South Canterbury
District Health Board

Annual Report

2014

www.scdhb.health.nz

A Snapshot

A year in health in South Canterbury

Summary of statistics from 1 July 2013 to 30 June 2014

19,146
emergency department presentations

11,263
inpatient discharges

29,529
specialist outpatients appointments

198
Major joint replacement procedures at Timaru Hospital

509,188
lab tests at Timaru Hospital and in the community

30,096
meals on wheels

310
mental health admissions

37,619
radiology examinations

41,770
district nurse community visits

1,094
chemotherapy attendances

635
births at Timaru Hospital

15,399
mental health face to face patient contacts

803
B4 School checks completed

2,671
elective operations (1768 as day surgery)

33,268
allied health professional patient contacts

97,668
patient meals at Timaru Hospital

From the Board

It is with pleasure we present this report detailing our positive performance for 2013/14. The South Canterbury District Health Board's (SCDHB) mission is to enhance the health and independence of the people of South Canterbury. We pride ourselves on punching above our weight and continuing our track record of excellent performance.

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

Individually these factors are important and a challenge to achieve, therefore our success across all performance measures, whilst operating within our financial means, is a proud achievement.

We continue to collaborate nationally and regionally on projects that ensure the effective and efficient delivery of healthcare, including significant representation on South Island Alliance groups. This means we take a collective responsibility for ensuring sustainable services across the South Island.

A selection of highlights from 2013/14 included:

- All health targets reached apart from CVD checks, where significant improvement was made.
- Mammogram screening – exceeded ministry target (target was 72%, we achieved 82.9%).
- B4 School checks – first in the country for the number performed.
- Childhood immunisations.
- Exceeded national expectations for timeliness scans of MRI, CT and urgent diagnostics colonoscopies.
- Met targets for readmission rates overall and 75 years and older.
- Significant reduction of falls with harm.
- Acute and elective length of stay target met.
- Did not attend (DNA) rate within target.
- Access and wait times for specialist mental health services met targets.

Our Members

All seven board members were re-elected in December 2013 elections demonstrating the communities' confidence in the current board members' performance in re-electing each one for another three year term. Of the appointed members, four new members began their term on 9 December 2013:

- Edie Moke
- Raeleen de Joux
- Murray Roberts
- Michael Boorer

Ongoing challenges for the board for 2013/14 and into the future include our ageing patients and workforce as well as exciting progression in the form of development and refurbishments to our facilities.

Our Kaumatua

Sadly this year saw the passing of Bruce Wikitoa our Kaumatua and employee for over 14 years.

Bruce was all things to all people. As well as our Kaumatua Bruce worked in our mental health unit, supported whānau in our hospital and provided significant contribution to our Te Reo Maori and Treaty of Waitangi workshops for our staff. Nothing was ever a problem and his smiling face and calming nature will be sadly missed.

Bruce was employed at SCDHB from 26 April 2000 to 10 July 2014.

Thank you

On behalf of the Board we would like to acknowledge the effort put in by staff, volunteers, and contracted providers both within the hospital and the wider South Canterbury health system. We appreciate and thank you all for the vital roles played by all providers. Your contribution is critical to the ongoing success and stability of health and disability services within the South Canterbury community.

Health is an important and unique sector that touches every one of us in the community, from newborn babies through to palliative care. The community and all the team should be very proud of the collective results our DHB has once again delivered.

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

Murray Cleverley
Chair

Ron Luxton
Deputy Chair

Nigel Trainor
Chief Executive

Contents

Nigel Trainor, South Canterbury District Health Board's Chief Executive

Registered Office

High Street

Private Bag 911, Timaru

TELEPHONE: 03 687 2100

FAX: 03 688 0238

EMAIL: ceo@scdhb.health.nz

WEBSITE: www.scdhb.health.nz

Auditor

Audit New Zealand

on behalf of the Auditor General

Bankers

Westpac Bank

Solicitors

Gresson Dorman & Co

PO Box 244, Timaru

Our Mission

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

South Canterbury District Health Board (SCDHB)

The SCDHB is governed by an 11 member board, six members are publicly elected and five are appointed by the Minister of Health. The Board concentrates on setting policy, approving strategy and monitoring progress towards meeting objectives. Management implements the Board's policy and strategies.

The Board's responsibilities include:

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

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

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

BOARD MEMBERS

Murray Cleverley, chair (elected)
Ron Luxton, deputy chair (elected)
Paul Annear (elected)
Peter Binns (elected)
Rene Crawford (elected)
Terry Kennedy (elected)
Ngaire Whytock (elected)
Edie Moke (appointed)
Raeleen de Joux (appointed)
Murray Roberts (appointed)
Michael Boorer (appointed)

Murray Cleverley
Chair

Ron Luxton
Deputy Chair

Raeleen de Joux

Rene Crawford

Peter Binns

Michael Boorer

Edie Moke

Ngaire Whytock

Murray Roberts

Paul Annear

Terry Kennedy

Board Committees

Current Board Committees

South Canterbury DHB has three statutory advisory committees, as well as three 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. Committees may include non-Board members who are appointed by the Board. Positions for committee members are advertised from time to time.

Community & Public Health Advisory Committee (CPHAC)

CPHAC advises the Board on the health needs and issues facing South Canterbury residents, and on the priorities for the use of health funding. It also advises the Board on how services funded and/or provided by SCDHB, and SCDHB's policies, will impact our population. Committee meetings, which are open to the public, are usually held every second month on the same day as the Board meeting.

Members

Ron Luxton (chair, board member)

Rene Crawford (board member)

Paul Annear (board member)

Peter Binns (board member)

Ngaire Whytock (board member)

Jan Gilbert

David Jack

Kevin Foley

Disability Support Advisory Committee (DSAC)

DSAC advises on the disability support service (DSS) needs of South Cantabrians and on the priorities for use of DSS funding. DSS includes assessment, treatment and rehabilitation, community-based services aimed at helping the disabled retain independence, and residential care. The committee makes sure that the services provided or funded, and the policies adopted, promote the inclusion and participation of people with disabilities in our society, and maximise their independence. Committee meetings, which are open to the public, are usually held every quarter.

Members

Ngaire Whytock (chair, board member)

Terry Kennedy (board member)

Raeleen de Joux (board member)

Peter Binns (board member)

Rene Crawford (board member)

Tony Gilchrist

Diane Nutsford

Margaret Wiberg

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. Committee meetings, which are open to the public, are held every second month on the same day as the Board meeting.

Members

Paul Annear (chair, board member)

Murray Roberts (board member)

Terry Kennedy (board member)

Ron Luxton (board member)

Michael Boorer (board member)

Christine Miller

David Sibley

Audit and Assurance Committee (AAC)

AAC is a non-statutory committee that ensures the Board appropriately discharges its responsibilities relative to financial reporting, regulatory compliance and risk management.

Members

Murray Roberts (chair, board member)

Murray Cleverley (board member)

Edie Moke (board member)

Ron Luxton (board member)

Michael Boorer (board member)

John Christie (Independent member)

CEO Remuneration Committee

This committee reviews and sets the remuneration of the Chief Executive in accordance with applicable State Services Commission guidelines.

Members

Murray Cleverley (chair, board member)

Murray Roberts (board member)

Ron Luxton (board member)

Maori Health Advisory Group

The Maori Health Advisory Group advises the Board on issues related to Maori health.

Members

Raeleen De Joux (chair, board member)

Edie Moke (board member)

Koriana Waller (Te Runanga o Arowhenua)

Suzanne Eddington (Te Runanga o Waihao)

Suzy Waaka (Te Runanga o Arowhenua)

Amanda Wills (Te Aitarakihi Trust)

Jo McLean (Te Runanga o Waihao)

Disclosure of Board Members' Interests

Paul Annear

Elected member; Physiotherapist in Private Practice (Timaru & Ashburton)

Shareholder & Director – FAIM Holdings – Family Company

Shareholder & Director – Timaru Holdings

Director. McLeod Building, Invercargill

Shareholder/Director Westhills Forestry Ltd

Daughter employed by Southlink Health as a NASC Assessor

Peter Binns

Elected member; MB, BChir, FRCS

Retired medical practitioner

Committee member: Timaru Greypower

Trustee, Line Trust SC

Murray Cleverley

Chair, South Canterbury DHB

Elected Member, South Canterbury DHB

Chair, Canterbury DHB

Director, Trust Aoraki

Managing Director of Business Class Ltd

Chairman, Opihi Vineyard Ltd

Director, Canterbury Economic Development Co. Ltd

Director, Warbirds over Wanaka

Director, Shoe Shield Ltd

Director, Animal Care Solutions

Director, Sky Solar Holdings Ltd

Partner, Cleverley Holdings Partnership

Director, SI Neurosurgical Services Board

Director, KCL Properties Ltd

Employee, CERA

Terry Kennedy

Elected member

Stroke Club, Member

Ron Luxton

Ronal (Ron) Luxton.

Board Deputy Chair, Elected Member

Chair, Aoraki MRI Charitable Trust

Trustee, Aoraki Foundation

Justice of the Peace

Trustee, Green-gables Trust.

Ngaire Whytock

Elected member

Registered Nurse

Member of Alzheimers SC Inc.

Residents Advocate for Presbyterian Support South Canterbury

Rene Crawford

Employed by SCDHB as an Associate Director of Allied Health

Member of the Physiotherapy Primary Intervention Group – Osteoarthritis Project, this project is funded in part by the SCDHB

Employed by University of Otago School of Physiotherapy as a Professional Practice Fellow – University of Otago School of Physiotherapy has a contract with SCDHB.

Brother employed by SCDHB as a Consultant Orthopaedic Surgeon

Physiotherapy New Zealand Education Group Executive Committee member

Physiotherapy New Zealand South Canterbury and Canterbury Branch Member

Board of Trustee – Cannington Primary School

Trustee – Temford Family Trust

Member Tennis South Canterbury Board

Murray Roberts

Appointed Member SCDHB

Director, Trust Aoraki Ltd

Principal Officer, Trust Aoraki Ltd

Consultant/Business Advisor to SGS New Zealand Ltd

Board Chair, Harlequins RFC Inc

Public Shareholder; Pharmacybrands Ltd

Trustee – Morrison Family Trust

Trustee – Meyer Family Trust

Trustee – Roberts Family Trust

Sister In Law employed at Christchurch Public Hospital as Service Manager:

Emergency Department, Intensive Care, Hagley Outpatients, Hyperbaric Medicine.

Edie Moke

CDHB Board member

Director of Health Benefits

Chair, Finance Audit & Risk, Health Benefits Ltd

Raeleen de Joux

Royal Australasian College of Physicians – Maori Health Committee member

National Cervical Screening Programme – casual contracted smear taker

Community Trust Mid/South Canterbury – Trustees

Timaru Maori Women's Welfare League – Secretary

Whakawhetu; Auckland University – Expert Advisory Group

NZ College of Midwives - Maori Advisor

Daughter employed by SCDHB

Michael Boorer

Member of the Order of St John

Sister employed by SCDHB as a Hospital Aide at Talbot Park

Director, Timaru Electricity Ltd

Director, SmartCo Ltd

Director, On Metering Ltd

The Year in Review

Working Together

The integration of primary and secondary health services continues to be a focus in the 2013/14 year both locally and across the South Island.

SOUTH ISLAND ALLIANCE HIGHLIGHTS

The past 12 months has seen several priority Alliance projects being introduced and consolidated across the South Island, whilst also establishing new groups to focus on important health areas. The enhanced co-operation between DHBs is resulting in improved care, increased quality, and more efficient services across the South Island, in line with the Alliance's vision of a sustainable, effective and innovative health and disability system that is best for people, best for system.

The **Quality and Safety** group are supporting DHBs with the Open for Better Care Campaign and working alongside other Alliance groups on quality improvement initiatives such as the Child Health group's Safe Sleep policy and the development of an electronic incident management reporting tool.

There is plenty of innovation in the **Information Services** area. We are leading the regional roll-out of **Electronic Prescribing and Administration** (also known as MedChart). The solution, now in use in 21 wards at Southern DHB and continuing to be implemented across the three core hospitals is being implemented in Canterbury.

Preparations are also underway to introduce the South Island Alliance's eReferrals system to Southern DHB. **eReferrals** replaces paper-based patient referrals with an electronic version and improves the reliability of the referrals process. The system, which was developed in Canterbury, has now been introduced in West Coast, Nelson Marlborough and South Canterbury with very positive feedback and over 300,000 referrals made using the system.

Health Connect South, the South Island clinical workstation designed to integrate with existing and future systems, is expected to go-live in mid-2015. It will provide DHB clinicians in the South Island with a single and standardised interface for clinical records, documentation and laboratory results, which will not only simplify access to patient information, but streamline patient and clinician transfers while improving quality and patient safety.

The Alliance's **Health of Older People** group has coordinated the roll out of the 'Walking In Another Shoes' programme across all South Island DHBs and driven the increased awareness and utilisation of interRAI. Working alongside the Regional Training Hub (SIRTH) have rolled out training to health care professionals across the region in Advance Care Planning, which trains health care professionals on understanding, initiating and participating in conversations to support a person about their end-of-life plan.

The **Support Services** group continues to work on areas like collective procurement in order to make savings for each DHB, and initiatives such as Love your Linen, which have been such a success at Southern, are being introduced regionally.

A **Palliative Care workstream** is being established, along with a **Major Trauma workstream,** to co-ordinate services and share ideas across the South Island. The relatively new **Elective Services** workstream has initiated the new South Island Bariatric Surgery Service to standardise access to weight loss surgery through a single service.

Attracting and Retaining Staff

GROWING OUR OWN

This year SCDHB welcomed our first two midwifery graduates who have trained locally in Timaru and commenced work as full time employees in February.

The CPIT midwifery programme includes an intake of 2-3 students per year in Timaru. It is an intensive three year programme delivered over 45 weeks of each year. The aim of including opportunities for midwives to train in satellite centres such as Timaru is to address workforce issues in rural and provincial areas. Rhiannon Fitzgerald has joined SCDHB as a continuity of care midwife and Kelly Allen as a member of the core midwifery team in Jean Todd.

Graduates Rhiannon Fitzgerald and Kelly Allan, Clinical Midwifery manager Julie Dockrill and Director of Nursing Midwifery and Allied Health Jane Brosnahan.

HEALTH CAREERS

Our ongoing focus on 'growing our own' future health workforce was again centred on Programme Incubator which entered its third year in 2014. This year the programme introduced a wide variety of health careers to more than 150 students from seven South Canterbury secondary schools. Delivered by DHB staff and community based health professionals the Programme Incubator brings careers to life through hands-on activities and the stories from the health professionals. The programme is very well supported with more than 40 health professionals taking part and Mobile Health Solutions providing tours of their Lithotripter bus. Mobile Health Solutions also provided work experience on their mobile surgical bus for two year 13 students. A further 24 students were provided work experience at the hospital and in the community to help cement their final career decisions.

South Canterbury DHB welcomes new graduate nurses who commenced in January 2014.

Graduating nurses from the Nurse entry to Practice (NetP) for 2013

The Year in Review

A Focus on Facilities

FACILITY STRATEGIC ASSESSMENT

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

1. The Gardens Block – the Board has approved work to be carried out to strengthen and refurbish the Gardens Block with work to be completed mid 2015. Once the project is completed the buildings will house SCDHB management and administrative services along with some spaces for Clinical Nurse Specialists and Allied Health.
2. Clinical Services Building Environment – Work is needed in the Clinical services Building to improve the quality of the indoor environment and provide improvements in energy efficiency. Some of these needs will be addressed in the Medical and Surgical Wards as changes are planned out. Other areas of the Hospital are being addressed on a prioritised basis through feedback and complaints from staff and the public. Areas being addressed are the Emergency Department, with air conditioning installed in 2013, and out patients with work to install air conditioning slated to being in Oct/Nov 2014. Options for other areas throughout the hospital are being researched for future works to be carried out.

   Improvements to the regulation of the temperature within the Clinical Services Building.
3. A new Emergency Department – including refurbishment, extension of out-patients, refit to include day patient services and a revision of the layout of the medical and surgical wards. Consultation and workshops are currently underway with staff, architects and medical planners looking at how to get the best combination of services for our hospital.

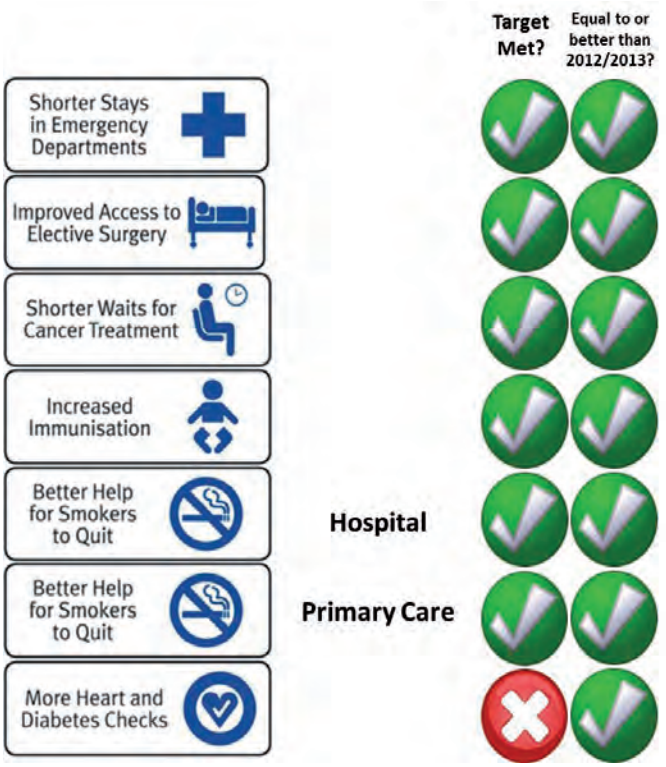
Timaru Hospital's 'Gardens Block'

The Year in Review

Meeting the Health Targets

The Minister of Health set seven health targets for all district health boards to work towards in the 2013/14 year, challenging health professionals working in both the community and the hospital.

	Target 2013/14	Result 2012/13	Result 2013/14	Did we meet target?
Percentage of patients admitted, discharged or transferred from the Emergency Department within six hours	95%	96%	96%	yes
Percentage of agreed elective surgery provided to patients	100%	106%	104%	yes
Percentage of cancer patients ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.	100%	100%	100%	yes
Percentage of eight- month-olds fully immunised	90%	88%	92%	yes
Percentage of hospitalised smokers provided with advice and help to quit smoking - In hospitals	95%	99%	99%	yes
Percentage of smokers provided with advice and help to quit smoking - In Primary Care	90%	76%	97%	yes
Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years.	75%	64%	81%	no



The Year in Review

Better Public 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 2013/14.

ACCREDITATION AND CERTIFICATION

A full certification/accreditation survey and assessment of SCDHB took place in May 2014.

Certification is a mandatory requirement of the Ministry of Health and ensures the organisation meets health and disability sector standards. Accreditation is voluntary, and is about looking at all aspects of an organisation's performance and comparing it with contemporary standards of client rights, standards of care, management and safety.

The assessments was undertaken by the DAA Group, and is report through to the Ministry of Health (HealthCert). They met with staff, patients and patient's family/whānau.

SCDHB was found to be generally performing well in terms of Certification, with some areas of improvement identified, which are currently being actioned. For the first time, the community can see information about the findings from Certification by accessing the Ministry of Health My DHB website (www.health.govt.nz).

The Accreditation report has only recently been received, and again performance was found to be generally good, with some recommendations made to how further improvements could be made.

CLINICAL NURSE SPECIALISTS ONCOLOGY TEAM

The arrival of two new Oncology Clinical Nurse Specialists promises even better care for patients receiving cancer care in South Canterbury. Joseph Mundava and Michelle O'Dowd recently joined Cancer Nurse Coordinator Christine Kerr in the Oncology Service at Timaru Hospital.

Mr Mundava and Ms O'Dowd are both new to New Zealand and come with a wealth of oncology experience. Ms Kerr said the three-strong team would mean an improved service for patients, and ensure more of the management and support of patients would be coordinated from Timaru.

"We will help patients through their treatment journey," Mr Mundava said, "They will get to know us and we will get to know them."

Cancer Nurse Coordinators are a new Ministry of Health initiative launched in 2013. The initiative aims to have specialist nurses acting as a single point of contact across different parts of the health service, to support patients newly diagnosed with cancer from the time a patient is referred, to the time they start their treatment.

Oncology Team: Joseph Mundava and Michelle O'Dowd recently joined Cancer Nurse Coordinator Christine Kerr (centre).

"We will help patients through their treatment journey, they will get to know us and we will get to know them."

The Year in Review

Timaru received Baby-Friendly Hospital Initiative (BFHI) in April this year. The certification last four years and ensures maternity services are centres of breastfeeding support, and to improve and promote exclusive breastfeeding.

MATERNITY QUALITY & SAFETY INITIATIVE

South Canterbury District Health Board (SCDHB) Midwifery Quality and Safety Programme (MQSP) implementation commenced 25 February 2013. The first Annual Report showed programme development and implementation activities for March to June of the 2012–13 year as well as priorities for the 2013–14 year. Including:

- MQSP is now well established and actively improving the quality of maternity services in the SCDHB region
- improved outcomes are being achieved or are anticipated
- alignment with the priorities of the National Maternity Monitoring Group (NMMG)
- improvement activities/actions planned for 2014–15
- actions planned to transition MQSP to business as usual to ensure governance, consumer and sector input and quality improvement activities continue beyond 30 June 2015.

STRANDED PATIENTS

The Health Round table Stranded Patients programme was successfully run in the medical service at Timaru Hospital in 2013.

From 2014, it has been rolled out to the Surgical and Assessment Treatment and Rehabilitation wards.
The purpose of the programme is to identify patients who may end up with a length of stay exceeding 21 days and to put processes into place to prevent, if possible, this from happening.

Patients can have extended lengths of stay for a variety of reasons

- Clinical condition
- Waiting for investigations
- Social issues
- Communication issues between clinical staff members
- Processes between departments

This programme focuses on preventing "wasted" time for both patients and staff by reducing the barriers and communication issues between departments.

CENTRE OF EXCELLENCE FOR THE HEALTH OF OLDER PEOPLE IN SOUTH CANTERBURY

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

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

The final high level concept plan was completed in December 2013 with the SCDHB Board approving the plan for implementation in February 2014. A project manager has been appointed to implement the recommendation from the concept plan over the next 18 Months.

ERAS (Early recovery after surgery)

ERAS aims to minimise the effects of surgery and optimise a quicker recovery post-surgery.

Mr Steve Earnshaw, Clinical Director Orthopaedics and Dr Russell Rarity, Clinical Director Anaesthetics are leading the SCDHB ERAS Orthopaedics Project which has focused on developing an ERAS programme for knee and hip arthroplasty and fractured neck of femur.

In December 2013 we joined the National ERAS Collaborative along with fellow DHBs. The SCDHB Project team also includes representatives from Outpatients and Surgical Ward, GP Liaison, Physiotherapy, Occupational Therapy, Theatre/Recovery, Quality facilitator, Decision Support Analyst and Orthopaedic Nurse. We have been identifying improvements to steps in the Patient journey, developing protocols and improving processes.

The National ERAS Collaborative Quality Improvement project ends in March 2015, we are currently in the final phase, the theme of which is 'Sustaining improvement'. Our Project Aim is to ensure that 100% of South Canterbury patients receiving Total Hip replacement, Total Knee replacement and Fractured Neck of Femur surgery are managed according to ERAS principles by November 2014. We are on track to achieve this aim.

The Year in Review

We are Open for Better Care

New Zealand's health and disability system already provides high standards of care very cost effectively. Health professionals have extensive knowledge, skills and commitment, and are already delivering excellent patient care.

However, we know patients are still being harmed – sometimes with serious and long-term consequences.

Open for better care is a national patient safety campaign co-ordinated by the Health Quality & Safety Commission.

The campaign focuses on reducing harm in the areas of:

- falls
- healthcare associated infections (surgical site infections [SSIs])
- perioperative harm
- medication safety

QUALITY ACCOUNT

Commencing last year, annually the SCDHB produces a document called Quality Accounts – it showcases the quality initiatives SCDHB has implemented to improve health for South Cantabrians over the previous twelve months. It also includes information on what we feel could be done better and what we have planned for the following year.

This year, before producing the document, our staff decided to consult the public to find out what they know, don't know or would like to know about the SCDHB and the access to healthcare that is available to our community.

South Canterbury District Health Board staff attended some of our local supermarkets and asked the public:

'What would you like to know about your district health board?'.

Staff who attended, found the sessions really useful with largely positive comments about our little DHB that punches above its weight. Valuable feedback was gathered for this years publication of the Quality Account. The Quality Account will be completed by November 2014 and available online at www.scdhb.health.nz and in hard copy on request. Contact details are also on our website.

FALLS PREVENTION

Six serious falls in the Assessment, Treatment and Rehabilitation (AT&R) Ward during 2012-2013 prompted a new falls prevention project at Timaru Hospital.

While common falls prevention strategies were in place (for example risk assessment, action plans, low bed heights and identification of high risk patients) the multidisciplinary Reducing Harm from Falls Project Team in charge of the project wanted to improve and standardise processes by introducing a Falls Care Bundle (a simple set of evidenced-based practices), which would reduce the number of serious falls by helping staff become more engaged with patients and their families about prevention and by addressing the perception that falls are always inevitable.

The Year in Review

We are Open for Better Care

'Falls prevention has to be balanced with other priorities,' says Kaye Cameron, Improvement Advisor and Nurse Coordinator Quality and Risk. 'We thought a Falls Care Bundle would work well because they've been shown to be straightforward and easy for nurses to relate to.'

The project team chose the Institute of Healthcare Improvement's Model for Improvement and used Plan-Do-Study-Act (PDSA) cycles to test and apply changes. They also used resources supplied by the Health Quality & Safety Commission – and some initiatives being used by Northland DHB – to create their Bundle of Care.

Ward staff began implementation in July 2013 with the goal of reducing the number of patients harmed by falls in the AT&R ward by 20 percent by April 2014. This would mean a total of 23 falls instead of the 29 which occurred between July 2012 and April 2013.

In fact the number of falls with harm fell by nearly 66 percent to just 10 – well ahead of the 20 percent reduction target. In addition there were no serious harm falls in the AT&R Ward between June 2013 and May 2014.

'The introduction of the Falls Care Bundle has really raised awareness of falls prevention in the ward. Staff and the project team are extremely proud of what we have achieved and are committed to continuing to reduce falls.'

She says a number of things have been vital to the success of the Falls Care Bundle.

Mr Wilson and Jeanette Pateman discuss his plan of care in Timaru Hospital

The internationally recognised Morse Falls Risk Assessment Tool is now used to assess patients and document their risk level into their falls action plans. The falls action plans are now incorporated into individual care plans, which ensures they are properly implemented.

A new patient information package has been developed and staff are being encouraged to engage with patients and families to help them become more involved in developing their own falls prevention planning. Posters around the ward have been used to promote staff awareness and nurse educators have been used to up-skill staff.

'However, what has really been vital,' says Kaye Cameron, is the way the project team has worked with staff, listening to them, gaining their input and presenting back to them.'

Mapping exercises are now underway at Timaru Hospital which identify where and when falls occur within all wards. Results are collated and sent to each ward, including a visual map of where falls are occurring that is easy for nurses to interpret and work with.

The Year in Review

Quality and Safety Markers

The HQSC Quality and Safety markers have now been running for a full year, and they are proving useful in evaluating the success of the Open for Better Care campaign and to determine whether the desired changes in practice and reductions in harm and cost have occurred.

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

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

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

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

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

A new Marker has been introduced this year under the "surgery" topic. It focuses on the prevention of Surgical Site Infections, measuring the administration of antibiotic within an hour prior to surgery beginning. The national goal is that this would occur
in 100% of the measure operations

The impact of the Open for Better Care campaign is being evaluated nationally using the QSM data and other feedback from DHBs .

Angela Shepard, Surgical Nurse, was the winner of the SCDHB patient safety campaign quiz. Here she is being presented with her prize by Mr Gavin Wilton, SCDHB clinical lead for the Surgical Site Infection Programme.

The next tranche of data that will be released by the HQSC will be for the June to September period, and is likely to be released publicly in early 2015.

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

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

SCDHB PERFORMANCE

Falls

By Quarter 4 of 2013/2014, SCDHB were reporting that 98% of older patients were receiving a falls risk assessment. This is an excellent result, and it supports the significant amount of activity and focus that has been placed on reducing falls (particularly those resulting in harm) across SCDHB. There has been a significant reduction in the number of Falls with Serious Harm reported in SCDHB over the last year.

Perioperative Harm

SCHDB has continued to perform well, using all three parts of the Surgical Checklist in 93% of operations audited (Quarter 4 2013/2014 results. This continues to exceeded the national threshold of 90%.

Hand Hygiene

In 2013 / 2014 SCDHB has seen a good, steady improvement in hand hygiene compliance, where we have improved from 54% compliance in the base line measure, to exceeding of the expected threshold of 70% compliance with audited hand hygiene moments.

Central Line Associated Bacteraemia

SCDHB data for the CLAB measure has now been incorporated into the QSM data set nationally, with SCDHB reporting 92% of ICU Central Line insertions compliant with good practice (national goal of 90% compliance).

Surgical Site Infection

In Quarter 4 of 2013/2014, SCDHB were recording a rate of 83% for the administration of antibiotics prior to surgery. There is ongoing work in this area regarding practice, and aligning this with national expectations.

The Year in Review

Māori Health and High Needs Population

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.

MĀORI HEALTH

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. The Arowhenua Whānau Services continue to work together to improve the health and wellbeing of whānau in South Canterbury including monitoring of key health indicators and providing education through huis and a celebration of culture in the annual FLAVA Festival.

HIGHLIGHTS FROM THE YEAR

Arowhenua Whāunau Services ran several educational wānanga over the year which were well attended and well received.

- Mental Health Awareness Hui Tuesday 8th October, 2013
- General Diabetes Management August 2013
- Understanding of carbohydrate significance November 2013
- First Aid Wānanga 21st March, 2014
- Gout Wānanga 10th April, 2014-
- Alzheimer's Wānanga 22nd April, 2014
- Tane Hauora, 12th June 2014
- Cardiovascular health Wānanga 21st August, 2013

ALCOHOL – WHAT'S THE HARM?

On Friday 23rd May the SCDHB hosted a hui at Te Aitarakihi Cultural Centre in Timaru. The hui was "Alcohol – What's the harm?", with the focus on providing information to parents and young adults about the effects and impacts of alcohol and an update on the latest regulations for alcohol supply and purchase. The hui was targeted at Māori but was open to all public with more than 70 people at the evening. Mr Norm Hewitt, former All Black and Dancing with the Stars Winner, Nathan Mikaere, Brainwave Trust and Shayne Broughton from Community & Public Health were all guest speakers.

Norm spoke about his personal 'lived' experience and many in the audience were moved by his honesty and willingness to share this. It has motivated him to encourage individuals and whānau to help stop the generational harm from alcohol.

Rangi Jenkins-Ashby attended the evening "It was really interesting. Norm had some stories that really made you think, he talked about how alcohol and drugs can really mess with your life. He has a really good outlook now, and shows that you can be successful if you don't choose that path."

Nathan Mikaere followed with an enlightening and entertaining presentation about adolescent brain development. The audience was taken on the journey of what is going on in the adolescent brain and gained insight into the behaviours we observe as a child that transition into adulthood. Huriata Weeks attended the hui and felt the information about the adolescent brain development particularly interesting. "Nathan was a great speaker, he highlighted the real and devastating effects of alcohol and drugs on our people, particularly our young people."

Shayne Broughton, Health Promoter and Liquor Licensor from Community & Public Health rounded out the evening talking about the sale and supply of alcohol – particularly the changes to the law around supply by parents and guardians to children.

"Lots of parents don't know that you can still buy alcohol for your children, but it has to be supplied in a safe way. Is the amount of alcohol appropriate, is where they are going to be drinking a safe environment? Is there food at the venue? And a way to get home? If the parent or guardian hasn't supplied the alcohol in a responsible manner they can be prosecuted."

The cultural centre hope to have similar hui in the future.

FLAVA FESTIVAL

Ka Toi Māori o Aoraki was an initiative that derived from the now historical Maori Youth Suicide Prevention strategy, Kia Piki Te Ora o Te Taitamariki.

This strategy was rolled out in South Canterbury through the formation of a key community team responsible for planning and implementing initiatives aimed at building resilience in Maori youth and supporting whānau/ community connectedness. Initially groups of rangatahi and tamariki were exposed to Te Ao Māori through local wānanga and supported to travel to specialized wānanga e.g. Taiaha, Career Workshops, Kapahaka etc.

In 2006, Kia Piki Te Ora o Te Taitamariki rangatahi identified an interest in developing a local schools competition to promote pride in their identity, to showcase their talents and to express their creativity. Several Hui later, the concept of an annual schools cultural festival was born. Rakatahi decided the theme for this initial festival would be FLAVA signifying the bringing together of people of all flavours in a celebration of culture. Although officially known as Ka Toi Māori o Aoraki, FLAVA is a name that appears to have stuck with the festival and has morphed into an anagram: Future; Learning; Achievement; Virtue; Autonomy

Future: motivation to look forward to our future

Learning: motivation to want to grow and expand your mind

Achievement: motivation to work hard and attain excellence

Virtue: motivation to be worth to self, family and community

Autonomy: motivation to help and be of service to others.

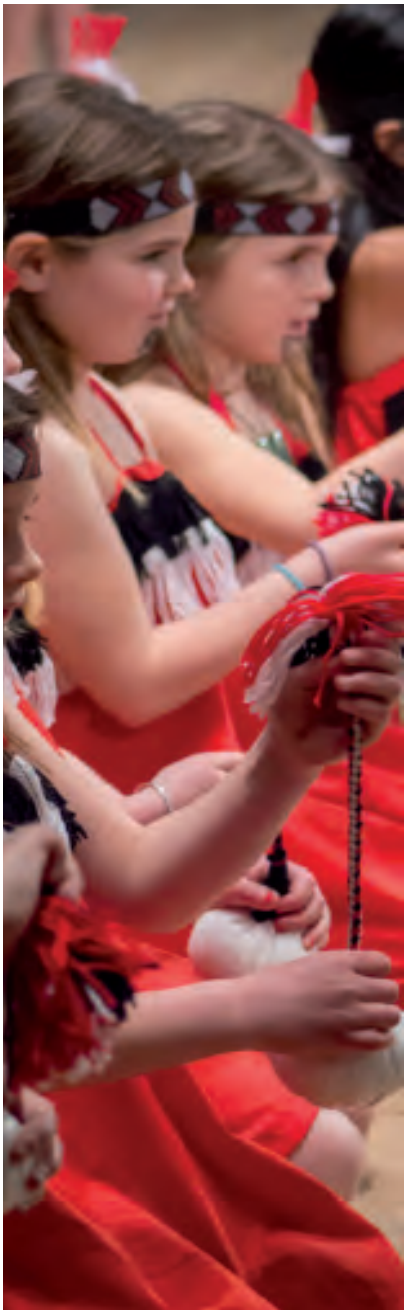
Ka Toi Māori o Aoraki is open to all early childhood, primary, secondary schools and tertiary education within the Arowhenua rohe (bordered by the Southern Alps and between the Waitaki and Rakaia rivers).

This year we held the seventh year of the FLAVA Festival, 'Ka Toi Māori o Aoraki', at the Theatre Royal on Friday, 16th August. Twenty-seven schools and early childhood centres from the Aoraki region, between the Waitaki and the Rakaia rivers, took part in Kapahaka, performing, arts, and contributed to visual arts. The festival theme coincided with Te Wiki o Te reo Māori 2013 (Māori Language Week), with this year's theme being Nga Ingoa Māori (Māori Place Names).

The festival was organised by a steering group that included, mainstream and Māori health providers, and a number of community organisations.

The FLAVA festival is growing in numbers every year and provides students with an opportunity to discover and experience a breath taking lens into Te Ao Māori (the world of Māori), and an awe-inspiring opportunity to showcase and view their wonderful talent. At the same time, whānau, friends and the wider community were able to view the festival and enjoy a truly bicultural festival that was comprised of three categories: kapahaka (traditional dance and waiata), performing arts (waiata, whaikōrero, short stage drama, music, dance and other stage performances) and visual arts (two- and three-dimensional paintings, drawings, sculptures, and weaving).

Once again, the festival was a huge success, with the Theatre Royal being packed to capacity for the full day. Groups that had clearly devoted long hours to perfecting their skills treated the audience to some incredibly colourful and exciting performances.



The Year in Review

Health Scorecard for Māori and High Needs Population

Year ending 30 June 2014

Enrolled Population Demographics

Age Group	Māori	%	Total Population
0-4 years	397	12%	3228
5-14 years	765	11%	6943
15-24 years	628	9%	6952
25-44 years	832	7%	12118
45-64 years	589	4%	15999
65+ years	178	2%	11567

Consultations, Admission, Registrations

	Māori	Non-Māori
GP Consultations	7690	170702
per patient	2.41	3.2
Nurse Consultations	1964	41893
per patient	0.61	0.8
ASH Rates per 100,000 (30/6/14)		
0-74 age group	199%	96%
0-4 age group	105%	80%
45-64 age group	279%	101%
Cancer treatment commencing within four weeks	100%	100%

The Year in Review

Health Scorecard for Māori and High Needs Population

Year ending 30 June 2014

	Indicator	Māori	Total	Target	Trend
Screening Programmes	8 month old childhood immunisation	100%	92%	90%	▲
	2 year old childhood immunisation	94%	96%	95%	▲
	HPV immunisation for girls 12+ years (1999 cohort)	62%	48%	65%	▲
	Flu vaccine for 65 years+	69%	68%	75%	▲
	Breast screening for women 45 - 69 years	73%	83%	70%	▲
	Cervical screening for women 20 -69 years	74%	79%	80%	▲
	Cardiovascular risk assessment 5 yearly 35+ years	72%	81%	90%	▲
	Diabetes detection	100%	100%	90%	▶
	Smoking status recorded	85%	86%	90%	▲
Patient Review/Advice	Diabetes annual review	47%	47%	72%	▲
	Brief Advice & Cessation Support given in primary care	100%	94%	90%	▲
	Brief Advice & Cessation Support given in secondary care	100%	99%	95%	▲
Mental Health	Access rates 0 - 19	4.80%	6.30%	2.93%	▲
	Access rates 20 - 64	8.33%	4.26%	6.41%	▲
	Access rates 65+	0.37%	0.48%	1.00%	▲
	Service users with crises intervention plan Adult 20+ (excluding addictions only)	71%	75%	95%	▼
	Service users with crises intervention plan Adult 20+ (addictions only)	80%	93%	95%	▼

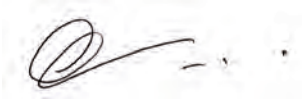
Statement of Financial Responsibility

FOR YEAR ENDED 30 JUNE 2014

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

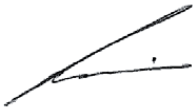
2. The Board and management of South Canterbury District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

3. In the opinion of the Board and management of South Canterbury District Health Board, the annual financial statements and the statement of service performance for the year ended 30 June 2014 fairly reflect the financial position and operations of South Canterbury District Health Board.



Murray Cleverley
Chair
31 October 2014

Ron Luxton
Deputy Chair
31 October 2014



Nigel Trainor
Chief Executive
31 October 2014

South Canterbury
District Health Board

Audit Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent auditor's report

To the readers of South Canterbury District Health Board's financial statements and performance information for the year ended 30 June 2014

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

We have audited:

- the financial statements of the Health Board on pages 26 to 49, that comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of movements in equity and statement of cashflows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board that comprises the statement of service performance on pages 52 to 84.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 26 to 49:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information because of limited control on information from third-party health providers

Reason for our qualified opinion

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

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

Audit Report

Our audit opinion on the performance information of the Health Board for the year ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 52 to 84:

- complies with generally accepted accounting practice in New Zealand;
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health Board's preparation of the financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

Audit Report

Our audit of the financial statements involved evaluating:

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

Our audit of the performance information involved evaluating:

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

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

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

Responsibilities of the Board

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

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

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

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

Audit Report

Responsibilities of the Auditor

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

Independence

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

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

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

Statement of Significant Accounting Policies

For Year Ended 30 June 2014

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 2014.

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 31 October 2014. 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 the 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 salary inflation factor. Any changes in these assumptions will impact on the carrying amount of the liability.

Statement of Significant Accounting Policies

Basis for Consolidation

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

Accounting Policies

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

1. Budget Figures

The budget figures are those approved by the Board and published in its Statement of Intent, which is the external accountability document prepared by SCDHB under the Crown Entities Act 2004. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of the financial statements.

2. Goods and Services Tax

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

3. Taxation

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

4. Donations and Bequest Funds

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

5. Trade and Other Receivables

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

6. Inventories

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

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

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

Statement of Significant Accounting Policies

7. Cash and Cash Equivalents

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

8. Property, Plant and Equipment

Classes of Property, Plant and Equipment

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

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

Owned Assets

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

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

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

Fixed assets vested from the Hospital and Health Service

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

9. Revaluation of Land and Buildings

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

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

Statement of Significant Accounting Policies

10. Disposal of Fixed Assets

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

11. Depreciation of Fixed Assets

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

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

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

12. Leases

Finance Leases

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

Operating Leases

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

13. Intangible Assets

Software

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

Amortisation

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

Software	2 to 10 years	10-50%

14. Impairment

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

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

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

Statement of Significant Accounting Policies

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 Statement of Comprehensive Income.

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

15. Investments in Equity Securities

SCDHB's investment in Health Benefits Limited is stated at cost less impairment losses.

Investments in other equity securities are classified as available-for-sale financial assets and are stated at 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 Statement of Comprehensive Income.

16. Employee Benefits

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

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

Annual Leave

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

Superannuation Schemes

Defined contribution schemes

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

Statement of Significant Accounting Policies

Defined benefit schemes

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

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

17. Revenue

Crown Funding

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

Goods Sold and Services Rendered

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

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

Revenue relating to Service Contracts

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

Interest Revenue

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

Donated or Subsidised Assets

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

18. Interest Expenditure

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

19. Cost Allocation

SCDHB has arrived at the net cost of service for each significant activity using the following cost allocation system. Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information. The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers, such as actual usage, staff numbers and floor area.

Statement of Significant Accounting Policies

20. Interest-bearing borrowings

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

21. Trade and Other Payables

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

22. Other Liabilities and Provisions

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

23. Financial Instruments

Financial Assets

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

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

Loans and receivables

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

Statement of Significant Accounting Policies

24. Standards Issued but not yet effective

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

NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement.* NX IAS 39 is being replaced through the following three 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 assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

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

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

25. Changes in Accounting Policies

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

Financial Statements

South Canterbury District Health Board
Statement of Comprehensive Income
for the year ended 30 June 2014

In thousands of New Zealand Dollars

	Note	Budget 2014	Actual 2014	Actual 2013
Revenue	*1*	177,463	179,359	173,207
Other Operating Income	*2*	2,135	1,644	3,219
Finance Income	*4a*	1,487	1,671	1,530
Total Income		181,085	182,674	177,956
Employee Benefit Costs	*3*	59,628	57,650	55,121
Outsourced personnel and other services		8,049	10,715	9,247
Clinical supplies		8,902	9,629	9,163
Infrastructure and non-clinical expenses		11,274	11,815	11,445
Payments to non-DHB health providers		62,418	60,221	60,150
IDF Outflows		23,720	24,426	25,348
Depreciation and amortisation expense	*7*	3,331	3,687	3,069
Finance costs	*4b*	360	326	321
Capital charge	*5*	1,958	2,075	1,950
Other operating expenses	*6*	1,243	1,455	1,406
Total Expenses		180,883	181,999	177,220
NET SURPLUS (DEFICIT)		202	675	736
Other Comprehensive Income				
Item that will not be reclassified to surplus/(deficit)				
Revaluation of land and buildings		-	2,327	-
Fair value through other comprehensive income financial assets		-	-	-
Total Other Comprehensive Income		-	2,327	-
TOTAL COMPREHENSIVE INCOME		202	3,002	736

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

Financial Statements

South Canterbury District Health Board
Statement of Movements in Equity
for the year ended 30 June 2014

In thousands of New Zealand Dollars

		Budget 2014	Actual 2014	Actual 2013
Balance at 1 July 2013		25,015	26,136	25,616
Comprehensive income/(expense)				
Net Surplus/(Deficit) for the year	9	202	675	736
Other Comprehensive Income	9	-	2,327	-
Total comprehensive income		202	3,002	736
Capital Movements				
Repayment to Crown	9	(200)	(217)	(216)
Contribution from Crown	9	-	-	-
Movement in Special Funds	9	-	-	-
Total of Capital Movements		(200)	(217)	(216)
Balance at 30 June 2014		25,017	28,921	26,136

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

Financial Statements

South Canterbury District Health Board
Statement of Financial Position
as at 30 June 2014

In thousands of New Zealand Dollars

	Note	Budget 2014	Actual 2014	Actual 2013
Public Equity				
General Funds	*9*	4,521	4,488	4,705
Accumulated Surplus	*9*	10,288	11,082	11,324
Equity from Donated Assets	*9*	962	1,778	861
Revaluation Reserve	*9*	9,246	11,573	9,246
		25,017	28,921	26,136
Special Funds	*9*	-	-	-
Total Equity		25,017	28,921	26,136
REPRESENTED BY:				
ASSETS				
Current Assets				
Cash and cash equivalents	*10*	12,504	22,458	19,292
Financial Assets	*11*	-	12,778	-
Debtors and other receivables	*12*	4,940	5,067	4,807
Inventories	*13*	1,000	920	920
Patient Trust Funds	*10*	25	30	31
Special Fund Assets	*9*	-	-	-
Total Current Assets		18,469	41,253	25,050
Non Current Assets				
Financial Assets	*11*	13,079	298	12,778
Property, plant and equipment	*7*	34,817	32,342	31,839
Intangible assets	*8*	788	704	532
Total Non Current Assets		48,684	33,344	45,149
TOTAL ASSETS		67,153	74,597	70,199
LIABILITIES				
Current Liabilities				
Creditors and other payables	*14*	11,587	12,952	12,985
Employee entitlements	*15*	10,856	11,091	10,265
Borrowings	*16*	-	12,778	-
Finance Lease Liability	*17*	-	169	169
Patient Trust Funds	*10*	25	30	31
Total Current Liabilities		22,468	37,020	23,450
Non Current Liabilities				
Term Loans	*16*	12,778	-	12,778
Finance Lease Liability	*17*	-	1,180	1,350
Employee Entitlements	*15*	6,890	7,476	6,485
Total Non Current Liabilities		19,668	8,656	20,613
TOTAL LIABILITIES		42,136	45,676	44,063
NET ASSETS		25,017	28,921	26,136

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

Financial Statements

South Canterbury District Health Board
Statement of Cashflows
for the year ended 30 June 2014

In thousands of New Zealand Dollars

	Note	Budget 2014	Actual 2014	Actual 2013
CASH FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from Ministry of Health & Other		179,300	180,873	176,490
Interest Received		1,487	1,671	1,530
		180,787	182,544	178,020
Cash was applied to:				
Payments to suppliers & employees		170,425	174,125	169,464
Capital Charge		1,943	2,075	1,950
Interest Paid		324	326	321
GST (net)		-	132	(153)
		172,692	176,658	171,582
Net cash inflow/(outflow) from operating activities	*17*	8,095	5,886	6,438
CASH FROM INVESTING ACTIVITIES				
Cash was provided from:				
Proceeds from the sale of assets		-	-	25
Proceeds from Sale of Investment		-	-	4
Term Deposits over 3 months		-	-	5,000
Decrease in Special Funds		-	-	555
		-	-	5,584
Cash was applied to:				
Purchase of fixed assets		8,486	2,036	4,958
Purchase of Shares			298	-
Increase in Special Funds		509	-	-
		8,995	2,334	4,958
Net cash inflow/(outflow) from investing activities		(8,995)	(2,334)	626
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was applied to:				
Finance Lease repayment		-	169	169
Repayment of Equity		200	217	216
		200	386	385
Net cash inflow/(outflow) from financing activities		(200)	(386)	(385)
Net increase/(decrease) in cash held		(1,100)	3,166	6,679
Opening cash and cash equivalents		13,604	19,292	12,613
Closing cash and cash equivalents	10	12,504	22,458	19,292
Made up of:				
Balances at bank		12,504	22,458	19,292

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

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

Notes to the Financial Statements

South Canterbury District Health Board
Notes to the Financial Statements
for the year ended 30 June 2014
In thousands of New Zealand Dollars

	Actual 2014	Actual 2013
1. Revenue		
Health & Disability Services (MoH contracted Revenue)	170,862	164,712
ACC Contracted Revenue	1,690	1,602
Inter District Patient Inflows	3,956	4,352
Other Health Revenue	2,851	2,541
	179,359	173,207
2. Other Operating Income		
Gain on sale of property, plant and equipment	39	1
Donations and bequests received	7	1,245
Rental Income	165	134
Other Non-health Revenue	1,433	1,839
	1,644	3,219
3. Employee benefit costs		
Wages and salaries	55,211	53,613
Contributions to defined contribution plans	1,128	872
Increase /(decrease) in employee benefit provisions	1,311	636
	57,650	55,121

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	1,671	1,530
	1,671	1,530
4b Finance costs		
Interest Expense	326	321
	326	321

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 2014 was 8% (2013: 8%).

6. Other operating expenses		
Fees to Auditor:		
Audit fees for financial statement audit	113	110
Directors' fees and expenses	323	311
Impairment of receivables (bad & doubtful debts)	5	23
Write down of inventory	112	69
Operating Lease Expense	902	893
	1,455	1,406

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

Notes to the Financial Statements

South Canterbury District Health Board
Notes to the Financial Statements
for the year ended 30 June 2014
In thousands of New Zealand Dollars

7. Property, plant and equipment

	Land	Buildings	Plant & equipment	Leased Assets	Motor vehicles	Work in Progress	TOTAL
Cost or Valuation							
Balance at 1 July 2012	2,463	21,760	24,299	-	1,643	9	50,174
Additions	-	1,595	3,144	1,686	173	(9)	6,588
Revaluations	-	-	-	-	-	-	-
Disposals	-	-	-	-	(48)	-	(48)
Balance at 30 June 2013	2,463	23,355	27,443	1,686	1,767	-	56,714
Balance at 1 July 2013	2,463	23,355	27,443	1,686	1,767	-	56,714
Additions	-	194	1,126	-	190	183	1,693
Revaluations	475	(2,163)	-	-	-	-	(1,688)
Disposals	-	-	(114)	-	(48)	-	(162)
Balance at 30 June 2014	2,938	21,386	28,455	1,686	1,909	183	56,557
Accumulated depreciation and impairment losses							
Balance at 1 July 2012	-	1,235	19,277	-	1,442	-	21,954
Depreciation expense	-	1,267	1,558	42	77	-	2,944
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	-	-	(23)	-	(23)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2013	-	2,502	20,835	42	1,496	-	24,875
Balance at 1 July 2013	-	2,502	20,835	42	1,496	-	24,875
Depreciation expense	-	1,513	1,715	169	119	-	3,515
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	(113)	-	(48)	-	(160)
Revaluations	-	(4,015)	-	-	-	-	(4,015)
Balance at 30 June 2014	-	-	22,437	211	1,567	-	24,215
Carrying amounts							
At 1 July 2012	2,463	20,525	5,022	-	201	9	28,220
At 30 June and 1 July 2013	2,463	20,853	6,608	1,644	271	-	31,839
At 30 June 2014	2,938	21,386	6,018	1,475	342	183	32,342

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

Valuation
Land and Buildings were valued to fair value as at 30 June 2014 by an independent registered valuer, John Dunckley, of Crighton Anderson Property & Infrastructure 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 $24,041,498 as at 30 June 2014. The valuation conforms to International valuation standards and was based on an optimised depreciation replacement cost methodology.

Land

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

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

Buildings

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

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

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

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

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

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

Notes to the Financial Statements

South Canterbury District Health Board
Notes to the Financial Statements
for the year ended 30 June 2014
In thousands of New Zealand Dollars

8. Intangible Assets

	Software
Cost	
Balance at 1 July 2012	1,559
Additions	57
Disposals	-
Balance at 30 June 2013	1,616
Balance at 1 July 2013	1,616
Additions	346
Disposals	-
Balance at 30 June 2014	1,962
Accumulated amortisation and impairment losses	
Balance at 1 July 2012	959
Amortisation expense	125
Disposals	-
Impairment losses	-
Balance at 30 June 2013	1,084
Balance at 1 July 2013	1,084
Amortisation expense	174
Disposals	-
Impairment losses	-
Balance at 30 June 2014	1,258
Carrying amounts	
At 1 July 2012	600
At 30 June and 1 July 2013	532
At 30 June 2014	704

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 2012	4,921	9,931	963	2,085	7,161	555	25,616
Surplus/(deficit)	-	736	-	-	-	-	736
Transfer from accumulated surplus	-	657	(102)	-	-	(555)	-
Revaluation of land and buildings	-	-	-	-	-	-	-
Contribution from the Crown	-	-	-	-	-	-	-
Repayment to the Crown	(217)	-	-	-	-	-	(217)
Balance at 30 June 2013	4,705	11,324	861	2,085	7,161	-	26,136
Balance at 1 July 2013	4,705	11,324	861	2,085	7,161	-	26,136
Surplus/(deficit)	-	675	-	-	-	-	675
Transfer from accumulated surplus	-	(917)	917	-	-	-	-
Revaluation of land and buildings	-	-	-	475	1,852	-	2,327
Contribution from the Crown	-	-	-	-	-	-	-
Repayment of equity	(217)	-	-	-	-	-	(217)
Balance at 30 June 2014	4,488	11,082	1,778	2,560	9,013	-	28,921

The unspent mental health ring-fence portion of retained earnings decreased to $0.321 million (30 June 2013: $0.375 million)

In thousands of New Zealand Dollars

Notes to the Financial Statements

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 Accumulated Surplus reflects these transactions.

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

	2014 Actual	2013 Actual
Opening Balance	-	555
Transfer from Retained Earnings in respect of:	-	-
Funds Received	-	-
- Interest Received	-	12
- Donations and Other	6	1,245
Transfer to Retained Earnings in respect of:	-	-
- Funds spent	(6)	(1,812)
Closing Balance 30 June	-	-

10. Cash and cash equivalents

	Actual 2014	Actual 2013
Cash on hand and at bank	22,458	19,292
Cash equivalents - term deposits	-	-
Total cash and cash equivalents	22,458	19,292

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

SCDHB administers certain funds on behalf of patients. These funds are held in a separate bank account and total $30,000 (2013: $31,000)

11. Investments

Current investments are represented by:		
Term deposits	12,778	-
Total current portion	12,778	-
Non-current investments are represented by:		
Term deposits	-	12,778
Shares	298	-
Total non-current portion	298	12,778
Total Investments	13,076	12,778

There were no impairment provisions for investments.

The DHB has an equity investment in Health Benefits Limited ("HBL"). HBL proposes to implement finance, procurement and supply chain shared services on behalf of all New Zealand District Health Boards ("DHBs"). Capital contributions have been made to HBL by the DHBs by the issue of B Class shares. Health Benefits Limited is an unlisted company. Accordingly, there are no published price quotations for this investment.

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

Notes to the Financial Statements

South Canterbury District Health Board
Notes to the Financial Statements
for the year ended 30 June 2014
In thousands of New Zealand Dollars

12. Debtors and other receivables

	Actual 2014	Actual 2013
Trade Debtors	1,318	1,077
Less: Provision for impairment	(5)	(29)
	1,313	1,048
Accrued Income	3,577	3,565
Prepayments	177	194
Total receivables & prepayments	5,067	4,807

The carrying value of receivables approximates their fair value.

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

Balance at 1 July	(29)	(13)
Additional provisions made	(5)	(29)
Receivables written off	29	-
Recovery of amounts already provided	-	13
Balance at 30 June	(5)	(29)

13. Inventories

Pharmaceuticals	348	389
Theatre supplies	449	427
Central stores	32	29
Other supplies	91	75
Total inventories	920	920

The write-down of inventories held for distribution amounted to $113,000 (2013: $68,000). There have been no reversals of write-downs.

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

14. Creditors and other payables

Trade creditors	1,417	2,221
Capital Charge due	122	70
Income in advance	261	170
Accrued expenses	11,152	10,524
Total Payables and Accruals	12,952	12,985

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 2014	Actual 2013
Current employee entitlements are represented by:		
Accrued salaries and wages	3,202	2,852
Annual Leave	6,175	5,871
Maternity Leave	31	-
Sick Leave	119	139
Retirement Gratuities	675	661
Senior Doctor Conference Leave	214	144
Senior Doctor Sabbatical Leave	31	54
Long Service Leave	283	247
Senior Doctor Study Costs	361	297
Total current portion	11,091	10,265
Non-current employee entitlements are represented by:		
Sick Leave	242	319
Retirement Gratuities	4,383	3,772
Senior Doctor Conference Leave	428	288
Senior Doctor Sabbatical Leave	609	556
Long Service Leave	947	956
Senior Doctor Study Costs	722	594
Other Employee Entitlements	145	-
Total non-current portion	7,476	6,485
Total employee entitlements	18,567	16,750

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 2014 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

Current borrowings are represented by:

Secured loan - Ministry of Health (MOH)

Current portion	12,778	-
Non current portion	-	12,778
	12,778	12,778

In thousands of New Zealand Dollars

Notes to the Financial Statements

Repayable as follows:		
Not later than one year	12,778	-
Later than one, not later than two years	-	12,778
Later than two, not later than five years	-	-
Beyond five years	-	-
	12,778	12,778
Interest rates:		
Ministry of Health interest rates	2.50%	2.50%

The MOH received a negative pledge from SCDHB. Without the MOH'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 did not have an overdraft facility at 30 June 2014 (2013: $nil).

17. Finance Lease Liability

SCDHB has entered into a finance lease for the purchase of MRI scanner equipment. The lease is over a period of ten years from April 2013 and no interest or finance charges are payable.
Finance lease liabilities are payable as follows:

	Actual 2014	Actual 2013
Not later than one year	169	169
Later than one year and not later than five years	674	675
Later than five years	506	675
Total present value of minimum lease payments	1,349	1,519
Current portion	169	169
Non current portion	1,180	1,350
Total present value of minimum lease payments	1,349	1,519

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

Description of finance lease arrangements
The DHB has entered into a lease with Aoraki MRI Charitable Trust for the provision on an MRI scanner. The lease is for a period of ten years and is interest free.

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

	Actual 2014	Actual 2013
Net surplus/(deficit) after taxation	675	736
Add/(less) non-cash items:		
Depreciation and amortisation expense	3,687	3,069
Total non cash items	3,687	3,069
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	(260)	348
(Increase)/decrease in inventories	-	4
Increase/(decrease) in payables and accruals	1,949	1,645
Increase/(decrease) in employee entitlements	(165)	636
Net working capital movement	1,524	2,633
Add/(less) movements in other items:		
Gain(Loss) on sale of fixed assets	-	-
	-	-
Net cash (outflow)/inflow from operating activities	5,886	6,438

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South Canterbury District Health Board
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19. Capital Commitments and Operating Leases

	Actual 2014	Actual 2013
Capital Commitments		
Property, plant and equipment	-	-
Intangible assets	-	-
Future calls on Health Benefits Shares	436	-
Total Capital Commitments	436	-

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

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

	Actual 2014	Actual 2013
Not later than one year	548	631
Later than one year and not later than five years	1,042	1,073
Later than five years	-	172
Total Non-cancellable Operating Leases	1,590	1,876

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

20. Contingencies

Contingent Liabilities

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

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

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

Lawsuits against the DHB
There were no outstanding legal claims against the DHB at year end.

Contingent Assets
The DHB has no contingent assets (2013 $nil).

21. 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 time to time decide.
- To fund, foster, promote and encourage medical research and clinical quality assurance by health professionals at Timaru and Talbot Hospitals.

The Trust has not been consolidated. For the year ended 30 June 2014, the Trust had total revenue of $7,160 (2013 $12,020) and a net deficit of $12,654 (2013 net deficit $68,969). The Trust had assets of $150,487 (2013 $159,044) and liabilities of $6,656 (2013 $2,924) as at 30 June 2014.

22. Related party transactions and key management personnel

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

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

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

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

During the year South Canterbury District Health Board paid Health Benefits Limited $273,320 as a contribution to operating expenditure and for shared banking facilities and $298,000 for "B" Class shares.The balance outstanding at year end was $13,946 (2013 $1,490).

HSC Charitable Trust
During the year ended 30 June 2014 the DHB invoiced the Trust a total of $5,099 (2013 $1,154) for costs associated with research trials. The balance outstanding at year end was $nil (2013 $nil).

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

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

- Michael Boorer is a member of the Order of St John which has provided patient transfer services to SCDHB to the value of $204,565 (2013: $267,853).

- Ron Luxton is the chairperson of Aoraki MRI Charitable Trust ("the Trust"). The Trust was established to raise funds for the provision of an MRI scanner, building and associated equipment for the benefit of the people of South Canterbury. During 2013 the Trust donated $1.2M to SCDHB for a building to house the MRI scanner, purchasing associated anaesthetic equipment and implementing the MRI service. The Trust also entered into a lease with the DHB for the provision of an MRI scanner. Details of the lease are disclosed in Note 17.

- Rene Crawford was employed by SCDHB as an Associate Director of Allied Health on terms and conditions that were no more favourable than the DHB would have adopted if she was not a member of the Board.

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 (2013 nil).

Key management personnel compensation

	Actual 2014	Actual 2013
Salaries and other short-term employee benefits	2,069	2,099
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	-
Total key management personnel compensation	2,069	2,099

23. Board Member Remuneration and Committee Member Payments

Board Members Payments & Attendance

Member	Fees Paid	Attendance
Paul Annear	$16,320	11
Peter Binns	$16,320	11
Michael Boorer (iii)	$2,720	2
Murray Cleverley (chairperson)	$33,600	9
Rene Crawford	$16,320	11
Raeleen De Joux (ii)	$9,169	5
Nicola Hornsey (i)	$7,272	3
Warwick Isaacs (i)	$7,272	3
Terry Kennedy	$16,320	10
Ron Luxton (deputy chair)	$20,400	10
Peter Lyman (i)	$7,272	5
Edie Moke (ii)	$9,169	6
Murray Roberts (ii)	$9,169	5
Ngaire Whytock	$16,320	9
TOTAL	$187,643	

The Board met 11 times in 2013/14.

(i) Retired 5 December 2013
(ii) Appointed 6 December 2013
(iii) Appointed 14 April 2014

Committee Members Payments

Member	Fees Paid
Paul Annear	$5,351
Peter Binns	$4,999
Michael Boorer	$1,840
Murray Cleverley	$12,500
Michael Cotton	$3,977
Rene Crawford	$5,000
Peter Dalziel	$1,667
Raeleen De Joux	$4,827
Suzanne Eddington	$7,614
Kevin Foley	$417
Janet Gilbert	$2,083
Tony Gilchrist	$1,250
Judy Hines	$3,636
Nicola Hornsey	$2,344
Warwick Isaacs	$2,344
David Jack	$2,083
Terence Kennedy	$5,000
Ronald Luxton	$7,029
Peter Lyman	$2,343
Mary McSherry	$1,591
Christine Miller	$2,500
Edie Moke	$2,809
Pamela Niles	$417
Diane Nutsford	$1,667
Murray Roberts	$3,160
Neil Savage	$2,727
David Sibley	$19,200
Koriana Waller	$1,667
Ngaire Whytock	$4,530
Margaret Wiberg	$417
Vivien Wood	$833
Kathleen Wright	$417
	$118,239

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 2014, no employees (2013: one) 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 (2013: nil).

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24. Employee remuneration

Range	Actual 2014	Actual 2013
$480,001 - $490,000	1	-
$350,001 - $360,000	-	1
$330,001 - $340,000	5	1
$320,001 - $330,000	2	3
$310,001 - $320,000	3	1
$300,001 - $310,000	2	6
$290,001 - $300,000	4	1
$280,001 - $290,000	2	4
$270,001 - $280,000	1	2
$260,001 - $270,000	2	3
$250,001 - $260,000	2	1
$240,001 - $250,000	4	3
$230,001 - $240,000	3	5
$220,001 - $230,000	1	
$210,001 - $220,000	1	3
$200,001 - $210,000		1
$190,001 - $200,000	2	1
$180,001 - $190,000	2	3
$170,001 - $180,000	-	1
$150,001 - $160,000	2	-
$140,001 - $150,000	4	3
$130,001 - $140,000	-	3
$120,001 - $130,000	4	2
$110,001 - $120,000	4	4
$100,001 - $110,000	16	18
TOTAL	67	70
Clinical staff	45	46
Management and other staff	22	24

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

25. Financial instrument risks

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

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

Market risk

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

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. SCDHB's exposure to fair value interest rate risk is limited to its bank deposits and borrowings which are held at fixed rates of interest.

Cash flow interest rate risk

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

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

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

Sensitivity analysis
As at 30 June 2014, 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 $112,000 (2013 $92,000) higher or lower. This movement is attributable to increased or decreased interest revenue on cash at bank and short term bank deposits. Borrowings and longer term deposits are at fixed rates. The sensitivity is higher in 2014 than 2013 because of overall higher interest rates receivable on consolidation of funds.

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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 2014 (30 June 2013 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:

	2014	2013
Cash at bank and term deposits	35,266	19,323
Debtors and Other Receivables	5,067	4,807
	40,333	24,130

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

Concentration of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health for 97% (2013: 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.

	2014	2013
COUNTERPARTIES WITH CREDIT RATINGS		
Cash at bank and term deposits		
AA minus rating	35,266	19,323
Total cash at bank and term deposits	35,266	19,323

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

	Gross Receivables 2014	Impairment 2014	Gross Receivables 2013	Impairment 2013
Trade receivables				
Not past due	1,234	-	923	-
Past due 0-30 days	73	-	89	-
Past due 31-120 days	11	5	66	29
Past due 121-365 days	-	-	-	-
Past due more than 1 year	-	-	-	-
Total	1,318	5	1,077	29

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

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

Contractual maturity analysis of financial liabilities

	Carrying amount	Contractual cash flows	Less than 1 year	More than 1 year
2014				
Creditors and other payables	12,952	12,952	12,952	-
Borrowings	12,778	12,778	12,778	-
Total	25,730	25,730	25,730	-
2013				
Creditors and other payables	12,985	12,985	12,985	-
Borrowings	12,778	12,778	-	12,778
Total	25,763	25,763	12,985	12,778

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South Canterbury District Health Board

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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	Carrying amount Actual	Fair Value Actual
2014				
Financial Assets				
Cash and cash equivalents	10	22,458	22,458	22,458
Term Deposits >3 <12 months	11	12,778	12,778	12,778
Term Deposits >12 months	11	-	-	-
Trade and other receivables	12	5,067	5,067	5,067
Special Funds	9	-	-	-
Patient Trust Funds	10	30	30	30
Equity investments	11	-	-	-
		40,333	40,333	40,333
Financial Liabilities				
Trade and other payables	14	12,952	12,952	12,952
Patient Trust Funds	10	30	30	30
Loan from MOH	16	12,778	12,778	12,778
Finance Lease Liability	17	1,349	1,349	1,349
		27,109	27,109	27,109

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

26. Capital management

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

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

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

27. Post balance date events

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

28. Explanation of significant variances against budget

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

Revenue was greater than budgeted by $1.589M due mostly to additional elective and general practise revenue received from the Ministry of Health.

Total Expenditure, which was $1.128M greater than budget, off set most of the additional revenue. The main contributors to the above budget expenditure were Outsourced Personnel costs, Inter District expenditure, Infrastructure expenditure and Depreciation

Payments to NGO's were $2.197M less than budget. The main contributors were Pharmaceuticals, Personnel Health and Disability Support expenditure.

Outsourced Personnel costs were $2.666M greater than budget however this was mostly off set by Employee Benefit costs which were $1.977M less than budget.

Infrastructure costs were $693k greater than budget. Repairs and Maintenance and consultancy costs were the main contributors.

Inter District flow expenditure was $566k greater than budget due to patient demand for tertiary services at other District Health Boards.

Clinical Supply expenditure were $727k greater than budget due to demand in the provider arm for cancer drugs.

Depreciation expense was $356k greater than budget. This was due to budgeting for the MRI lease as a operating lease however the actual expense was changed to a financial lease after consulting with Audit NZ.

Cost of Services

South Canterbury DHB Financials by Output Class

	2013/14 Budget	2013/14 Actual
Revenue	*in thousands of New Zealand dollars*	*in thousands of New Zealand dollars*
Population Based Funding	160,776	160,776
Other MOH Funding	6,597	8,674
IDF Inflow	3,980	3,980
Total Revenue	**171,353**	**173,430**
Expenditure		
Early Detection and Management		
DHB Provider	4,205	4,205
Non DHB Provider	34,276	35,267
Total Early Detection and Management	**38,481**	**39,472**
Intensive Assessment & Treatment		
DHB Provider	69,613	69,613
Non DHB Provider	27,739	27,859
Total Intensive Assessment & Treatment	**97,352**	**97,472**
Prevention		
DHB Provider	1,384	1,384
Non DHB Provider	1,606	1,294
Total Prevention	**2,990**	**2,678**
Support & Rehabilitation		
DHB Provider	8,176	8,176
Non DHB Provider	24,152	23,579
Total Support & Rehabilitation	**32,328**	**31,755**
Total Expenditure	**171,151**	**171,377**
Net Surplus/(Deficit)	**202**	**2,053**

Good Employer

Leadership, Accountability and Culture: Our leadership, working collaboratively within SCDHB and with other DHBs is key to provide direction and to ensure more patient focussed service delivery. Improving clinical leadership and the integration of Primary and Secondary Care has and will continue to make a positive contribution in this regard. Clinical Governance is now established, strengthening its contribution to patient safety and oversight of clinical practice. The organisation is also continuing its structured approach to develop current and future clinical leaders. This process has been taken a further step by encouraging internal and external secondments and partnerships with other DHBs and Tertiary Institutions offering leadership/management training opportunities.

A number of engagement forums meet regularly to encourage a cooperative working environment. The staff forum led by the Chief Executive Officer, local Joint Consultative Committee (ASMS), Local Engagement Group (RDA) and Bi-Partite Action Group (All CTU affiliated unions) are examples.

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

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

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

SCDHB follows a pro-active strategic approach to employee health by providing a number of initiatives to enable staff to understand and improve their own health. We have continued with our Health4you programme targeting improved nutrition and encouraging physical activity over the past year.

The organisation does not tolerate any form of harassment or workplace bullying and ensures all staff are aware of policies and procedures to deal with such a situation. Employees are able to access independent and confidential Employee Assistance Programme Providers to which they may self refer.

SCDHB has increased training for health and safety representatives, chemical handlers and management to prepare all for the proposed legislative changes, promoting ownership of health and safety and clarification of responsibilities.

SCDHB has implemented a software solution and making good progress implementing a workload acuity process under the Safe Staffing and Healthy Workplaces agenda in collaboration with the unions. We have also established a Care Capacity Demand Management Council to drive the effective implementation and champion the programme throughout the organisation.

Remuneration and Recognition: We endeavour to remunerate all staff fairly and consistently, ensuring that remuneration and conditions are in line with collective employment agreements. SCDHB has developed initiatives which enable staff to feel more valued and appreciated in an informal and formal way.

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

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

Flexibility and work design: The changing models of care, service delivery pressures and increased focus on productivity and sustainability resulted in the development of new positions interacting with various disciplines across primary and secondary services.

For individuals who require flexible working arrangements SCDHB has a formal request process based on the Act for employees with caring responsibilities and other individual requests for flexibility are considered on a case by case basis. Currently 32% of staff are full-time employees, 49% are part-time and 19% are casual. We have engaged with our managers enhancing their awareness of legal changes and encouraged them to consider and implement flexible work options which benefit all parties.

Good Employer

Workforce as at 30 June 2014

Staff Ethnicity	Number
African	11
American	2
Asian Undefined	4
Australian	2
British/Irish	26
Chinese	7
Cook Island Māori	2
Dutch	1
European Undefined	74
Fijian	1
Filipino	5
German	1
Indian	8
Latin American	4
Middle Eastern	6
Not Available	79
NZ European	605
NZ Māori	42
Object To This	4
Other	16
Other Asian	11
Other European	40
Southeast Asian	3
Sri Lankan	2
Tongan	1
TOTAL	**959**

Staff Mix by Gender	Number	Percentage
Female	796	83%
Male	163	17%
TOTAL	**959**	**100%**

Staff Mix by Hours of Work (FTE)	Number	Percentage
Casual/Pool	179	18.67%
Less than 0.25 FTE	13	1.36%
0.25 to 0.49 FTE	59	6.15%
0.5 to 0.74 FTE	200	20.86%
0.75 to 0.99 FTE	198	20.65%
1 FTE	310	32.33%
TOTAL	**959**	**100%**

Staff Mix by Average Age	Age
Administration/Management	49.63
Allied Health	46.91
Medical	45.28
Nursing	46.34
Support Personnel	49.8
Average age of all staff	47.5

Disability

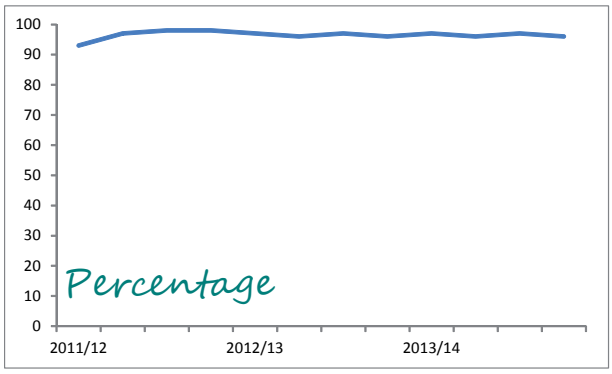
Specific data is not currently available but individuals with disabilities applying for vacancies are given full consideration based on the requirements of the position.

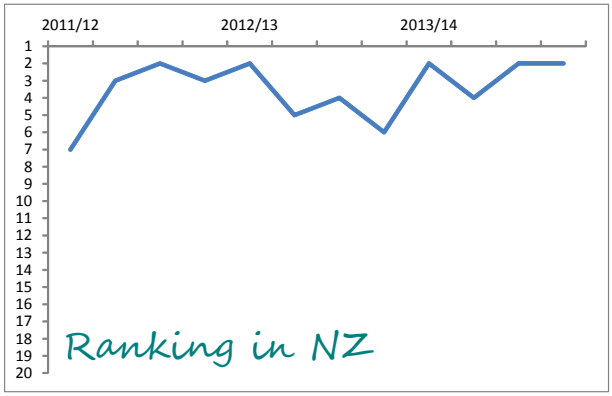
Health Target Results

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 2011/12	93	7th
Q2	97	3rd
Q3	98	2nd
Q4	98	3rd
Q1 2012/13	97	2nd
Q2	96	5th
Q3	97	4th
Q4	96	6th
Q1 2013/14	97	2nd
Q2	96	4th
Q3	97	2nd
Q4	96	2nd

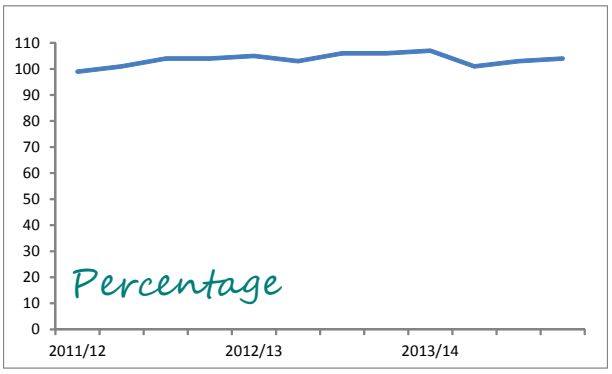


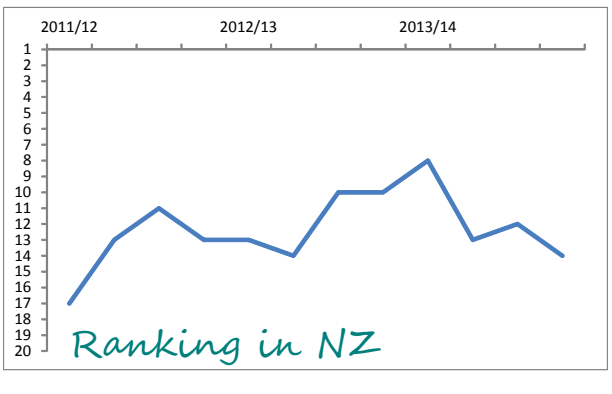


Improved Access to Elective Surgery

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 2011/12	99	17th
Q2	102	13th
Q3	104	11th
Q4	104	13th
Q1 2012/13	105	13th
Q2	103	14th
Q3	106	10th
Q4	106	10th
Q1 2013/14	107	8th
Q2	101	13th
Q3	103	12th
Q4	104	14th





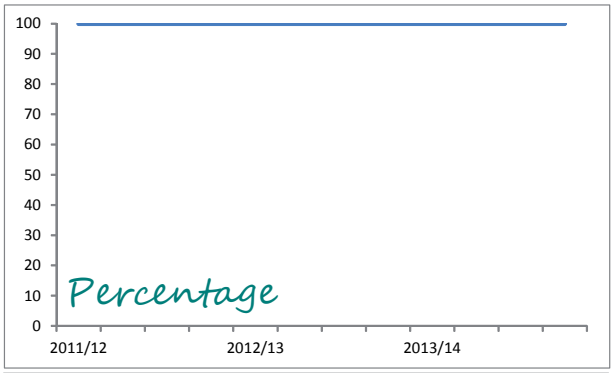
This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

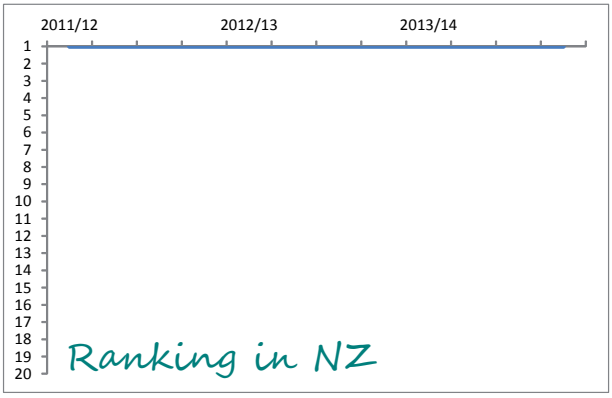
Health Target Results

Shorter Waits for Cancer Treatment

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

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2011/12	100	1st
Q2	100	1st
Q3	100	1st
Q4	100	1st
Q1 2012/13	100	1st
Q2	100	1st
Q3	100	1st
Q4	100	1st
Q1 2013/14	100	1st
Q2	100	1st
Q3	100	1st
Q4	100	1st

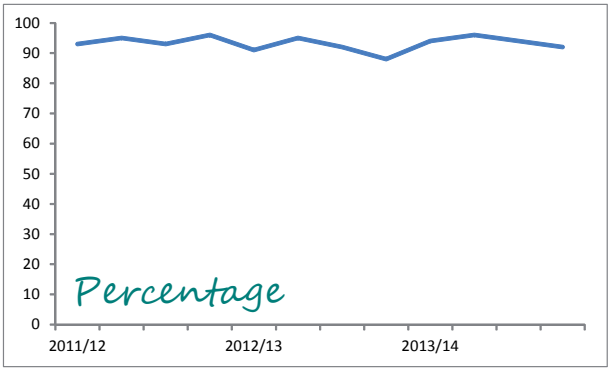


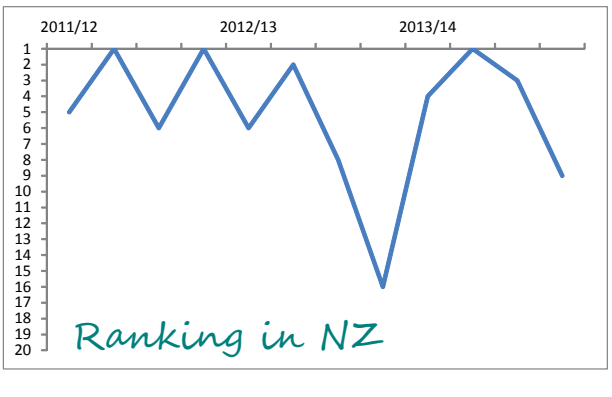


Increased Immunisation

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

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2011/12	93	5th
Q2	95	1st
Q3	93	6th
Q4	96	1st
Q1 2012/13	91	6th
Q2	95	2nd
Q3	92	8th
Q4	88	16th
Q1 2013/14	94	4th
Q2	96	1st
Q3	94	3rd
Q4	92	9th





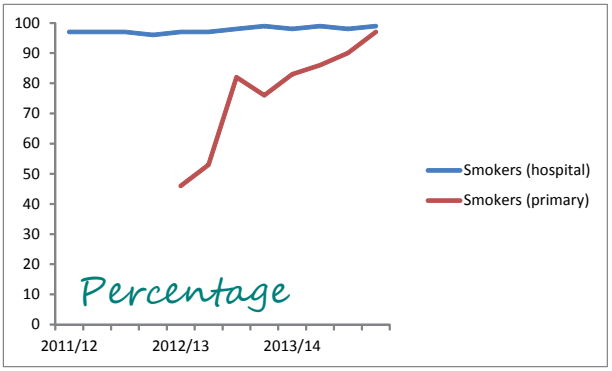
This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

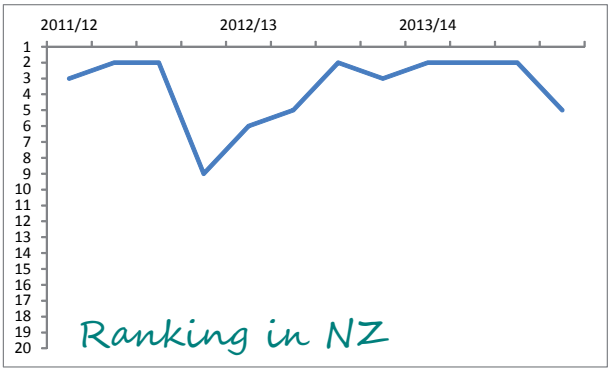
Health Target Results

Better Help for Smokers to Quit

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

QUARTER	PERCENTAGE OF PATIENTS (in hospitals) %	PERCENTAGE OF PATIENTS (in Primary Care) %	RANKING OUT OF 20 DHBs
Q1 2011/12	97		3rd
Q2	97		2nd
Q3	97		2nd
Q4	96		9th
Q1 2012/13	97	46*	6th
Q2	97	53*	5th
Q3	98	82*	2nd
Q4	99	76*	3rd
Q1 2013/14	98	83	2nd
Q2	99	86	2nd
Q3	98	90	2nd
Q4	99	97	5th



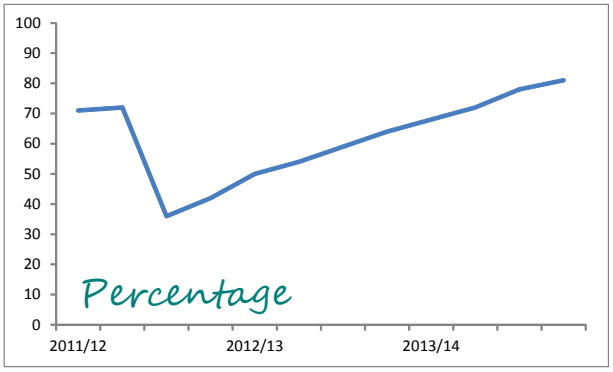


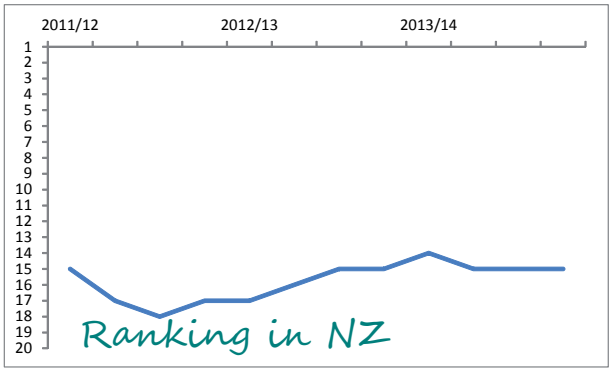
More Heart and Diabetes Checks

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

QUARTER	PERCENTAGE OF PATIENTS %	RANKING OUT OF 20 DHBs
Q1 2011/12	71	15th
Q2	72	17th
Q3	36*	18th
Q4	42	17th
Q1 2012/13	50	17th
Q2	54	16th
Q3	59	15th
Q4	64	15th
Q1 2013/14	68	14th
Q2	72	15th
Q3	78	15th
Q4	81	15th

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





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

Statement of Service Performance

Improving Health Outcomes for our Population

HOW WE MEASURE OUR PERFORMANCE?

DHBs are responsible for delivering against the health sector goal: "All New Zealanders lead longer, healthier and more independent lives" and for meeting Government commitments to deliver 'better, sooner, more convenient health services'.

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

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

The South Island DHBs collectively identified four strategic outcomes and a core set of associated indicators, which demonstrate whether we are making a positive change in the health of our populations. These are long-term outcomes (5-10 years in the life of the health system) and as such, aim for a measurable change in the health status of our populations over time, rather than a fixed target.

- *Outcome 1: People are healthier and take greater responsibility for their own health.*
  Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. These programmes create health-promoting physical and social environments which support people to take more responsibility for their own health and to make healthier choices.
    - A reduction in smoking rates.
    - A reduction in obesity rates.

- *Outcome 2: People stay well in their own homes and communities.*
  Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better management of their illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness.
    - A reduction in the rate of acute medical admission.
    - A reduction in premature ischemic heart disease rates.

- *Outcome 3: People with complex illness have improved health outcomes.*
  Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, people's health outcomes and quality of life can be improved.
    - A reduction in the rate of acute readmissions.
    - A reduction in premature cancer mortality rates.

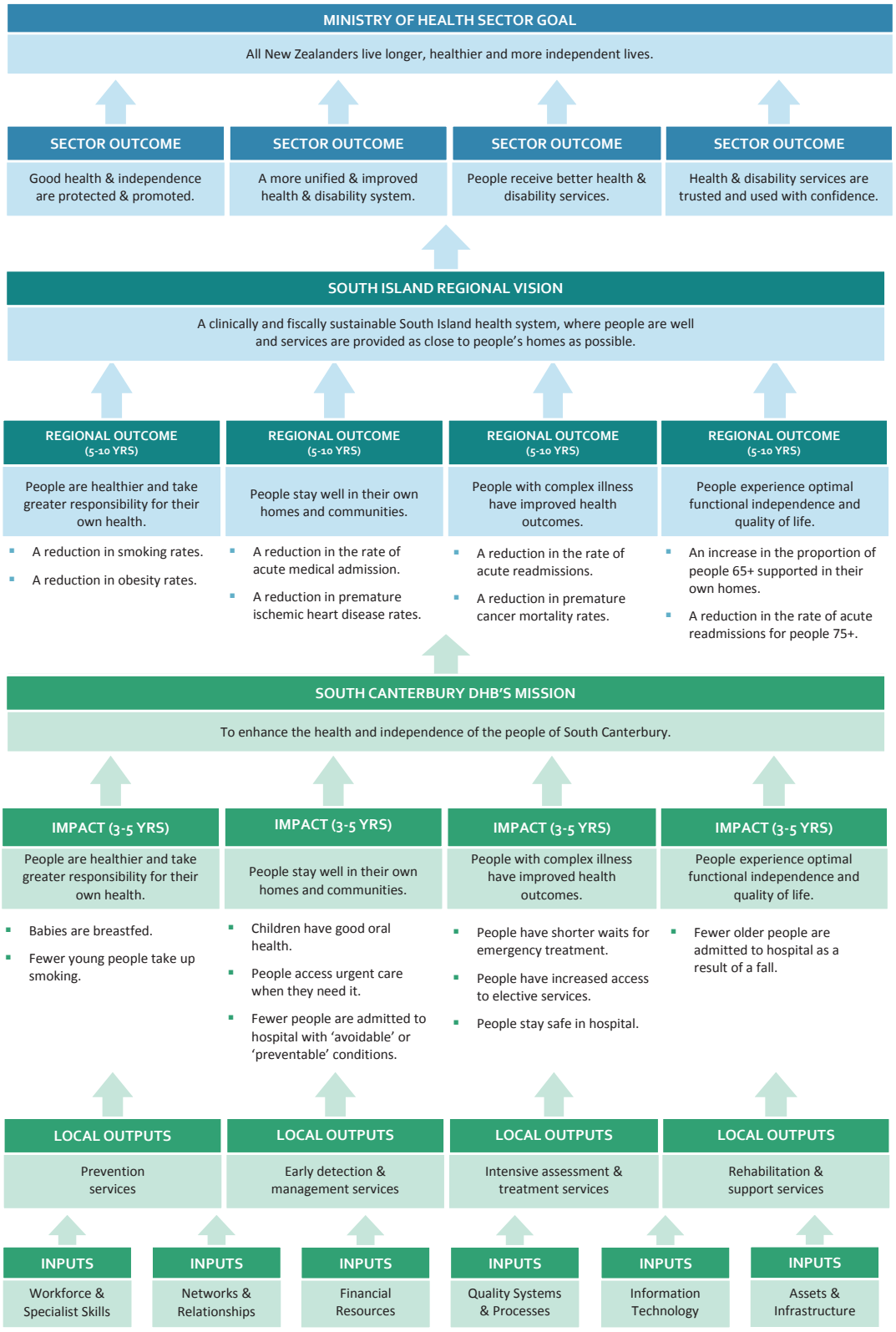
- *Outcome 4: People experience optimal functional independence and quality of life.*
  As well as providing early intervention and treatment, health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on patient care such as pain management or palliative services to improve the quality of life.
    - An increase in the proportion of people over 65 supported in their own homes.
    - A reduction in the rate of acute readmissions for people over 75.

Some previous years results for outcome and impact measures have been updated on graphs in this document to reflect the most current data available and may be different from those previously published.

The following intervention logic diagram (Figure 1) visually demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired longer-term outcomes and the delivery of the expectations and priorities of Government.

Statement of Service Performance

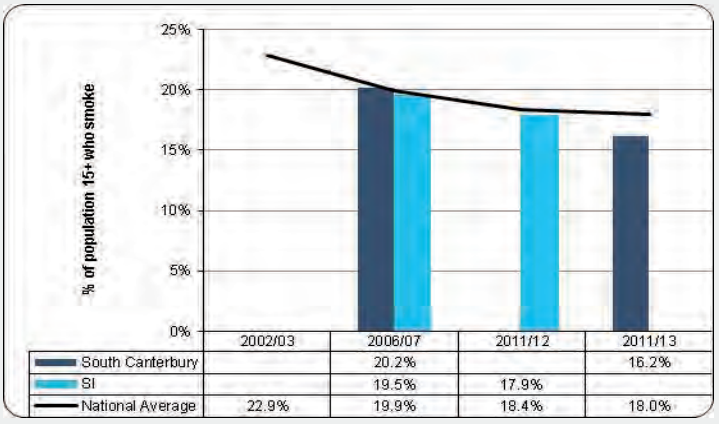
Figure 1: intervention logic diagram



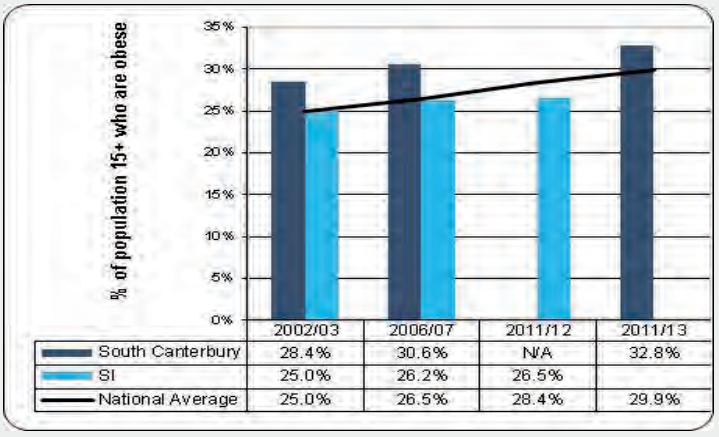
Statement of Service Performance

LONG-TERM OUTCOME MEASURE 1: People are healthier & take greater responsibility for their own health

Outcome Goal	Outcome Measure	Comment
A reduction in smoking rates.	The percentage of the population (15+) who smoke.	This data is sourced from the published 2011/12 National NZ Health Survey. South Canterbury's current result is an average of two years Health Survey data (2011/12 and 2012/13) and is an update to the 2011/12 published report. The size of the South Canterbury sample is noted as being small. Between the 2006 South Canterbury Census result (21.2%) and the 2013 Census result (16.2%) a 5% reduction has been noted. Effective health promotion programmes along with high levels of patient screening and easy access to cessation support continue to impact positively on this downward trend.
A reduction in obesity rates.	The percentage of the population (15+) who are obese.	This data is sourced from the published 2011/12 National NZ Health Survey. South Canterbury's current result is an average of two years Health Survey data (2011/12 and 2012/13) and is an update to the 2011/12 published report. The size of the South Canterbury sample is noted as being small. This result sits close to the national average.



	2002/03	2006/07	2011/12	2011/13
South Canterbury		20.2%		16.2%
SI		19.5%	17.9%	
National Average	22.9%	19.9%	18.4%	18.0%

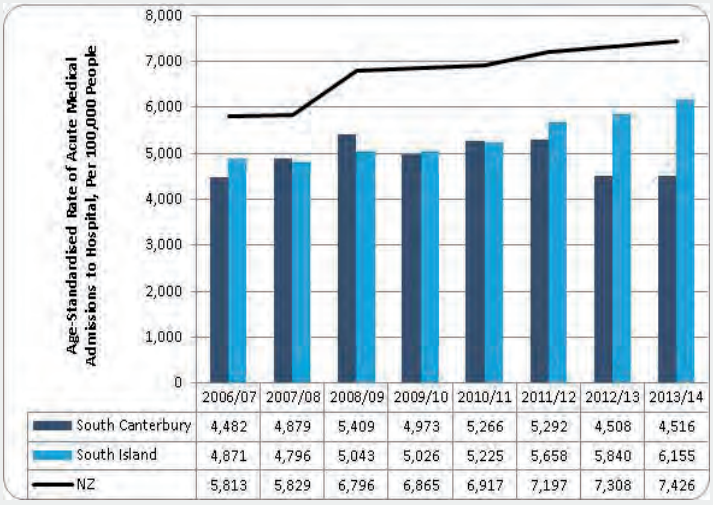


	2002/03	2006/07	2011/12	2011/13
South Canterbury	28.4%	30.6%	N/A	32.8%
SI	25.0%	26.2%	26.5%	
National Average	25.0%	26.5%	28.4%	29.9%

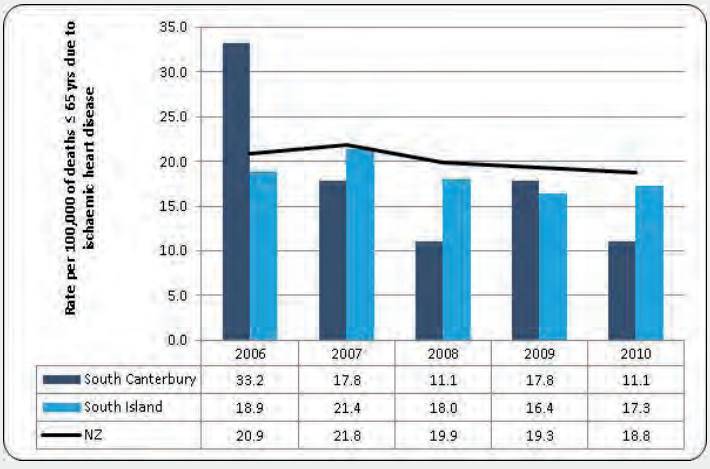
Statement of Service Performance

LONG-TERM OUTCOME MEASURE 2: People stay well in their own homes and communities.

Outcome Goal	Outcome Measure	Comment
A reduction in the rate of acute medical admissions.	The rate of acute medical admissions to hospital (age-standardised, per 100,000).	South Canterbury's result in this measure has maintained last year's performance and remains well below both the South Island and national result. This can be attributed to the fact that the DHB has primary care and community supports which effectively maintain people in the community and that there is timely access to outpatient specialist advice and treatment plan when patient need indicates this is required.
A reduction in premature ischemic heart disease rates.	The rate of death due to ischemic heart disease in people aged ≤65 (per 100,000).	The South Canterbury result for 2010 shows a return to the improved level recorded in 2008. It is important to note that this result reflects relatively small numbers. No subsequent published reports have been received.



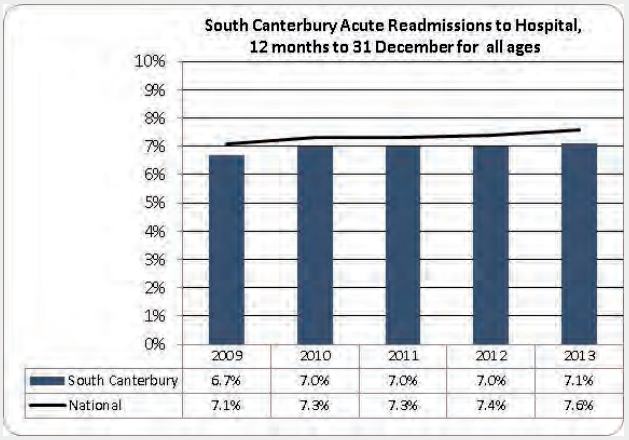
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
South Canterbury	4,482	4,879	5,409	4,973	5,266	5,292	4,508	4,516
South Island	4,871	4,796	5,043	5,026	5,225	5,658	5,840	6,155
NZ	5,813	5,829	6,796	6,865	6,917	7,197	7,308	7,426



	2006	2007	2008	2009	2010
South Canterbury	33.2	17.8	11.1	17.8	11.1
South Island	18.9	21.4	18.0	16.4	17.3
NZ	20.9	21.8	19.9	19.3	18.8

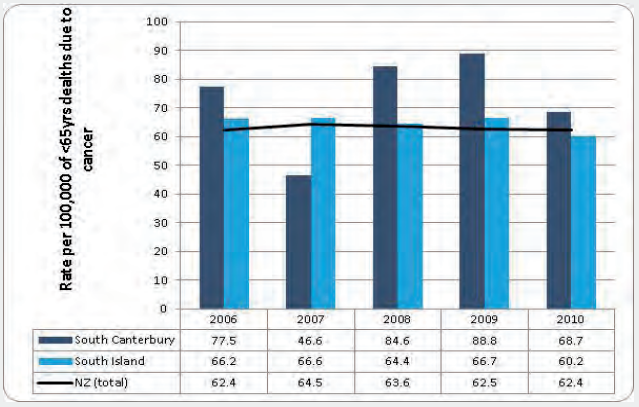
Statement of Service Performance

Outcome Goal	Outcome Measure	Comment
A reduction in the rate of acute readmissions.	The rate of acute readmissions to hospital within 28 days of discharge.	The result for 2013 for this measure is comparable with previous years and remains below the national average.



	2009	2010	2011	2012	2013
South Canterbury	6.7%	7.0%	7.0%	7.0%	7.1%
National	7.1%	7.3%	7.3%	7.4%	7.6%

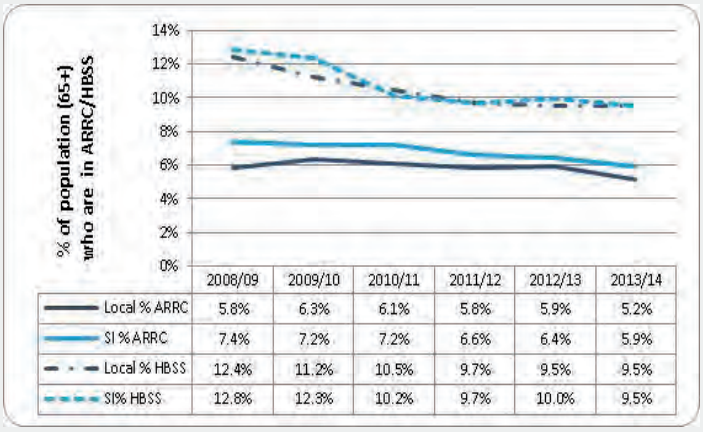
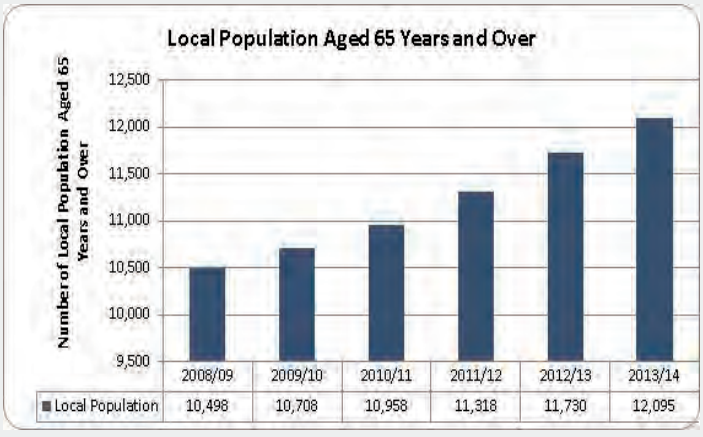
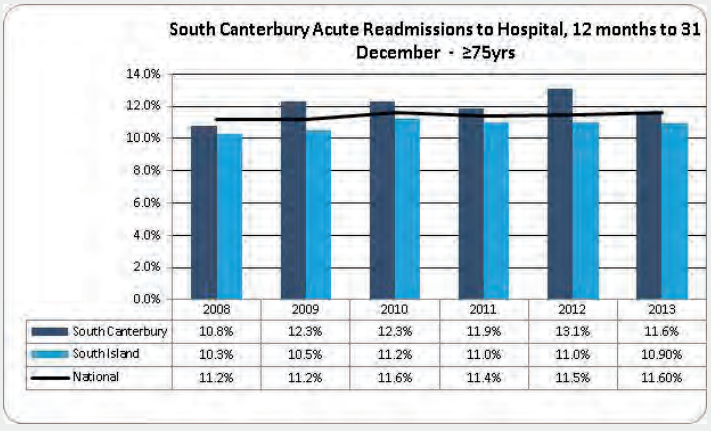
Outcome Goal	Outcome Measure	Comment
A reduction in premature cancer mortality rates.	The rate of deaths due to cancer in people aged ≤65 (per 100,000).	The result for 2010 is significantly less than the previous two years however it is important to note that this result reflects relatively small numbers. No subsequent published reports have been received.



	2006	2007	2008	2009	2010
South Canterbury	77.5	46.6	84.6	88.8	68.7
South Island	66.2	66.6	64.4	66.7	60.2
NZ (total)	62.4	64.5	63.6	62.5	62.4

Statement of Service Performance

LONG-TERM OUTCOME MEASURE 4: People experience optimal functional independence and quality of life.

Outcome Goal	Outcome Measure	Comment
An increase in the proportion of people over 65 supported in their own homes.	The percentage of the older population (≤65) living in ARRC compared against those receiving HBSS.	Results for this measure are comparable with the previous year and consistent with current results for the South Island.  2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 Local % ARRC 5.8% 6.3% 6.1% 5.8% 5.9% 5.2% SI % ARRC 7.4% 7.2% 7.2% 6.6% 6.4% 5.9% Local % HBSS 12.4% 11.2% 10.5% 9.7% 9.5% 9.5% SI% HBSS 12.8% 12.3% 10.2% 9.7% 10.0% 9.5% There is a slight increase in the population over 65 years in line with predictions. It is expected that the proportion of those in this population group over 85 years of age will increase in the future.  2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 Local Population 10,498 10,708 10,958 11,318 11,730 12,095
A reduction in the rate of acute readmissions for people over 75.	The rate of acute readmissions to hospital for people aged ≥75yrs (within 28 days of discharge).	South Canterbury DHB's result for this measure is an improvement on the previous year and in-line with the national result.  2008 2009 2010 2011 2012 2013 South Canterbury 10.8% 12.3% 12.3% 11.9% 13.1% 11.6% South Island 10.3% 10.5% 11.2% 11.0% 11.0% 10.90% National 11.2% 11.2% 11.6% 11.4% 11.5% 11.60%

Statement of Service Performance

HOW HAVE WE PERFORMED?

MEDIUM-TERM IMPACT MEASURES

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

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

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

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Impact Goal

More babies are breastfed.

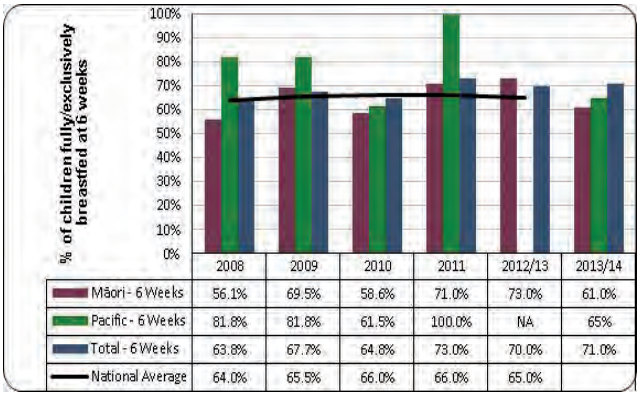
Impact Measure

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

Comment

Whilst the result for the total population has been maintained the result for Māori at 61.0% is a 12% reduction on the previous year. This result does not include Arowhenua Whānau Services data and it is unknown how many individuals the Plunket data includes i.e. whether or not this significant drop is simply attributed to small numbers.

Data sourced from Plunket via the Ministry of Health



	2008	2009	2010	2011	2012/13	2013/14
Māori - 6 Weeks	56.1%	69.5%	58.6%	71.0%	73.0%	61.0%
Pacific - 6 Weeks	81.8%	81.8%	61.5%	100.0%	NA	65%
Total - 6 Weeks	63.8%	67.7%	64.8%	73.0%	70.0%	71.0%
National Average	64.0%	65.5%	66.0%	66.0%	65.0%	

Statement of Service Performance

Impact Goal

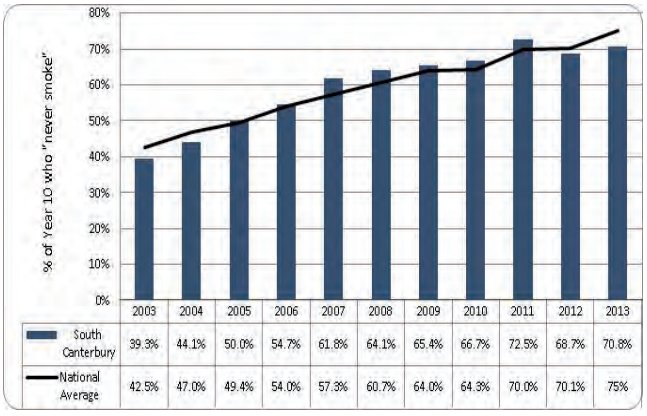
Fewer young people take up tobacco smoking.

Impact Measure

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

Comment

The result for 2013 is a slight improvement on the previous year and closer to levels reported in 2011. This fluctuation is probably due to the small sample size.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
South Canterbury	39.3%	44.1%	50.0%	54.7%	61.8%	64.1%	65.4%	66.7%	72.5%	68.7%	70.8%
National Average	42.5%	47.0%	49.4%	54.0%	57.3%	60.7%	64.0%	64.3%	70.0%	70.1%	75%

Data sourced from national Year 10 ASH survey

OUTCOME: PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Impact Goal

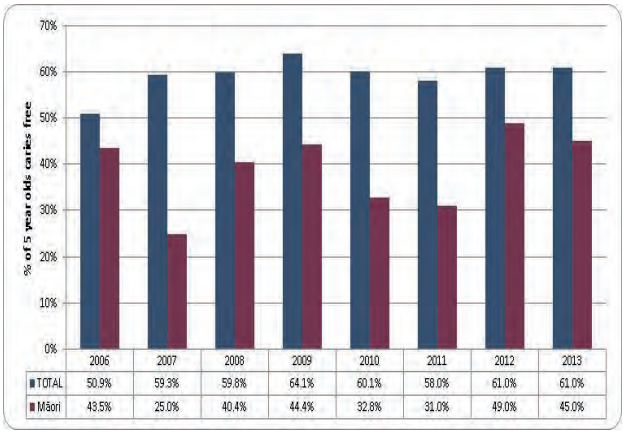
Children have good oral health.

Impact Measure

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

Comment

Performance during 2013 has been maintained with a result for the total population which meets the expected standard.



	2006	2007	2008	2009	2010	2011	2012	2013
TOTAL	50.9%	59.3%	59.8%	64.1%	60.1%	58.0%	61.0%	61.0%
Māori	43.5%	25.0%	40.4%	44.4%	32.8%	31.0%	49.0%	45.0%

Data sourced from Ministry of Health

Statement of Service Performance

Impact Goal

People access urgent care when they need it.

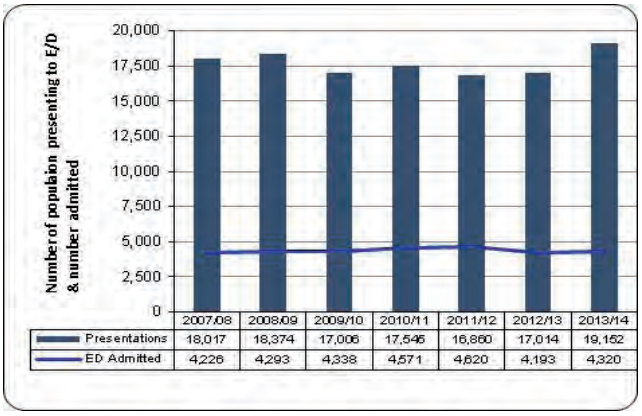
Comment

The total number of people presenting at ED in the prior four years remained static. This altered in 2013/14 with an increase of 2000 presentations. It may be noted that there has been an increase in triage 4 & 5 presentations over the past year. This is an area of focused service improvement with primary care in the coming year. There has been shift within the result with fewer children under 6 years presenting to ED with the commencement of free GP visits for this age group.

Data sourced from National Minimum Data Set

Impact Measure

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



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Presentations	18,017	18,374	17,006	17,545	16,860	17,014	19,152
ED Admitted	4,226	4,293	4,338	4,571	4,620	4,193	4,320

Impact Goal

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

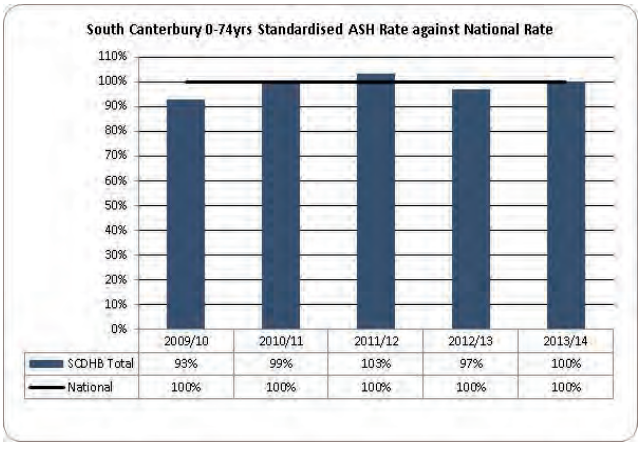
Comment

The result for 2013/14 is comparable with previous years.

Data sourced from the Ministry of Health

Impact Measure

The rate of avoidable hospital admissions for the South Canterbury population per 100,000 population (0 – 74 yrs).



	2009/10	2010/11	2011/12	2012/13	2013/14
SCDHB Total	93%	99%	103%	97%	100%
National	100%	100%	100%	100%	100%

Statement of Service Performance

OUTCOME: PEOPLE WITH COMPLEX ILLNESS HAVE IMPROVED HEALTH OUTCOMES

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Impact Goal

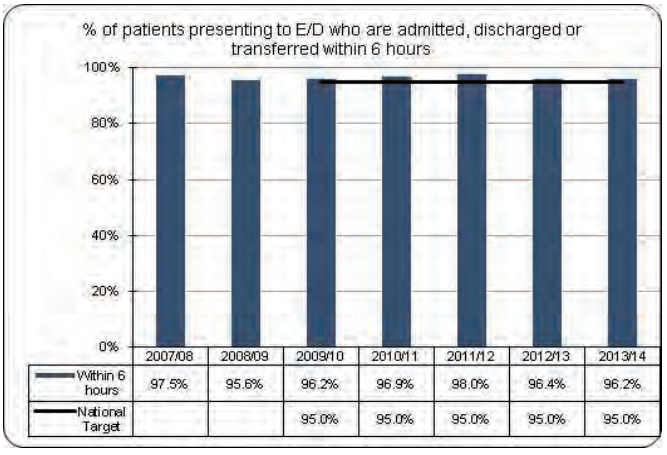
People have shorter waits for treatment.

Impact Measure

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

Comment

South Canterbury continues to consistently meet this national health target.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Within 6 hours	97.5%	95.8%	96.2%	96.9%	98.0%	96.4%	96.2%
National Target			95.0%	95.0%	95.0%	95.0%	95.0%

Data sourced from SCDHB

Impact Goal

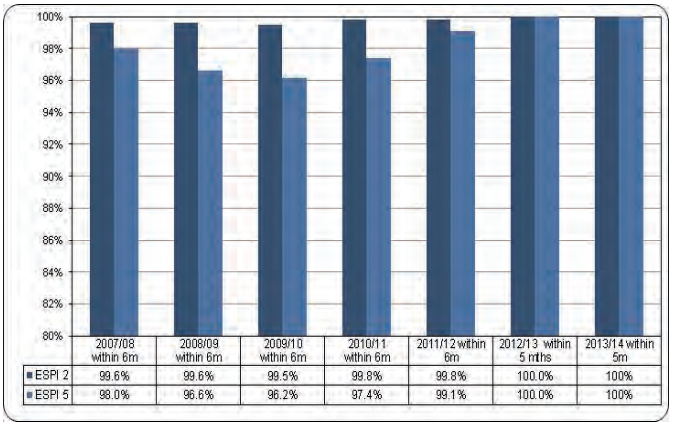
People have increased access to elective services.

Impact Measures

The time people wait from referral to First Specialist Assessment (ESPI 2) is ≤5 months by June 2013 and ≤4 months by December 2014.
The time people wait from commitment to treat until treatment (ESPI 5) is ≤5 months by June 2013 and ≤4 months by December 2014.

Comment

Elective Service Performance Indicator 2 relates to the percentage of patients provided with a First Specialist Appointment within 5 months of referral. Elective Service Performance Indicator 5 relates to the percentage of patients given a commitment to treatment within 5 months. South Canterbury DHB's achievement against this reducing target has been sustained for 2013/14.



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

Data sourced from SCDHB

Statement of Service Performance

Impact Goal

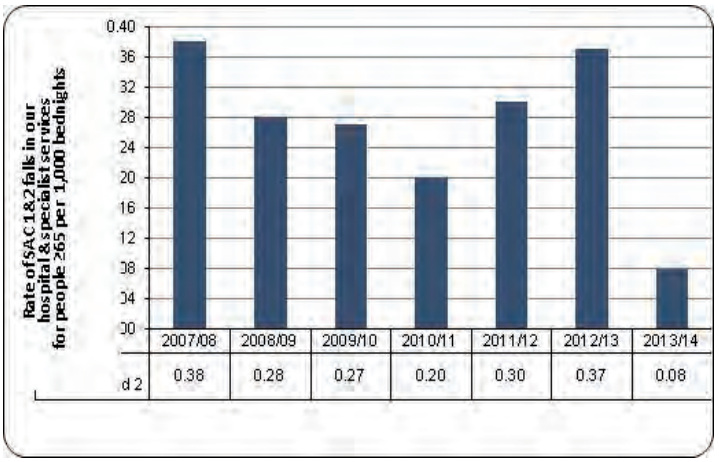
People stay safe in hospital.

Impact Measures

The rate of SAC1 and 2 falls (all ages) in South Canterbury DHB Hospitals.

Comment

The excellent result achieved in 2013/14 is due to the focus of the Falls Prevention and Management programme carried out by the DHB. There were no falls within this category recorded within hospital services.



Data sourced from SCDHB

OUTCOME: PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

Impact Goal

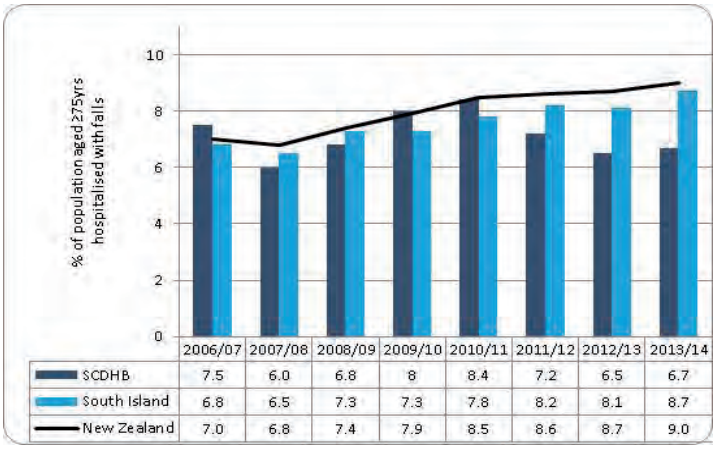
Fewer older people are admitted to hospital as a result of a fall.

Impact Measure

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

Comment

Performance against this measure has been sustained in 2013/14 and continues to sit well below both South Island and national results. This remains largely attributable to the South Canterbury Community Falls Prevention Programme.



Data sourced from SCDHB

Statement of Service Performance

STATEMENT OF SERVICE PERFORMANCE 2013/14

MEASURING OUR NON-FINANCIAL PERFORMANCE

As part of evaluating our performance, we provide an annual forecast of the services we plan to deliver and report actual delivery against that forecast at the end of each year. The following section presents our actual performance against the forecast outputs presented in our Statement of Expectations for 2013 – 2014.

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

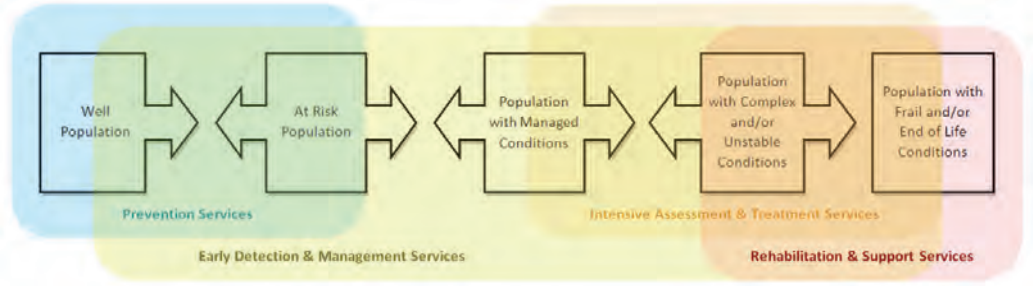
The output measures chosen are those activities which reflect a reasonable picture of activity across the whole of the South Canterbury health system and have the potential to make the greatest contribution to the health and wellbeing of our population in the shorter term and to the health outcomes we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

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

We have set targets for each output measure to demonstrate the expected standard. Where available we have included prior year's baseline data to support evaluation of our performance over time as well as national results for 2013/14 to give context in terms of what we are trying to achieve.

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

OUTPUT GROUPING SET AGAINST THE CONTINUUM OF CARE FOR OUR POPULATION



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

Some data is collected on calendar rather than financial years and where this occurs is indicated as such. Results are based on data available at the time of producing this report and may be subject to change as additional coding and invoicing is completed. ◊ indicates where the target for 2013/14 has been updated since writing the Statement of Expectations and # indicates that a previously published result has been updated. Any other irregularities have been footnoted.

Statement of Service Performance

WHAT HAVE WE DELIVERED – PERFORMANCE RESULTS

South Canterbury District Health Board continues to perform well against a range of performance measures including meeting target for five of the six health targets and significant improvement (16%) being demonstrated from the previous year against the remaining target. Where the targets set out in the following tables has been achieved this has been indicated with a √ in the status column. For those measures where target has not been achieved these results have been indicated with an x and a comment explaining variance to target has been included as a footnote. Those measures purely relating to estimated service delivery which are demand driven have been indicated with a ∞.

OUTPUT CLASS - PREVENTION SERVICES

Preventative health services promote and protect the health of the whole population. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

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

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

Whilst slightly below national target SCDHB has managed to maintain its performance against breast feeding targets. Excellent results were achieved against the Better Help for Smokers to Quit health target with DHB cessation services directed more at patients with high complexity requiring more intensive support. Provision of Green Prescriptions continues to increase with a significant increase in volumes advised during 2013/14. The DHB continues to performance well above the national benchmark score of 70 for its Family Violence Intervention Programme.

Population based screening results show either achievement against or progress towards national targets with SCDHB being ranked number one for B4SCs.

Results for immunisation measures all met targets with the exception of HPV. Unfortunately there continues to be a high number of active declines for the HPV vaccination. There has been some increase in coverage through the school based programme and improving the rate of access further will remain a focus over the 2014/15 year.

Statement of Service Performance

OUTPUT MEASURES

Health Promotion and Education Services These services inform people about risks and support them to be healthy. Success is measured by greater awareness and engagement, reinforced by programmes that support people to maintain wellness, change personal behaviours and make healthier choices.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/ Estimated Delivery 2013/14	Current National Average	Achievement against Target
Percentage of babies breast-fed (exclusive and full) in the district at 6 weeks of age	C,Q [1]	73% (2011)	70%	70%	≥ 73%	-	x
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age	C,Q [1]	54% (2011)	56%	56%	≥ 58%	-	x
Percentage of babies breast-fed (exclusive and full) in the district at 6 months of age	C,Q [1]	26% (2011)	25%	27%	≥ 28%	-	x
No. of people in South Canterbury accessing smoking cessation programmes	V[2]	1205	873	548	≥ 1000	-	x
Percentage of people who receive brief invention to quit smoking in the hospital setting	C	96%	98.8%	99.2%	≥ 95%	95.7%	√
Percentage of people who receive brief invention to quit smoking in the primary care setting	C	35.4%	76%	97.3%	≥ 90%	85.8%	√
No. of Green Prescription referrals	V [3]	360	385	414	≥ 405 incr. to 520 ◊	-	√
Percentage of education settings engaged with WAVE	C [4]	≥ 99%	99%	99.1%	≥ 99%	-	√
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to child abuse above the national benchmark score of 70	Q [5]	91	96	96	≥91	-	√
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to partner abuse above the national benchmark score of 70	Q [5]	92	92	92	≥92	-	√

[1] The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal period and the value of breast feeding support during the post natal period. Data is sourced from Plunket via the Ministry of Health and excludes data from AWS.

[2] These volumes relate to DHB funded programmes and the target for 2013/14 is targeted at people with specialised needs. Others will be referred to programmes such as Quitline. This variance of actual delivery against target can be explained by the triage process that occurs which sees persons without associated long term health conditions being referred onto Quit line, instead of the Smoking Cessation Team. There is a clear relationship with Quit line that after initial contact, if indicated then they will refer these persons through to that team. As such although the referral numbers are lower than expected, the patient complexity is high with more patients requiring more intensive support.

Statement of Service Performance

[3] The Green Prescription initiative is a way to improve the health of New Zealanders. This service is provided on referral to Sport Canterbury for adults and focuses on sustaining physical activity to improve health outcomes. This target was increased to 520 following publication of the Annual Plan and whilst the initial target was comfortably met the end of year result fall short of the target revised by the Ministry of Health. Initiatives implemented in the later part of the 2013/14 year are beginning to show improved results.

[4] WAVE stands for "Well-being and Vitality in Education". It is a health promotion initiative that works collaboratively between education, health and Sport Canterbury and works across all levels of education to help create and support health environments.

[5] The Family Violence Intervention Programme audits compliance against the National Guidelines for Partner and Child Abuse and contract specifications for this service. The last Programme evaluation audit was performed in mid 2013, and reported as the Actual for 2012/2013. The next audit has been delayed until August/September 2014 therefore the 2012/13 result stands as current.

Population Based Screening These services are mostly funded and provided through the National Screening Unit and help identify people at risk of illness earlier. They include breast and cervical screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years	T [6]	75.8% # (20-69 years)	76.03% (20-69 years)	78.7%	≥ 80%	76.6%	x
Percentage of Māori enrolled women aged 25 – 69 years who have had a cervical screen in the last three years	T [6]	46.5% (20-69 years)	70% (20-69 years)	50.7%	≥ 80%	63%	x
Percentage of enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	T [6]	81.4% # (45-69 years)	73.12% (45-69 years)	82.9% (45-69 years)	≥70%	72.54%	√
Percentage of Māori enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	T [6]	80%	72% (45-69 years)	82.9% (45-69 years)	≥ 70%	65.7%	√
No. of B4 School Checks completed	V [7]	652	816	803	≥ 680	-	√
Percentage of eligible population provided with a B4 School Check	C [7]	95.58%	>100%	112%	≥ 95%	-	√
No. of 'high needs' B4 School Checks completed	V [7]	74	87	82	≥ 65	-	√
Percentage of eligible 'high needs' population provided with a B4 School Check	C [7]	≥100%	>100%	119%	≥ 95%	-	√

Statement of Service Performance

[6] These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. The age band for cervical screening has changed to 25 – 69 years and the age band for mammography has been changed to 45-69 years). The result for Māori for cervical screening has been negatively influenced by ethnicity data capture on the National Cervical Screening Programme Register. This issue will be resolved as women return for their next screening and ethnicity data is updated. The local result for Māori taken from the PHO Performance Programme for is 74.02% which is closer to target.

[7] The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development. These targets are nationally set and have been exceeded due to additional children 'being found' at pre-school visits by the Vision and Hearing tester. This group comprises overseas families on work visas (dairy industry workers), and families ex Christchurch.

Immunisation These services reduce the transmission and impact of vaccine-preventable diseases including unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
Percentage of 8 months old fully immunised on time	T,C	96% #	88%	92%	≥ 90%	91.6%	√
Percentage of 2 years old fully immunised on time	T,C	94%	94%	97%	≥ 95%	93%	√
Percentage of the eligible population receiving the flu vaccination	C[8]	66.79%	68%	68.67%	≥ 70%	-	x
No. ≥ 65 year olds immunised for pneumonia	C [9]	793 #	391	223	≥180	-	√
No. of HPV vaccinations completed for consenting adolescents through the school based programme.	V [10]	141	154	171	200	-	x

[8] Whilst the target was not met by the end of June the programme was extended until the end of August and 71% had been achieved by the end of July 2014.

[9] This immunisation programme commenced in 2011. The planned volumes for the first two years of this programme were set at 850/year to address the back log and then reducing to 180/year ongoing. The vaccine is expected to last 5 years.

[10] The measure is based on young women 12 - 18 who have been provided with all three doses. A school based programme was commenced in 2013. 171 girls born in 2000 completed their HPV course by June 2014. These are predominantly girls that started in the school based programme in 2013 but the total also includes some girls who had their HPV at their GP. Unfortunately there continues to be a high number of active declines for the HPV vaccination. This year there were 118 girls who formally declined so we were not able to reach our target of vaccinating 200 year 8 girls.

Statement of Service Performance

OUTPUT CLASS - EARLY DETECTION & MANAGEMENT

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

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori and Pacific health services, pharmacy services, community radiology and diagnostic services and child oral health services.

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

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

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

All primary health care targets were achieved or close to achievement with excellent progress being made in the development of Aoraki Health Pathways.

Good results were also demonstrated in the area of long term condition management with pleasing results in the uptake of the Multi-condition Rehabilitation and Encounter Programmes. Whilst the result for the health target More Heart & Diabetes Checks fell slightly short of target a significant improvement is noticed from the previous year.

Results for oral health are variable and these remain a focus for the DHB. The result for medicines reconciliation is also disappointing however planned implementation of IT solutions in 2014/15 will support this process.

The DHB performed well above national target for waiting times for MRI, CT and urgent diagnostic colonoscopy. An area for improvement is improving the percentage of people accepted for a diagnostic colonoscopy who receive their procedure within six weeks.

Statement of Service Performance

OUTPUT MEASURES

Primary Health Care These services are offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. people in the district enrolled with a Primary Care Provider	V	55,709 #	56,272	56,807	≥ 56,000	-	∞
Percentage of eligible people enrolled in the Care Plus Programme	C [1]	83.5%	81.46%	84%	≥ 82%	-	√
No. Aoraki HealthPathways in place	Q [2]	139	265	391	350	-	√
Percentage of newborns enrolled with a GP within four weeks of birth	T [3]	NEW	NEW	100%	90%	-	√
Avoidable Hospital Admission (ASH) 0 – 74 years (Total) rate	Q [4]	99% #	102%	100%	≤98%	100%	x

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

2 Aoraki HealthPathways website contains clinical pathways which provide general practice with information on referrals, specialist advice, diagnostic tools, GP procedure subsidies and patient handouts.

3 This result is a snapshot in time as the data is difficult to extract.

4 Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved integration between primary and secondary services. This measure was changed in 2012/13 to a percentage and results have been re-calculated as per the revised Ministry of Health definition.

Statement of Service Performance

Long Term Conditions Programme These services are targeted at people with high need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention, self-management strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
Percentage of people who have had an Annual Diabetes Review	C[5]	69%	41.4%	Not Available	≥ 72%	-	-
No. of patients who have completed the Multi-condition Rehabilitation Programme	V[6]	NEW	NEW	92%	≥ 70%	-	√
No. of patients enrolled in the Diabetes Encounter Programme	V[7]	NEW	NEW	135	≥ 130	-	√
No. of patients enrolled in the Diabetes Re-engagement Programme	V[7]	NEW	NEW	53	≥ 150	-	x
Percentage of the eligible population who have had their cardiovascular risk checked in the last 5 years	C[8]	42.4% #	64.4%	81.2%	≥ 90%	84.4%	x

[5] Diabetes Annual Reviews, although no longer funded remain an important component in the management of diabetes within the community, and are a requirement for persons on the Diabetes Care Improvement Package Programmes. As annual diabetes reviews are no longer funded this data is not available as this was previously captured through coding for payment. Some practices report that they are not using the diabetic screening code within Medtech for the diabetes annual reviews, therefore this information is not being reported nor counted to the target. South Canterbury DHB has recently introduced a new Diabetes Annual Review Advanced form into practices and it is hoped that this will increase the use of a formalized screening form.

[6] The multi-condition rehabilitation programme replaces the previous community based pulmonary rehabilitation programme. It provides a rehabilitation programme for persons with a wide range of long term conditions including cardiac, diabetes and respiratory.

[7] The Diabetes Encounter Project works with newly diagnosed diabetics or those commencing insulin in the community. The patient receives intensive input in a planned way from their GP, Practice Nurse and the Clinical Nurse Specialist Diabetes. The aim of this input is to get good glycaemic control within a short time frame. The variance in the result against target for service delivery for the Diabetes re-engagement is encouraging as this is indicating that as a region, we are getting higher coverage of people engaged with their primary care provider and therefore not requiring this service. It is the goal of this programme that such people are engaged with their primary care team; therefore the reduced numbers to re-engagement must be seen as a positive. The Diabetes Re-engagement Project seeks to target those persons within general practice, with known diabetes whom are not engaged with primary care, therefore have either poor glycaemic control, or unknown glycaemic control. The person receives intensive input as per the engagement pilot.

[8] This refers to CVD risk assessments undertaken in primary care in line with the expectations of the PHO Performance Programme and the 'More heart and diabetes checks' health target. Whilst this target was not met the impact of a number of initiatives has seen a consistently significant improvement quarter on quarter resulting in a 17% improvement on the previous year's result.

Statement of Service Performance

Oral Health These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well functioning, efficient service.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
Percentage of children under five years enrolled in DHB funded dental services	C[9]	67% # (2011)	76.7% (2012)	70.9% (2013)	≥ 83%		x
Percentage of adolescents accessing DHB funded oral health services	C[9]	91.4% (2011)	88.6% # (2012)	88.7% (2013)	≥ 91% Nat target 85%	70%	X √ (Nat. target)
Percentage of children caries free at five years of age	C	58% (2011)	60.18% (2012)	61% (2013)	≥ 61%	57%	√
Oral Health Decayed, Missing and Filled Teeth score at year eight	C	1.29 (2011)	1.2 (2012)	1.08 (2013)	≤ 1.2	1.14	√
Percentage of enrolled preschool and primary school children overdue for their scheduled examination	T[9]	6% (2011)	9% (2012)	10% (2013)	≤ 6%	-	x

[9] In order to reach the target of ≥ 83% more children under the age of 12 months need to be enrolled. Currently Well Child Providers are referring at the core 5 check at 9 – 12 months. The implementation of a multiple provider enrolment form (which includes dental) at birth should see an improvement in this result. South Canterbury team is making steady progress on reducing the number overdue for scheduled examination. Whilst slightly below target for the percentage of adolescents accessing DHB funded oral health services we are achieving above the national target.

Pharmacy As long term conditions become prevalent, demand for pharmaceuticals will likely increase. The LTC service has been introduced to provide a greater hand on role of community patient's pharmaceutical management. To improve service quality in the hospital setting we have also introduced medicines interventions monitoring along with medicines reconciliation to reduce the number of New Zealanders harmed each year by medication errors in our hospital.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. of medicines reconciliations completed	Q[10]	NEW	NEW	27.2% (Oct 2013 – June 2014)	75%	-	x

Statement of Service Performance

[10] 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. Prioritised inpatients have completed medicine reconciliation within 24 hours of admission. Prioritised patients are patients on medical, ICU, surgical and AT&R wards. Whilst 27.2% of medicine reconciliations occurred during the reported nine month period only 13.59% of these occurred within 24 hours. Planned implementation of ePrescribing & Administration and ePharmacy in 2014/15 is expected to improve this result.

Community Referred Tests & Diagnostic Services These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, and radiographers. To improve performance, we will target improved primary care access to diagnostics without the need for a hospital appointment to improve clinical referral processes and decision making. community referred laboratory test are demand driven.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. community referred laboratory tests	V[11]	215,695	252,873	282,429	Est. 245,000	-	∞
No. community referred radiology examinations	V[12]	11,249	10,067	10,564	Est. 10,240	-	∞
Percentage of accepted referrals for a MRI scan receive their scan within six weeks	T[13]	NEW	84%	99.4%	75%	60.7%	√
Percentage of accepted referrals for a CT scan receive their scan within six weeks	T[13]	NEW	87%	99.3%	85%	80.4%	√
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within two weeks	T[13]	NEW	NEW	73%	50%	55.2%	√
Percentage of people accepted for a diagnostic colonoscopy who receive their procedure within six weeks	T[14]	NEW	NEW	31.9%	50%	37.9%	x

[11] This volume is demand driven.

[12] This volume is demand driven.

[13] South Canterbury District Health Board has performed well above the national targets for these measures.

[14] Extensive validation of waiting lists has been undertaken over the past 4 months. With the waiting time initiative funding this has enabled a greater number of procedures to be undertaken from April - June 2014. The focus for the forthcoming year will be to continually validate lists and ensure that patients are being appropriately treated as per guidelines, and to increase capacity for additional procedures.

Statement of Service Performance

OUTPUT CLASS - INTENSIVE ASSESSMENT AND TREATMENT SERVICES

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

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

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

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

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

Health targets for Shorter Stays in Emergency Departments and Shorter waits for Cancer Treatments were both met as were targets for length of stay and readmission rates. A highlight for the DHB this year has been the notable decrease in the number of falls resulting in significant injury or death. This is primarily attributed to a Falls Prevention Project which was undertaken within the AT&R unit. The result for the percentage of complaints resolved within 23 working days fell well short of target and this measure is being reviewed for validity. The DHB continues to demonstrate low rates for hospital acquired infections.

All volumes and targets within elective services were met with the exception of elective theatre time utilisation. This area is a focus for 2014/15.

The number of babies born in our maternity unit was above estimated delivery. Whilst the caesarean rate remains above the national average it shows an improvement on the previous year. SCDHB has been recognised as having achieved BFHI Accreditation on four successive occasions and as such their period of accreditation has been extended to four years.

Results for assessment, treatment and rehabilitation services are all below the estimated level of service delivery. This reflects the move to delivering services to older people in the community setting and a mix of changes in clinical practice and medical staffing cover over this period. These vacancies have now been filled. There continues to be no waiting list for these services.

DHB specialist mental health services continue to demonstrate good rates of access to services and waiting times.

Statement of Service Performance

OUTPUT MEASURES

Acute Services These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly creating an urgent need of care. For more complex acute conditions, hospital based services include emergency services, acute medical and surgical services and intensive care services. Productivity measures such as length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. of patients seen at ED that are not admitted	V[1]	10,926	12,821	12,481	≤10,705	-	∞
Percentage of patients discharged or transferred from ED within 6 hours	T	96.5%	96.4%	96.2%	≥95%	93.9%	√
No. of acute medical/surgical patients discharged from Timaru Hospital	V[2]	6,885	6,527	6,637	≤6,200	-	∞
Standardised length of stay for acute patients	T[3]	NEW	4.73# (2012)	4.18 (March 2014)	≤4.73 decr. to 4.5days ◊	3.94	√
Standardised readmission rate	Q[4]	7% #	10.37%	7.2%	≤8.52%	7.6%	√
Percentage of patients requiring radiation or chemotherapy who receive this treatment within four weeks	T	100%	100%	100%	100%	100%	√
Rate of falls in the hospital categorised as a SAC 1 or 2	Q[5]	14	16	3	≤12	-	√
Percentage of complaints resolved within 23 working days	Q[6]	81%	65%	75%	90%	-	x
Hospital acquired blood stream infection rate	Q	0.8	0.8	0.4	0.6	-	√
Central line acquired bacteraemia rate	Q[7]	NEW	2	0	0	-	√

1 There are no clinical issues in this result; assessed patient need informs necessity to admit. The overall demand on ED is reviewed each month and additional planning/ action are undertaken with primary care if the demand grows beyond acceptable sector levels.

2 The measure is demand driven and shows a decrease in acute demand from previous year predominately in general medicine acute admissions.

3 Average length of stay was previously a combined result for acute and elective admissions. MoH altered target during the year. This target was revised by the Ministry of Health following publication of the Annual Plan.

4 Previous results have been re-calculated as per the revised Ministry of Health definition.

Statement of Service Performance

[5] SAC refers to the Severity Assessment Code assigned to an adverse event based on the degree of harm caused and the likelihood of the reoccurrence of a similar event. There has been a continued and well communicated focus on reducing falls across SCDHB, including an Improvement project in our Assessment, Treatment & Rehabilitation Unit. It is felt that the combination of these two activities has contributed to the reduction in SAC1 and SAC2 falls across the organisation.

[6] A review and report paper was put to the Hospital Advisory Committee (HAC) and Board on the 25th July outlining the reasons for the percentage of complaints resolved within 23 working days not reaching the 90% target. The recommendations put forward in the paper were accepted by HAC, and supported by the Board, and these will be worked through in the coming months.

[7] A low incidence of hospital acquired infections can be reflective of effective infection control procedures. This measure is per 1,000 inpatient bed days.

Elective Services These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes surgery and specialist assessments. National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing increasing needs and matching commitments to capacity.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
Total no. of elective First Specialist Assessments (FSA)	V	8,539	8,558	9,428	≥8,910	-	√
No. non contact secondary services surgical FSAs	V, T[8]	584	714	779	≥700	-	√
No. non contact secondary services medical FSAs	V, T[8]	274	368	503	≥440	-	√
No. of Cost Weight Deliveries CWDs	V	3,663	3,690	3,775.7	≥3,595	-	√
No. of elective surgical discharges (incl. cardiology & dental)	V	3,039	3,064	3,001	≥2,887	-	√
No. Health Target surgical elective discharges	V[9]	2,730	2,790	2,740	≥2,634	-	√
Standardised length of stay for elective patients	T[10]	NEW	3.77	3.4 (March 2014)	≤3.52 days	3.25	√
Standardised day surgery rate	Q[11]	61.7%	62.60%	66.2%	≥62%	-	√
Day of surgery admission rate	Q[11]	98.3%	99.10%	Not available	≥99%	-	-
Elective theatre time utilisation	Q[12]	84.4%	83.3%	81.9%	≥85%	-	x
Did Not Attend (DNA) rate for medical/surgical	Q	3.3%	3.1%	2.8%	≤3.3%	-	√

[8] Non-contact FSA are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity across the system, reducing wait time for patients and taking waste and duplication out of the system.

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

[10] Average length of stay was previously a combined result for acute and elective admissions.

[11] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own homes and frees up hospital beds where capacity is tight. Day case, day of admission rates and average length of stay are balanced against readmissions rates to ensure service quality is appropriate. The result for 2013/14 for day surgery is raw data rather than a standardised result as this is no longer provided by the Ministry of Health. Data for day of surgery is not available as this also is no longer a national reporting requirement and was previously provided by the Ministry of Health.

[12] This is the sum of occupancy time for all patients in an elective session, calculated as a percentage of the scheduled session duration. Performance amongst specialities is variable. For those specialities not reaching target reasons include patients who did not arrive for surgery despite having been pre-admitted, day of surgery cancellations where they were not able to be replaced and surgical procedures taking less time than planned. The time for patient turnover during theatre lists has also influenced the result for some specialties. Theatre time utilisation remains a focus for all staff working in the perioperative setting and through TPOT and ERAS programmes we will continue to work to reduce the avoidable cancellations that can impact upon theatre time utilisation.

Maternity Services These 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, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. deliveries in the SCDHB Maternity Unit	V[13]	544	621	635	≤550	-	∞
Percentage of births delivered by Caesarean Section	Q[14]	23.6%	26.5%	24.4%	≤23%	-	x
Post natal average length of stay	T[15]	2.5days	2.42days	2.26	≥2.8days	-	x
Baby Friendly Hospital Accreditation is maintained	Q[16]	Yes	Yes	YES	Yes	-	√

[13] Result indicates no. of babies born.

[14] This has been trending above the national average since 2012. An in-depth audit has been undertaken for the 2012 and 2013 year and shows that procedures performed were clinically indicated.

[15] This result reflects the woman's choice. Women are encouraged to stay in the unit until breast feeding is established with results showing we have an 87% breast feeding rate on discharge.

[16] The Baby Friendly Hospital Initiative is a worldwide programme of the World Health Organisation and UNICEF. It was established in 1992 to encourage maternity hospitals to deliver a high standard of care and implement best practice in relation to infant feeding for pregnant women and mothers and babies. An assessment and accreditation process recognises those that have achieved the required standard. SCDHB has been recognised as having achieved BFHI Accreditation on four successive occasions and as such their period of accreditation has been extended to four years.

Statement of Service Performance

Assessment, Treatment and Rehabilitation Services (AT&R) These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered from a specialist inpatient unit, outpatient clinic and also in the home environment.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. of ATR bed days utilised > 65years	V	4,559	3,528	3,111	≤4,000	-	∞
No. of ATR bed days utilised <65years	V	435	457	383	est. 400	-	∞
No. of ATR bed days utilised - psycho-geriatric	V	471	602	568	≤650	-	∞
No. of AT&R outpatient attendances	V[17]	546	358	234	≥450	-	∞
No. of AT&R domiciliary visits	V[17]	2,774	2,288	2,216	≥2,700	-	∞

[17] This reflects the move to delivering services to older people in the community setting and a mix of changes in clinical practice and medical staffing cover over this period. These vacancies have now been filled. There is no waiting list for these services.

Specialist Mental Health Services These are services for the most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services	C[18]	4.7% (Mar-12)	5.29% (Mar-13)	6.4% (March 2014)	4.74%	3.38% (March 2014)	√
Percentage of people (aged 20 – 64) who have accessed specialist mental health services	C[18]	3.8% (Mar-12)	3.58% (Mar-13)	4.37% (March 2014)	3.48%	3.81% (March 2014)	√
Percentage of people (aged 65+) who have accessed specialist mental health services	C[18]	0.6% (Mar-12)	0.45% (Mar-13)	0.38% (March 2014)	1%	2.19% (March 2014)	√
Percentage of people referred for non-urgent mental health services seen within three weeks	T[19]	87.3% (Sept 12)	87%	89.4% (March 2014)	80%	78.7% (March 2014)	√

Statement of Service Performance

Percentage of people referred for non-urgent mental health services seen within eight weeks	T[19]	93.5% (Sept - 12)	95.7% (Sept-12)	95.5% (March 2014)	95%	93.5% (March 2014)	√
Percentage of people referred for non-urgent addiction services seen within three weeks	T[20]	77.5% (Sept 12)	91.9%	89% (March 2014)	80%	79.6% (March 2014)	√
Percentage of people referred for non-urgent addiction services seen within eight weeks	T[20]	95.8% (Sept 12)	97.6%	98.3% (March 2014)	95%	93.2% (March 2014)	√
Percentage of long-term clients (aged 0 – 19) with a current relapse prevention plan	C[21]	100%	100%	100%	95%	-	√
Percentage of long-term clients (aged 20 - 64) with a current relapse prevention plan	C[21]	91%	91.6%	91%	95%	-	x

[18] The national expectation is that around 3% of the total population will need to access specialist mental health service. This measure includes specialised services provided by the DHB and NGOs. The result for over 65 years includes access to psycho geriatric services. This result reflects PRIMHD data only and is considered incomplete as information is also collected on the PMS and is not included in this result. This data integrity issue will be resolved with future data capture occurring solely on PRIMHD.

[19] Results reflect the total for provider arm performance only.

[20] Results reflect the total for provider and NGO performance.

[21] Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what action to take. This result excludes those with addictions only. These results are for Q4. Variance against target is due to a staff performance issue which has now been resolved.

Statement of Service Performance

OUTPUT CLASS - REHABILITATION AND SUPPORT SERVICES

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

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

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

GENERAL COMMENT

OUTPUT MEASURES

Palliative Care 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 means of early intervention, assessment, treatment of pain and other supports.	**Notes**	**2011/12 Result**	**2012/13 Result**	**2013/14 Result**	**Target/Estimated Delivery 2013/14**	**Current National Average**	**Achievement Against Target**
No. of clients receiving palliative care in the home	V[1]	NEW	98	52	est. 120	-	∞
No. clients accessing a South Canterbury Hospice bed	V	144	115	152	≥144	-	∞

[1] This is demand driven. These results represent a 'point in time' result i.e. as at 30 June 2014 there were 52 known palliative patients being visited by the District Nurses and does not reflect activity during the full year. Going forward a process has been put in place to monitor the number of new and discharged palliative patients visited by District Nurses.

Statement of Service Performance

Needs Assessment & Support These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
Percentage of InterRAI first assessments completed within target timeframe	T[2]	85%	92%	91%	90%	-	√
Percentage of InterRAI reviews completed within target timeframe	T[2]	NEW	91.5%	89%	85%	-	√

[2] InterRAI is a comprehensive clinical assessment tool that has been rolled out nationally to ensure consistency of assessments.

Home & Community Support These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. people (total) supported by Home Community Support Services	V[3]	981	965	971	1000	-	∞
No. dementia patients supported by Home Community Support Services	V[3]	NEW	15	25	20	-	∞
No. of domiciliary district nursing visits delivered	V[4]	31,758 #	33,345	29,964	35,000	-	∞
Readmission rate for patients ≥ 75 years	Q	12.8% (Sept-12)	13.8%	9.9%	13.06%	10.6%	√

[3] Home Community Support Services are services delivered in the person's home to assist them to remain at home. A new service delivery for high and complex patients to be provided at home is now included in this result. This result includes Community First Dementia clients only.

[4] Changes in clinical practice have resulted in fewer but longer visits for venous leg ulcers, and faster healing times. Visit frequency for much of this group has reduced from twice a week to once a week. Other time ACC access has been variable and this has impacted on reported results. This service is demand driven and all eligible patients have received services.

Statement of Service Performance

Residential Care Services These services are 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 is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. subsidised residential care bed days	V[5]	177,221	173,205	175,283	est. 184,601	-	∞

[5] This volume is demand driven.

Respite & Day Care These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term in nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.	Notes	2011/12 Result	2012/13 Result	2013/14 Result	Target/Estimated Delivery 2013/14	Current National Average	Achievement Against Target
No. people accessing day care	V[6]	144 #	147	156	≥150	-	∞
No. people accessing dementia day care	V[6]	NEW	13	12	≥14	-	∞
Percentage of respite bed days utilised	C[6]	85% #	97%	99%	≥95%	-	√
Percentage of dementia respite bed days utilised	C[6]	94% #	99%	99%	≥90%	-	√

[4] Demand driven.

Our Values

Integrity
We will always act with the utmost integrity.

Collaboration
We will actively collaborate with others.

Accountability
We promote accountability.

Respect
We will show respect to all.

Excellence
We strive for excellence in everything we do.

High Street, Private Bag 911, Timaru, New Zealand

TELEPHONE: 03 687 2100 FACSIMILE: 03 688 0238
EMAIL: ceo@scdhb.health.nz WEB: www.scdhb.health.nz