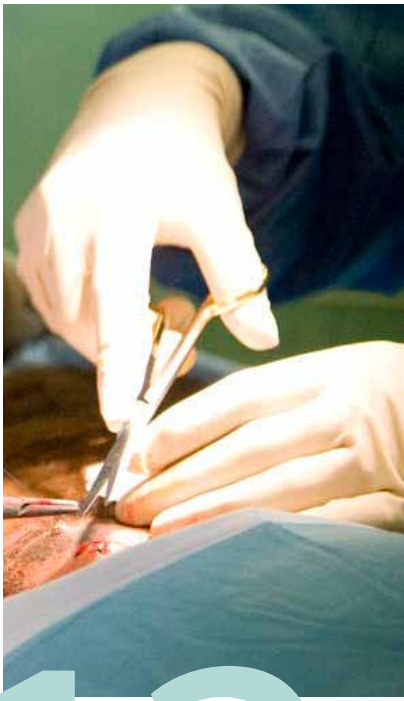

Annual Report 2012

South Canterbury District Health Board

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Auditor

Audit New Zealand

on behalf of the Auditor General

Bankers

ANZ Bank

Solicitors

Gresson Dorman & Co

PO Box 244, Timaru

Our Mission

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

Contents

From the Board

It gives us great pleasure to present the Annual Report of the South Canterbury District Health Board (SCDHB) for 2011/12.

SCDHB prides itself on its track record of outstanding performance and we are pleased to report the continuation and strengthening of our performance over the past year. Performance is measured across many indicators including the governments health targets, service levels, workforce, and financial targets in which we once again excelled. 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, especially as we are the only District Health Board across the South Island to have done so.

Locally we have completed a number of key planning documents which set a solid foundation for moving services within South Canterbury forward. These plans include the Health Services Plan, the Workforce Plan and the Facility Master Plan. The Health Services Plan identifies our direction of "Integrating health services in South Canterbury: to be the best provincial health service in the land". We believe our track record demonstrates that we are already achieving this goal, but recognise continuous improvement is necessary to enhance how we deliver services and extract greater value from the funding that is made available to us.

The workforce plan also uncovers significant challenges. The demographics of our population indicate that we will face substantial increases over the next 10 to 20 years in people over 65, and even higher numbers over 85, while simultaneously the working age population will reduce. This creates pressure and challenges, and a need to start responding to this urgently.

On the facility front we, like many others, have faced significant challenges with seismic stability of our buildings. Immediate action was taken to strengthen our laundry and supply buildings, we closed Kowhai House which housed Child & Adolescent Psychiatric Services, and recently closed our Garden Block which housed all medical staff, clinical administration, audiology and two clinics. Further challenges are expected in the coming year as we move forward with planning to strengthen the main hospital.

To ensure we invest our funds wisely we undertook a Facility Master Plan which sets out the future direction for capital development of Timaru Hospital. The plans are exciting and widely accepted by all involved, however challenging when considering overall affordability. The board and management had to make a difficult decision that recognised the plan will need to be a long term process. The first visible sign of development has commenced with the construction of the building to house the MRI Scanner. We would like to extend a huge thank you to the community for their exceptional generosity by donating in excess of $3 million to fund this exciting initiative. The opening of the new service is scheduled for later this year or very early in 2013. This will be a facility the whole community can be proud of.

Primary Care has seen significant development of the Aoraki Health Pathways. Health pathways provide health professionals guidance as to the appropriate pathways and treatment for a growing list of health concerns. The guidelines have been developed in partnership with clinicians from both primary and secondary care to streamline processes, reduce wastage, and speed up people's access to the most appropriate service for their needs.

On behalf of the Board we would like to acknowledge the tremendous effort put in by staff, volunteers, and contracted providers both within the hospital and the wider South Canterbury Health System. The hospital is the most physically visible of the health services, however the role that 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 are critical to the ongoing success and stability of health and disability services within the South Canterbury community. We thank you all for the part that you play within the delivery of these vital services.

Murray Cleverley Chair	Ron Luxton Deputy Chair	Chris Fleming Chief Executive

Board and Committees

Murray Cleverley
Chair

South Canterbury District Health Board is governed by an 11-member board, 7 members publically 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.

Ron Luxton
Deputy Chair

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)
Richie Smith (appointed until his resignation in February, 2012)

Paul Annear

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 Hospital 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 (Maori representative)
Koriana Waller (Maori representative)

Peter Binns

Board and Committees

Community and Public Health Advisory Committee (CPHAC)
CPHAC advises the board on the health needs and issues facing South Canterbury residents, and on the priorities for use of health funding.
MEMBERS
Ron Luxton, chair
Rene Crawford, deputy chair
Peter Binns
Peter Lyman
Murray Cleverley
Mike Cotton (community representative)
Jan Gilbert (community representative)
David Jack (community representative) *joined in October, 2011*
Suzanne Eddington (Maori representative)
Dr Daniel Williams (Medical Officer of Health, ex officio)


Rene Crawford

Disability Support Services Advisory Committee (DSSAC)
DSSAC 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 (Maori representative)


Nicola Hornsey

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
Richie Smith, resigned in February, 2012, John Christie, appointed in May, 2012
Ron Luxton
Murray Cleverley
Nicola Hornsey


Warwick Isaacs

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
Nicola Hornsey

Maori Health Advisory Group - non-statutory
The Maori Health Advisory Group advises the Board on issues related to Maori health.
MEMBERS
Peter Lyman, chair
Peter Binns, deputy chair
Mandy Homes (Arowhenua)
Koriana Waller (Arowhenua)
Suzanne Eddington (Waihao)
Raeleen De Joux (Te Aitarakihi)
Viv Wood (Waihao)


Terry Kennedy

Board Interests Register at June 30, 2012

Peter Lyman

Richie Smith

Ngaire Whytock

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: AIM 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 representative on Safer Communities Committee of Timaru District Council

Murray Cleverley MBA, FEcD, AFNZIM

Elected member, Board Chair

Principal Officer: Trust Aoraki

Managing Director: Business Class Ltd

Chairman: All Risk Insurance Ltd, Opihi Vineyard Ltd, Warbirds over Wanaka

Director: Canterbury Economic Development Co. Ltd, NZ Petfoods Ltd, Shoe Shield Ltd, Animal Care Solutions, Sky Solar Holdings Ltd, NZ Chambers of Commerce, Auckland Adventure Jets Ltd, District Health Boards New Zealand, South Island Neurosurgical Services Board

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

Trustee: Mid and South Canterbury Community Trust

Board member: Presbyterian Support South Canterbury Inc, Lake Tekapo School Board of Trustees

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

Planning for the Future

Decisions were made in the 2011/12 year that will significantly impact health services in South Canterbury over the next 20 to 30 years. These initiatives required significant focus and energy to ensure the best long-term solutions for the people of South Canterbury.

SOUTH ISLAND ALLIANCE

The South Island Alliance (a partnership between the five south island district health boards) is making steady progress towards a more clinically and financially sustainable south island health system. Good advances have been made in the 2011/12 year and plans for improving shared services are making a difference. The South Island Alliance will deliver shared services under the South Island Regional Services Health Plan. Representatives from South Canterbury DHB are involved at a governance level, and are working in each of the work streams. Achievements include the roll out of InterRAI across the south island, resulting in fair and consistent access to services for older people.

SOUTH CANTERBURY HEALTH SERVICES PLAN

One of the first decisions made by the Board in the 2011/12 financial year was to sign off the first South Canterbury Health Services Plan. This plan will guide the future shape and direction of health and disability services in South Canterbury. The vision of the Health Service Plan is to be "the best provincial health service in the land". This vision is challenging. Over the next decade South Canterbury will face considerable pressure with investment needed in hospital and community services, workforce pressures, and a tough fiscal outlook. The plan identifies five key themes which will be priorities for investment:

- Prevention and early intervention
- Ensuring a resilient primary care sector
- Achieving seamless patient flow
- Becoming a centre of excellence for older persons care
- Offering the best hospital services

Meeting the Health Targets

The Minister of Health set six health targets for all district health boards to work towards in the 2011/12 year, challenging health professionals working in both the community and the hospital.

	Target 2011/12	Result start of year	Result end of year	Did we meet target?
Percentage of patients admitted, discharged or transferred from the Emergency Department within six hours	95%	93%	98%	yes
Percentage of agreed elective surgery provided to patients	100%	99%	104%	yes
Percentage of cancer patients needing radiation treatment who receive this within four weeks of their first specialist assessment	100%	100%	100%	yes
Percentage of two-year-olds fully immunised	95%	93%	96%	yes
Percentage of hospitalised smokers provided with advice and help to quit smoking	95%	97%	96%	yes
Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years.	60%	28%	42%	no*

* New target in 2012.

SMOKEFREE AWARD

Minister of Health Tony Ryall and Rangitata MP Jo Goodhew recognised the work of the Smokefree team with an award for their work on the "supporting hospitalised smokers to quit" health target. Mr Ryall said: "Congratulations to South Canterbury DHB for your hard work … In the last year at South Canterbury DHB, 1,867 smokers were admitted to hospital and 1,740 were offered brief advice to quit. That equates to 44 fewer smokers and 653 years of life added back to your community."

The Year in Review

Attracting and Keeping 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 2011/12.

INCUBATOR PROGRAMME VISITS HIGH SCHOOLS

Senior high school students gained a unique perspective on working in the health sector through "Programme Incubator" in 2012. It has always been challenging to provide work experience in a busy health environment such as a hospital, where factors such as patient privacy and health and safety need to be addressed. Programme Incubator brings the health workplace to the classroom. Through a variety of activities that are fun and educational, the students get "hands on" experience and hear from health professionals from a wide variety of roles. Programme Incubator was developed by the Hawkes Bay District Health Board four years ago and is now running in seven DHBs and more than 50 schools throughout New Zealand.

STAFF ADDRESS WORKPLACE CULTURE

The "Making a Difference Group" is a group of diverse DHB employees brought together by a common goal: zero tolerance of bullying and harassment. The group met regularly in 2011/12 to update policy, produce educational resources and train staff. Their aim was to make sure every staff member had the tools and support they needed to handle difficult situations appropriately.

Working Together

The integration of primary and secondary health services was a focus in the 2011/12 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 HEALTH PATHWAYS

South Canterbury DHB launched a new reference website for health workers on March 13, 2012. Aoraki HealthPathways allows health professionals in both primary and secondary care to quickly check the most up-to-date clinical management and referral pathway for their patient. It is not a public website. HealthPathways originally started in Christchurch in 2008 and is now being picked up by all DHBs across the South Island. SCDHB had several groups of hospital doctors, nurses and general practitioners working together since May, 2011, to develop a series of local patient pathways.

GP LOCUMS HIRED

A new scheme to provide on-going cover to South Canterbury general practitioners was introduced in 2011/12 by Primary and Community Services. Under the new scheme, the DHB recruits locum GPs to work in the district for several months at a time and subcontracts the locums to local general practitioners. Locum GPs recruited to the scheme are experienced practitioners who are approved by the New Zealand Medical Council. The scheme's first appointee, Dr Tom Sheddan, trained in Glasgow, Scotland.

CAREERS EXPO

Students and members of the public were encouraged to consider a health career at the South Canterbury Careers Expo.

A Focus on Facilities

The importance of health facilities to the community was highlighted in the Canterbury earthquakes. With this in mind, SCDHB placed considerable focus on facility development and improvements in 2011/12.

FACILITY MASTER PLAN

South Canterbury DHB is facing significant challenges from an ageing population, workforce shortages, and the rising demand for health care. These challenges are reflected in the development of the Facility Master Plan to guide redevelopment of the Timaru Hospital site over the next 10 years. The next step will be to move forward with improving the front entrance area, the mental health unit at Kensington, and climate control in the hospital.

RESPONDING TO EARTHQUAKE RISK

An engineer's review of all DHB buildings was commissioned before the major Canterbury earthquakes in September, 2010, and February, 2011. This review, along with lessons learned in the earthquakes, resulted in extensive changes to some DHB buildings and infrastructure in the 2011/12 year. This included strengthening the Health Care Linen and Supply buildings to prevent bricks falling away from the walls in an earthquake. Further examination of the Garden's Block in 2012 questioned the safety of that building in a severe earthquake. It was decided to vacate the building. Garden's Block staff moved into the Administration Building and shared offices while the hunt was on for alternative office accommodation in Timaru.

COMMUNITY SUPPORT FOR AN MRI SCANNER

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 doctor'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 August 23, 2011, a fundraising campaign to bring an MRI Scanner to South Canterbury was launched as a joint project between the DHB and the Aoraki Foundation. Less than a year later, the community had donated $2.8 million – enough to buy the scanner and a building to house it. More than 4,000 organisations, families and individuals made donations. Members of the MRI Fundraising Campaign Committee say thankyou below.

END OF AN ERA AT KOWHAI HOUSE

Kowhai House was a 1930s two-storey brick building on the corner of High and Queen Streets. It was home to the Child and Adolescent Mental Health team for many years. The building was closed on December 13, 2011, on engineer's advice. Staff moved across the road to the Kensington Centre, which has become a new permanent home for the service. In June, 2012, the board decided to demolish Kowhai House as it was surplus to requirements.

Providing Excellent Hospital Services

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 2011/12.

ELECTIVE SERVICES

A concentrated effort to improve patient waiting times in 2011/12 resulted in big improvements for patients. By the end of the year there were no patients waiting longer than six months for their first specialist assessment (ESPI 2) and no patients waiting longer than six months for treatment (ESPI 5). Timaru Hospital was the first in the country to achieve this result. Timaru Hospital recorded 3039 elective surgical discharges, and about 30,000 attendances at consultant-led outpatient clinics in 2011/12.

EXPANDING "THE PRODUCTIVE WARD"

The Productive Ward – Releasing Time to Care programme focuses on improving ward processes and environments so frontline staff can spend more time on patient care and improve safety, reliability and efficiency. Now in its third year at South Canterbury DHB, the programme was rolled out further in 2011/12, including in the Timaru Hospital operating theatres. The programme is based on the "lean" philosophy devised by Toyota in the 1990s. This can be summed up as preserving value with less work. Working more productively on the wards is improving patient satisfaction, reducing waste and reducing staff frustration. In the medical ward, staff now spend 62 percent of their time directly caring for patients, up from 39 percent before the programme began.

RESPONDING TO CONCERNS ABOUT SUICIDE

DHB secondary mental health services stepped up to lead a community response to suicide in 2011/12. A new group called the South Canterbury Suicide Prevention Reference Group met for the first time at Timaru Hospital in December, 2011. Represented at the meeting were DHB mental health services, public health services, local iwi, the police, WINZ, and community organisations including Victim Support, the Senior Citizens' Association, Family Works and the Aoraki Multicultural Council. The new group started work on drawing up an action plan to promote mental health and reduce suicidal behaviour. The work continues into 2012/13.

MANAGING MEDICATION IN HOSPITAL

Timaru Hospital joined other hospitals around the country in rolling out the National Medication Chart in 2011/12. The National Medication Chart (NMC) keeps a record of all the medications taken by a patient while they are in hospital. Each patient has their own chart which forms part of their patient record. The national chart has been created by the Health Quality and Safety Commission. It standardises the way medicines are prescribed across the country and reduces the risk of medication errors, making a hospital stay safer for patients.

The Year in Review

Improving Safety and Quality

ACCREDITATION AND CERTIFICATION

A certification/accreditation survey of Timaru Hospital took place in May, 2012. 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. A group of surveyors from the Designated Audit Agency spent four days on the Timaru Hospital site meeting patients, family/whanau and staff. Timaru Hospital was found to provide a high standard of service overall, with some recommendations for improvement.

Strong Clinical Leadership

CLINICAL GOVERNANCE REVIEW

Clinical Governance has been defined as "the framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish." In 2011/12 the DHB established the new role of General Manager, Clinical Governance, and started work on a review that will determine a future clinical leadership structures to guide the development of primary and secondary health services in South Canterbury.

CLINICAL LEADERSHIP GROUPS

The 2011/12 year was one of consolidation along with advances. Much of the work of the previous year continued within the Primary Care Clinical Governance Group. While their role is to provide leadership in primary care, this group enjoys representation from across the whole DHB, enabling a strong interface between primary and secondary services.
The continuing development and rollout of Aoraki Health Pathways, a tool to improve integration across primary and secondary sectors, has had a pleasing response.
The Clinical Council continues its work in the secondary sector, providing a voice to the Board on clinical matters via the Hospital Advisory Committee.
The six clinical director structure continues to function strongly within secondary care, providing leadership and direction to their departments, working in conjunction with service managers.

TIMARU HOSPITAL BIRTHS BY YEAR

Year	Triplets (sets)	Twins (sets)	Total Births
03/04	1	7	557
04/05	0	2	571
05/06	0	6	542
06/07	0	10	620
07/08	0	5	597
08/09	0	4	626
09/10	0	12	633
10/11	0	8	594
11/12	0	4	554

Reaching out to the 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. There were many new initiatives in the 2011/12 year.

FIVE YEARS OF WAVE

The WAVE (Wellbeing and Vitality in Education) health education project celebrated its five-year anniversary in 2012. WAVE focuses on health promotion for children in education settings in South Canterbury. Nutrition and physical activity are the two major issues being addressed by this project. 94 percent of education settings in South Canterbury DHB participate in WAVE. This includes all tertiary education providers and secondary schools, 95 percent of primary schools and 86 percent of early childhood education centres. The five-year evaluation showed a number of significant improvements. More early childhood teachers are working with external providers to promote physical activity. Primary schools have shown improvements in the area of nutrition (for example, students being able to identify healthy food choices) and more primary school teachers are learning about SunSmart.

HPV VACCINATION OFFERED IN SCHOOLS

In March 2012, public health nurses returned to some schools to offer the first dose of the Human Papilloma Virus (HPV) vaccination to teenage girls. Free HPV vaccination protects against many forms of cervical cancer. HPV vaccination is showing extremely positive results with 10 years immunity confirmed and the expectation of life-time coverage against vaccine preventable HPV infections. The vaccine is also provided by general practices.

NEW IMMUNISATION INITIATIVES

Two new immunisation programmes protected the young and the old in South Canterbury in 2012: free whooping cough vaccine for people caring for babies, and free pneumovax vaccine for older people at risk of pneumonia. Over the past two years whooping cough notifications in New Zealand have doubled. Parents and close caregivers are responsible for transmitting the disease to children in more than 70 percent of cases. The DHB offered free whooping cough booster vaccines to health professionals working with babies, to parents, caregivers and early childhood education staff. In a second new initiative, the DHB also offered a free vaccine to at-risk people aged over 65 to help prevent invasive pneumococcal disease, a major cause of death in older people.

Maori 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.

In 2011/12 the DHB established a Maori Health Plan for the district. It included both national initiatives to improve the health of Maori, and local initiatives targeted at the South Canterbury population.

GP PRACTICE ENROLLED POPULATION

AGE GROUP	MAORI	%	TOTAL POPULATION
0 - 5 years	313	10%	3137
6 - 17 years	647	10%	6769
18 - 24 years	517	7%	7049
25 - 44 years	685	6%	12050
45 - 64 years	501	3%	15962
65+ years	156	1%	10770

CONSULTATIONS AND ADMISSIONS

	MEASURE	MAORI	NON-MAORI
GP Consultations	number	23,693	155,154
	per patient	1.08	1.0
Nurse Consultations	number	5,316	27,625
	per patient	1.31	1.0
Ambulatory Sensitive Hospitalisation rates per 100,000 (30/6/12)	0-74 age group	88	120
	0-4 age group	49	84
	45-64 age group	111	126
Elective Surgery (30/06/11)	number	134	2975
	rate per 10,000 population	334.48	402
Cancer treatment starting within four weeks	percentage of patients	100%	100%

HEALTH SCORECARD FOR MAORI AND HIGH NEEDS POPULATION

AREA OF PERFORMANCE	INDICATOR	MAORI AND HIGH NEEDS	TOTAL POPULATION	TARGET	TREND
Screening Programmes	2 year old childhood immunisation	92%	94%	95%	▸
	HPV immunisation for girls 12+ years (1998 cohort)	40%	29%	65%	▲
	Flu vaccine for 65 years+	67.92%	66.79%	75%	▲
	Breast screening for women 45 - 69 years	74.43%	79%	75%	▲
	Cervical screening for women 20 -69 years	68.75%	73.38%	75%	▼
	Cardiovascular risk assessment 5 yearly 35+ years	46.10%	42.41%	60%	▲
	Diabetes detection	100%	100%	90%	▲
	Smoking status recorded	67.49%	63.73%	90%	▲
Patient Review/Advice	Diabetes annual review	65%	69%	72%	▲
	Diabetes management less than 65mmol/mol HbA1c	65%	76%	83%	▼
	Smoking cessation advice given in primary care	34.60%	33.98%	90%	▲
	Smoking cessation advice given in secondary care	100%	96.60%	95%	▲
	Exclusively breastfeeding at 6 months	32%	27%	27%	▲
Mental Health	Access rates 0 - 19	3.99%	4.73%	2.93%	▲
	Access rates 20 - 64	7.98%	3.77%	6.41%	▲
	Access rates 65+	3.63%	2.50%	1%	▲
	Service users with crises intervention plan adult 20+ (excluding addictions)	100%	91%	95%	▸
	Service users with crises intervention plan adult 20+ (addictions only)	75%	97%	95%	▲

Statement of Financial Responsibility

FOR YEAR ENDED 30 JUNE 2012

1. The Board and management of South Canterbury Distirct 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 2012 fairly reflect the financial position and operations of South Canterbury District Health Board.

Murray Cleverley
Chair
26 October 2012

Ron Luxton
Deputy Chair
26 October 2012

Chris Fleming
Chief Executive
26 October 2012

South Canterbury
District Health Board

Independent Auditor's Report

To the readers of
South Canterbury District Health Board's
financial statements and statement of service performance
for the year ended 30 June 2012

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 statement of service performance of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 18 to 44, that comprise the statement of financial position, statement of commitments and statement of contingencies as at 30 June 2012, 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 statement of service performance of the Health Board on pages 45 and 48 to 58.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 18 to 44:
    - comply with generally accepted accounting practice in New Zealand; and
    - fairly reflect the Health Board's:
        - financial position as at 30 June 2012; and
        - financial performance and cash flows for the year ended on that date; and

- the statement of service performance of the Health Board on pages 45 and 48 to 58:
    - complies with generally accepted accounting practice in New Zealand; and
    - fairly reflects the Health Board's service performance for the year ended 30 June 2012, including:
        - its performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
        - its revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 26 October 2012. 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.

Audit Report

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 statement of service performance are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, 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 statement of service performance 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.

An audit also involves 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;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance 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.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

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 statement of service performance 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.

Independence
When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants.

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

Matters relating to the electronic presentation of the audited financial statements and statement of service performance

This audit report relates to the financial statements and statement of service performance of South Canterbury District Health Board (the Health Board) for the year ended 30 June 2012 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 26 October 2012 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.

Statement of Significant Accounting Policies

FOR YEAR ENDED 30 JUNE 2012

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 2012.

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 26 October 2012. 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.

Statement of Significant Accounting Policies

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 surplus/deficit 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 surplus/deficit.

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

Statement of Significant Accounting Policies

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 surplus/deficit 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 surplus/deficit.

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 surplus/deficit. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the surplus/deficit will be recognised first in the surplus/deficit 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 surplus/deficit 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 surplus/deficit 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 surplus/deficit.

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

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.

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 surplus/deficit.

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 surplus/deficit.

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 surplus/deficit 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 principal 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 surplus/deficit.

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 surplus/deficit 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 surplus/deficit. 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 surplus/deficit.

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 surplus/deficit.

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 surplus/deficit.

24. Standards issued but not yet effective

Certain new standards, amendments and interpretations to existing standards have been published that are not yet effective for the year ended 30 June 2012, and have not been applied in preparing these financial statements. The adoption of these standards is not expected to have a material effect on the DHB's financial statements. Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the 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 new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. The DHB has not yet assessed the effect of the new standard and expects it will not be adopted early.

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 2012
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	Budget 2012	Actual 2012	Actual 2011
Revenue	*1*	168,806	170,227	167,859
Other Operating Income	*2*	1,919	2,536	2,356
Finance Income	*4a*	1,263	1,331	1,248
Total Income		171,988	174,094	171,463
Employee Benefit Costs	*3*	54,746	54,786	52,142
Outsourced personnel and other services		8,065	9,122	9,548
Clinical supplies		8,296	8,983	9,431
Infrastructure and non-clinical expenses		10,251	10,811	9,716
Payments to non-DHB health providers		60,706	59,737	60,975
IDF Outflows		23,730	24,003	21,825
Depreciation and amortisation expense	*7&8*	3,297	3,190	3,232
Finance costs	*4b*	530	302	353
Capital charge	*5*	1,783	1,681	1,929
Other operating expenses	*6*	1,084	1,175	1,258
Total Expenses		172,488	173,790	170,409
NET SURPLUS (DEFICIT)		(500)	304	1,054
Other Comprehensive Income				
Gains on property revaluations		-	-	981
Total Other Comprehensive Income		-	-	981
TOTAL COMPREHENSIVE INCOME		(500)	304	2,035

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 2012
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	Budget 2012	Actual 2012	Actual 2011
Balance at 1 July, 2011		23,449	25,511	23,254
Comprehensive income/(expense)				
Net Surplus/(Deficit) for the period	*9*	(500)	304	1,054
Other Comprehensive Income	*9*	-	-	981
Total Comprehensive Income		(500)	304	2,035
Capital Movements				
Repayment to Crown	*9*	(205)	(217)	(217)
Contribution from Crown	*9*	-	18	446
Mental Health Ringfence	*9*	-	-	(7)
Movement in Special Funds	*9*	-	-	-
Total of Capital Movements		(205)	(199)	222
Balance at 30 June, 2012		22,744	25,616	25,511

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 2012

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	Budget 2012	Actual 2012	Actual 2011
Public Equity				
General Funds	*9*	4,481	4,921	5,120
Retained Earnings	*9*	8,142	9,931	9,563
Equity from Donated Assets	*9*	988	963	1,031
Revaluation Reserve	*9*	8,265	9,246	9,246
		21,876	25,061	24,960
Special Funds	*9*	868	555	551
Total Equity		22,744	25,616	25,511
REPRESENTED BY:				
Current Assets				
Cash and cash equivalents	*10*	4,907	12,613	16,511
Financial Assets	*11*	15,000	5,000	10,000
Debtors and other receivables	*12*	4,777	5,156	5,483
Inventories	*13*	935	924	872
Patient Trust Funds	*10*	16	25	18
Special Fund Assets	*9*	-	556	551
Total Current Assets		25,635	24,274	33,435
Non Current Assets				
Financial Assets	*11*	3	12,781	3
Property, plant and equipment	*7*	30,488	28,220	29,475
Intangible assets	*8*	3,360	600	163
Total Non Current Assets		33,851	41,601	29,641
TOTAL ASSETS		59,486	65,875	63,076
LIABILITIES				
Current Liabilities				
Creditors and other payables	*14*	13,021	11,342	12,933
Employee entitlements	*15*	8,553	9,659	8,977
Borrowings	*16*	10,000	-	10,000
Patient Trust Funds	*10*	16	25	18
Total Current Liabilities		31,590	21,026	31,928
Non Current Liabilities				
Term Loans	*16*	-	12,778	-
Employee Entitlements	*15*	5,152	6,455	5,637
Total Non Current Liabilities		5,152	19,233	5,637
TOTAL LIABILITIES		36,742	40,259	37,565
NET ASSETS		22,744	25,616	25,511

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

STATEMENT OF CASHFLOWS
FOR THE YEAR ENDED 30 JUNE 2012
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	Budget 2012	Actual 2012	Actual 2011
CASH FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Ministry of Health & Other		170,424	174,434	169,875
Interest Received		606	1,331	1,248
		171,030	175,765	171,123
Cash was applied to:				
Payments to suppliers & employees		165,457	169,980	163,332
Capital Charge		1,727	1,681	1,929
Interest Paid		360	302	353
GST (net)		-	159	21
		167,544	172,122	165,635
Net cash inflow/(outflow) from operating activities	17	3,486	3,643	5,488
CASH FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from the sale of assets		-	11	44
Term deposits over 3 months		-	10,000	5,000
Decrease in Special Funds		-	-	308
		-	10,011	5,352
Cash was applied to:				
Purchase of fixed assets		7,313	2,350	3,252
Term Deposits over 3 months		-	17,778	-
Increase in Special Funds		-	3	-
		7,313	20,131	3,252
Net cash inflow/(outflow) from investing activities		(7,313)	(10,120)	2,100
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
New Borrowings - CHFA		-	12,796	-
Proceeds from Equity injections		-	-	446
		-	12,796	446
Cash was applied to:				
Repayment of loans		-	10,000	-
Repayment of Equity		205	217	217
		205	10,217	217
Net cash inflow/(outflow) from financing activities		(205)	2,579	229
Net increase/(decrease) in cash held		(4,032)	(3,898)	7,817
Opening Cash and cash equivalents		8,939	16,511	8,694
Closing cash and cash equivalents	10	4,907	12,613	16,511
Made up of:				
Balances at bank		4,907	12,613	16,511

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

STATEMENT OF COMMITMENTS
AS AT 30 JUNE 2012
IN THOUSANDS OF NEW ZEALAND DOLLARS

	Actual 2012	Actual 2011
Capital Commitments		
Property, plant and equipment	267	-
Total Capital Commitments	267	-
Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.		
Non-Cancellable Operating Lease Commitments:		
Less than one year	719	647
One to two years	382	488
Two to five years	622	537
Over five years	378	491
	2,101	2,163
Other Non-Cancellable Contracts:		
SCDHB has entered into non-cancellable contracts for the provision of goods and services.		
Details of the commitments under these contracts are as follows:		
Not later than one year	16,968	11,522
Later than one year and not later than two years	8,650	7,301
Later than two years and not later than five years	10,076	13,246
Over five years	-	-
	35,694	32,069
Total Operating Commitments	37,795	34,232

The DHB has entered into a number of service agreements with health providers for the provision of health services to the community. These agreements include fixed amount as well as demand-driven contracts.

STATEMENT OF CONTINGENCIES
AS AT 30 JUNE 2012

Contingent liabilities
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 employers ceased to participate in the scheme, SCDHB could be responsible for an increased share of the deficit.

The group has outstanding legal proceedings at year end. The DHB disputes these claims by third parties and believes it is unlikely that material financial loss will eventuate.

Contingent assets
There were no contingent assets as at 30 June, 2012 (2011: Nil)

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

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2012

IN THOUSANDS OF NEW ZEALAND DOLLARS EXCEPT WHERE OTHERWISE INDICATED

	Actual 2012	Actual 2011
1. Revenue		
Health & Disability Services (MoH contracted Revenue)	161,237	158,827
ACC Contracted Revenue	1,732	1,730
Inter District Patient Inflows	4,770	5,671
Other Health Revenue	2,488	1,631
	170,227	167,859
2. Other Operating Income		
Gain on sale of property, plant and equipment	17	(44)
Donations and bequests received	1	11
Rental Income	163	132
Other Non-health Revenue	2,355	2,257
	2,536	2,356
3. Employee benefit costs		
Wages and salaries	52,389	49,345
Contributions to defined contribution plans	897	860
Increase /(decrease) in employee benefit provisions	1,500	1,937
	54,786	52,142
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	1,331	1,248
	1,331	1,248
4b. Finance costs		
Interest Expense	302	353
	302	353
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 2012 was 8% (2011: 8%).		
6. Other operating expenses		
Fees to Auditor:		
Audit fees for financial statement audit	105	94
Directors' fees and expenses	284	264
Impairment of receivables (bad & doubtful debts)	14	13
Write down of Inventory	85	199
Operating Lease Expense	687	688
	1,175	1,258

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

7. Property, plant and equipment

Parent

	Land	Buildings	Plant/ Equipment	Motor Vehicles	Work in Progress	Total
Cost or Valuation						
Balance at 1 July 2010	2,572	26,272	21,647	1,523	208	52,222
Additions	75	784	2,094	48	194	3,195
Revaluations	(184)	(5,396)	-	-	-	(5,580)
Disposals	-	-	(1,018)	(41)	-	(1,059)
Balance at 30 June 2011	2,463	21,660	22,723	1,530	402	48,778
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
Accumulated depreciation and impairment losses						
Balance at 1 July 2010	-	5,259	17,346	1,254	-	23,859
Depreciation expense	-	1,393	1,540	137	-	3,070
Impairment losses	-	-	-	-	-	-
Disposals	-	-	(945)	(29)	-	(974)
Revaluations	-	(6,652)	-	-	-	(6,652)
Balance at 30 June 2011	-	-	17,941	1,362	-	19,303
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
Carrying amounts						
At 1 July 2010	2,572	21,013	4,301	269	208	28,363
At 30 June and 1 July 2011	2,463	21,660	4,783	168	402	29,475
At 30 June 2012	2,463	20,525	5,022	201	9	28,220

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

The Garden's Block building was vacated in July, 2012, due to a new seismic assessment which was obtained. Further information is being sought to determine the future of this building. Crighton Anderson, who are qualified property infrastucture valuers, advised that the land and building valuation carried out in 2011 required no further adjustment for impairment in 2012.

Revaluation
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.

Restrictions
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 2010	838	-	838
Additions	54	-	54
Disposals	-	-	-
Balance at 30 June 2011	892	-	892
Balance at 1 July 2011	892	-	892
Additions	667	-	667
Disposals	-	-	-
Balance at 30 June 2012	1,559	-	1,559
Accumulated amortisation and impairment losses			
Balance at 1 July 2010	567	-	567
Amortisation expense	162	-	162
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2011	729	-	729
Balance at 1 July 2011	729	-	729
Amortisation expense	230	-	230
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2012	959	-	959
Carrying amounts			
At 1 July 2010	271	-	271
At 30 June and 1 July 2011	163	-	163
At 30 June 2012	600	-	600

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 2010	4,891	8,484	747	2,269	5,996	867	23,254
Surplus/(deficit)	-	1,054	-	-	-	-	1,054
Transfer from/(to) retained earnings	-	32	284	-	-	(316)	-
Mental Health ringfence	-	(7)	-	-	-	-	(7)
Revaluation of land and buildings	-	-	-	(184)	1,165	-	981
Contribution from the Crown	446	-	-	-	-	-	446
Repayment to the Crown	(217)	-	-	-	-	-	(217)
Balance at 30 June 2011	5,120	9,563	1,031	2,085	7,161	551	25,511
Balance at 1 July 2011	5,120	9,563	1,031	2,085	7,161	551	25,511
Surplus/(deficit)	-	304	-	-	-	-	304
Transfer from/(to) retained earnings	-	64	(68)	-	-	4	-
Mental Health Ringfence	-	-	-	-	-	-	-
Revaluation of land and buildings	-	-	-	-	-	-	-
Contribution from the Crown	18	-	-	-	-	-	18
Repayment of equity	(217)	-	-	-	-	-	(217)
Balance at 30 June 2012	4,921	9,931	963	2,085	7,161	555	25,616

The unspent mental health ring-fence portion of retained earnings decreased to $0.492 million (30 June 2011: $0.523 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 reflects these transactions.

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

	Actual 2012	Actual 2011
Opening Balance	551	867
Transfer from Retained Earnings in respect of:		
Funds Received		
- Interest Received	4	26
- Donations and Other	1	5
Transfer to Retained Earnings in respect of:		
- Funds spent	(1)	(347)
Closing Balance 30 June	555	551

10. Cash and Cash Equivalents

	Actual 2012	Actual 2011
Cash on hand and at bank	613	4,511
Cash equivalents - term deposits	12,000	12,000
Total cash and cash equivalents	12,613	16,511

The carrying value of short-term deposits with maturity dates of three months or less approximates their fair value.
The weighted average effective interest rate for term deposits is 3.36% (2011: 3.47%)
SCDHB administers certain funds on behalf of patients. These funds are held in a separate bank account and total $25,000 (2011: $18,000)

11. Investments

	Actual 2012	Actual 2011
Current investments are represented by:		
Term deposits	5,000	10,000
Total current portion	5,000	10,000
Non-current investments are represented by:		
Term Deposits	12,778	-
Equity investment - SISSAL Share Capital	3	3
Total non-current portion	12,781	3
Total Investments	17,781	10,003

There were no impairment provisions for investments.
The equity investment in SISSAL is classified as an available-for-sale financial asset and is stated at its fair value, with any resultant gain or loss, except 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 surplus/deficit.

Maturity analysis and effective interest rates of term deposits
One term deposit has been taken for a term longer than 3 months. The deposit matures on 6 November 2012 and has an effective interest rate of 4.65%. 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%. Short-term deposits are invested at fixed rates ranging from 3.00% to 3.81%. As these deposits are at a fixed interest rate and measured at amortised cost, an increase or decrease in interest rates during the period would not impact the measurement of the investments and hence there would be no impact on the surplus/deficit or equity. The carrying amounts of term deposits approximate their fair value.

12. Debtors and other receivables

	Actual 2012	Actual 2011
Trade Debtors	1,090	738
Less: Provision for impairment	(13)	(2)
	1,077	736
Accrued Income	3,844	4,747
Prepayments	235	-
Total receivables & prepayments	5,156	5,483

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 as shown above.

13. Inventories

	Actual 2012	Actual 2011
Pharmaceuticals	372	330
Theatre supplies	451	425
Central stores	32	43
Other supplies	69	74
Total inventories	924	872

The write-down of inventories held for distribution amounted to $84,000 (2011: $199,000). 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

	Actual 2012	Actual 2011
Trade creditors	1,099	1,813
Capital Charge due	44	423
Income in advance	395	395
Accrued expenses	9,804	10,302
Total Payables and Accruals	11,342	12,933

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

	Actual 2012	Actual 2011
Current employee entitlements are represented by:		
Accrued salaries and wages	2,702	2,512
Annual leave	5,414	4,963
Maternity leave	-	75
Sick leave	117	83
Retirement gratuities	735	669
Senior doctor conference leave	108	123
Senior doctor sabbatical leave	32	33
Long service leave	265	250
Senior doctor study costs	286	269
Total current portion	9,659	8,977
Non-current employee entitlements are represented by:		
Sick leave	330	261
Retirement gratuities	3,795	3,238
Senior doctor conference leave	215	246
Senior doctor sabbatical leave	575	467
Long service leave	968	888
Senior doctor study costs	572	537
Total non-current portion	6,455	5,637
Total employee entitlements	16,114	14,614

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 2012 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 2012	Actual 2011
Current borrowings are represented by:		
Secured loan - Crown Health Financing Agency (CHFA)	12,778	10,000
	12,778	10,000
Total current portion	-	10,000
Non current portion	12,778	-
	12,778	10,000
Repayable as follows:		
Not later than one year	-	10,000
Later than one, not later than two years	-	-
Later than two, not later than five years	12,778	-
Beyond five years	-	-
	12,778	10,000
Interest rates:		
Crown Health Financing Agency interest rates	2.50%	3.00%

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 has an overdraft facility with ANZ Bank for $1million (2011: $1million). Additionally, undrawn facilities with CHFA total $nil (2011: $2.788million).

17. Reconciliation of Net Surplus/(Deficit) to Net Cash From Operating Activities	Actual 2012	Actual 2011
Net surplus/(deficit) after taxation	304	1,054
Add/(less) non-cash items:		
Depreciation and amortisation expense	3,169	3,230
Total non cash items	3,169	3,230
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	328	(413)
(Increase)/decrease in inventories	(53)	262
Increase/(decrease) in payables and accruals	(1,591)	614
Increase/(decrease) in employee entitlements	1,497	785
Net working capital movement	181	1,248
Add/(less) movements in other items:		
Gain(Loss) on sale of fixed assets	(11)	(44)
	(11)	(44)
Net cash (outflow)/inflow from operating activities	3,643	5,488

18. HSC Charitable Trust

SCDHB's predecessor was 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 from time to time de cide.
- 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 2012, the Trust had total revenue of $19,477 (2011 $21,434) and a net surplus of $3,069 (2011 net surplus $2,162). The Trust had assets of $233,009 (2011 $226,306) and liabilities of $7,198 (2011 $2,407) as at 30 June 2012.

19. 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.

(Continued over page)

19. Related party transactions and key management personnel (continued)
The following transactions were carried out with related parties other than those outlined on the previous page:

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 paid South Island Shared Services Agency Limited $52,103 for support with Funder operations during the period (2011 $234,000). The balance outstanding at year end was $nil (2011 $60,000).

HSC Charitable Trust
During the year ended 30 June 2012 the DHB invoiced the Trust a total of $3,262 (2011 $4,800) for costs associated with staff and other costs and $nil (2011 $99,500) for donated assets.

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 provided annual plan and project management services to SCDHB to the value of $19,330 during the year (2011; $57,000).
- Nicola Hornsey is a board member of Presbyterian Support. Presbyterian Support South Canterbury Inc provides aged care, home support, meals on wheels and other services to the SCDHB to the value of $6.68 million (2011 $6.04million).
- Riche Smith is a director of Klondyke Fresh Limited which supplied milk to SCDHB to the value of $nil during the year (2011 $42,000).
- Warwick Isaacs, a Board member, was the CEO of Timaru District Council until August 2011. During the year SCDHB paid Timaru District Council for rates and other municipal services to the value of $108,770 (2011 $127,000)
- 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.
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 (2011 nil).

Key Management Personnel Compensation	Actual 2012	Actual 2011
Salaries and other short-term employee benefits	1,879	1,734
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	-
Total key management personnel compensation	1,879	1,734

20. Board Member Remuneration and Committee Member Payments

BOARD MEMBERS PAYMENTS & ATTENDANCE

Member	Fees Paid	Attendance[1]
Paul Annear	$16,000	10
Peter Binns	$16,000	11
Murray Cleverley (chair)	$32,000	11
Rene Crawford	$16,000	11
Nicola Hornsey	$16,000	11
Warwick Isaacs	$16,000	7
Terry Kennedy	$16,000	10
Ron Luxton (deputy chair)	$20,000	9
Peter Lyman	$16,000	10
Richie Smith	$9,333	6
Ngaire Whytock	$16,000	9
TOTAL	**$189,333**	

[1] The board met11 times in 2011/12. Richie Smith resigned from the Board in January, 2012.

COMMITTEE MEMBER PAYMENTS & ATTENDANCE

Member	Fees Paid	Attendance
Paul Annear	$5,000	7
Jan Beck-Manawatu	$417	1
Peter Binns	$5,000	9
Murray Cleverley	$12,500	10
Michael Cotton	$2,917	6
Rene Crawford	$5,000	10
Peter Dalziel	$2,083	5
Raeleen De Joux	$3,333	8
Suzanne Eddington	$3,917	9
Janet Gilbert	$417	5
Tony Gilchrist	$1,250	4
Nicola Hornsey	$5,625	7
Warwick Isaacs	$5,625	8
Terence Kennedy	$5,000	9
Ronald Luxton	$5,625	8
Peter Lyman	$5,625	9
Christine Miller	$2,500	6
Diane Nutsford	$1,250	4
David Sibley	$2,500	6
Richie Smith	$1,458	
Koriana Waller	$3,333	8
Ngaire Whytock	$3,281	4
John Wilson	$417	
Vivien Wood	$2,083	4
Kathleen Wright	$417	2
TOTAL	**$86,573**	

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 2012, no employees (2011: 1) 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 (2011: nil).

21. Employee Remuneration

EMPLOYEE REMUNERATION

Range	Actual 2012	Actual 2011
$340,001 - $350,000	1	-
$330,001 - $340,000	3	-
$320,001 - $330,000	1	-
$310,001 - $320,000	2	4
$300,001 - $310,000	2	3
$290,001 - $300,000	5	2
$280,001 - $290,000	2	-
$270,001 - $280,000	1	3
$260,001 - $270,000	2	3
$250,001 - $260,000	3	4
$240,001 - $250,000	2	3
$230,001 - $240,000	5	3
$220,001 - $230,000	4	1
$210,001 - $220,000	1	4
$200,001 - $210,000	-	-
$190,001 - $200,000	-	-
$180,001 - $190,000	3	3
$170,001 - $180,000	1	2
$160,001 - $170,000	1	1
$150,001 - $160,000	-	2
$140,001 - $150,000	-	2
$130,001 - $140,000	1	3
$120,001 - $130,000	9	5
$110,001 - $120,000	1	2
$100,001 - $110,000	16	12
TOTAL	**66**	**62**
Clinical staff	52	49
Management & Other Staff	14	13

The $100k salary band is prepared on an accrual basis.

The current Chief Executive's salary is in the $310,001 to $320,000 range.

22. Financial Instrument Risks

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

The Board has a series of policies providing risk management for interest rates, operating and capital expenditures denominated in a foreign currency, and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury 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 2012, 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 $60,000 (2011 $75,000) higher or lower. This movement is attributable to increased or decreased interest revenue on short term bank deposits. Borrowings and longer term deposits are at fixed rates. The sensitivity is lower in 2012 than 2011 because of moving cash into longer term investments at fixed rates
.

Foreign currency risk
Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. SCDHB's Treasury policy allows for exchange hedging. However, there were no foreign currency forward exchange contracts (or option agreements) in place as at 30 June 2012 (30 June 2011 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:

	Actual 2012	Actual 2011
Cash at bank and term deposits	18,193	27,080
Debtors and Other Receivables	5,156	5,483
	23,349	32,563

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% (2011: 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.

	Actual 2012	Actual 2011
Counterpaties with Credit Ratings		
Cash at bank and term deposits		
AA rating	18,193	27,080
Total cash at bank and term deposits	18,193	27,080

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

	Gross Receivables 2012	Impairment		Gross Receivables 2011	Impairment
Trade receivables					
Not past due	767	-		660	-
Past due 0-30 days	110	-		60	-
Past due 31-120 days	213	13		18	2
Past due 121-365 days	-	-		-	-
Past due more than 1 year	-	-		-	-
Total	1,090	13		738	2

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 Cashflow	Less than one year	More than one year
2012				
Creditors and other payables	11,342	11,342	11,342	-
Borrowings - CHFA	12,778	12,778	-	12,778
Total	24,120	24,120	11,342	12,778
2011				
Creditors and other payables	12,933	12,933	12,933	-
Borrowings - CHFA	10,000	10,000	10,000	-
Total	22,933	22,933	22,933	-

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

	Note	Amortised Cost	Available for sale	Carrying amount actual	Fair Value actual
2012					
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*	556	-	556	556
Patient Trust Funds	*10*	25		25	25
Equity investments	*11*	-	3	3	3
		36,128	3	36,131	36,131
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	-	24,145	24,145
2011					
Financial Assets					
Cash and cash equivalents	*10*	16,511	-	16,511	16,511
Term Deposits >3 <12 months	*11*	10,000	-	10,000	10,000
Trade and other receivables	*12*	5,483	-	5,483	5,483
Special Funds	*9*	551	-	551	551
Patient Trust Funds	*10*	18	-	18	18
Equity investments	*11*	-	3	3	3
		32,563	3	32,566	32,566
Financial Liabilities					
Trade and other payables	*14*	12,933	-	12,933	12,933
Patient Trust Funds	*10*	18	-	18	18
Loan from CHFA	*16*	10,000	-	10,000	10,000
		22,951	-	22,951	22,951

23. Capital Management
SCDHB's capital is it's equity, which comprises accumulated funds and other reserves. Equity is represented by net assets.
SCDHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which imposes restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.
SCDHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure SCDHB effectively achieves its objectives and purpose, whilst remaining a going concern.

24. Post Balance Date Events
Significant post balance day events of which the Board are aware are as follows:
- Change in Banking Arrangements
Post balance date, SCDHB has decided to join the shared banking service provided by Health Benefits Limited (HBL). The funds that will be transferred to HBL , will be invested by HBL on behalf of SCDHB.

25. 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 $2.106M due to revenue input from the Ministry of Health from Primary care that was unbudgeted.
Employee benefit costs were overall on budget. There was an increase of $696K in Nursing Staff Wages, due to FTE being over budget, and $758K under budget on Medical Staff Wages due to the level of contract medical staff, accounted for as outsourced personnel.
Outsourced Personnel were $1.057M over budget, including $515K for Senior Medical Officers and $500K for Junior Medical Staff.
Clinical supplies were $687K greater than budget, including $413K on Medical Supplies. Budget savings of $200K were not achieved and there was an overspend of $123K on the Operating Theatre due to higher demand.
Infrastructure and non-clinical expenses were $560K higher than budget, including $442K in repairs and maintenance and costs related to seismic assessments and remedial work.

Statutory Information

Shares or Interest Held
South Island Shared Service Agency Limited (SISSAL) 60 fully paid ordinary shares, 6% interest held.

Donations
No donations were made.

Capital Invested $3,253,000

Partnerships, Joint Ventures or Other Involvements None

SUMMARY OF REVENUE AND EXPENSES BY OUTPUT CLASS 2011/2012

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Management		Treatment		Prevention		Support & Rehabilitation		Total	
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Revenue	43,155	42,923	94,798	93,374	3,648	2,967	32,493	31,768	174,094	171,032
Total Revenue	43,155	42,923	94,798	93,374	3,648	2,967	32,493	31,768	174,094	171,032
Expenditure										
Funder Arm	34,707	35,041	21,107	21,171	1,858	1,220	26,089	26,047	83,761	83,479
Provider Arm	7,619	7,404	72,032	70,592	1,733	1,695	5,844	5,302	87,228	84,993
Governance	693	778	1,516	1,611	57	52	535	619	2,801	3,060
Total Expediture	43,019	43,223	94,655	93,374	3,648	2,967	32,468	31,968	173,790	171,532
Surplus/(Deficit)	136	(300)	143	0	0	(0)	25	(200)	304	(500)

Good Employer

Leadership, Accountability and Culture:

Our leadership, working collaboratively within SCDHB and with other DHBs is key to providing direction and patient-focussed service delivery. Improving clinical leadership and the integration of primary and secondary care will continue to make a positive contribution in this regard. Clinical governance is now more established, strengthening its contribution to patient safety and oversight of clinical practice. The organisation is also continuing with its structured approach to develop current and future clinical leaders.

Recruitment, Selection and Induction:

SCDHB has developed a workforce strategy to support the attraction and retention of staff and the building of capability as a priority. Initiatives have been launched 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 value the contribution a diverse workforce with different skills, experiences and perspectives makes and this is reflected in our approach to recruitment and our work environment.

Safe and Healthy Environment:

SCDHB aims to maintain a safe and healthy environment and participates in the ACC Workplace Safety Management Practices Programme, maintaining tertiary level status. 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. Examples include subsidised gym membership, and various other free or low cost physical activities. Following the business report we have continued with our Health4You programme, targeting improved nutrition and encouraging physical activity ove the past year. Workshops were held for managers to identify the organisational and other barriers to healthy nutrition for staff.

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 this situation. Staff formed a team to evaluate and improve policy and procedrues and took an active role communication the new process and support available to all employees, encouraging the building of a healthy supportive workplace environment. SCDHB will be reviewing tools and solutions to consider a workload acuity process under the Safe Staffing and Healthy Workplaces agenda, in collaboration with the unions.

Remuneration and Recognition:

SCDHB endeavours to remunerate all staff fairly and consistently. The employee team formed to consider and implement initiatives which enable staff to feel more valued and appreciated are continuing with actions in this regard.

Employee Development:

Our performance review process provides 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.

Flexibility and Work Design:

The changing models of care, service delivery pressures and increased focus on productivity and sustainability will result in the development of new positions across primary and secondary services. For individuals who require flexible work arrangements SCDHB has a formal request process based on the Act for employees with caring responsibilities. Other individual requests for flexibility are considered on a case by case basis. Currently 32% of staff are full-time employees, 49% are part-time and 19% are casual.

Good Employer

WORKFORCE AT JULY 1, 2012

Staff Ethnicity	Number
German	1
Indian	3
Korean	1
Middle Eastern	7
NZ European	599
NZ Maori	39
Other Asian	10
Other European	38
Southeast Asian	3
Sri Lankan	1
Tongan	1
Not Available	99
Object	4
Other	14
TOTAL	**942**

Staff Mix by Gender	Number	Percentage
Female	794	84.29%
Male	148	15.71%
TOTAL	**942**	**100%**

Staff Mix by Hours of Work (FTE)	Number	Percentage
Casual/Pool	179	19.00%
Less than 0.25FTE	14	1.49%
0.25 to 0.49 FTE	75	7.96%
0.5 to 0.74 FTE	181	19.21%
0.75 to 0.99 FTE	190	20.17%
1 FTE	303	32.17%
TOTAL	**942**	**100%**

Staff Mix by Average Age	Age
Administration/Management	48
Allied Health	47
Medical	45.4
Nursing	46.5
Support Personnel	48
Average age of all staff	47

Statement of Service Performance

As a Crown entity, South Canterbury District Health Board is required to report annually on its service performance. On the following pages are the Board's achievements against the service performance measures described in its Statement of Intent and Annual Plan for 2011/12. The measures are aligned to the Board's key strategic objectives as outlined in the South Canterbury Health Services Plan. These are:

- prevention and early intervention,
- ensuring a resilient primary care sector,
- achieving seamless patient flow,
- becoming a centre of excellence for older persons care, and
- offering the best hospital services

The following service performance measures include national measures which are consistent across DHBs.

Smoking

Smoking kills an estimated 5,000 people in NZ every year and smoking related diseases are a significant cost to the health sector. Smoking is also a major contributor to inequalities in health and to a number of long-term conditions including heart disease, cancers and respiratory disease. Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Smoking Cessation	Number of people participating in smoking cessation programmes	548	1014	600	1205
	+Percentage of people who receive advice and support to quit smoking in the hospital setting	80%	93.7%	95%	96%
	+Percentage of people who receive advice and support to quit smoking in the primary care setting *	-	-	90%	35.4%
Reduce Smoking Initiation (calendar year)	+Percentage of Year 10 students who have never smoked	65.4% (2009)	66.7% (2010)	66%	72.5% (2011)
	Percentage of smokers in the SCDHB population	21.9% (2005 Census)	N/A**	20%	N/A**

* This was a new measure in 2011/12. We have made a good start on this indicator but have experienced several data capture challenges in the past year. These have since been resolved and it is expected that progress will improve in 2012/13.
** Census deferred until March 5, 2013.

Breastfeeding

By increasing breastfeeding rates, especially among Māori and Pacific people, the DHB will be promoting and protecting good health and independence, as breastfeeding benefits the physical and emotional health of both mothers and infants. The measure contributes to the high level outcome of New Zealanders living longer, healthier and more independent lives.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Breastfeeding Rates	+Percentage of babies breast-fed (exclusive and full) at six weeks	67.7% (2009)	65% (2010)	68%	73% (2011)
	+Percentage of babies breast-fed (exclusive and full) at 3 months	54% (2009)	52% (2010)	57%	54% (2011)*
	+Percentage of babies breast-fed (exclusive and full) at six months	25.5% (2009)	24% (2010)	26%	26% (2011)
Baby Friendly Hospital Initiative	+SCDHB Maternity Facility is BFHI Accredited	Achieved	Achieved	Achieved	Achieved
Baby Friendly Community Initiative	+Number of NGOs that are working on breastfeeding initiatives	-	-	10	17
South Canterbury Breast Feeding Plan	+Delivery of initiatives in Breast Feeding Plan	-	-	Achieved	Substantially Achieved

* Informal feedback suggests that the proportion of women returning to work before infants are 3 months old has increased in response to the declining economic situation. This has subsequently impacted on breast feeding rates at 3 months.

+ Indicators with one plus sign are new this year.
++ Indicators with two plus signs have been updated from the 2011 Annual Report.

Statement of Service Performance

Screening

Population based screening services are mostly funded and provided through the National Screening Unit to help identify people at risk of illness Screening services include breast screening, cervical cancer screening, newborn hearing testing, and antenatal HIV screening.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Cervical Screening	Percentage of enrolled women aged 20-69 who have had a cervical screen in the last three years	76.05%	73.51%++	77%	73.82%*
	Percentage of high needs enrolled women aged 20 -69 years who have had a cervical screen in the last three years	72.82%	69.51%++	75%	69.40%*
Breast Screening	Percentage of high needs enrolled women aged 45-65 who have had breast screening mammography in the national mammography screening programme	73.48%	77.96%++	75%	74.43%
PHO Performance Programme	PHO Performance Programme targets for screening are met	-	-	-	Not Achieved**

* Cervical screening rates are based on a projected population denominator. We believe this declining performance is a statistical artefact. The individual practice systems cannot identify the volume of women not screened.
** Performance against PPP targets is variable with full achievement for some targets. Data capture difficulties continue to be a challenge but we are making progress.

Immunisation

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Two-Year-Old Immunisation Rates	Percentage of two-year-olds fully immunised for their age at 24 months	91%	95%	91%	94%
Flu vaccination for over 65-year-olds	Percentage of over 65-year-olds receiving the flu vaccination	-	-	65%	66.31%
Cold Chain Failures	+Number of reported cold chain failures	-	-	0	7*

* One practice experienced two events due to some demolition work being carried out. Of the seven failures one required destruction of vaccine.

Diabetes and Care Plus

Long-term conditions comprise the major health burden for New Zealand now and in the future. These conditions are the leading cause of death and disproportionately affect Māori and Pacific people. As the population ages and lifestyles change, these conditions are likely to increase significantly. Improving outcomes for people with diabetes and cardiovascular disease will take a 'whole of system' approach that encourages healthier lifestyles and supports early diagnosis, management plans and access to treatment.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Diabetes Annual Review	Percentage of people with diabetes who have had an annual review	-	61%	72%	69%*
Diabetes Management	Percentage of people with diabetes who have a HbA1c equal to or less than 8	-	83%	83%	76%**
Care Plus Programme	+ and ++Number of people enrolled in the Care Plus programme each quarter	-	2692	2600	2821
	Percentage of eligible people enrolled in the Care Plus Programme	78.8%	79.8%	>80%	83.5%

* Good steady progress for total population. Māori specific performance has improved from 39% to 65%. There is a data lag for this indicator.
** HbA1c measure has changed to target of 65mmol/mol.

Statement of Service Performance

Oral Health

Regular dental care has life-long benefits for improved health and wellbeing. Early contact with health promotion and prevention services and reduced risk factors, such as poor diet, has lasting benefits in improved nutrition and healthier body weights. Māori children are three times more likely to have decayed, missing or filled teeth. Improved oral health is a proxy measure of equity of access and the effectiveness of mainstream services in targeting those in most need.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Pre and primary-school dental health	Number of children under five enrolled in DHB funded dental services	2,448	2,624	3,240	2,340*
	Percentage of children caries free at five years of age:				
	Māori	44.44%	33%	51%	31%
	Other	67.09%	64%	68%	62%
	Total	64.07%	60%	66%	58%*
	+Number of pre-school and primary school children who have been examined according to their planned recall	-	-	-	Pre-school 95% Primary school 93%
	++Proportion of children with DMFT at Year 8:	(2009)	(2010)		(2011)
	Māori	2.19	1.79	2.15	2.06
	Other	1.64	1.07	1.35	1.22
	Total	1.68	1.13	1.45	1.29
Adolescent dental health	Percentage of adolescents using oral health services	83%	85%	88%	91.4%

* There appears to be some discrepancy in the targets which have been used for South Canterbury as the number of children under 5 appears different to our birth rate and the Ministry projections. Canterbury DHB Clinical Director, Community Dental Service is reviewing the data. It is also expected that the introduction of more intensive preventative actions will lead to improvement and a reduction in inequalities.

Medication

There are often changes to a patient's medicine when their care is handed over to other health professionals, such as during admission to, transfer or discharge from hospital. Some of these medicine changes are unintentional due to poor information and some are intentional but not clearly documented. Both types of change can result in medication errors and/or patient harm. Medicine reconciliation is about obtaining the most accurate list of patient medicines, allergies and adverse drug reactions and comparing this with the prescribed medicines and documented allergies and adverse drug reactions. Any discrepancies are then documented and reconciled.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Medicine Reconciliation	+Percentage of patients whose medicines are reconciled within 24hours of admission or transfer.	-	-	75%	N/A*
Medication adverse events, secondary services	+Average number of medication adverse events each quarter which may cause patient harm	-	-	-	45**

* Medicines reconciliation has not progressed beyond a trial period as we are awaiting an electronic format. Due to an anticipated delay with this initiative a paper based solution will be rolled out over 2012/13.
** This result relates to those actual and potential medication adverse events which have been self-reported and covers prescribing, dispensing and administration errors. Most events do not result in patient harm. This measure is recorded to identify opportunities to improve medication management.

Community Pharmacy

Pharmacy services are aligned to the requirements of the Pharmaceutical Schedule including the provision and dispensing of medicines. Pharmaceuticals are demand driven and there will be an increase in the dispensing of pharmaceutical items as more people engage with health services. The DHB has participated in national pharmacy initiatives to improve the effectiveness and use of pharmaceutical treatments.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Community pharmaceuticals	++Total community dispensing volume	1.194 million items	1.383 million items	1.350 million items	1.430 million items*

* Estimated July 2012. The target is an indicative forecast by Pharmac, who manage the pharmaceutical schedule and budget. Actual volume is demand driven.

Statement of Service Performance

Diagnosis

These are services a health professional may refer a person to for help to diagnose a health condition, or as part of treatment. These services are demand driven and are likely to increase as more people engage with health services and respond to health promotion messages about early diagnosis.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Testing and Diagnostics	++Number of community laboratory tests	228,886	244,407	233,000	215,695*
	Number of community radiology examinations	10,161	11,341	10,161	11,249**
	+Number of audiology procedures	1,527	1,421	1,400	1,374***

* Estimated July 2012.
** Demand driven with GP direct referrals for some medical imaging.
*** Demand driven.

Emergency/Acute Care

ED length of stay is seen as an important measure of the quality of care in our public hospital. Long stays in ED reflect overcrowding which can lead to compromised standards in privacy and dignity for patients and are linked to negative outcomes such as increased mortality and longer lengths of stay.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Emergency Services	Percentage of patients admitted, discharged or transferred from the Emergency Department within six hours	96.2% ++	96.4%	96.5%	96.5%
	++Number of acute medical/surgical admissions to hospital	6,800	6,748	6,800	6,885*

* Demand driven. This measure is now reported as a percentage.

Maternity

Maternity services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Maternity Services	++Number of deliveries in SCDHB funded facilities	623	598	-	541
	Number of first obstetric consultations	-	-	-	N/A
	Number of subsequent obstetric consultations	-	-	-	N/A
	Percentage of caesarean sections performed	22%	24%	22%	23.6%*
	++Average post natal length of stay	2.7 days	2.7 days	2.5 days	2.5 days

* While this result is slightly above the target of 22%, it is maintained within acceptable national intervention rates and is favourable against national benchmarking data.

+ Indicators with one plus sign are new this year.
++ Indicators with two plus signs have been updated from the 2011 Annual Report.

Statement of Service Performance

Electives

The Government wants the public health system to deliver better, sooner, more convenient health care for all New Zealanders. In order to achieve this, the growth in elective surgical discharges must keep up with population growth. This in turn will increase access and achieve genuine reductions in waiting times for patients. All patients also have the right to clarity about whether they will receive publicly funded treatment, timeliness and fairness in ensuring that prioritisation status is based on a patient's level of health need compared to other patients.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Elective Services	++Number of elective (planned) case-weights (CWD)	3,506	3,547	3,610	3,663
	+Number of total elective surgical discharges	2,877	2,971	2,887	3,039
	++Number of health target elective discharges	2,611	2,670	2,634	2,730
	++Number of first specialist assessments (FSAs)	8,119	8,487	7,674	8,539
	++Percentage of day surgery	60.8%	61.1%	64%	61.7%*

* Target not met but is an improvement on 2010/11.

Cancer Treatment

Cancer treatment is provided across all DHBs, with different services provided at different DHBs. This requires DHBs to collaborate across boundaries to ensure services are integrated and patients receive seamless care.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Cancer Treatment Waiting Times	Percentage of patients treated within four week waiting time	89%	100%	100%	100%

Length of Stay

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Acute Admission Length of Stay	+Average standardised length of stay for acute admissions	4.43 days	4.42 days	4.0 days	4.66 days*

* The target is to treat and discharge acute admissions within 4.0 days, i.e. to reduce length of stay. SCDHB has continued to have a large number of patients staying more than 8 days. These were a mixture of elderly orthopaedic patients with complex co-morbidities, and medical patients, many of whom were elderly with complex social issues. A report has been generated identifying all patients with a length of stay over 8 days. This can be accessed by all clinical nurse managers from the acute services, who are using this tool to ensure case reviews are undertaken on these patients to identify barriers to discharge. A formal plan is then developed in conjunction with the multi disciplinary team. This process has been working well in the medical and surgical wards and has identified a number of blocks in patient flow.

Avoidable Admissions

There are a number of admissions to hospital for conditions seen as preventable through appropriate early intervention and a reduction in risk factors. These avoidable admissions provide an indication of the access and effectiveness of screening, early intervention and community-based care. A reduction in these admissions will reflect better management and treatment of people across the whole system and will free up hospital resources for more complex and urgent cases. The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Avoidable Hospital Admissions	++Avoidable hospital admission rates:				
	0-4 Māori	61.4	66	95	49
	0-4 Other	96	97	98	84
	45-64 Māori	79.8	103	95	111*
	45-64 Other	123.2	122	112	126*
	0-74 Māori	78.5	89	95	88
	0-74 Other	116.6	120	111	122*

* South Canterbury has not meet these targets for some years. There are a number of initiatives underway to improve performance e.g. CVD/diabetes projects. Note there is a data lag for this indicator.

Readmissions to Hospital

Unplanned acute readmission rates are a measure of quality of care, efficiency and the appropriateness of discharge for hospital patients. They are also a quality counter-measure to balance improvements in productivity and reduced length of stay.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Unplanned Readmissions	Percentage of patients readmitted	9.97%++	9.75%	9.23%	9.78%*

* SCDHB ranks as the 7/20 DHB for this indicator. Formal management plans are developed by the multi disciplinary team for patients with complex and chronic needs prior to discharge. These plans are shared with the patient so they have an understanding of what health care providers can offer them and what limitations there may be.

Mortality

Mortality rates are a measure of clinical outcomes for hospital patients and are related to the safety and efficacy of treatment. Maintaining or reducing our current mortality rates will demonstrate the maintenance of clinical quality standards and a balance against productivity gains such as reduced length of stay.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Mortality Rates	Mortality rates within 30 days	-	-	1.33	1.47*

*The number of deaths within 30 days includes a high number of hospitalisation events for patients in end stages of disease. SCDHB has completed a review of palliative care in the district. The recommendations include improved access to care in the community. We have started to build and promote community-based services to increase support for those who wish to die in their own home and avoid hospitalisation at the end of life.

+ Indicators with one plus sign are new this year.
++ Indicators with two plus signs have been updated from the 2011 Annual Report.

Statement of Service Performance

Helping Older People

These are services that determine a person's eligibility and need for publicly funded support services and then determine the best mix of supports based on their strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The number of assessments completed indicates access and responsiveness.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
NASC - Needs Assessment and Service Coordination	++Number of InterRAI first assessments	250	278	350	288
	+Number of InterRAI reassessments	N/A	968	1020	1284
	+Number of service co-ordination events	1560	1683	1600	1670
	Response time to assessment	-	Target Achieved	85% within 20 days	Target Achieved

Respite Care

These are services giving people a break from a routine or regimented programme so crisis can be averted or a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. They may include support and respite for families, caregivers and others. Services are expected to increase over time as more people are supported to remain in their own homes.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Day Programmes and Respite Care	++Number of day programme days	140	174	140	144*
	++Number of respite care bed days	1900	2132	2200	2700*
	+Percentage of allocated respite care used	93%	93%	90%	95%

* These results are demand driven. The provision of day programmes and respite care allows for clients to be supported to remain in their own homes and the targets set are the minimum expected.

Aged Care

These are services provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days alongside an increase in the number of home-based support service hours indicates more people being successfully supported to continue living at home.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Age Related Care	++Number of funded aged residential care bed nights	159,140	177,674	159,600	175,811*
	+Number of rest home new admissions	150	151	155	141*
	Percentage of older people living in aged residential care	5.3%	5.9%	5.4%	6.12%**

* Result is demand driven. The target set for 2011/12 assumed the return of earthquake evacuees to Canterbury, however these people have remained in our region.
** Result is demand driven. The target set for 2011/12 assumed the return of earthquake evacuees to Canterbury however some of these people have remained in our region.

Support at Home

These are services designed to support people to continue living in their own homes and restore functional independence. They may be short or long-term in nature. An increase in the number of people being supported indicates increased capacity in the system, and success is measured against a decreased or delayed entry into residential or hospital services.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Home Based Support Services	++Number of people receiving home based support	968	-	1020	981*
	+Number of people receiving home based support with high complex need	357	-	380	308**
	+Number of people receiving home based support with very high complex need	30	-	40	48

* Result is demand driven.
** Result is demand driven. Movement of clients to the complex category has reduced in 2011/12 due to the restorative model of care improving outcomes for clients.

End of Life

These are services that improve the quality of life of patients and their families facing life threatening illness through the prevention and relief of suffering by early intervention, assessment, the treatment of pain and other support.

AREA OF PERFORMANCE	MEASURE	BASELINE FROM 2009/10	RESULT 2010/11	TARGET 2011/12	RESULT 2011/12
Palliative Care	Number of palliative care patients provided with community palliative care by South Canterbury Hospice.	113	113	113	144

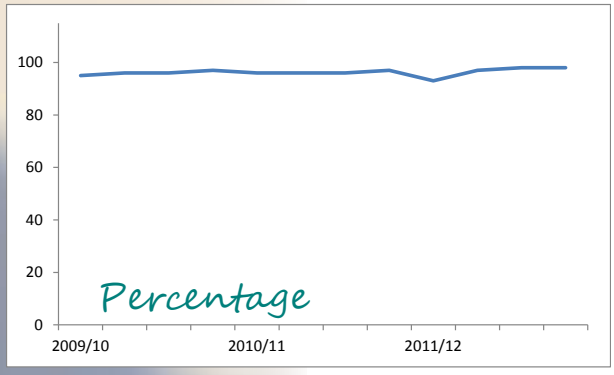
+ Indicators with one plus sign are new this year.
++ Indicators with two plus signs have been updated from the 2011 Annual Report.

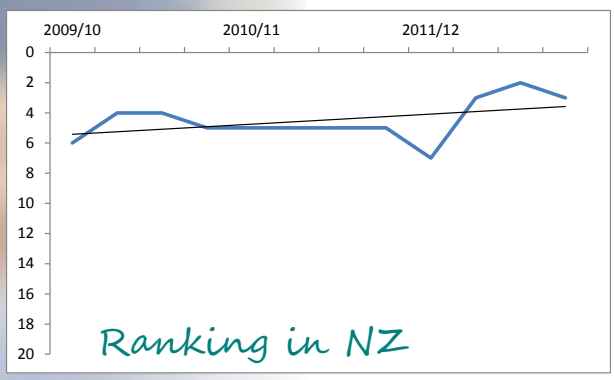
Health Target Results

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 2009/10	95	6th
Q2	96	4th
Q3	96	4th
Q4	97	5th
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

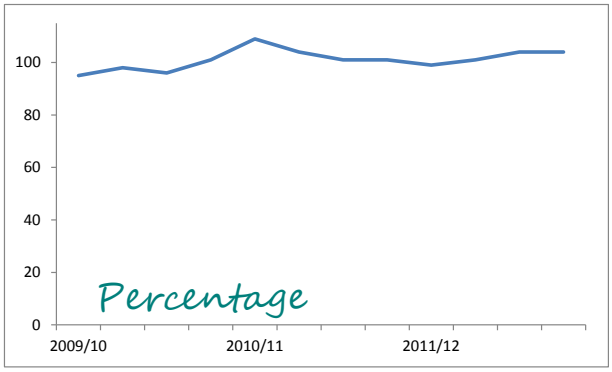


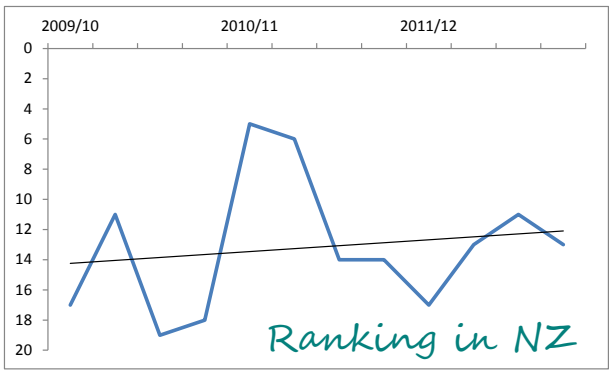


Improved Access to Elective Surgery

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 2009/10	95	17th
Q2	98	11th
Q3	96	19th
Q4	101	18th
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





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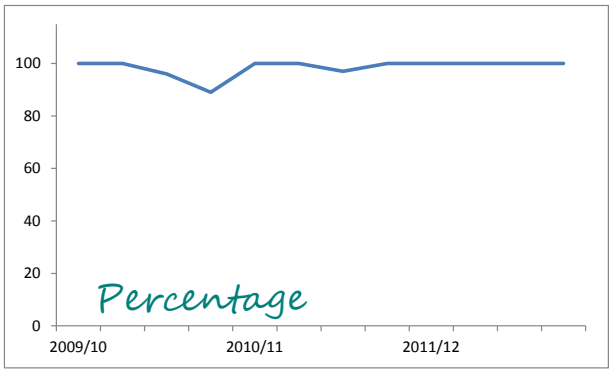
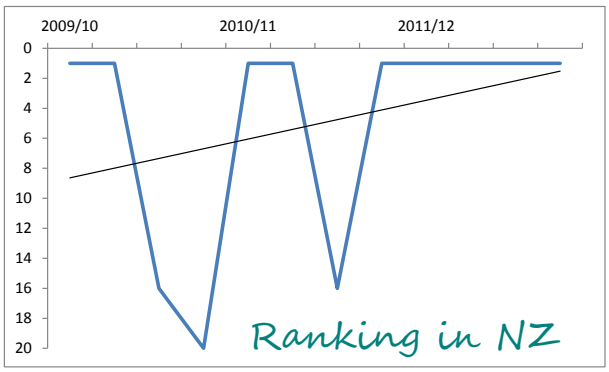
Health Target Results

Shorter Waits for Cancer Treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy. 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 2009/10	100	1st
Q2	100	1st
Q3	96	16th
Q4	89	20th
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

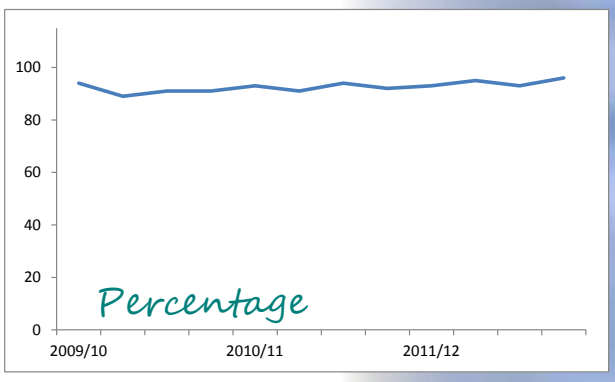


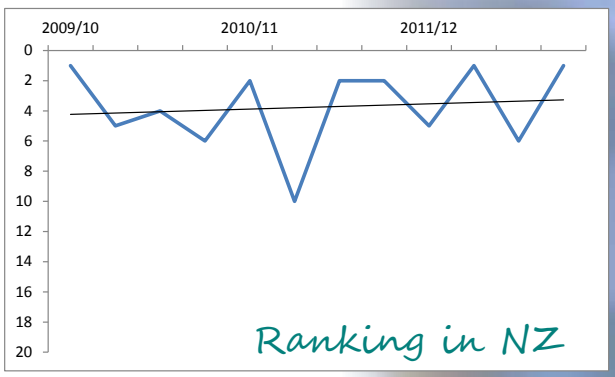


Increased Immunisation

The national immunisation target is 95 percent of two year olds will be fully immunised by July 2012.

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2009/10	94	1st
Q2	89	5th
Q3	91	4th
Q4	91	6th
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





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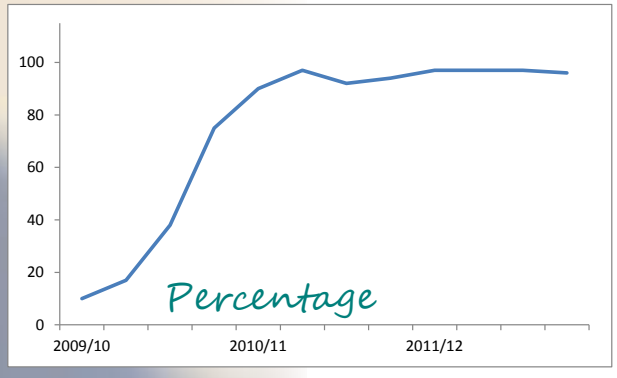
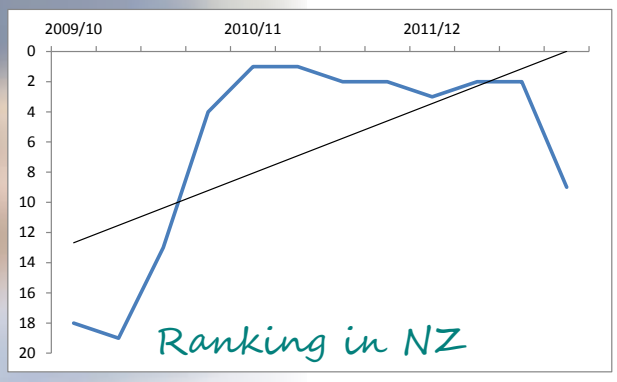
Health Target Results

Better Help for Smokers to Quit

The target is that 95 percent of hospitalised smokers will be provided with advice and help to quit by July 2012. The data covers patients presenting to Emergency Departments, day stay and other hospital based interventions.

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2009/10	10	18th
Q2	17	19th
Q3	38	13th
Q4	75	4th
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



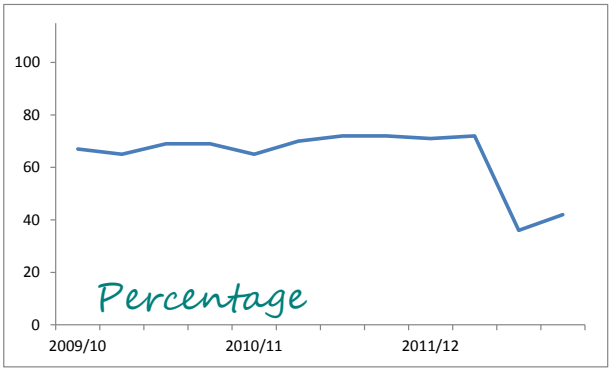


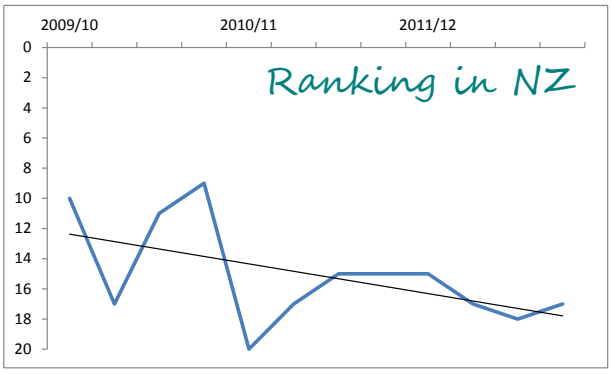
More Heart and Diabetes Checks

The target is that, by July 2012, 60 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. This target has changed over time and also included diabetes measures up until quarter two 2011/12.

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2009/10	67	10th
Q2	65	17th
Q3	69	11th
Q4	69	9th
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

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





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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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