehabilitation		Total	
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Revenue	43,399	42,999	102,571	102,419	3,471	3,471	27,276	27,187	176,078	176,078
									1,245	
Total Revenue	43,399	42,999	102,571	102,419	3,471	3,471	27,276	27,187	177,955	176,078
Expenditure										
Funder Arm	33,466	34,944	28,554	27,616	1,542	1,665,	21,767	21,468	85,329	85,693
Provider Arm	7,785	7,598	73,402	73,066	1,574	1,739,721	5,950,000	5,441,174	88,709	87,845
Governance	792	757,023	1,817	1,737	69,432	66,354	501,708	478,507	3,180	3,038
Total Expenditure	42,043	43,299	103,773	102,419	3,185	3,471	28,218	27,387	177,218	176,578
Surplus/(Deficit)	1,356	(300,000)	(1,202,394)	0	285,873	(0)	(951,027)	(200,000)	736,106	(500,000)

Good Employer

Leadership, Accountability and Culture
Our leadership, working collaboratively within SCDHB and with other DHBs is key to providing direction and to ensure more patient focussed service delivery. Improving clinical leadership and the integration of Primary and Secondary Care has and will continue to make a positive contribution in this regard. Clinical Governance is now established, strengthening its contribution to patient safety and oversight of clinical practice. The organisation is also continuing its structured approach to develop current and future clinical leaders.

Recruitment, Selection and Induction
SCDHB is implementing the actions of our Workforce Strategy Plan to support the attraction and retention of staff and the building of capability as a priority. Initiatives are now established to encourage South Canterbury youth to choose a health career that meets the future health workforce needs and to support the on-going inclusion of the older workforce. We also support the development of regional and national relationships to improve recruitment efforts and to establish a public health employer brand.

Equal Employment Opportunities
We value the contribution a diverse workforce with different skills, experiences and perspectives makes and this is reflected in our approach to recruitment and the work environment we provide.

Safe and Healthy Environment
SCDHB aims to maintain a safe and healthy environment and therefore participates in the ACC Workplace Safety Management Practices Programme.

SCDHB follows a pro-active strategic approach to employee health by providing a number of initiatives to enable staff to understand and improve their own health. We have continued with our Health4You programme targeting improved nutrition and encouraging physical activity over the past year. Workshops were held for managers to identify the organisational and other barriers to healthy nutrition for staff. A recent employee survey of past activities will inform future programme development. Activities with a social context e.g. team building and employee resilience will be promoted.

The organisation does not tolerate any form of harassment or workplace bullying and ensures all staff are aware of policies and procedures to deal with such a situation. The team formed to improve policy and procedures are continuing to communicate the process and support available to all employees encouraging the building of a healthy supportive workplace environment..

SCDHB has implemented a software solution and will be implementing a workload acuity process under the Safe Staffing and Healthy Workplaces agenda in collaboration with the unions.

Remuneration and Recognition
We endeavour to remunerate all staff fairly and consistently, SCDHB is developing and implementing initiatives which enable staff to feel more valued and appreciated in an informal and formal way.

Employee Development
Our performance review process provides a means for two-way communication whereby all employees review their performance, progress career development 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.

We have recently reviewed our learning and development strategy to ensure that it aligns with strategic planning, workforce development and operational requirements and encourages a continuous learning culture.

Flexibility and work design
The changing models of care, service delivery pressures and increased focus on productivity and sustainability resulted in the development of new positions interacting with various disciplines across primary and secondary services. For individuals who require flexible working arrangements SCDHB has a formal request process based on the Act for employees with caring responsibilities and other individual requests for flexibility are considered on a case by case basis. Currently 31% of staff are full-time employees, 50% are part-time and 19% are casual.

WORKFORCE AT JULY 1, 2013

Staff Ethnicity	Number
African	9
American	2
Asian Undefined	1
Australian	2
British/Irish	29
Chinese	4
Cook Island Māori	2
Dutch	1
European Undefined	74
Fijian	1
Filipino	6
German	1
Indian	5
Latin American	2
Middle Eastern	7
Not Available	96
NZ European	615
NZ Māori	40
Object To This	3
Other	17
Other Asian	9
Other European	40
Southeast Asian	2
Sri Lankan	1
Tongan	1
TOTAL	**970**

Staff Mix by Gender	Number	Percentage
Female	815	84.02%
Male	155	15.98%
TOTAL	**970**	**100%**

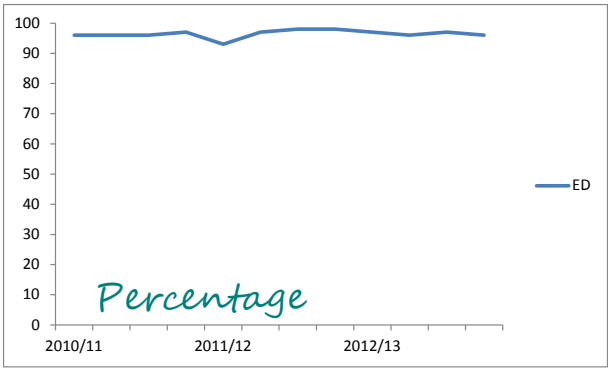
Staff Mix by Hours of Work (FTE)	Number	Percentage
Casual/Pool	192	19.79%
Less than 0.25FTE	14	1.44%
0.25 to 0.49 FTE	71	7.32%
0.5 to 0.74 FTE	196	20.21%
0.75 to 0.99 FTE	194	20.00%
1 FTE	303	32.24%
TOTAL	**970**	**100%**

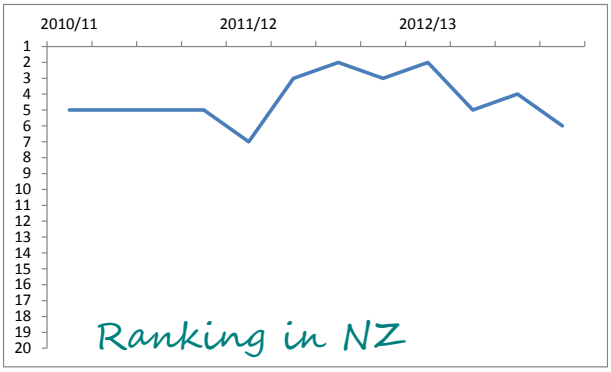
Staff Mix by Average Age	Age
Administration/Management	48.4
Allied Health	47.4
Medical	45.3
Nursing	46.2
Support Personnel	48.2
Average age of all staff	46.7

Shorter Stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2010/11	96	5th
Q2	96	5th
Q3	96	5th
Q4	97	5th
Q1 2011/12	93	7th
Q2	97	3rd
Q3	98	2nd
Q4	98	3rd
Q1 2012/13	97	2nd
Q2	96	5th
Q3	97	4th
Q4	96	6th

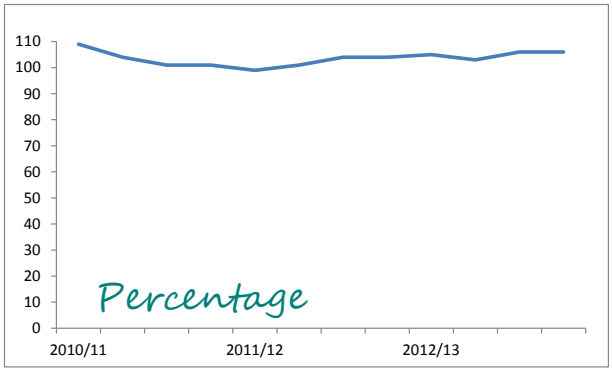




Improved Access to Elective Surgery

The target is an increase in the volume of elective surgery by an average of 4,000 discharges per year.

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2010/11	109	5th
Q2	104	6th
Q3	101	14th
Q4	101	14th
Q1 2011/12	99	17th
Q2	101	13th
Q3	104	11th
Q4	104	13th
Q1 2012/13	105	13th
Q2	103	14th
Q3	106	10th
Q4	106	10th

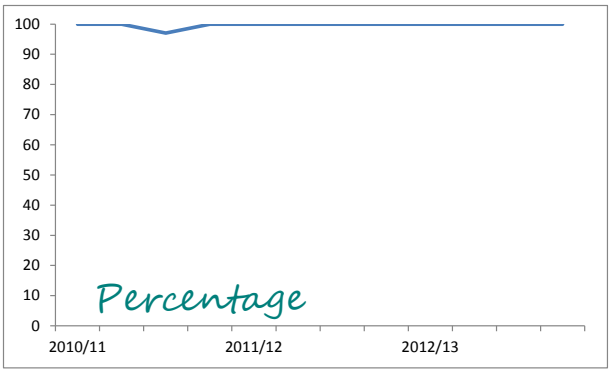


This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

Shorter Waits for Cancer Treatment

The target is all patients, wait less than four weeks for radiotherapy or chemotherapy treatment. Six regional oncology centres provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

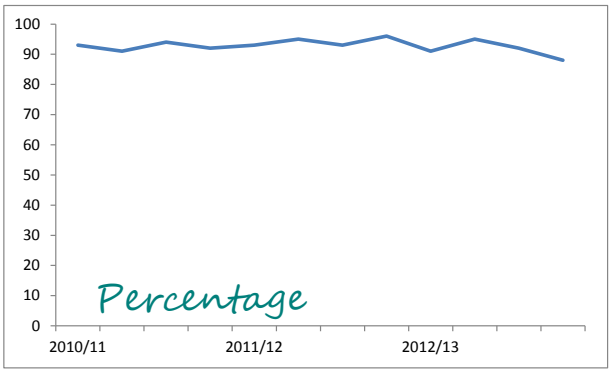
QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2010/11	100	1st
Q2	100	1st
Q3	97	16th
Q4	100	1st
Q1 2011/12	100	1st
Q2	100	1st
Q3	100	1st
Q4	100	1st
Q1 2012/13	100	1st
Q2	100	1st
Q3	100	1st
Q4	100	1st



Increased Immunisation

The national immunisation target is 85 percent of eight-month-olds will have their primary course of immunisation at six weeks, three months and five months on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014.

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2010/11	93	2nd
Q2	91	10th
Q3	94	2nd
Q4	92	2nd
Q1 2011/12	93	5th
Q2	95	1st
Q3	93	6th
Q4	96	1st
Q1 2012/13	91	6th
Q2	95	2nd
Q3	92	8th
Q4	88	16th

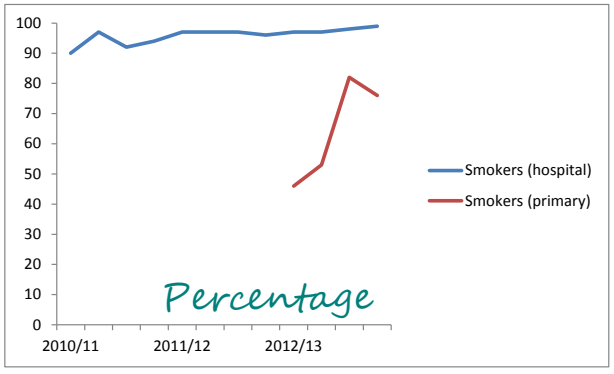


This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

Better Help for Smokers to Quit

The target is that 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.
*New primary care target was introduced for 2012/13.

QUARTER	PERCENTAGE OF PATIENTS (in hospitals) %	PERCENTAGE OF PATIENTS (in Primary Care) %	RANKING OUT OF 20 DHBs
Q1 2010/11	90		1st
Q2	97		1st
Q3	92		2nd
Q4	94		2nd
Q1 2011/12	97		3rd
Q2	97		2nd
Q3	97		2nd
Q4	96		9th
Q1 2012/13	97	46*	6th
Q2	97	53*	5th
Q3	98	82*	2nd
Q4	99	76*	3rd

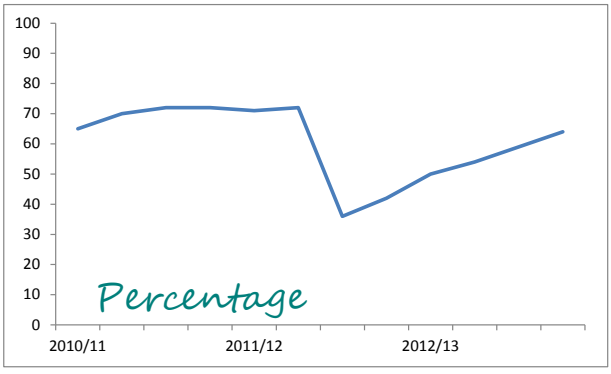


More Heart and Diabetes Checks

The target is that 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved in stages by July 2014. The target was 75% by June 2013.

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2010/11	65	20th
Q2	70	17th
Q3	72	15th
Q4	72	15th
Q1 2011/12	71	15th
Q2	72	17th
Q3	36*	18th
Q4	42*	17th
Q1 2012/13	50	17th
Q2	54	16th
Q3	59	15th
Q4	64	15th

*A new target was introduced in quarter three 2011/12.



This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

WHAT ARE WE TRYING TO ACHIEVE?

The mission statement of the South Canterbury District health Board (SCDHB) is "to enhance 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, will improve the efficiency and effectiveness of the whole South Canterbury health system.

Understanding the dynamics of our population and the drivers of demand is fundamental when determining which services to fund for our population and at which level. Just as fundamental is our ability to assess whether the services we are purchasing and providing are making a measureable difference in the health and wellbeing of our population.

This section provides an overview of the key elements of our outcomes framework. The South Island DHBs identified three strategic outcomes and a core set of associated outcome performance measures, at a population level, which demonstrate whether we are making a measurable positive change in the health of the South Island population of time:

PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH: The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing.

PEOPLE STAY WELL AND MAINTAIN THEIR FUNCTIONAL INDEPENDENCE: The development of primary and community-based services that provide early diagnosis and treatment, and support people to better manage enduring health conditions, reduce the complications of disease and injury and maintain functional independence in their own homes and communities.

PEOPLE RECOVER FROM COMPLEX ILLNESS AND / OR MAXIMISE THEIR QUALITY OF LIFE: The development of systems and models of care that free up secondary and specialist services to provide timely and appropriate complex care and advice to reduce the progression of illness, better support people's functional capacity and improve people's quality of life.

LONG-TERM OUTCOME MEASURES

Our aim is to make a measurable change over time rather than achieve a fixed target.

Outcome Goal

People are healthier & take greater responsibility for their own health.

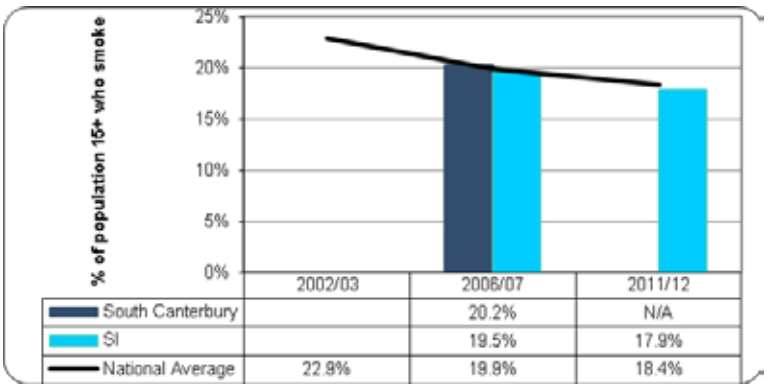
Outcome Measure

A reduction in smoking rates.

Comment

Results are taken from the NZ Health Survey and are not available at the SCDHB level. The prevalence of smoking in South Canterbury is expected to reflect the result for the South Island with a decline noted in 2011/12. Effective public messaging along with the successful implementation of patient screening and easy access to cessation support are contributing to this result.

The percentage of the population (15+) who smoke.



	2002/03	2006/07	2011/12
South Canterbury		20.2%	N/A
SI		19.5%	17.9%
National Average	22.8%	19.8%	18.4%

Statement of Service Performance

Outcome Goal

People stay well & maintain their functional independence.

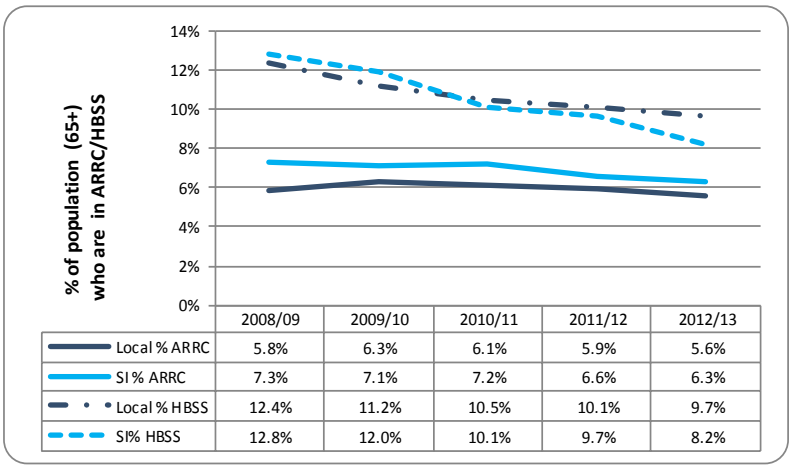
Outcome Measure

An increase in the proportion of the population supported to manage their long-term conditions & stay well.

Comment

Restorative Home Based Support Services (HBSS) are provided following a clinical needs assessment and are targeted to those people most able to 'age in place'. It is expected in out years as our population ages that HBSS will increase while Aged Related Residential Care (ARRC) services will increase at a slower rate. SCDHB will continue to develop its restorative community services to support people to remain in their own home e.g. allied health input and falls prevention programme helping people to remain as well as possible.

The percentage of the older population (≥65) living in ARRC compared against those receiving HBSS.



	2008/09	2009/10	2010/11	2011/12	2012/13
Local % ARRC	5.8%	6.3%	6.1%	5.9%	5.6%
SI % ARRC	7.3%	7.1%	7.2%	6.6%	6.3%
Local % HBSS	12.4%	11.2%	10.5%	10.1%	9.7%
SI% HBSS	12.8%	12.0%	10.1%	9.7%	8.2%

Outcome Goal

People stay well & maintain their functional independence.

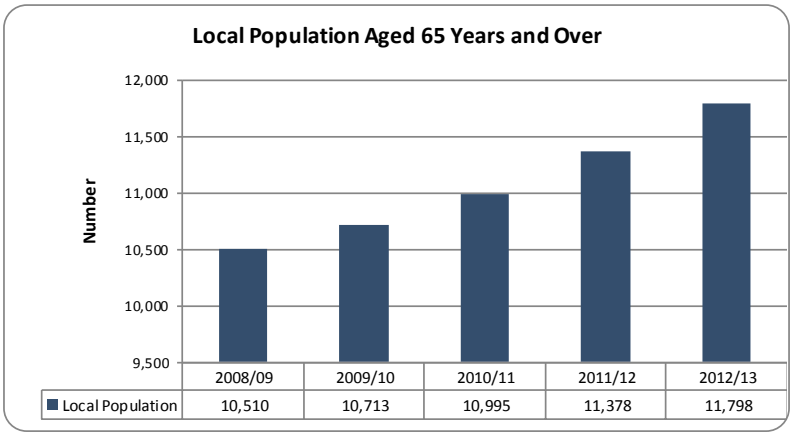
Outcome Measure

An increase in the proportion of the population aged over 65 supported to maintain functional independence.

Comment

There has been a steady increase in the number in our local population over the age of 65 years since 2008/09. This has been a major driver in the Centre of Excellence for Health of Older Persons project as our population becomes more elderly.

The number of the South Canterbury population aged ≥65.



	2008/09	2009/10	2010/11	2011/12	2012/13
Local Population	10,510	10,713	10,995	11,378	11,798

Outcome Goal

People recover from complex illness and / or maximise their quality of life.

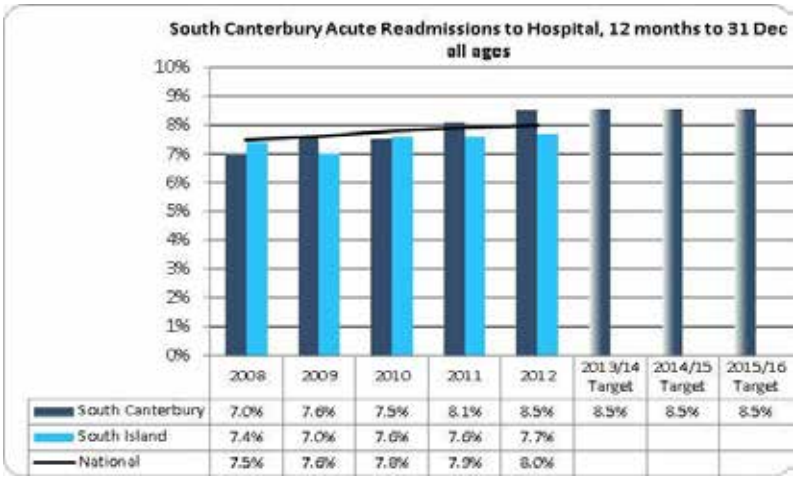
Outcome Measure

A reduction in acute (unplanned) readmissions to hospital and specialist services.

Comment

While SCDHB's result for 2012 is higher than both the National and South Island result work planned in 13/14 is expected to reduce this result significantly in out years. Targets are set each financial year as part of the planning cycle based on data provided by the MoH.

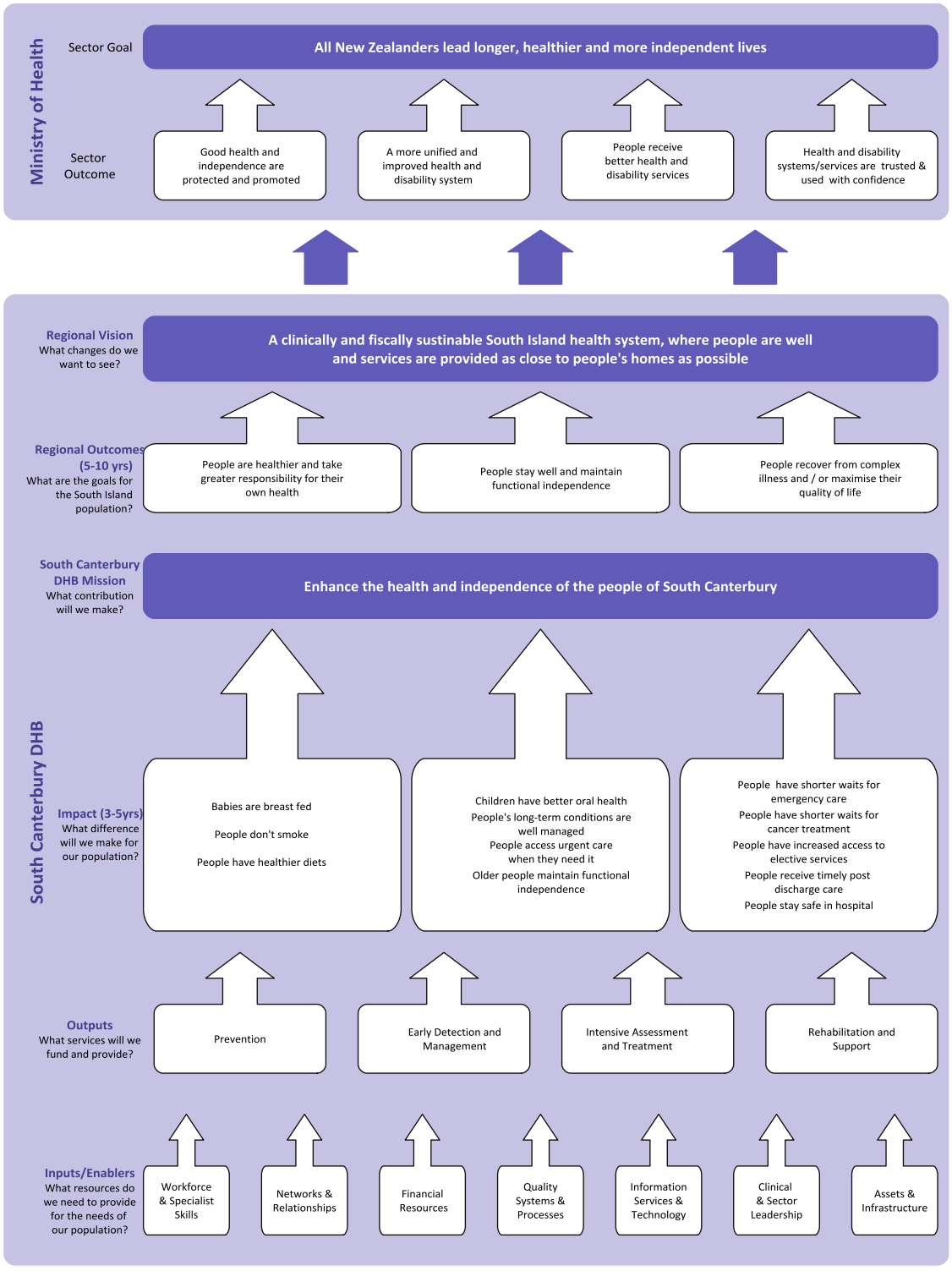
The planned Supportive Discharge Project is also expected to impact on performance as patients are discharged with appropriate services to support their recovery from an inpatient stay.



	2008	2009	2010	2011	2012	2013/14 Target	2014/15 Target	2015/16 Target
South Canterbury	7.0%	7.6%	7.5%	8.1%	8.5%	8.5%	8.5%	8.5%
South Island	7.4%	7.0%	7.6%	7.6%	7.7%			
National	7.5%	7.6%	7.8%	7.9%	8.0%			

Statement of Service Performance

The following intervention logic diagram visually demonstrates how these strategies goals and the outcomes we are seeking will contribute to the overarching sector goals of Government, and how the outputs we fund and provide to achieve these outcomes will have an impact on the health and wellbeing of the South Canterbury population. The intervention logic provides both a framework for the way we approach our work and a means of monitoring and demonstrating our success.



HOW HAVE WE PERFORMED?

MEDIUM-TERM IMPACT MEASURES

Eleven impact measures supporting the three strategic goals demonstrate where we can make 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. Performance results are broken down by ethnicity wherever possible to assess the impact our strategies and interventions are having on Māori Health.

South Canterbury District Health Board continues to perform steadily across the following selected impact measures. Comment relating to each measure has been included.

OUTCOME: PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Impact Goal

More babies are fully and exclusively breastfed.

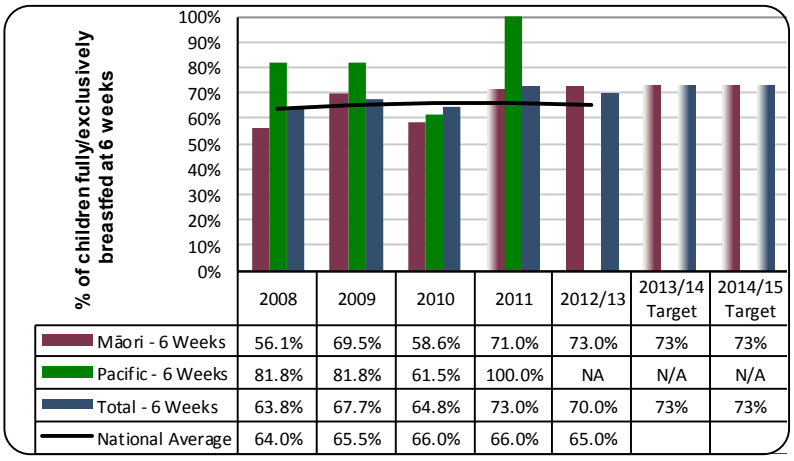
Comment

The timeframe for reporting this measure moved from a calendar year to a financial year in 2012/13 therefore the first six months of 2012 are not represented on this graph. Results for 2012/13 remain at or close to target and well above the national average. South Canterbury breast feeding promotion initiatives such as the "Big Latch On" and peer support programme have contributed to improved results from 5 years ago. SCDHB aims to hold this current level of performance in future years.

Data sourced from Plunket via the Ministry of Health.

Impact Measure

The percentage of South Canterbury babies fully/exclusively breastfed at 6 weeks.



	2008	2009	2010	2011	2012/13	2013/14 Target	2014/15 Target
Māori - 6 Weeks	56.1%	69.5%	58.6%	71.0%	73.0%	73%	73%
Pacific - 6 Weeks	81.8%	81.8%	61.5%	100.0%	NA	N/A	N/A
Total - 6 Weeks	63.8%	67.7%	64.8%	73.0%	70.0%	73%	73%
National Average	64.0%	65.5%	66.0%	66.0%	65.0%		

Impact Goal

Fewer young people take up tobacco smoking.

Comment

The expected national trend is an increase in the number of year 10 who have never smoked. Targets are set for the financial year as part of the planning cycle.

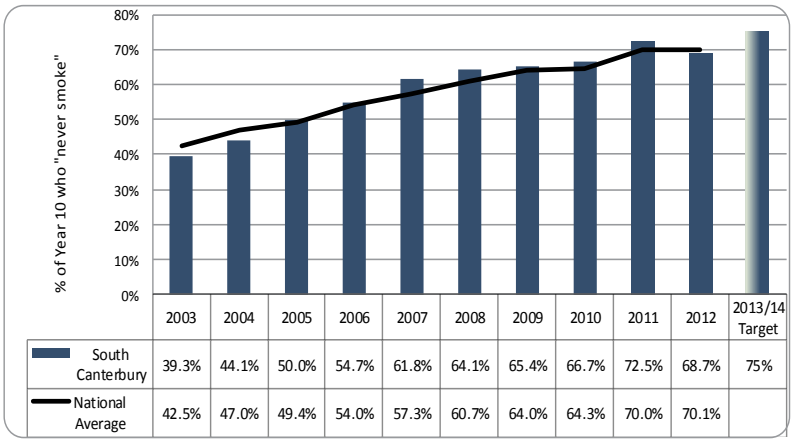
The total sample of South Canterbury students who participated in the national Year 10 ASH survey for 2012 was 265. This is a reduction of 55 from 2011 and 191 from 2009 and 2010. While the result for 2012 is slightly lower than 2011 it remains an improvement on the proceeding years.

Improved performance over the last 10 years is partially due to WAVE (Wellbeing & Vitality in Education: SCDHB's Intersectoral child & youth health project) of which smoke free is a key component.

Data sourced from national Year 10 ASH survey.

Impact Measure

The percentage of 'never smoked' among Year 10 South Canterbury students.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013/14 Target
South Canterbury	39.3%	44.1%	50.0%	54.7%	61.8%	64.1%	65.4%	66.7%	72.5%	68.7%	75%
National Average	42.5%	47.0%	49.4%	54.0%	57.3%	60.7%	64.0%	64.3%	70.0%	70.1%	

OUTCOME: PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Impact Goal

More children have good oral health.

Comment

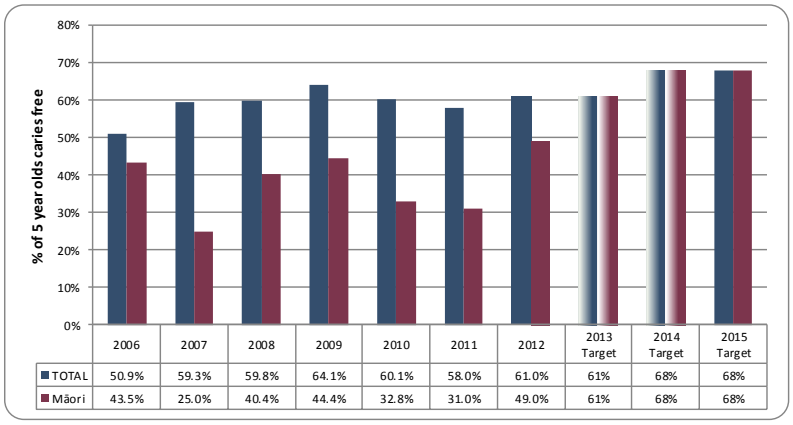
Steady progress continues to be made during 2012 in the area of child oral health especially for Māori where a significant improvement is noted. This is the result of improved targeting of this group and effective linkages with health promotion programmes.

The continued practice of applying fluoride vanish to children at high risk of decay is also expected to impact on results in future years.

Data sourced from Ministry of Health.

Impact Measure

The percentage of South Canterbury children caries-free (no holes or fillings) at age 5.



	2006	2007	2008	2009	2010	2011	2012	2013 Target	2014 Target	2015 Target
TOTAL	50.9%	59.3%	59.8%	64.1%	60.1%	58.0%	61.0%	61%	68%	68%
Māori	43.5%	25.0%	40.4%	44.4%	32.8%	31.0%	49.0%	61%	68%	68%

Impact Goal

People better manage their long-term conditions.

Comment

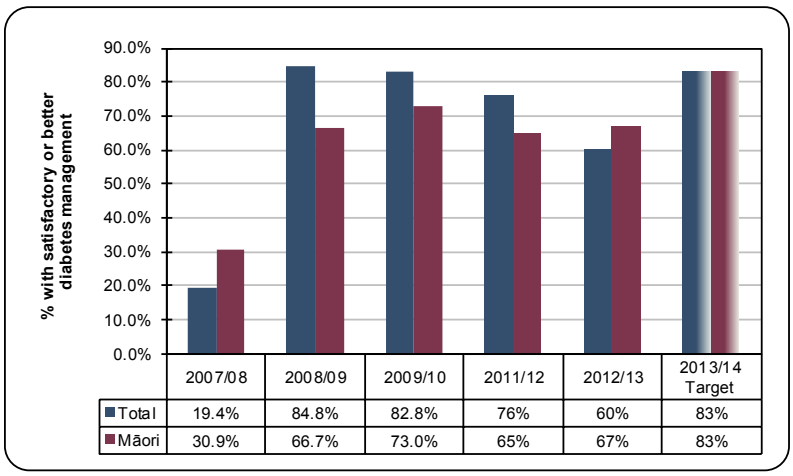
2012/13 saw a sharp decrease in the total number of people presenting for their annual diabetes review as the annual 'Get Checked' programme was no longer publicly funded. This reduced sample size may have impacted on the result for this period.

The SCDHB Diabetes Improvement Package includes a number of initiatives including the Encounter Programme which is a programme designed for newly diagnosed type 2 diabetes, those starting insulin therapy or those with poor metabolic control who need to re-engage with their general practice. This programme requires an annual diabetes review and will continue during 2013/14.

Data from SCDHB.

Impact Measure

The percentage of the South Canterbury population identified with diabetes with HbA1c≤64mmol/mol.



	2007/08	2008/09	2009/10	2011/12	2012/13	2013/14 Target
Total	19.4%	84.8%	82.8%	76%	60%	83%
Māori	30.9%	66.7%	73.0%	65%	67%	83%

Impact Goal

More people access care appropriate to their needs.

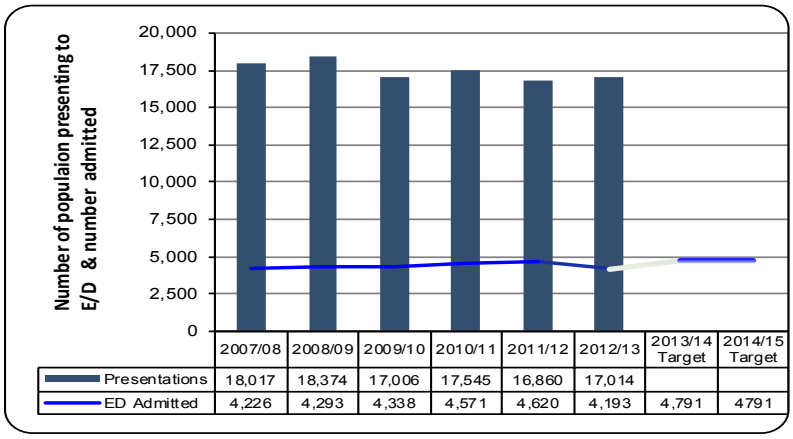
Comment

ED presentations at SCDHB remain relatively flat along with the ratio of admission arising from an ED presentation at 4:1. SCDHB tracks the number of ED presentations that were re-directed to primary care and this remains at the same rate as the previous 3 years as well. Overall with a greater than national proportion of population >65 years and population increase, ED results are stable.

Data sourced from National Minimum Data Set.

Impact Measure

The number of people presenting at ED and the number admitted.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14 Target	2014/15 Target
Presentations	18,017	18,374	17,006	17,545	16,860	17,014		
ED Admitted	4,226	4,293	4,338	4,571	4,620	4,193	4,791	4791

Impact Goal

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

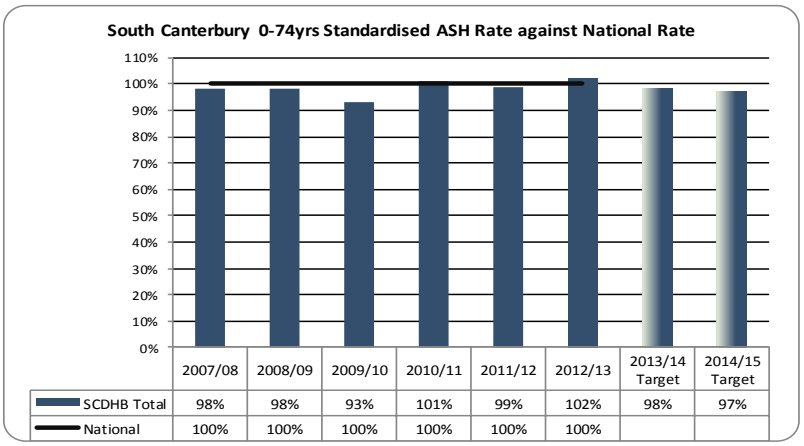
Comment

The result for 2012/13 is comparable with the two previous years with all avoidable hospital sensitive admission targets for 2012/13 met.

Data sourced from the Ministry of Health.

Impact Measure

The rate of actual to expected avoidable admissions for the South Canterbury population (0 – 74 yrs).



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14 Target	2014/15 Target
SCDHB Total	98%	98%	93%	101%	99%	102%	98%	97%
National	100%	100%	100%	100%	100%	100%		

Impact Goal

More, older people maintain functional independence.

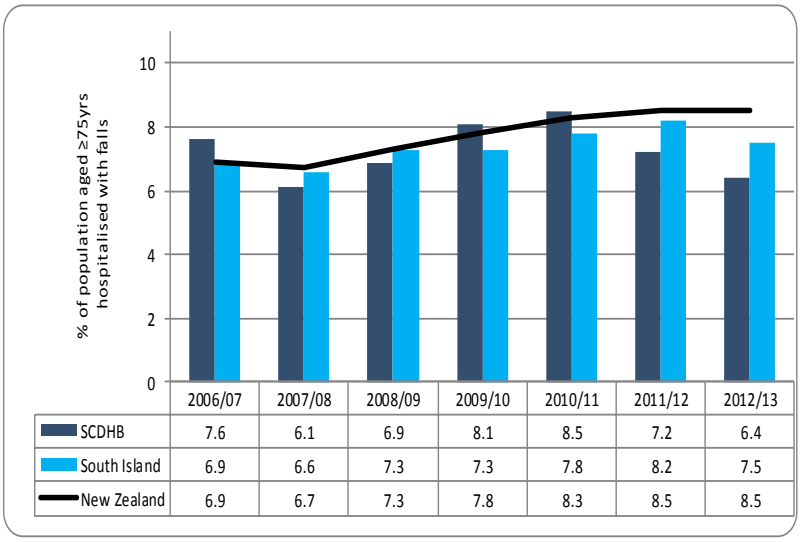
Comment

The percentage of the population over 75 years admitted to hospital as a result of a fall has declined over the last two years. The impact of the South Canterbury Community Falls Prevention Programme has contributed to this result for South Canterbury which is well below that of the South Island and New Zealand as a whole. The focus of the SCDHB Falls Prevention Work Plan over the next year is to work alongside the community falls prevention group as guided by a combined steering group. Initiatives include activity to increase referrals to the community 'Stay on Your Feet' programme.

Data sourced from the Ministry of Health (NMDS Warehouse).

Impact Measure

The percentage of the South Canterbury population (75+) admitted to hospital as a result of a fall.



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
SCDHB	7.6	6.1	6.9	8.1	8.5	7.2	6.4
South Island	6.9	6.6	7.3	7.3	7.8	8.2	7.5
New Zealand	6.9	6.7	7.3	7.8	8.3	8.5	8.5

OUTCOME: PEOPLE RECOVER FROM COMPLEX ILLNESS AND/OR MAXIMISE THEIR QUALITY OF LIFE

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Impact Goal

More people receive timely emergency care.

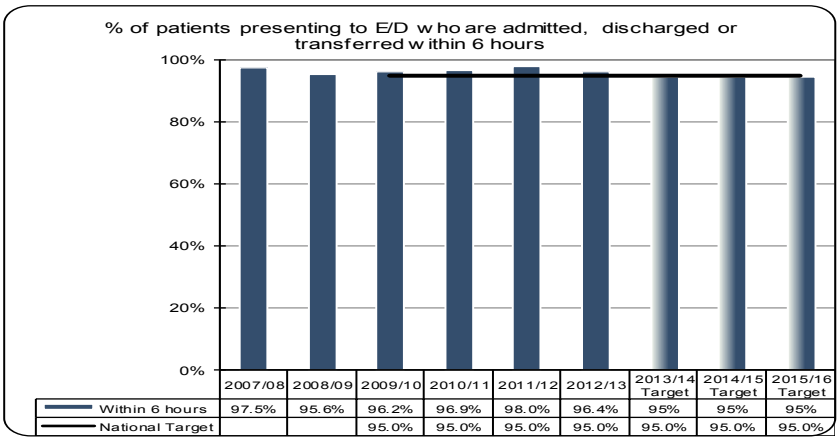
Comment

SCDHB continues to successfully meet this Health Target.

Data sourced from SCDHB.

Impact Measure

The percentage of patients presenting at ED who are admitted, discharged or transferred within six hours.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14 Target	2014/15 Target	2015/16 Target
Within 6 hours	97.5%	95.6%	96.2%	96.9%	98.0%	96.4%	95%	95%	95%
National Target			95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Impact Goal

More people receive timely cancer services.

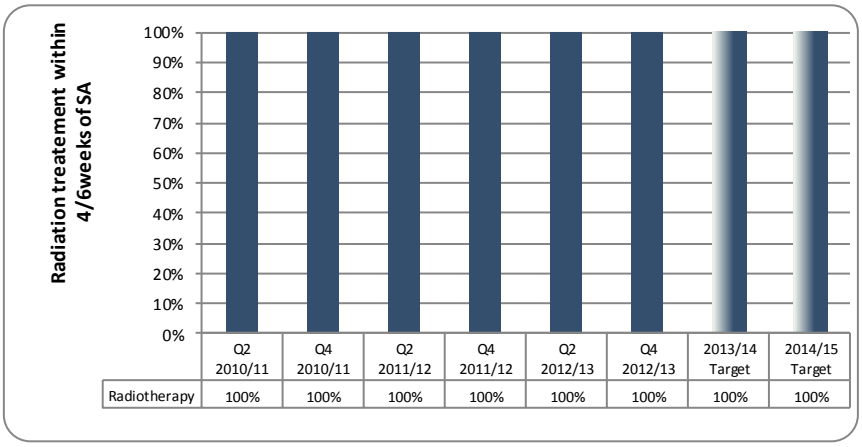
Comment

SCDHB continues to successfully meet this Health Target.

Data sourced from SCDHB.

Impact Measure

Everyone needing radiation treatment will have this within four weeks.



	Q2 2010/11	Q4 2010/11	Q2 2011/12	Q4 2011/12	Q2 2012/13	Q4 2012/13	2013/14 Target	2014/15 Target
Radiotherapy	100%	100%	100%	100%	100%	100%	100%	100%

Impact Goal

More people receive timely access to elective surgical services.

Comment

Elective Service Performance Indicator 2 relates to the percentage of patients provided with a First Specialist Appointment within 5 months of referral.

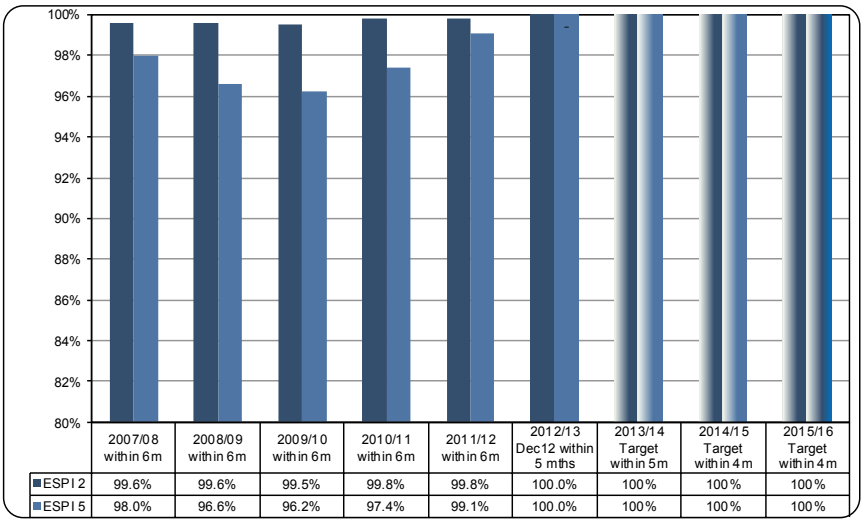
Elective Service Performance Indicator 5 relates to the percentage of patients given a commitment to treatment within 5 months.

SCDHB successfully met the Elective Services Performance Indicators 2 and 5. It was a Ministry of Health directive to reduce the commitment timeframes for specialty assessment and treatment from 6 months to 4 months by December 2014.

Data sourced from SCDHB.

Impact Measure

Elective Services Performance Indicators 2 & 5.



	2007/08 within 6m	2008/09 within 6m	2009/10 within 6m	2010/11 within 6m	2011/12 within 6m	2012/13 Dec12 within 5 mths	2013/14 Target within 5m	2014/15 Target within 4m	2015/16 Target within 4m
ESPI 2	99.6%	99.6%	99.5%	99.8%	99.8%	100.0%	100%	100%	100%
ESPI 5	98.0%	96.6%	96.2%	97.4%	99.1%	100.0%	100%	100%	100%

Impact Goal

Fewer people experience adverse events that cause harm in our hospital and specialist services.

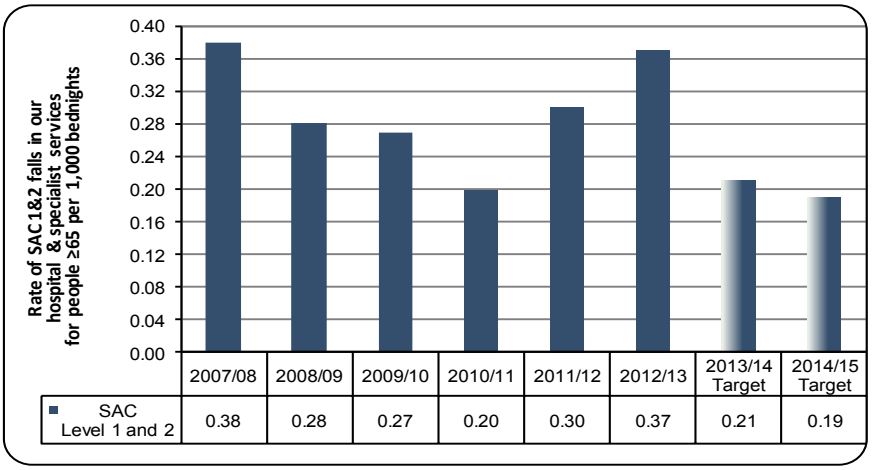
Comment

SAC refers to the Severity Assessment Code assigned to an adverse event based on the degree of harm caused and the likelihood of the reoccurrence of a similar event with a SAC 1 score being the most serious.

SCDHB will continue to focus on reducing falls in its hospital and ARRC services inline with the Health Quality & Safety Commissions National Safety Programme.

Impact Measure

The rate of SAC1 and 2 falls in South Canterbury DHB (65+).



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14 Target	2014/15 Target
SAC Level 1 and 2	0.38	0.28	0.27	0.20	0.30	0.37	0.21	0.19

There has been an increase in the number of reported SAC 1 & 2 events in the last two years. Recommendations from internal investigations into serious falls are being implemented such as reviewing the falls assessment tool and Falls Action Plan. Continued implementation of initiatives such as "Care Calling" (hourly checking on the patient) is also expected to see a reduction in the number of falls with serious injury reported.

Data sourced from SCDHB.

STATEMENT OF SERVICE PERFORMANCE 2012/13

MEASURING OUR NON-FINANCIAL PERFORMANCE

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 Intent for 2012 – 2015.

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'*.

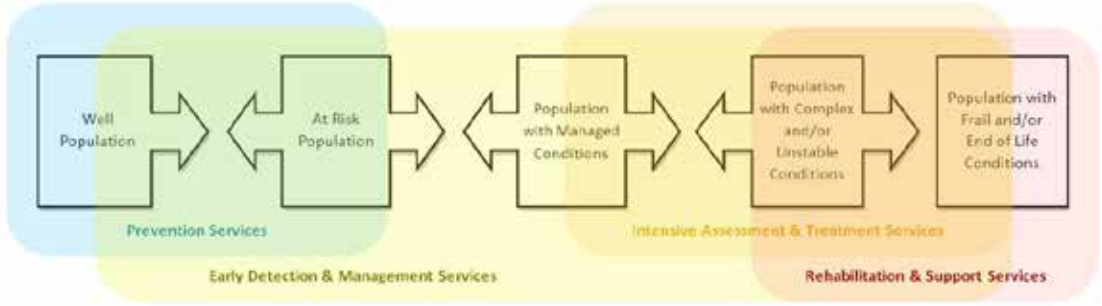
The output measures chosen are those activities which reflect a reasonable picture of activity across the whole of the South Canterbury health system and have the potential to make the greatest contribution to the health and wellbeing of our population in the shorter term and to the health outcomes we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

We have used a mix of measures of Quantity (V), Quality (Q) 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. Timeliness measures demonstrate where services are delivered within recommended timeframes.

We have set targets for each output measure to demonstrate the expected standard. Where available we have included a prior year's baseline to support evaluation of our performance over time as well as national results for 2012/13 to give context in terms of what we are trying to achieve.

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

OUTPUT GROUPING SET AGAINST THE CONTINUUM OF CARE FOR OUR POPULATION



Access to a significant proportion of publicly funded health services e.g. laboratory tests, emergency care, maternity services and palliative care is unrestricted or demand-driven. Targets set for these measures are simply a forecast or estimate of expected demand with actual use of these services included to give the reader a picture of what is happening across our health system.

Some data is collected on calendar rather than financial years and where this occurs is indicated as such. Where a measure is new from the previous year this is indicated with a * and 2011/12 results which have been updated as data is confirmed or where the definition for the measure has been revised are indicated with a ◊. Results for 2012/13 are based on data available at the time of producing this report and may be subject to change as data collection and analysis is finalised. Any other irregularities have been footnoted.

WHAT HAVE WE DELIVERED – PERFORMANCE RESULTS

South Canterbury District Health Board's results for 2012/13 demonstrate achievement across a range of performance measures. These have been indicated with a '✓' in the status column. For those targets not achieved progress is evident and these areas will remain a focus for service improvement during 2013/14. These have been indicated with an '✗' and a comment explaining variance to target has been included as a footnote. Those measures purely relating to estimated service delivery which are demand driven have been indicated with a ∞.

PREVENTION SERVICES

Preventative health services promote and protect the health of the whole population. 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.

Success is defined by positive changes in behaviours and high coverage levels, which signal engagement in programmes and the effectiveness of positive health messaging and the quality of the support and advice being provided. Successful provision of these services will reduce risk factors such as smoking and increase positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population.

SCDHB continues to perform well in breast feeding promotion activities with results for breast feeding in South Canterbury exceeding national averages. The health target for brief advice and support to quit smoking in the hospital setting was achieved and whilst the result for the primary care fell short of the national target the SCDHB was the third highest DHB and significant progress has been made since 2011/12.

Good results were achieved for population health screening, especially in the area of B4 School Checks with SCDHB's performance being rated first nationally. Whilst the health target for CVD screening was not achieved significant progress has been made since 2011/12. This has largely resulted from targeting low income work places and focusing support to general practice.

Results for immunisation generally remain on target. The health target relating to eight month olds being fully immunised on time was achieved. The result for two year olds being fully immunised on time was just below target but higher than the national average. The immunisation outreach service continues to work with hard to reach families to improve access.

OUTPUT MEASURES

HEALTH PROMOTION & EDUCATION SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
Attendance at annual breastfeeding 'Big Latch On' forum *	V[1]	59	77	62	-	✓
Breast feeding support programme attendees *	V[1]	461	370	325	-	✓
Maintenance of BFHI accreditation	Q	Achieved	Achieved	Achieved	-	✓
No. local business engaged in 'Breast feeding Welcome Here' programme *	V	14	17	15	-	✓
No. early childhood centres with breast feeding friendly environments *	V	9	12	9	-	✓

HEALTH PROMOTION & EDUCATION SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
Breast feeding rates at 6 weeks	V[2]	Total – 73% Māori *– 71%	70% 73%	68%	65% 58%	✓
Breast feeding rates at 3 months	V[2]	Total – 54% Māori* -36%	56% 54%	57%	55% 43%	x
Breast feeding rates at 6 months	V[2]	Total – 26% Māori *-30%	25% 25%	27%	24% 15%	x
No. people in South Canterbury accessing smoking cessation programmes	V[3]	1205	873	1250	-	x
Percentage of people who receive brief intervention to quit in the hospital setting	Q	96%	98.8%	95%	95.8%	✓
Percentage of people who receive brief intervention to quit in the primary setting	Q[4]	35.4%	76%	90%	56.9%	x
Service Users quit outcomes at 4 weeks – self-reported *	Q[5]	-	Not available	25%	-	-
Service Users quit outcomes at 4 weeks – carbon monoxide validated *	Q[5]	-	Not available	35%	-	-
Percentage of schools Smoke free compliant *	Q	100%	100%	100%	-	✓
Percentage of Year 10 students who 'never smoked'	Q[6]	72.5% (2011)	68.70% (2012)	73%	70.1%	x
Percentage of education settings with a WAVE Memorandum of Agreement *	Q[7]	99%	99%	99%	-	✓
No. of Green Prescription referrals	V[8]	360	385	385	-	✓
Percentage of adults having 2+fruits a day *	V[9]	59.7% (06/07)	Not available	62.7%	-	-
Percentage of adults having 5+vegs a day *	V[9]	78.9% (06/07)	Not available	81.9%	-	-

1. The increase in number of attendees at the "Big Latch On' forum from 2011/12 is due to successful profiling of this event. The number of breast feeding support programme attendees while well over target is down on the 2011/12 year due to the transition between programme coordinators who do this work on a voluntary basis
2. The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal period and the value of breast feeding support during the post natal period. Data is sourced from Plunket via the Ministry of Health. This result is for the 2012/13 financial year compared to the 2011 result which is for the calendar year. Result excludes data from Arowhenua Whānau Services.
3. This result reflects only those people referred by their GP for cessation support to the Primary and Community Services community smoke free team, it does not include those accessing support from their GP or practice nurse, Quitline or Aukati Kaipaipa. The result for 2012/13 compared to the previous year reflects a reduction in referrals as general practice increases its role in cessation support.
4. Primary Care practices have made very good progress towards this target and will continue to work towards achieving the 90% health target. The significant increase on the 2011/12 result is partially due to an improvement in the way data is coded providing a more accurate result of coverage and the delivery of the DHBs action plan to meet this Government priority. A Smokefree facilitator working in primary care has been trained to deliver smoking cessation group therapy in the community. This initiative will further enhance this service.
5. This data is not available until end of October 2013.

6. The number of student surveyed in 2012 was 265 compared to 320 in 2012. This is a reduction of 55. The reduced sample size may have affected the result for 2012 however at 68.7% this remained an improvement on results proceeding 2011.
7. WAVE stands for "Well-being and Vitality in Education". WAVE is a health promotion initiative that works collaboratively to support all education settings in South Canterbury to help create and support healthy environments.
8. The Green Prescription initiative is a way to improve the health of New Zealanders. This service is provided on referral to Sport Canterbury for adults and focuses on sustaining physical activity to improve health outcomes.
9. This data is not currently available.

POPULATION BASED SCREENING	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
Percentage of enrolled women aged 20 – 69 years who have had a cervical screen in the last three years	T[10]	73.82%	76.03%	78%	76.72%	x
Percentage of high needs enrolled women aged 20 – 69 years who have had a cervical screen in the last three years	T[10]	69.40%	70.12%	75%	69.33%	x
Percentage of high needs enrolled women aged 45 – 69 years who have had a breast screening mammography as part of the national mammography screening programme	T[10]	69.95%◊	73.12%%	75%	63.85%	x
Percentage of pregnant women being screened for HIV *	Q[11]	Not available	100%	100%	-	√
Percentage of newborn being offered hearing screening *	Q	100%	100%	100%	-	√
Total no. of B4 School Checks completed *	V[12]	652	816	680	-	√
Percentage of eligible population (total) receiving B4 School Checks*	Q[12]	96%	100%	95%	-	√
No. 'high needs' B4 School Checks completed *	V[12]	74	87	65	-	√
Percentage of eligible population (high needs) receiving B4 School Checks *	Q[12]	100%◊	100%	95%	-	√
Percentage B4 School Checks with need referred as a comparison to the national average - Dental *	T[13]	19%	81%	50%	National average 75%	√
Percentage B4 School Checks with need referred as a comparison to the national average - Growth *	T[13]	0%	100%	100%	National average 100%	√
Percentage of the eligible population who have had their CVD Risk Assessment in the last 5 years	T[14]	42%	64.4%	75%	67.1%	x

10. These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. South Canterbury's results for cervical screening for 2012/13 are close to the current national averages and the result for the 'high needs' cohort is well above the national average. The age band for this cohort has changed from 45 – 65 years to 45 – 69 years.
11. Due to issues following the Canterbury earthquake we did not receive data until the last two quarters of the 2011/12 year and is not considered reliable to report. This result relates to women delivered in the SCDHB Jean Todd Maternity Unit only.
12. The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development. The increase in the B4SCs completed in 2012/13 is partially due to setting an internal target 95% of children in the district

and also to an increase in the number of 4 year olds living in the district. Close inter-departmental and inter-agency liaison also identifies high needs children requiring assessment and timely follow up.

13. MoH quality reports include measures of individual DHB referral patterns as compared to national averages. This table covers two areas where previous DHB performance has not previously been aligned with national averages. The aim is to be at or above the national result. This result is for the period January – June 2013. The significant improvement in the 2012/13 result is due to clarification of criteria for referral and improved recording practises.

14. CVDRA assists people to understand their modifiable lifestyle risks to minimise their likelihood of having a serious cardiac event. CVDRA screening is improving over time as the public become more aware of the importance of this screening opportunity. Further support has been provided to primary care by providing 'near patient' testing for lipids at medical centres. This allows for opportunist screening. Initiatives such as delivering CVDRA screening in the workplace will continue.

IMMUNISATION SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
Percentage of 8 month olds fully immunised on time *	T[15]	-	88%	85%	90.1%	✓
Percentage of 2 year olds fully immunised on time	T[16]	Total – 94% Māori – 92%	94% 92%	>95%	92%	✗
Percentage of eligible population receiving the flu vaccination	Q	66.79%	68%	68%	-	✓
No. of ≥65 year olds immunised for pneumonia *	V[17]	793	391	850	-	✗
No. HPV vaccinations completed for consenting adolescents *	V[18]	184	208	200	-	✓

15 Measuring of this indicator commenced in 2012/13

16 These targets were missed by a very small number of children. The immunisation outreach programme continues to work with individuals to improve future results.

17 This immunisation programme commenced in 2011. The planned volumes for the first two years of this programme were set at 850/year to address the back log and then reducing to 180/year ongoing. The vaccine is expected to last 5 years. The result for 2012/13 reflects that targets for the first two years were not accessed at the level expected. Targets for subsequent years have been revised to ≥180.

18 The measure is based on young women 12 - 18 who have been provided with all three doses. A school based programme commenced in 2013. This result also includes those adolescents vaccinated by youth health & sexual health clinics, general practice, Family Planning clinic and Arowhenua Whānau Services.

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 general practice, primary and community services, personal and mental health services, Māori and Pacific health services, pharmacy services, community 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 and provide an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes.

Some of these services are demand-driven, such as pharmaceuticals and laboratory tests, and services are provided with a mix of public and private funding and may include co-payments for general practice services and pharmaceuticals.

Statement of Service Performance

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

The discontinuation of the publicly funded 'Get Checked' programme has impacted on the volume of annual diabetes reviews and the decreased number of reviews may have impacted on the percentage of people with good diabetes management i.e. HbA1c

There is evidence of improved child oral health with results for caries free at five years. The rate of decayed, missing or filled teeth at year eight also improved for Māori children. .

SCDHB has made a good start with the recently introduced national measure of waiting time for MRI and CT with results for June well above national averages. All avoidable hospital admission targets for this year have been achieved.

PRIMARY HEALTH CARE	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. of people in the district enrolled with a Primary Care provider *	V[1]	55709	56,272	55,900	-	∞
Percentage of people in the Care Plus Programme	Q	83.5%	81.46%	82%	-	✗
Percentage of people with diabetes who have had an Annual Review – Māori	Q[2]	Total – 69% Māori *– 67.2%	Total - 41.4% Māori - 42%	72%	-	✗
Percentage of people with diabetes who have HbA1c ≤64%	Q[2]	76%	60%	83%	-	✗
No. retinal screens completed *	V	988	1,024	994	-	✓

1 Care Plus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users.

2 Results for Māori include all high needs clients. These results may be understated as annual diabetes reviews were no longer publicly funded in 2012/13 and coding for payment no longer occurs. The SCDHB Diabetes Improvement Package includes a number of initiatives including the Encounter Programme which is a programme designed for newly diagnosed type 2 diabetes, those starting insulin therapy or those with poor metabolic control who need to re-engage with their general practice. This programme requires an annual diabetes review and will continue during 2013/14.

ORAL HEALTH	Notes	2011 Result	2012 Result	Target/Est. Delivery 2012	Current NZ result	Achievement against target
Percentage of children under 5 enrolled in DHB funded dental services *	Q[3]	76.7%	76.7%	81%	-	✗
Percentage utilisation of adolescent oral health services	Q[4]	91.4%	88.6%	88%	78%	✓
Percentage of children caries free at 5 years of age	Q	Total – 58% Māori – 31%	Total – 60.18% Māori – 49.18%	66%	-	✗
Rate of oral health Decayed, Missing and Filled (DMF) score at year 8	Q	Total – 1.29 Māori – 2.06	Total – 1.20 Māori – 1.47	1.45	-	✗

3. There are currently only a small number of children under the age of 12 months who are enrolled. This is expected to improve with the introduction of the newborn triple enrolment form. If you exclude those children in their first year of birth the result is well over 80%.

4. The target set in the SCDHB Annual Plan for 2012/13 for utilisation of adolescent oral health services was set at 91% however this target was revised on receipt of the Monitoring Framework Performance Measures which set a target of 88%.

PHARMACY	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. medication interventions by hospital clinical pharmacist for the inpatient population *	V[5]	-	Not available	Baseline data	-	-
Total community dispensing volume	V[6]	1.430 million items	1,247,619	1.546 million items	-	∞

[5] This measure was to be introduced in 2012/13. As no NZ eSolution for hospital intervention activity exists, a local MS Excel database is being developed similar to a version developed by Whanganui DHB. All South Island DHBs have prioritised the Information System (IS) projects that are collectively underway in the region. The local SCDHB database was originally planned to be operational in 2012/13 and is now a regional project for 2013– 2015 subject to prioritisation with ePharmacy, EMR and ePA software solutions all due for regional roll out in the coming year/s.

[6] The target is an indicative forecast but was not adjusted for the introduction of the new Community Pharmacy Services by DHBs which was expected to reduce dispensing numbers in South Canterbury due to the increased involvement of the community pharmacy in the patient's medication management and a reduction in close control dispensing.

COMMUNITY REFERRED TESTS & DIAGNOSTIC SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. community laboratory tests	V[7]	215,695	252,873	245,000	-	∞
No. community radiology examinations	V[7]	11,249	10,067	10,444	-	∞
No. audiology procedures	V[7]	1,374	1,353	1,500	-	∞
Waiting time for MRI – waiting or scanned within 42 days *	T[8]	-	84%	Baseline data	52%	-
Waiting time for CT MRI – waiting or scanned within 42 days *	T[8]	-	87%	Baseline data	79%	-
Avoidable hospital admissions 0 – 4 years Total *	Q[9]	75%	83%	<95%	100%	✓
Avoidable hospital admissions 45 – 64 Total *	Q[9]	104%	95%	105%	100%	✓
Avoidable hospital admissions 0 – 74 Total *	Q[9]	107%	102%	104%	100%	✓

[7] These indicators are demand driven. The Audiology Department was moved to a temporary location following the evacuation of the Garden's Block due to seismic risk. This temporary facility does not have soundproofing or electromagnetic shielding which has had an impact on scheduling and subsequent productivity.

[8] Waiting time monitoring commenced in 2012/13. This result is produced on a monthly basis with the above result being for June 2013.

[9] Some hospital admissions are seen as preventable through early intervention; they provide an indication of the access and effectiveness of primary and secondary services. The result for 2011/12 was presented as a standardised intervention rate. This measure was changed in 2012/13 to a percentage.

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\ enabling 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. 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.

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.

The health target for patients seen in the emergency department within six hours and patients requiring radiation or chemotherapy treatment within four weeks were both achieved as were the ED triage timeframes.

A steady increase in the number of non-contact First Specialist Appointments (FSA) is reported and has contributed to the decreased number of face to face FSAs performed. The five month target for providing a FSA and commitment to treatment were both met as were the elective surgery volumes. An improvement in day surgery rate from the previous year is noted, but remains just short of target. The day of surgery target was comfortably met.

Whilst activity in ATR services is less than predicted there have been no waiting lists during 2012/13 for these services. Work continues on ensuring patients are discharged in a timely manner and where appropriate assessment is provided in the community.

OUTPUT MEASURES

ACUTE SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. of patients seen at ED – Non admitted *	V[1]	10,926	12,821	10,705	-	∞
Percentage of patients seen in ED admitted to an inpatient bed *	Q[1]	27.4%	24.64%	27.5%	-	x
Percentage of patients discharged or transferred from ED within 6 hours	T	96.5%	96.4%	95%	93.5%	√
Percentage of triage timeframes met:						
Triage 1 *	T[2]	100%	100%	100%	-	√
Triage 2 *	T[2]	89%	87.5%	80%	-	√
Triage 3 *	T[2]	87%	87.4%	75%	-	√
No. of acute medical/surgical patients discharged from Timaru Hospital	V[3]	6,885	6,527	6,200	-	∞
Standardised length of stay for acute inpatients	T[4]	4.66 days	4.35 days	4 days	3.93 days	x
Standardised unplanned readmission rate	Q[5]	10.38%◊	10.37%	10.4%	10.32%	√
Percentage of patients requiring radiation who receive this treatment within 4 weeks	T	100%	100%	100%	100%	√
Percentage of patients requiring chemotherapy who receive this treatment within 4 weeks	T	100%	100%	100%	100%	√

[1] There are no clinical issues in this result; patient need informs necessity to admit.

[2] The assessment of patients on arrival to decide how urgent their illness or injury is and how soon treatment is required is called triaging. Triaging aims to ensure that those patients assessed as having the most urgent need are treated more quickly than those patients with a less urgent need. Patients triaged 1 should be treated immediately triaged 2 within 10 minutes and triaged 3 treated within 30 minutes.

[3] This measure is demand driven and shows a decrease in acute demand from previous year predominately in surgical acute admissions.

[4] Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision. This is a combined result for acute and elective/arranged inpatients and is as at the end of March 2013 whereas the result for the previous year is for acute patients only.

[5] This target was suggested by the Ministry of Health as it was the average performance for the standardised acute readmission rate as measured in the 2008/09 base year. SCDHB's result sits close to the national average.

ELECTIVE SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
Total no. of elective FSAs delivered	V[6]	8,539	8558	8,742	-	✗
No. non contact Secondary Services FSAs *	V[7]	Surgical - 584 Medical – 274	Surgical – 714 Medical – 368	Surgical -475 Medical -350	-	✓
Percentage of patients provided with an FSA within 5 months of referral *	T[8]	99.8%	100%	100%	-	✓
No. elective caseweighted discharges	V	3,663	3,690	3,595	-	✓
Percentage of patients given a commitment to treatment within 5 months *	T[8]	99.1%	100%	100%	-	✓
Total no. of elective surgical discharges (including cardiology and dental)	V	3,039	3,064	2,887	-	✓
Total no. health target surgical elective discharges	V[9]	2,730	2,790	2,634	-	✓
Standardised day surgery rate	Q[10]	61.7%	62.60%	64%	-	✗
Day of surgery admission rate *	Q[10]	98.3%	99.10%	99%	86.3%	✓
Standardised length of stay for elective and arranged inpatients *	Q[11]	4.55	4.35 days	4 days	3.93	✗
Elective theatre time utilisation *	Q[12]	84.4%	83.30%	85%	-	✗

[6] The decrease in face to face FSAs is more than offset by an increase in non contact FSA activity.

[7] Non-contact FSA are those where specialist advice and assessment is provided to General Practitioners without the need for the patient to attend a face to face appointment with the specialist, increasing capacity across the system, reducing wait times for patients and taking duplication and waste out of the system. These results relate to secondary services and the increase noted from the previous year is indicative of a change in practice and this trend will continue as integrated care is embedded.

[8] These results are consistent with the previous year. It was a Ministry of Health directive to reduce the commitment timeframes for specialty assessment and treatment from 6 months to 4 months by December 2014. The target timeframe was reduced to five months by the 30 June 2013. This is the DHB result as at the 30 June 2013.

[9] This number counts elective surgery volumes based on the national target definition (excludes cardiology and dental volumes).

[10] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own homes and frees up hospital beds

where capacity is tight. Whilst the result for 2012/13 is slightly under the projected target this level of day surgery remains one of the highest in the country.

[11] This is a combined result for acute and elective/arranged inpatients and is as at the end of March 2013.

[12] The Productive Operating Theatre (TPOT) is underway at SCDHB with theatre utilisation a focus in this national programme initiative.

MATERNITY SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. of deliveries in the SCDHB Maternity Unit	V[13]	544 ◊	621	550	-	∞
Percentage of births delivered by Caesarean Section	Q	23.6%	26.5%	23%	-	✗
Post natal average length of stay	Q[14]	2.5 days	2.42 days	2.71 days	-	✗

[13] Result indicates number of babies born and is demand driven.

[14] While this target has not been reached there is no pressure for women to be discharged from the Jean Todd Maternity Unit and this result reflects women's choice.

ASSESSMENT TREATMENT & REHABILITATION SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. of ATR bed days utilised *	V[15,19]	>65 years – 4,559	>65 years – 3,528	>65 years – 4,200	-	∞
		<65 years – 435	<65 years – 457	<65 years - 400		
		psycho geriatric - 471	psycho geriatric - 602	psycho geriatric - 650		
No. of ATR outpatient attendances *	V[16,19]	546	358	479	-	∞
No. of ATR domiciliary visits *	V[17,19]	2774	2288	2,700	-	∞
Percentage of ATR patients discharged from the ATR inpatient unit by 1100hrs *	T[18]	69%	57.20%	75%	-	✗

[15] This relates to funded bed days and is demand driven.

[16] Although numbers of outpatient consultations utilised was lower than projected there has been no waiting list.

[17] SCDHB uses a multi-disciplinary team approach to providing community services. The ATR service uses a single point of entry methodology for managing community referrals. There was no waiting list during 2012/13.

[18] Patient transportation and availability of family in the day time to pick up their family member remains a residual challenge for ATR to meet this target.

[19] As integrated services are developed more older people will be cared for in the community and changes in referral patterns to ATR services will continue to change.

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.

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

Statement of Service Performance

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.

All aged care providers are now trained in the use of the Liverpool Care Pathway.

Pleasing results are noted for the timeliness of InterRAI assessments and reviews for home and community support services.

The emerging stroke service is producing some pleasing results and the community falls prevention programme continues to gain traction.

The focus for the community mental health team in the coming year will continue on supporting mental health clients on discharge through effective crisis planning and timely follow up.

The number of district nursing visits has been declining over the past years as more patients are being referred to primary care or to community clinics to support the restorative model of care. Planned volumes have subsequently been reduced in out years.

General and dementia respite beds have been well utilised during 2012/13.

PALLIATIVE CARE	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. of clients receiving palliative care in the home *	V[1]	-	98	Baseline data	-	∞
No. of clients accessing a hospice bed	V[1]	144	115	113	-	∞
Percentage of aged care providers trained to provide the Liverpool Care Pathway *	V[2]	100%	100%	100%	-	✓

1 This is demand driven.

2 The Liverpool Care Pathway is an international programme adopted nationally and reflects best-practice care. This was introduced in South Canterbury for those aged care providers holding a palliative care contract.

NEEDS ASSESSMENT & SUPPORT	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
Percentage of InterRAI assessments completed within target timeframe	T[3]	85%	92%	90%	-	✓
Percentage of InterRAI reviews completed on clients within target timeframe *	T[3]	-	Non-complex-92% Complex-91%	Baseline data	-	-
No. mental health assessments completed *	V[1]	-	43	50	-	∞
No. mental health reviews completed *	V	-	228	200	-	✓

3 InterRAI is a comprehensive clinical assessment tool that has been rolled out nationally to ensure consistency of assessments. The category 'complex includes those patients considered 'high and complex'.

REHABILITATION PROGRAMME	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
Percentage of patients referred to the stroke service on admission to an inpatient bed *	Q	-	97%	90%	-	✓

Average length of stay for stroke – acute inpatient bed *	T	3 days	5.7 days	5 days	-	x
No. of attendees at the pulmonary rehabilitation programme *	V[4]	15	N/A	20	-	-
No. of attendees at the community falls prevention programme *	V[5]	160	212	200	-	√
Percentage of long-term clients with up to date relapse prevention/treatment plans (for long-term mental health clients) *	Q[6]	95%	93%	95%	-	x
Percentage of clients followed up within 7 days of discharge from the inpatient mental health unit *	T[7]	49%	66%	90%	-	x
No. of readmissions to the mental health inpatient unit *	Q[8]	6	9	7	-	x

4 The Pulmonary Rehabilitation Programme has been incorporated into the Multi-condition Rehabilitation programme which commenced in August 2012. Over 60 people with a long-term condition attended the Multi-condition Rehabilitation Programme during 2012/13.

5 There was an increase in the number of referrals received during 2012/13 compared with the previous year as this programme continues to be promoted locally.

6 Relapse prevention planning minimises the medium to longer-term impacts of serious mental illness, improving outcomes for clients. Accordingly all clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what actions to take. The short fall in this result reaching target relates to a very small number of clients which due to the size of this client group tends to skew the overall result.

7 Vacancies and unplanned staff leave affected the timeliness of follow up and this result. An improvement in the later part of the year was noted with a result of 100% recorded in June 2013.

8 9 readmissions equates to a readmission rate of 5.6%. This result is well within the Ministry target of 10%.

HOME & COMMUNITY SUPPORT SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. of people supported by Home Care Support Services	V[9]	981	965	1,000	-	∞
No. of dementia patients supported by Home Care Support Services *	V[10]	-	15	Baseline data	-	∞
Percentage of subsidised people living in Age Related Residential Care	V[11]	6.12%	5.6%	5.8%	-	√
Percentage of >65 year population supported by Home Care Support Services *	V[9]	-	Non complex-5% Complex-3% High complex-1%	Baseline data	-	∞
No. of district nursing visits delivered *	V[12]	41,397	33,345	40,400	-	x
No. Meals on Wheels provided *	V[13]	33,408	34,252	36,000	-	∞

9 Home Care Support Services are services delivered in the person's home to assist them to remain at home. Monitoring the number of dementia patients receiving HCSS support services commenced in 2012/13. This result is as at the 30 June and is demand driven.

10 This measure is demand driven. The result for this measure was unable to be presented by level of complexity as intended.

11 This measure relates to residents over 65 years.

12 This measure is demand driven and excludes Health of Older People visits. The number of visits has been declining over the past years as more patients are being referred to primary care or to community clinics to support the restorative model of care. The volume of wound care visits has also declined as wound care practices have been increasingly more effective. The target for 2013/14 has been reduced to 35,000.

13 This measure is demand driven.

RESIDENTIALCARE SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. subsidised residential care bed days *	V[14]	Rest home-85,947	Rest home-81,372	Rest home-85,000	-	∞
		Hospital-66,216	Hospital-66,889	Hospital-65,500		
		Dementia-15,395	Dementia-15,330	Dementia-15,576		
		Psychogeriatric-9,663	Psychogeriatric-9,614	Psychogeriatric-9,800		
No. subsidised long term residential mental health clients *	V[14]	12	9	12	-	∞
No. Aged Related Residential Care bed days funded *	V	177,221	173,205	175,175	-	∞

[14] These measures are demand driven. This measure relates to bed nights funded in South Canterbury.

RESPITE & DAY SERVICES	Notes	11/12 Result	12/13 Result	Target/Est. Delivery 12/13	Current NZ result	Achievement against target
No. people accessing day care *	V[14]	187	147	120	-	∞
No. people accessing dementia day *care	V[14]	-	13	14	-	∞
Percentage of planned respite bed days utilised *	Q	85%	97%	90%	-	✓
Percentage of planned dementia respite bed days utilised *	Q	94%	99%	85%	-	✓

Safety Markers

The HQSC intend the Quality and Safety markers to help evaluate the success of the Open for Better Care campaign and to determine whether the desired changes in practice and reductions in harm and cost have occurred.

The QSMs concentrate on the four areas of harm covered by the campaign:

- falls
- healthcare associated infections (hand hygiene and central line associated bacteraemia)
- surgery
- medication.

The process measures show whether the desired changes in practice have occurred at a local level (e.g., giving older patients a falls risk assessment and developing a care plan for them). The outcome measures focus on harm and cost that can be avoided.

The markers set the following thresholds for DHBs' use of interventions and practices known to reduce patient harm:

- 90 percent of older patients are given a falls risk assessment
- 90 percent compliance with procedures for inserting central line catheters
- 70 percent compliance with good hand hygiene practice
- All three parts of the WHO surgical safety checklist used in 90 percent of operations.

The impact of the Open for Better Care campaign will be monitored by tacking the QSMs over time.

The next tranche of data that will be released by the HQSC will be for the June to September period, and is likely to be released publicly in late 2013 or early 2014.

Appended to this paper are the baseline data as reported on the HQSC website:

http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/

SCDHB PERFORMANCE

Falls

SCDHB reported 91% of older patients audited were assessed for their falls risk on admission to hospital. This exceeds the national threshold of 90%.

Work continues on reducing the rate of falls, and particularly falls with harm.

Perioperative Harm

All three parts of the Surgical Checklist were used in 91% of operations audited. This exceeded the national threshold of 90%. This base line data gives a good basis for SCDHB to work from.

Hand Hygiene

SCDHB reported 54% compliant Hand Hygiene moments audited. This is below the expected threshold of 70%.

Further actions taken regarding Hand Hygiene compliance since this data was collected are:

- Increase in the number of trained Gold auditors. We have increased our number of trained auditors from 1 to 3.
- Review of Hand Hygiene auditing process in an effort to achieve the required hand hygiene moments per reporting period
- To put more emphasis on the training and education role of the trained auditors whilst they are undertaking audits across the hospital
- Hand Hygiene was a specific topic for discussion at the September Staff Forum

Central Line Associated Bacteraemia

No data for SCDHB was reported in the baseline as we currently do not use the national insertion bundle; principally we are non-compliant with the drape proposed within the bundle.

Data is being reported to the national group co-ordinating the project, and the intention is that they will be publishing SCDHB data in future, stating that it was achieved without using the national insertion bundle.

Work is ongoing around our compliance with the national insertion bundle.

Our Values

Integrity

We will always act with the utmost integrity by:

- Being transparent, open and honest in our dealings with everyone
- Ensuring there are no 'hidden agendas'
- Working for the common good of our community
- Responding to others needs within our capacity and capability
- Cultivating credibility, demonstrating a proven track record through our actions
- Fostering trust with each other and our community

Collaboration

We actively collaborate with others by:

- Consulting with and keeping people well informed
- Being open to and respectful of others opinions, ideas and ways of doing things
- Communicating clearly, sharing information in a timely manner in the most appropriate way
- Responding appropriately when speaking to and in correspondence with others
- Showing a willingness to negotiate, avoiding dismissive behaviours
- Involving those people in the decision making process who are most affected

Accountability

We promote accountability by:

- Taking both personal and collective responsibility for our actions and outcomes
- Adhering to legislation, standards, policy and due process
- Doing what we say we will do and doing it when we say we will do it
- Taking personal responsibility to work effectively with others
- Owning up to our own mistakes and learning from these
- Being punctual fully focussed and committed to the task in hand.
- Acknowledging and addressing difficult issues.

Respect

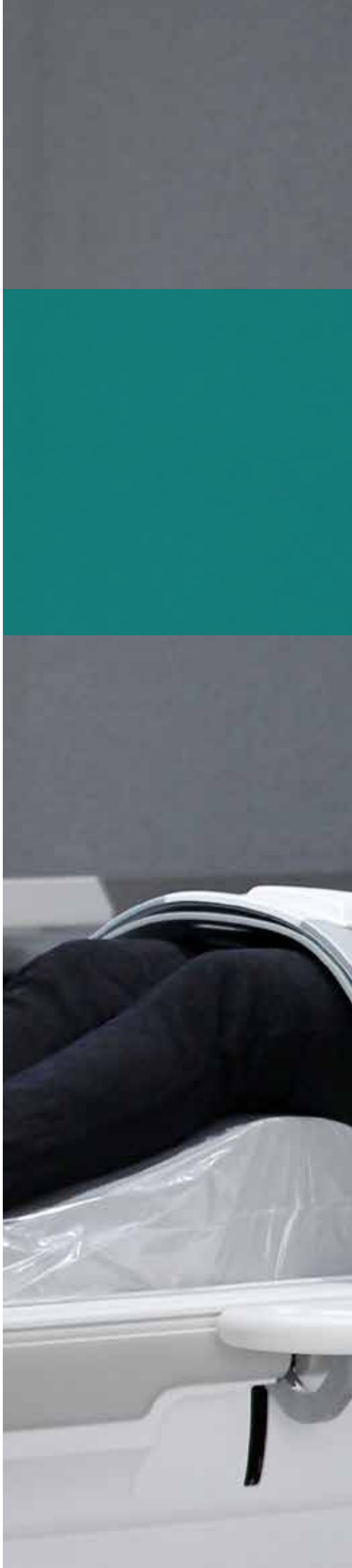
We show respect to all by:

- Recognising time is a valuable resource, both in the way we use each others time, and the way we use patient's time
- Recognising that the diversity of skills within the organisation is a vital part of a vibrant health organisation and treating each person as a valued individual
- Treating others as we would expect to be treated
- Acknowledging staff efforts ensuring credit is given where credit is due
- Supporting each other in our roles and valuing the contribution each team member makes
- Having a 'no blame 'culture, ensuring feedback is constructive

Excellence

We strive for excellence in everything we do by:

- Embracing evidence based practices in all our activities
- Never tiring of doing what's right for our population, delivering the right care at the right time and in the most appropriate setting by the right people
- Ensuring resources are used wisely to deliver the best service possible to our patients and the community
- Not tolerating waste
- Fostering Continuous Quality Improvement and Innovation
- Cultivating a culture of staff empowerment to make and adapt to change



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