South Canterbury
District Health Board

The South Canterbury District Health Board

Statement of Intent

2014-2018

Enhancing the health and independence of the people of South Canterbury

www.scdhb.health.nz

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CHAPTER 1: INTRODUCTION & STRATEGIC INTENTIONS

1.1 Executive Summary

South Canterbury District Health Board is one of 20 District Health Boards (DHBs) that were established under the Health and Disability Act 2000 (the NZPHD Act) and is the Government's funder and provider of public health services for the population resident in the South Canterbury District. SCDHB is categorised as a Crown Agent under the *Crown Entities Act 2004* and is accountable to the Minister of Health.

The Statement of Intent (SOI) is SCDHB's key accountability document to Parliament and covers the period July 2014 – June 2018. It provides a high level focus on key financial and non-financial objectives and performance targets chosen to demonstrate how the DHB is improving the health and well being of its community and reducing inequalities.

This Statement of Intent has been prepared to meet the Minister of Health's expectations for DHBs as well as the requirements of section 42 of *the NZPHD Act 2000*, section 139 of the *Crown Entities Act 2004, as amended by Section 49 of the Crown Entities Amendment Act 2013* and the requirements of the *Public Finance Act.*

The South Canterbury District Health Board (SCDHB) will continue to strive to ensure the future sustainability of health services in South Canterbury. The SCDHB continues to achieve fiscal sustainability, maintain high levels of access to services across the continuum of services and high quality standards evidenced by consistent achievement through accreditation and certification processes, as well as maintaining low staff vacancy and turnover rates. We enjoy high confidence from our community and upper quartile performance in most of the indicators which DHBs are measured against including the national health targets. We are continuing to work actively locally, regionally and nationally to ensure that this performance is maintained and to develop and deliver integrated health and disability services for our population.

The SCDHB is committed to contributing to the Government's key aims of New Zealanders living longer, healthier and more independent lives, continuing economic growth and to the Governments Better Public Services.

The SCDHB faces a range of challenges which centre on a number of factors including:

- Maintaining and enhancing the level of access to health and disability services our community enjoys given the changes to our population projections following the 2013 census;
- Ensuring and enhancing the quality and safety of the services we both fund and deliver;
- Developing an integrated health system which supports seamless patient journeys;
- Supporting the existing health and disability workforce and creating a sustainable health workforce for the future;
- Achieving greater productivity and efficiency gains to enable reinvestment in the South Canterbury health system; and
- Upgrading our facilities to meet the changing requirements of changed models of care.

SCDHB continues to participate in the development of South Island wide services and to ensure the DHB is well placed to meet these challenges. Government priorities, the South Island Regional Health Services Plan, the South Canterbury Health Service Plan, the SCDHB Workforce Development Plan and the Facilities Master Plan underpin the development of the DHB Statement of Intent 2014 – 2018. These plans are inter-woven and provide the direction of travel and guidance for the South Canterbury health system development and prioritisation of resources and activity in out years.

1.2 Population Health Profile

The health status of South Cantabrians appears to be similar or slightly better than that of New Zealanders generally. The health status of Māori in South Canterbury is better than New Zealand Māori, although their health status remains below that of non-Māori, which is the key issue we wish to address through the execution of our Māori Health Plan.

It should be noted that robust statistical analysis is sometimes limited by the size of South Canterbury's small population base. For this reason, unless there are marked statistical differences identified, SCDHB relies on Canterbury region or national information and direction in setting its health priorities.

The biggest health threat to the community remains chronic disease with lifestyle the leading cause including smoking, poor nutrition and lack of physical activity, with the impact increased by an aging population. The DHB continues to focus on long term condition management including lifestyle education with the aim of reducing rates of Ambulatory Sensitive Hospitalisation (ASH).

As health status is linked to socio-economic status, we also have a keen interest in the equitable and sustainable economic development of South Canterbury.

1.3 DHB Scope of Operations

SCDHB is one of 20 District Health Boards (DHBs) that were established under the Health and Disability Act 2000 and is the Government's funder and provider of public health services for the 55,626[1] people resident in the South Canterbury District.

DHB objectives[2] are to improve, promote and protect the health, wellbeing and independence of our population and to ensure effective and efficient care of people in need of health services or disability support services. Our mission statement is "Enhancing the health and independence of the people of South Canterbury"[3] and to achieve this we work with our consumers, our communities, health and disability service providers and other agencies to ensure the quality, safety and coordination of health and disability services for our population.

1.4 Funding and Provision of Services

DHBs are allocated funding on a national Population Based Funding Formula. South Canterbury has a very stable population (neither growing nor declining significantly). We have one of the highest percentages of population over 65 years which will continue to place unique pressures on us and require us to seek further efficiencies in our resource allocation to ensure we remain in a fiscally sustainable position.
To achieve this we continue to make Value for Money an intrinsic component of all service development and delivery and engage in a number of efficiencies and productivity initiatives including line by line review of funding allocations.

SCDHB will work actively with Health Benefits Limited (HBL) through its programme to deliver efficiencies from back office functions and infrastructure over a five year period. We are committed to engage in any initiative that contributes to this objective on the assumption that any initiative will deliver a net gain financially.

The DHB will continue to earn additional revenue from other sources such as MOH direct funding (outside the funding envelope), ACC, interest income, sale of goods and other commercial activities such as laundry and Talbot Park.

The DHB's strategy, planning and accountability role has oversight and responsibility for:

- Driving strategic direction;
- Oversight of planning;
- Funder role; and
- Maintaining accountability.

This role includes working with services to plan and implement service development which reflects our strategic direction and includes funding and monitoring performance of all health services we fund for the people of South Canterbury including Secondary Services, Primary and Community Services, Non- Government organisations or other DHBs through Inter District Flows.

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[1] *Usually resident population - Statistics New Zealand for 2013*

[2] *DHB performance objectives are specified in section 22 of the NZPHD Act*

[3] *Independence related to enabling people with disabilities to fully participate in society*

The Funder faces cost pressures from demand within secondary services and primary and community services and also faces significant risk in Inter District Flows and in increased demand for DSS services for older people (aged related residential care and home and community support services). The DHB will continue to utilise ring fenced funding in out years.

DHBs have been advised that funding increases in out years will be of the same nominal value as that contained in the 2014/15 funding envelope; that assumption does place pressure on the DHB to continue to live within its means.

Primary and Community Services includes the role of a Primary Health Organisation (PHO) and other DHB provided community services. This structure has provided the platform for the development of integrated health services and we will continue to consolidate progress to date, increasing the services being delivered in primary care and, further increasing access to diagnostic services in conjunction with Aoraki HealthPathways development.

Secondary Services includes the services provided by Timaru Hospital and Talbot Park (an aged residential care hospital and psychogeriatric level facility for older people). Timaru Hospital provides 24 hour 7 day a week acute medical and surgical services, maternity, neo-natal and paediatric services, mental health services and also provides Assessment Treatment and Rehabilitation (ATR) services. It also provides a range of tertiary services through visiting clinicians and outreach services.

SCDHB is committed to maintaining the same range of services and level of access to services identified in this Statement of Intent and ensuring continued emphasis on improving the quality and safety of services provided while balancing this against ensuring efficiency and productivity gains are maximised. We are also committed to the national elective service requirements and to meet the health targets. We will also work with South Island Service Level Alliances and Workstreams to implement regional service plans. We have no plans to exit or significantly alter any services and to prioritise service access based on clinical need and will work with South Island DHBs towards achieving equitable access to services across the South Island.

The DHB has a South Canterbury Public Health Plan, developed annually by Public and Community Health (Canterbury DHB) in conjunction with the South Canterbury DHB and other health promotion providers in South Canterbury. This joint planning enables a whole of system approach to developing integrated models of care i.e. to include public health and health promotion in the development of all models of care and to ensure our investment in health promotion is coordinated and contributing to achieving improved outcomes for our population.

1.5 Purchasing of Services

In order to deliver new health services and programmes, and to continue to deliver the range of health services which we must provide, or provide access to for our population under our Service Coverage Schedule obligations, we will enter into Service Agreements with a range of primary health providers and NGOs for the provision of services and planned activities to be delivered.

1.6 Treaty of Waitangi

DHB's responsibilities to Māori

Through our Māori Consultation Framework which is used by our Iwi/Māori Health Relationship Partners and our organisation we will ensure Māori participation and partnership in health planning, service design, development and delivery, and in the protection of Māori well-being. Our Māori Health Plan developed annually includes national and local Māori health priorities. We are committed to our statutory obligations to Māori under the NZ Public Health & Disability Act and we are advised by our Māori Health Advisory Committee.

Investment in Māori Services

As an agent of the Crown we are committed to the principles of the Treaty of Waitangi and we will continue to maintain our investment in Māori Provider services and in mainstream services provided for Māori.

1.7 Population Profile

Figure 1: Population Profile

South Canterbury District Health Board

What the 2013 Census Tells Us

The census was held on the 5th of March 2013, two years after it was cancelled as a result of the 2011 Christchurch earthquake and seven years after the previous census. The census is a snapshot in time that indicates how the profile of our population is changing. Consideration of these changes is crucial to the planning of future health services in South Canterbury.

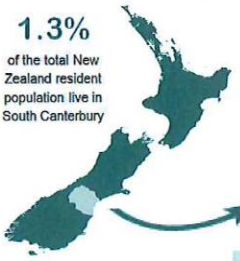
55,626 residents

3.2% increase in the number of residents in South Canterbury since 2006.

20.4% of our population are aged 65 years or older.

7.2 % of our population are **Māori**

1.3% of the total New Zealand resident population live in South Canterbury



79% of our population live in the Timaru District.

7% live in the Mackenzie District.

14% live in the Waimate District.

2% decrease in the number of families with dependent children.

1.3% increase in the number of one parent families with dependent children.

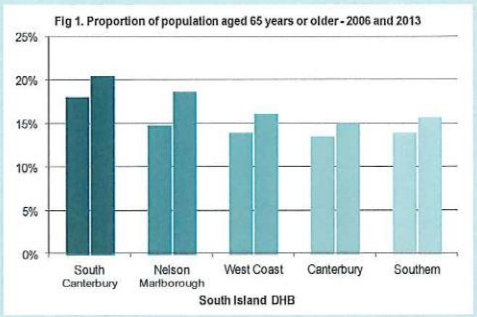
16.2% of those aged 15 years or older are regular smokers, down from 21.2% in 2006.

16.2%

Our Aging Population

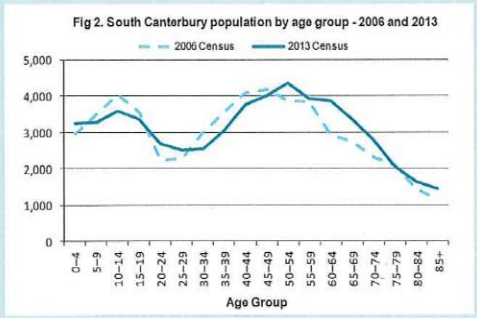
South Canterbury's resident population has increased by 3.2% since 2006. We are continuing to see our older residents making up a greater proportion of our population. 20.4% of our population are now aged 65 years or older. This is the highest proportion of any DHB in the country.

Figure 1 illustrates our aging population in comparison to other South Island DHBs:



There has been a decrease in the number of younger people in South Canterbury since 2006. Whilst there has been an increase of 291 children aged 0-4 years, there has been a decrease of 864 young people aged between 5-19 years. There are now 2.1% fewer families with dependent children in South Canterbury than in 2006.

Figure 2 illustrates the makeup of our population by age group:

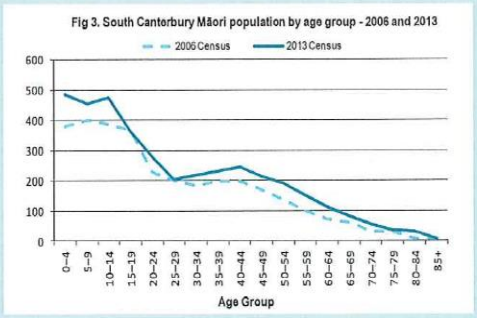


What We Do Not Know

Updated population projections and estimates

The current Statistics New Zealand population projections are still based on the 2006 Census results. Projections based on the 2013 Census results will not be made available until December 2014. The current Statistics New Zealand population estimates (which our funding is based on) are also still based on the 2006 Census results. Updated population estimates will be made available in August 2014.

Ethnicity



South Canterbury's population has become more diverse since 2006. 7.2% of our population are Māori, up from 6% in 2006. Despite this, South Canterbury still has the lowest proportion of Māori of any South Island DHB. As Figure 3 demonstrates, our Māori population are much younger than our total population. 38% of South Canterbury Māori identify as Ngāi Tahu/Kāi Tahu.

South Canterbury has also seen increased proportions of Pacific and Asian ethnicities. 1.1% of our population identify as Pacific ethnicity, up from 0.8% in 2006. 2.5% of our population identify as an Asian ethnicity, up from 1.5% in 2006.

Data source: Statistics New Zealand, Census of Population and Dwellings, 2013

1.8 Strategic Context

Populations are ageing, long-term conditions are becoming more prevalent and the needs of vulnerable populations are escalating. As people's conditions become more complex, the care required is more costly in terms of time, resources and dollars.

Although DHBs may differ in size, structure and approach, they all have a common goal: to improve the health and wellbeing of their populations by delivering high quality and accessible health care. With increasing demand for services, workforce shortages and rising costs, this is increasingly challenging and the health system faces an unsustainable future.

To ensure the sustainability of the health system, DHBs need to shift their population's health needs away from the complex end of the continuum of care and support more people to stay healthy and well.

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHB service planning.[4]

International direction emphasises that an aligned, 'whole of system' approach is required to ensure service sustainability, quality and safety while making the best use of limited resources. This entails four major shifts in service delivery:

1. Early intervention, targeted prevention and self management and a shift to more home-based care;
2. A more connected system and integrated services, with more services provided in community settings;
3. Regional collaboration clusters and clinical networks, with more regional service provision; and
4. Managed specialisation, with a shift to consolidate the number of tertiary centre/hubs.

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely and accessible care being paramount. However, less-complex care (traditionally provided in hospital settings) is increasingly being provided in the community.

The focus is shifting towards supporting people to better manage their own health and to stay well, with the support of connected and integrated clinical networks and multidisciplinary teams.

1.9 National Direction

These international shifts are consistent with the changes being driven across the New Zealand health system to meet the Government's commitment to providing *'better, sooner, more convenient health services'*.[5]

At the highest level DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga) and by the requirements of the New Zealand Public Health and Disability Act - with the ultimate health sector outcomes being that:

- All New Zealanders lead longer, healthier and more independent lives; and
- The health system is cost effective and supports a productive economy.

DHBs are expected to contribute to meeting health sector outcomes and Government commitments by: increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money**.**

1.10 Regional Direction

In delivering its commitment to '*better, sooner, more convenient health services*' the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

[4] *Trends in Service Design and New Models of Care: A Review, 2010, Ministry of Health, www.nationalhealthboard.govt.nz.*

[5] *John Key, National Party Health Discussion Paper 2007.*

The South Island Alliance was established in 2011 to formalise the partnership between the five South Island DHBs. In 2013 it was agreed to further develop the approach with a framework that ensures all regional activity aligns to agreed goals. The '*best for patients, best for system*' framework has become '*Best for People, Best for System'* supporting a focus on the whole population. The shared vision has also been revised to include disability to ensure key population groups are identified within the framework.

Our regional vision is a sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible.

While each DHB is individually responsible for the provision of services to its own population, working regionally enables them to better address their shared challenges and support improved patient care and more efficient use of resources. The South Island DHBs are committed through the Alliance to make the best use of all available resources, strengthen clinical and financial sustainability and increase access to services for the South Island population.

Canterbury, Nelson Marlborough, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for 1,004,380 people (23.7%) of the total NZ population.

The success of the Alliance relies on improving patient flow and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to better connect the services and clinical teams involved in a patient's care.

Closely aligned to the national direction the shared outcome goals of the South Island Alliance are:

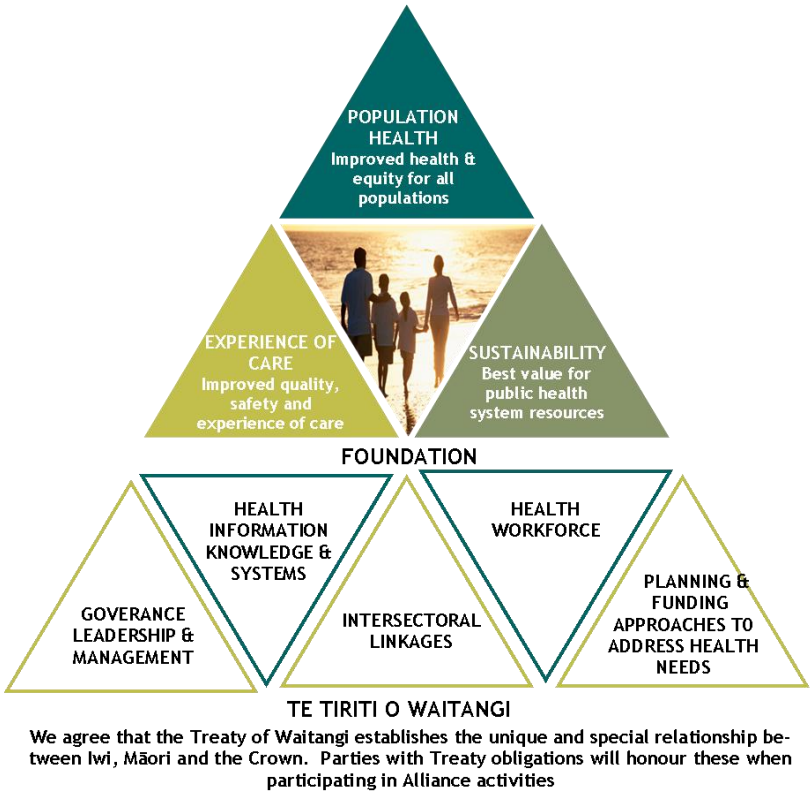
- Improved health and equity for all populations;
- Improved quality safety and experience of care; and
- Best value for public health system resources.

To help ensure success, regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multidisciplinary representation from community and primary care, as well as hospital and specialist services and consumers involvement.

Seven service areas have been prioritised: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity will also focus on: cardiac, elective surgery, neurosurgery, public health, stroke and major trauma services. Regional asset planning and workforce planning, through the South Island Regional Training Hub, will contribute to improved delivery in all service areas.

All South Island DHBs are involved in the majority of the service level alliances and work streams and lead at least one priority area. The Regional Health Services Plan is available from the South Island Alliance website: www.sialliance.health.nz.



1.11 Local Direction

In reviewing the South Canterbury Health Service Plan for the SCDHB our initial five priorities have been extended to seven service priorities:

- Promotion of healthy lifestyle choices in our local population and targeted prevention;
- Identification and early interventions for “at risk” populations;
- Management of Long Term Conditions which focuses on self-management strategies;
- Integration of services to support seamless patient flows;
- Sustainable secondary services;
- Development of child and youth services; and
- Coordinated services for older people.

The SCDHB will continue to build on progress to date and will undertake a number of initiatives to support and facilitate the ongoing development of integrated models of care. This will include revising Allied Health and Clinical Nurse Specialist roles to ensure alignment with integrated models of care and developing an ambulatory model of care to facilitate integration between primary and secondary care. The SCDHB will also continue to implement regional IT projects in accordance with the South Island Alliance IT Plan and Aoraki HealthPathways. Our DHB structure with Primary and Community Services as part of the DHB continues to support and facilitate the integration of services. Primary and Community Services is an integral part of the health service development in South Canterbury and participates strongly in the governance, management and delivery of health services.

Integrated service development will focus on child and youth health, long term conditions, and coordinated services for older people including the implementation of the recommendations of the Centre of Excellence for Health of Older Peoples services completed in 2013. The development of integrated service models for child and youth services is being undertaken across primary and secondary health services and includes work with all other agencies providing services for children and youth.

The SCDHB Clinical Board which covers primary and secondary governance is leading the DHB’s development of clinical governance and quality and safety improvement for the DHB. Quality and safety improvement initiatives are being pursued at a local level and we are actively participating in the South Island Quality and Safety Service Level Alliance.

1.12 Signatories

DATED THIS DAY OF 2014

(Made under sections 138, 139, 141, 144 and 146-149 of the Crown Entities Amendment Act 2013).

_____

Murray Cleverley
Chairman of the Board

_____

Ron Luxton
Deputy Chairman of the Board

1.13 Improving Health Outcomes for our Population

What are we trying to achieve?

DHBs are expected to deliver against the national health sector outcomes: "*All New Zealanders lead longer, healthier and more independent lives*" and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability DHBs need to demonstrate whether they are succeeding in meeting those commitments and in improving the health and wellbeing of their populations. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service access indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing its strategic framework, the South Island DHBs identified three strategic regional outcome goals. To achieve these goals they have agreed a number of key strategies which will be achieved through the delivery of regional initiatives and the collective activity of all five South Island DHBs. A comprehensive indicator set is currently under development, to sit alongside the regional strategic framework and enable evaluation of regional activity.

While the regional framework is developed, the South Island DHBs have identified four collective outcomes where individual DHB performance will contribute to regional success - along with a core set of associated outcomes indicators, which will demonstrate whether they are making a positive change in the health of their populations. These are long-term outcome indicators (5-10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target.

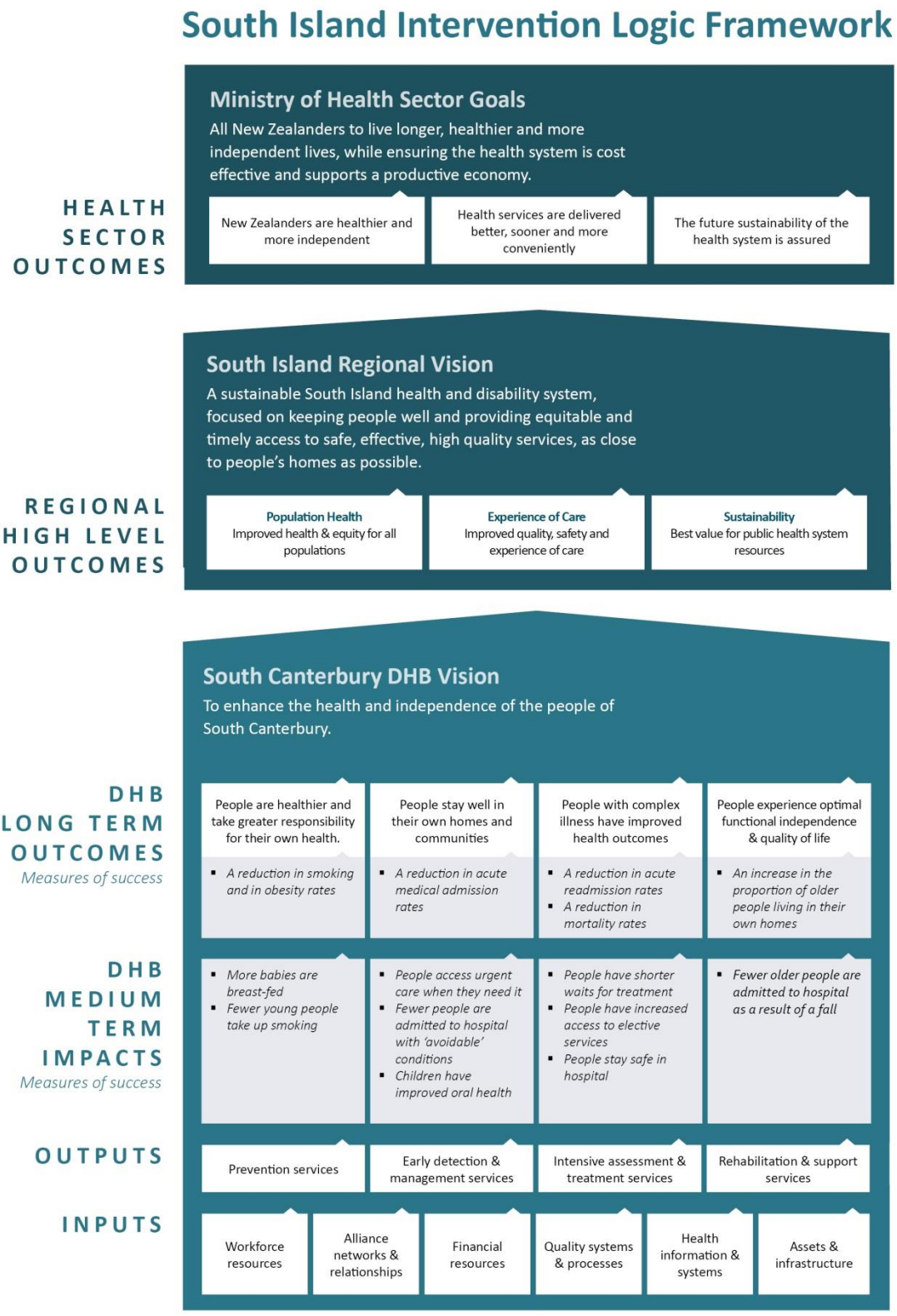
- **Outcome 1: People are healthier and take greater responsibility for their own health.**
  - A reduction in smoking rates.
  - A reduction in obesity rates.
- **Outcome 2: People stay well in their own homes and communities.**
  - A reduction in acute medical admission rates.
- **Outcome 2: People with complex illnesses have improved health outcomes.**
  - A reduction in acute readmission rates.
  - A reduction in all cause mortality rates.
- **Outcome 3: People experience optimal functional independence and quality of life.**
  - An increase in the proportion of the population over 75 living in their own homes.

Each of the South Island DHBs has also identified a set of associated medium-term (3-5 years) indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance and each DHB has set local targets to evaluate their performance over the next three years.

South Island Intervention Logic Framework

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

Figure 2: South Island Intervention Logic Diagram



STRATEGIC OUTCOME GOAL 1

People are healthier and take greater responsibility for their own health

Why is this outcome a priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions. Long-term conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions.

These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

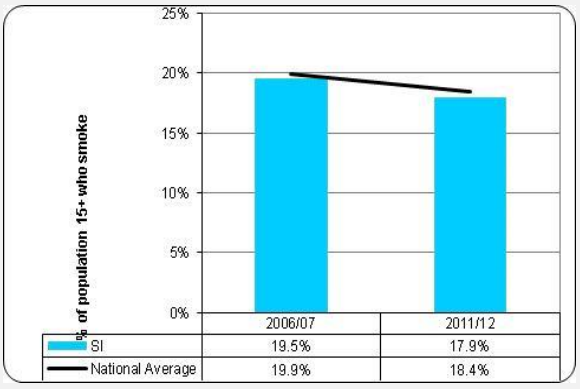
We will know we are succeeding when there is:

A reduction in smoking rates.

- *Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money is available for necessities such as nutrition, education and health. Supporting our population to say 'no' to tobacco smoking is our foremost opportunity to reduce inequalities and target improvements in the health of our population.*

Data sourced from national NZ Health Survey.[6]

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

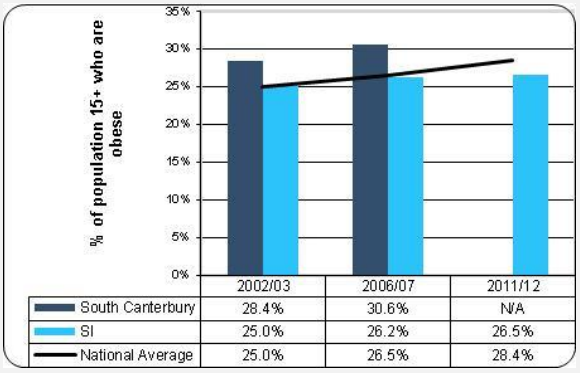


A reduction in obesity rates.

- *There has been a rise in obesity rates in NZ in recent decades, and the 2011/12 NZ Health Survey found that one in ten children (10%) and three in ten adults (28%) are obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.*

Data sourced from national NZ Health Survey.6

Outcome Measure: The percentage of the population (15+) who are obese.



IMPACT MEASURES MEDIUM TERM (3-5 YRS)

Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following

[6] *The NZ Health Survey was completed by the Ministry of Health in 2003/04, 2006/07 and 2011/12. Results by region and district are subject to MoH availability. 'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.*

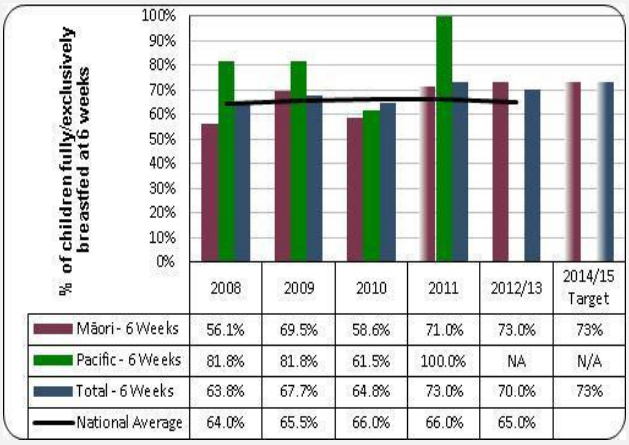
headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

More babies are breastfed.

- *Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life. Breastfeeding also contributes to the wider wellbeing of mothers.*
- *Although breastfeeding is natural, it sometimes doesn't come naturally, so it's important that mothers have access to appropriate support and advice.*
- *An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.*

Data sourced from Plunket via the Ministry of Health.[7]

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



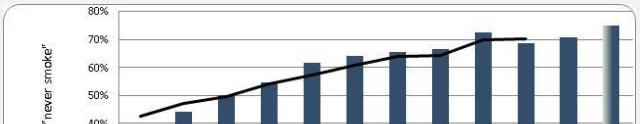
	2008	2009	2010	2011	2012/13	2014/15 Target
Māori - 6 Weeks	56.1%	69.5%	58.6%	71.0%	73.0%	73%
Pacific - 6 Weeks	81.8%	81.8%	61.5%	100.0%	NA	N/A
Total - 6 Weeks	63.8%	67.7%	64.8%	73.0%	70.0%	73%
National Average	64.0%	65.5%	66.0%	66.0%	65.0%	

Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up smoking.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

Data sourced from national Year 10 ASH Survey.[8]

The percentage of 'never smokers' among Year 10 students.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014/15 Target
South Canterbury	39.3%	44.1%	50.0%	54.7%	61.8%	64.1%	65.4%	66.7%	72.5%	68.7%	70.8%	75%
National Average	42.5%	47.0%	49.4%	54.0%	57.3%	60.7%	64.0%	64.3%	70.0%	70.1%		

STRATEGIC OUTCOME GOAL 2

People stay well in their own homes and communities

Why is this outcome a priority?

For most people, their general practice team is their first point of contact with health services. General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection, diagnosis and timely provision of treatment. The general practice team is also vital as a point of continuity and effective coordination across the continuum of care, particularly in terms of improving the management of care for people with long-term conditions and reducing the exacerbations of those conditions and the complications of injury and illness.

Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well.

When people are supported to stay well in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

[7] *The 2011 result is only for the second half of the 2011 year (i.e. July to December) due to MoH data availability.*

[8] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz.*

OUTCOME MEASURES LONG TERM (5-10 YEARS)

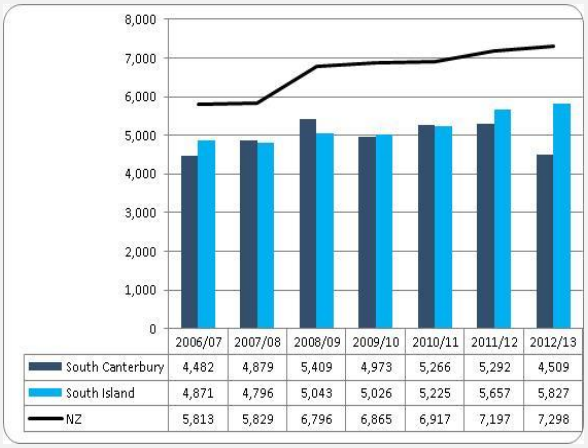
We will know we are succeeding when there is:

A reduction in acute medical admissions.

- *The impact long-term conditions have on quality of life and demand growth is significant. By improving the management of long-term conditions, people can live more stable, healthier lives, and avoid deterioration that leads to acute illness, hospital admission, complications and death.*
- *Reducing acute hospital admissions also has a positive effect on productivity in hospital and specialist services - enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.*
- *Acute medical admissions can be used as a proxy measure of improved conditions management by indicating that fewer people are experiencing an escalation of their condition leading to an urgent (acute) or complex intervention. They can also be used to indicate access to appropriate and effective care and treatment in the community.*

Data sourced from National Minimum Data Set.

Outcome Measure: The rate of acute medical admissions to hospital (age-standardised, per 100,000).



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
South Canterbury	4,482	4,879	5,409	4,973	5,266	5,292	4,509
South Island	4,871	4,796	5,043	5,026	5,225	5,657	5,827
NZ	5,813	5,829	6,796	6,865	6,917	7,197	7,298

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

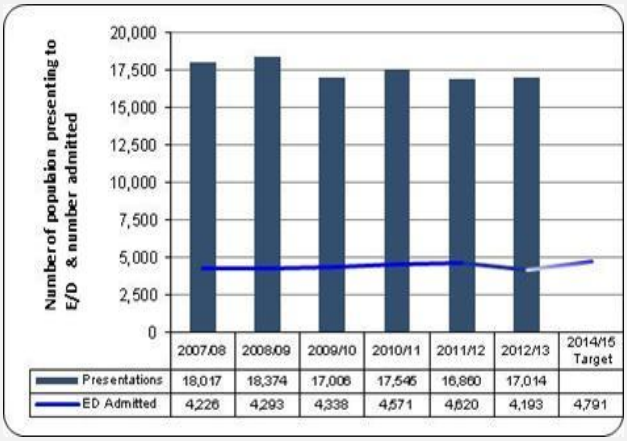
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

People access urgent care when they need it.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, which is not necessarily in hospital Emergency Departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the proportion of the population presenting to the Emergency Department (ED) and an increase in the number admitted can be seen as a proxy measure of the availability and uptake of alternative community options to more appropriately manage and support people. A higher percentage of admissions for those who present to ED indicate that people are attending ED appropriately and that those who could be attended to in primary and community care systems are using the correct pathways of health care.*

Data sourced from individual DHBs.[9]

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



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

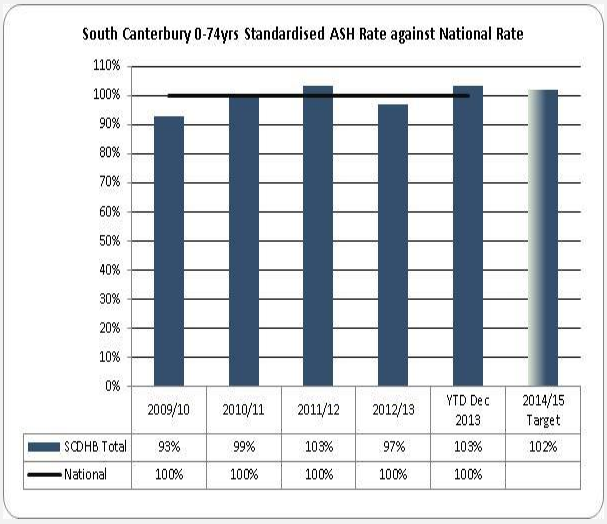
[9] *'Presenting' and 'Admitted' are defined by the Ministry of Health national ED health target.*

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

- *A number of admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.*
- *These admissions provide an indication of the quality of early detection, intervention and disease management services. A reduction would indicate improvements in care and would also free up hospital resources for more complex and urgent cases.*
- *The key factors in reducing avoidable admissions include improving integration between primary and secondary services, access to diagnostics and the management of long-term conditions. Achievement against this measure is therefore seen as a proxy measure of a more unified health system, as well as a measure of the quality of services being provided.*

Data sourced from the Ministry of Health. [10]

The rate of avoidable hospital admissions per 100,000 population (<75).



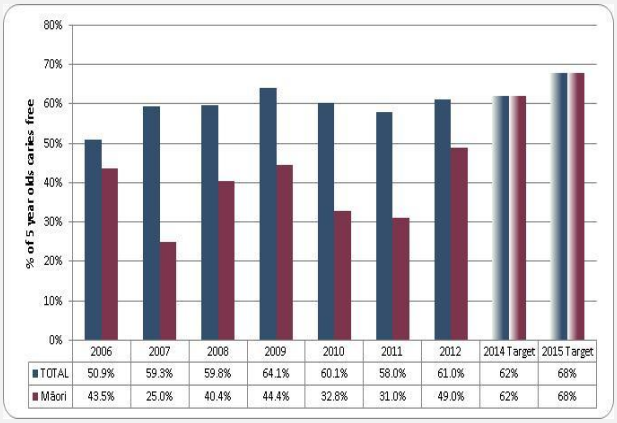
	2009/10	2010/11	2011/12	2012/13	YTD Dec 2013	2014/15 Target
SCDHB Total	93%	99%	103%	97%	103%	102%
National	100%	100%	100%	100%	100%	

Children have improved oral health.

- *Oral health is an integral component of lifelong health and impacts a person's comfort in eating and ability to maintain good nutrition, self esteem and quality of life.*
- *Good oral health not only reduces unnecessary complications and hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition - helping to keep people well.*
- *Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy measure of equity of access and the effectiveness of services in targeting those at risk.*

Data sourced from Ministry of Health.

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



	2006	2007	2008	2009	2010	2011	2012	2014 Target	2015 Target
TOTAL	50.9%	59.3%	59.8%	64.1%	60.1%	58.0%	61.0%	62%	68%
Māori	43.5%	25.0%	40.4%	44.4%	32.8%	31.0%	49.0%	62%	68%

STRATEGIC OUTCOME GOAL 3

People with complex illness have improved health outcomes

Why is this outcome a priority?

For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures. At the same time Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. Shorter waiting lists and wait times are indicative of a well functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that have a negative impact of the health of our population.

[10] *This measure is based on the national DHB performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate.*

OUTCOME MEASURES LONG TERM (5-10 YEARS)

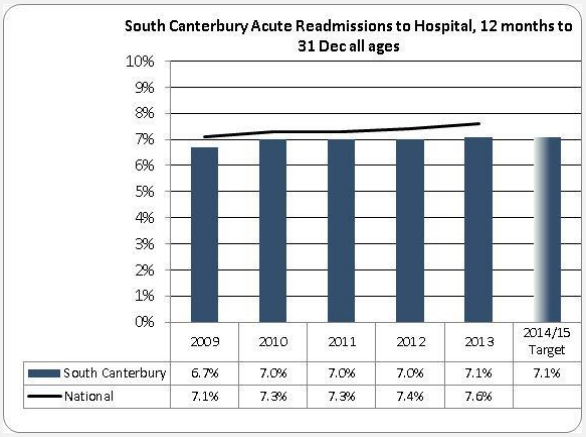
We will know we are succeeding when there is:

A reduction in acute readmissions.

- *An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.*
- *Acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration - ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.*
- *Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.*
- *They also serve as a counter-measure to balance improvements in productivity and reductions in the length of stay and provide an indication of the integration between services to appropriately support people on discharge.*

Data sourced from Ministry of Health.

Outcome Measure: The rate of acute readmissions to hospital within 28 days of discharge.



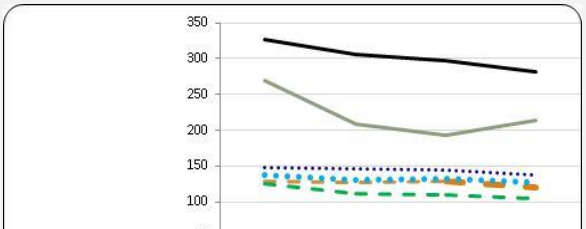
	2009	2010	2011	2012	2013	2014/15 Target
South Canterbury	6.7%	7.0%	7.0%	7.0%	7.1%	7.1%
National	7.1%	7.3%	7.3%	7.4%	7.6%	

A reduction in mortality rates.

- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases the options for treatment and the chances of survival.*
- *Premature mortality (death before age 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition the more harmful impacts and complications of a number of complex illnesses can be reduced.*
- *A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.*

Data sourced from MoH mortality collection.

Outcome Measure: The rate of all cause mortality for people aged under 65 (age standardised per 100,000).



	2007	2008	2009	2010
South Island Maori	269	209	193	213
NZ Maori	326	305	298	282
South Island Non-Maori	130	128	129	121
NZ Non-Maori	126	112	109	105
South Island Total	137	131	132	127
NZ Total	149	146	144	138

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

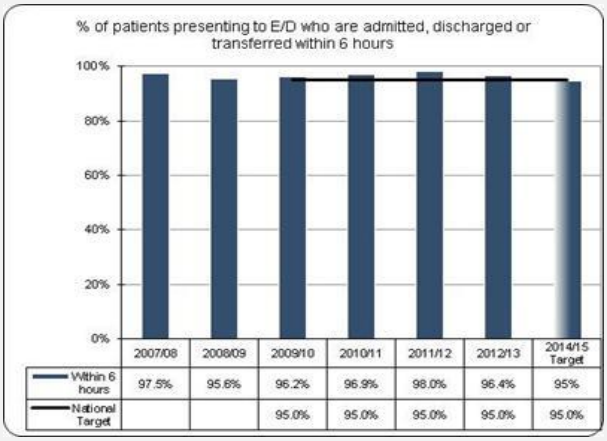
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

People have shorter waits for treatment.

- *Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.*
- *Long waits in ED are linked to overcrowding, negative outcomes, longer hospital stays and compromised standards of privacy and dignity for patients. Enhanced performance will not only improve outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.*
- *Solutions to reducing ED wait times need to address the underlying causes of delay, and therefore span not only the hospital but the whole health system. In this sense, this indicator is indicative of how responsive the system is to the urgent care needs of the population.*

Data sourced from individual DHBs.[11]

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



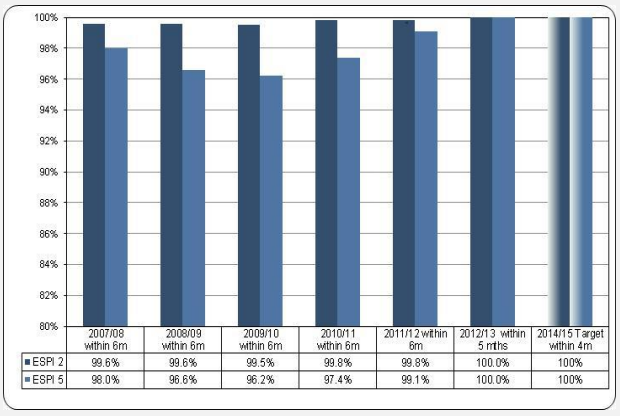
People have increased access to elective services.

- *Elective (non-urgent) services are an important part of the healthcare system: these services improve the patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *Timely access to services and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.*
- *Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is indicative of how responsive the system is to the needs of the population.*

Data sourced from Ministry of Health.[12]

The time people wait from referral to First Specialist Assessment (ESPI 2).

The time people wait from commitment to treat until treatment (ESPI 5).

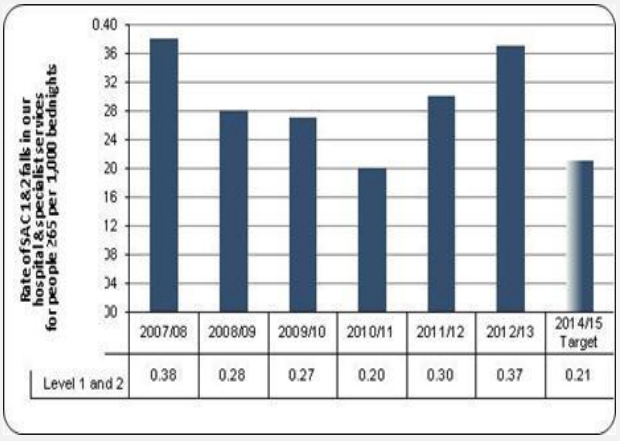


People stay safe in hospital.

- *Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.*
- *The rate of falls is particularly important, as these patients are more likely to have a prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *A key factor in reducing adverse events is the engagement of staff and clinical leaders in improving processes and championing change. Achievement against this measure is therefore also seen as a proxy indicator of an engaged and capable workforce with the capacity and capability to improve service delivery.*

Data sourced from individual DHBs.[13]

The rate of SAC level 1 and 2 falls in South Canterbury Hospitals.



[11] *This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10.*

[12] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available. Historical data is against a six month target, while the target reduces to 5 months for 2013/14 and 4 months from January 2015.*

[13] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days.*

STRATEGIC OUTCOME GOAL 4

People experience optimal functional independence and quality of life

Why is this outcome a priority?

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.

With an ageing population, the South Island will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources across the system.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

We will know we are succeeding when there is:

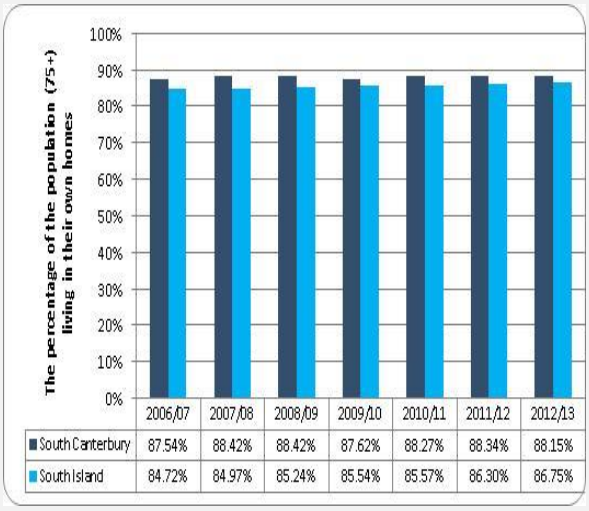
An increase in the proportion of the population living in their own home.

- *While living in Aged Related Residential Care (ARRC) is appropriate for a small proportion of our population, evaluation of older people's services have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.*
- *Living in ARRC facilities is also a more expensive option, and resources could be better spent providing appropriate levels of Home-Based Support Service (HBSS) to people to stay well in their own homes.*
- *An increase in the proportion of people supported in their own home can be used as a proxy measure of how well the system is managing age-related long-term conditions and responding to the needs of our older population.*

Data sourced from Client Claims Payments provided by SIAPO.

Statistics NZ projections for the 75+ population were higher prior to the 2013 census results have evidenced.

Outcome Measure: The percentage of the population (75+) living in their own homes.



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
South Canterbury	87.54%	88.42%	88.42%	87.62%	88.27%	88.34%	88.15%
South Island	84.72%	84.97%	85.24%	85.54%	85.57%	86.30%	86.75%

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

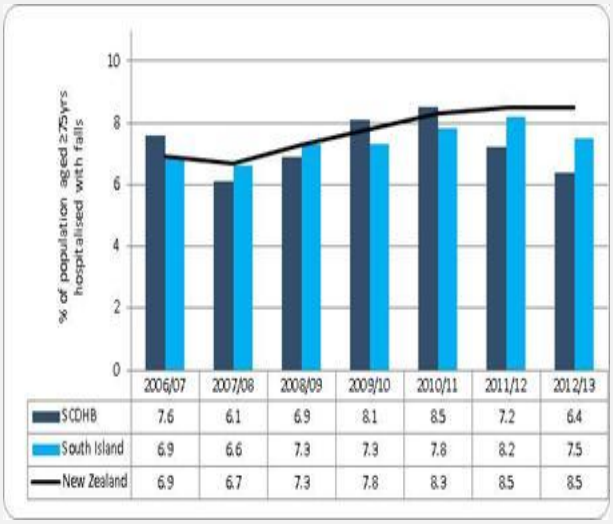
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicator will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

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

- *Around 22,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, those who do experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the relative demand on acute and aged residential care services.*
- *The solutions to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*
- *A reduction in falls can therefore be seen as a proxy measure for improved health service provision for older people.*

Data sourced from National Minimum Data Set.

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



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

CHAPTER 2: FINANCIAL PERFORMANCE

- Forecast financial statements (for current and 3 following years)
- Measures and standards necessary to assess DHB financial performance
- Significant assumptions
- Additional information to reflect the operations and position of the DHB.

SOUTH CANTERBURY DISTRICT HEALTH BOARD
CONSOLIDATED - SCDHB
ANNUAL PLAN 2014/15 **000'S**

Statement of Forecast Comprehensive Income	2012/13 Actual	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Revenue	176,425	179,500	181,554	184,044	187,203	189,819
Finance Income	1,530	1,636	1,613	1,623	1,633	1,522
	177,955	181,136	183,167	185,667	188,836	191,341
Personnel Costs	56,777	59,075	62,385	63,007	63,636	64,270
Outsourced Personnel & Other Services	9,248	10,630	8,532	8,616	8,700	8,785
Clinical Supplies	10,310	11,258	10,569	10,633	10,698	10,764
Infrastructure & Non Clinical Expenses	9,973	9,869	8,775	8,823	8,876	8,930
Payments to Non DHB Health Providers	60,121	59,434	61,007	62,438	64,502	65,980
IDF Outflows	25,349	24,334	25,807	25,972	26,138	26,305
Financing Charges	2,346	2,364	2,304	2,318	2,332	2,346
Depreciation	3,095	3,686	3,720	3,743	3,766	3,788
Total Expenses	177,219	180,650	183,099	185,550	188,647	191,169
OPERATING SURPLUS (DEFICIT)	736	486	68	118	188	172
NON RECURRING ITEMS						
TOTAL SURPLUS (DEFICIT)	736	486	68	118	188	172

SOUTH CANTERBURY DISTRICT HEALTH BOARD
CONSOLIDATED - SCDHB
ANNUAL PLAN 2014/15 **000'S**

Statement of Forecast Comprehensive Income	2010/11 Actual	2011/12 Forecast	2012/13 Plan	2013/14 Plan	2014/15 Plan	2017/18 Plan
SURPLUS (DEFICIT)	**736**	**486**	**68**	**118**	**188**	**172**
Other comprehensive income	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL COMPREHENSIVE SURPLUS (DEFICIT)	**736**	**486**	**68**	**118**	**188**	**172**

SOUTH CANTERBURY DISTRICT HEALTH BOARD

CONSOLIDATED - SCDHB

ANNUAL PLAN 2014/15 **000'S**

Statement of Forecast Cash Flows	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Actual	Forecast	Plan	Plan	Plan	Plan
Cash Flow From Operating						
Receipts - Interest						
Receipts - Other	176,490	179,890	181,555	184,045	187,204	189,699
Total Receipts	176,490	179,890	181,555	184,045	187,204	189,699
Payments - Interest	321	319	324	320	320	320
Payments - Other	169,617	176,806	182,993	185,782	186,374	178,635
Total Payments	169,938	177,125	183,317	186,102	186,694	178,955
Net Cash From Operating	6,552	2,765	(1,762)	(2,057)	510	10,744
Cash Flow From Investing						
Decrease in Investments						
Interest Received	1,530	1,633	1,613	1,623	1,633	1,643
Sale of Fixed Assets	0	0	0	0	0	0
Investment Receipts - Other						
Total Receipts	1,530	1,633	1,613	1,623	1,633	1,643
Capital Expenditure	5,069	2,783	9,457	2,911	10,616	12,601
Investments including Restricted and Trust Funds Assets	0	0	0	0	0	0
Investment Payments - Other	555	0	0	0	0	0
Total Payments	5,624	2,783	9,457	2,911	10,616	12,601
Net Cash From Investing	(4,094)	(1,150)	(7,844)	(1,288)	(8,983)	(10,958)
Cash Flow From Financing						
Equity Injections (Repayment)	0	0	0	0	0	0
New Debt (Repayment)	0	0	0	0	0	0
Other Equity Movement	216	216	216	216	216	216
Other Non Current Liability Movement	3,454	0	0	0	0	0
Net Cash From Financing	3,670	216	216	216	216	216
Overall Increase/(Decrease)	**6,128**	**1,831**	**(9,390)**	**(3,129)**	**(8,257)**	**2**
Add: Opening Cash Balance	13,194	19,322	21,153	11,763	8,634	377
Closing Cash	19,322	21,153	11,763	8,634	377	379

SOUTH CANTERBURY DISTRICT HEALTH BOARD
CONSOLIDATED - SCDHB
ANNUAL PLAN 2014/15 **000'S**

Statement of Forecast Financial Position	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Actual	Forecast	Plan	Plan	Plan	Plan
EQUITY						
General Funds	5,477	4,222	4,006	3,790	3,574	3,358
Retained Earnings	10,552	10,986	11,054	11,172	11,359	11,532
Revaluation Reserve	9,246	9,246	9,246	9,246	9,246	9,246
Other Reserves - Donated Assets and Special Funds	860	1,961	1,859	1,859	1,859	1,859
TOTAL EQUITY	26,135	26,415	26,165	26,067	26,038	25,995
ASSETS						
Current Assets						
Cash and Cash Equivalents	19,322	21,153	11,763	8,634	377	379
Financial Assets	0	0	0	0	0	0
Debtors & Other Receivables	4,839	4,760	4,610	4,610	4,610	4,581
Other Current Assets	920	972	970	971	970	1,000
Total Current Assets	25,081	26,885	17,343	14,215	5,957	5,960
Add Non Current Assets	45,146	44,209	52,087	54,163	62,149	61,255
Total Non Current Assets	45,146	44,209	52,087	54,163	62,149	61,255
TOTAL ASSETS	**70,227**	**71,094**	**69,430**	**68,378**	**68,106**	**67,215**
LIABILITIES						
Current Liabilities						
Bank Overdraft	0	0	0	0	0	0
Creditors & Other Payables	12,100	2,429	11,929	10,788	10,546	10,573
Borrow ings	0	0	0	0	0	0
Other Current Liabilities	11,380	21,807	10,817	11,004	11,003	10,128
Total Current Liabilities	23,480	24,236	22,746	21,792	21,549	20,701
Non Current Liabilities						
Employee Entitlements	6,485	6,485	6,560	6,560	6,560	6,560
Term loans	14,127	13,958	13,959	13,959	13,959	13,959
Total Non Current Liabilities	20,612	20,443	20,519	20,519	20,519	20,519
TOTAL LIABILITIES	**44,092**	**44,679**	**43,265**	**42,311**	**42,068**	**41,220**
NET ASSETS	26,135	26,415	26,165	26,067	26,038	25,995

SOUTH CANTERBURY DISTRICT HEALTH BOARD
CONSOLIDATED - SCDHB
ANNUAL PLAN 2014/15 **000'S**

Statement of Forecast Changes in Equity	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Actual	Forecast	Plan	Plan	Plan	Plan
Equity at Beginning of the Period	(25,598)	(26,135)	(26,415)	(26,165)	(26,067)	(26,038)
Net Surplus (Deficit) for the Period						
Net Surplus (Deficit) for the Period	(736)	(486)	(68)	(117)	(189)	(172)
OTHER MOVEMENTS						
Movement in Revaluation Reserve	0	0	0	0	0	0
Movement in Special Funds	0	(1,101)	0	0	0	0
Movement in Equity - Other	199	1,307	318	215	217	215
Total Other Movements	199	206	318	215	217	215
Equity at End of the Period	(26,135)	(26,415)	(26,165)	(26,067)	(26,038)	(25,995)

SOUTH CANTERBURY DISTRICT HEALTH BOARD
FUNDER
ANNUAL PLAN 2014/15 **000'S**

Prospective Income Statement	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Actual	Forecast	Plan	Plan	Plan	Plan
Revenue						
MOH Funding						
Excluding Mental Health Services	152,229	150,551	151,987	154,337	156,686	159,035
Mental Health Services	11,173	11,359	11,738	11,809	11,882	11,954
MoH Funding Sub-Contracts	0	6,758	6,437	6,437	6,437	6,437
Inter District Flows - Inflows						
Excluding Mental Health Services	3,866	3,474	3,263	3,283	3,303	3,323
Mental Health Services	486	483	446	449	451	454
Other Income		15	23	23	22	22
Total Revenue	167,754	172,640	173,894	176,338	178,782	181,226
Expenditure						
Personal Health						
Provider - Personal Health	63,636	67,011	66,130	66,505	66,488	67,143
Pharmaceuticals	17,028	16,285	16,765	16,867	16,970	17,074
Laboratories	2,674	2,684	2,368	2,382	2,397	2,412
General Practioners	11,353	10,966	11,392	11,461	11,472	11,542
Dental	1,191	1,141	1,314	1,322	1,330	1,338
Maternity	707	69	35	35	35	36
Pallative Care	1,078	1,166	1,177	1,184	1,191	1,199
Other Funder Services	2,066	2,259	2,314	3,303	4,982	6,011
IDF Outflows	22,020	21,323	22,939	23,079	23,220	23,361
Total Personal Health	121,753	122,904	124,434	126,140	128,087	130,115
Mental Health						
Provider - Mental Health	7,435	7,644	7,719	7,766	7,813	7,861
Expenditure	2,984	2,958	3,527	3,549	3,570	3,592
IDF Outflows	1,322	1,197	987	993	999	1,005
Total Mental Health	11,741	11,799	12,233	12,308	12,383	12,458
Disability Support						
Provider - DSS	7,364	7,090	7,339	7,412	7,487	7,561
Expenditure	20,551	21,303	21,464	21,679	21,895	22,114
DSS IDF Outflows	2,007	1,814	1,881	1,900	1,919	1,938
Total Disability Support	29,922	30,207	30,684	30,991	31,301	31,614
Maori Health						
Expenditure	489	593	651	655	659	663
Public Health						
Provider - Public Health	244	367	333	335	337	339
Governance & Funder Administration						
Governance & Funder Admin	3,139	3,286	3,566	3,588	3,610	3,632
Total Expenditure	167,288	169,156	171,901	174,016	176,376	178,821
Total Results						
Total Revenue	167,754	172,640	173,894	176,338	178,782	181,226
Total Expenditure	167,288	169,156	171,901	174,016	176,376	178,821
Net Surplus (Deficit)	466	3,484	1,993	2,322	2,406	2,405

SOUTH CANTERBURY DISTRICT HEALTH BOARD
FUNDER
ANNUAL PLAN 2014/15 **000'S**

Prospective Income Statement	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Actual	Forecast	Plan	Plan	Plan	Plan
Revenue						
MOH Funding						
Excluding Mental Health Services	152,229	150,551	151,987	154,337	156,686	159,035
Mental Health Services	11,173	11,359	11,738	11,809	11,882	11,954
MoH Funding Sub-Contracts	0	6,758	6,437	6,437	6,437	6,437
Inter District Flows - Inflows						
Excluding Mental Health Services	3,866	3,474	3,263	3,283	3,303	3,323
Mental Health Services	486	483	446	449	451	454
Other Income		15	23	23	22	22
Total Revenue	167,754	172,640	173,894	176,338	178,782	181,226
Expenditure						
Personal Health						
Provider - Personal Health	63,636	67,011	66,130	66,505	66,488	67,143
Pharmaceuticals	17,028	16,285	16,765	16,867	16,970	17,074
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General Practioners	11,353	10,966	11,392	11,461	11,472	11,542
Dental	1,191	1,141	1,314	1,322	1,330	1,338
Maternity	707	69	35	35	35	36
Pallative Care	1,078	1,166	1,177	1,184	1,191	1,199
Other Funder Services	2,066	2,259	2,314	3,303	4,982	6,011
IDF Outflows	22,020	21,323	22,939	23,079	23,220	23,361
Total Personal Health	121,753	122,904	124,434	126,140	128,087	130,115
Mental Health						
Provider - Mental Health	7,435	7,644	7,719	7,766	7,813	7,861
Expenditure	2,984	2,958	3,527	3,549	3,570	3,592
IDF Outflows	1,322	1,197	987	993	999	1,005
Total Mental Health	11,741	11,799	12,233	12,308	12,383	12,458
Disability Support						
Provider - DSS	7,364	7,090	7,339	7,412	7,487	7,561
Expenditure	20,551	21,303	21,464	21,679	21,895	22,114
DSS IDF Outflows	2,007	1,814	1,881	1,900	1,919	1,938
Total Disability Support	29,922	30,207	30,684	30,991	31,301	31,614
Maori Health						
Expenditure	489	593	651	655	659	663
Public Health						
Provider - Public Health	244	367	333	335	337	339
Governance & Funder Administration						
Governance & Funder Admin	3,139	3,286	3,566	3,588	3,610	3,632
Total Expenditure	167,288	169,156	171,901	174,016	176,376	178,821
Total Results						
Total Revenue	167,754	172,640	173,894	176,338	178,782	181,226
Total Expenditure	167,288	169,156	171,901	174,016	176,376	178,821
Net Surplus (Deficit)	466	3,484	1,993	2,322	2,406	2,405

SOUTH CANTERBURY DISTRICT HEALTH BOARD
PROVIDER
ANNUAL PLAN 2014/15 **000'S**

Prospective Income Statement	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Actual	Forecast	Plan	Plan	Plan	Plan
Income						
Internal Revenue	78,679	82,102	81,521	82,018	82,126	82,905
Internal Revenue DSS						
Government and Agencies Income	2,912	2,694	2,957	2,975	2,993	3,011
Other Income	7,289	5,802	6,316	6,355	7,061	7,104
Total Income	88,880	90,598	90,794	91,348	92,180	93,020
Expenditure						
Personnel	56,442	58,839	61,956	62,576	63,201	63,833
Outsourced Services	8,922	10,231	8,084	8,165	8,246	8,329
Clinical Supplies	10,310	11,258	10,569	10,633	10,698	10,764
Infrastructure	8,715	8,333	7,406	7,445	7,491	7,536
Financing Charges	985	1,014	984	990	996	1,002
Depreciation	3,095	3,686	3,720	3,743	3,766	3,788
Total Expenditure	88,469	93,361	92,719	93,552	94,398	95,253
Operating Result	411	(2,763)	(1,925)	(2,204)	(2,218)	(2,232)

SOUTH CANTERBURY DISTRICT HEALTH BOARD
GOVERNANCE & FUNDER ADMINISTRATION
ANNUAL PLAN 2014/15 **000'S**

Prospective Income Statement	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	Actual	Forecast	Plan	Plan	Plan	Plan
INCOME						
Internal Revenue	3,139	3,286	3,566	3,588	3,610	3,632
Other Revenue	0	0	0	0	0	0
TOTAL INCOME	3,139	3,286	3,566	3,588	3,610	3,632
EXPENDITURE						
Personnel Costs	335	236	429	432	434	437
Outsourced Services	326	399	448	451	453	456
Other Operating	1,258	1,536	1,369	1,377	1,386	1,394
Financing Charges	1,361	1,350	1,320	1,328	1,336	1,344
Depreciation	0	0	0	0	0	0
TOTAL EXPENDITURE	3,280	3,521	3,566	3,588	3,610	3,632
NET SURPLUS/(DEFICIT)	(141)	(235)	0	0	0	0

2.1 Planned Net Results

SCDHB has more than a ten-year history of achieving or bettering its financial plans. It plans to utilise retained Mental Health surpluses in the next two years, and to utilise ring fence Primary & Community equity (as allowed by the agreement reached with the Ministry of Health on the disestablishment of Aoraki Primary Health Organisation) in the next three years, this is included in the planned surplus for each year.

The accumulated Mental Health surplus (Forecast to be $0.4M @ 30 June 2014) will be spent to continue funding Mental Health services in 2014/15 and 2015/16.

To the extent SCDHB achieves a surplus in any one year it may then plan to run an off-setting deficit in the subsequent years.

SCDHB has also maintained an internal ring fence for Primary Health; this is due to our structure of covering the role of the PHO within the DHB. As at 31 January 2014 the DHB had $0.450M of equity that was ring fenced for Primary. This document includes expenditure of $0.3M of ring fence primary funding which will be utilised on Primary Care initiatives.

The DHB will review for accounting purposes the valuation of its land and buildings in May 2014. A provision for an increase in capital charge and depreciation impacts in the financial forecasts should the revaluation result in a 10% increase in value of land and buildings , along with the inclusion of works on Kensington, the Gardens Block and a large number of IS initiatives have been allowed for. A full revaluation was last completed in June 2013.

Planning includes productivity and efficiency savings. Savings are generated through local, regional and national initiatives, including working with Health Benefits Limited (HBL). HBL are targeting a number of savings from their programs and some of these will be offset by investment required in the short term, but overall SCDHB has a target of net overall gain.

2.2 Cost and Volume Assumptions

The following assumptions have been utilised in the development of financial forecasts, and the management actions being put in place to deliver against the plan:

- The community pharmaceutical budget stays within $16.8M for 2014/15;
- NGOs will on average receive 0.61% increase in 2014/15;
- Primary care will receive an increase of 1.0% on first contact services and on average 0.61% across other services;
- The Ministry continues to provide the “good performance” advance of one month’s revenue (about $10M);
- Net Inter District Flows will be $22.1M out to other DHBs, this is made up of an inflow of $3.7M and an outflow of $25.8M;
- Except for demand and continued refinement of needs based prioritisation within service lines, there are no changes to the nature, mix or volume of services planned to be funded or provided by SCDHB;
- If there are any services devolved by the Ministry of Health to SCDHB they will be devolved in a fiscally neutral manner;
- Employee costs have been calculated using employment agreement settlements where these exist. The assumption used in 2015/16 is a 1.0% settlement and in 2016/17 a 1.0% settlement;
- Any increase in volumes from demographic increase delivered by the SCDHB Provider will be absorbed by the current FTE as an efficiency saving;
- Health Benefits Limited - Provision has been made for the operational costs of Health Benefits Limited and provision of $44K has been made to purchase “b” class shares in Health Benefits Ltd as a contribution for the Finance, Procurement and Supply Chain business case. No other cost

provision has been made at this stage. Cost savings have been incorporated into the Prospective Income Statements; these will be achieved via national, regional and local projects.

The expectation is that any approved unbudgeted operational expenditure will be offset by extractable operational efficiencies, either directly attributable to the business cases or through other savings initiatives Health Benefits Limited initiate to compensate. Unbudgeted capital contributions may be incurred if the business cases are compelling to justify the investment.

- Health Quality & Safety Commission – there has been provision for the maternity system operational costs and capital expenditure associated with medicines management system. However, these are subject to business cases, the rationale for this, is given the tight fiscal environment health is operating within; any proposal for enhancements should be compelling and deliver adequate extractable gains.
- The updates to various cost lines from the introduction of the in-house MRI have been included.
- SCDHB has provisioned funding for initiatives that are yet to be announced in the 2014/15 budget process.

Assumptions for out years have been extrapolated out based on the figures for the 2014/15 year.

2.3 Efficiency Targets

SCDHB will continue to work at containing the cost growth and reviewing the revenue from other activities to ensure that the DHB can continue to live within the funding available while maintaining service delivery. When recognising industrial settlement pressures, step increases, and inflationary and other cost and quality pressures, the only way SCDHB is able to provide a break even financial forecast is by planning for the delivery of financial efficiency gains. In undertaking the planning the following areas have been identified as areas for which gains have been incorporated:

- A full annual review of the commercial laundry prices will lead to a price increase of 1%. These are being implemented and the net gain to SCDHB will be $13,000;
- Changes within the provider, line by line review will continue to hold costs;
- SCDHB will continue to work with HBL and Pharmac as part of the interim national procurement to obtain 'quick wins' from procurement, establish category management and aid in the development of a national pharmaceutical schedule; this will be in advance of the full establishment of the standard financial management information system for all DHBs;
- The food and household contracts expires in Oct 2014. HBL have advised these will be rolled forward for a further 12 months. No further savings are anticipated;
- SCDHB will continue to actively work with HBL on the Linen and Laundry business case to help refine options for savings across the sector;
- Work with HBL to progress the detailed business case for the national infrastructure programme scheduled to be released in July. It is anticipated that this will be cost neutral from a DHB's perspective;
- SCDHB is actively working with the other South Island DHBs to implement regional IS solutions, this has seen the development of the first shared Clinical Information System, shared PACS and a shared Radiology Information System. In the next three years SCDHB will implement Electronic Medicine Management, e-referrals, e-Maternity and a Self-care Portal with the other South Island DHBs, with the development of a new Patient Administration System for implementation at SCDHB in 2018. These collaborative projects will over time save the DHBs expenditure but will also enable improvements to be made to the patient journey and change the way health care is delivered to consumers enabling a sustainable and integrated service to be provided over the coming years;
- Procurement savings from local, national and regional collaboration with HBL, Southern DHB and regional DHBs will continue, and
- SCDHB will also actively work with HBL on the back office function solution and supports the business case currently being developed by HBL; however the planning assumption is that any investment required by HBL will be at least offset by additional savings over and above the efficiencies explicitly included above.

Summary of Key Actions							
		2014/15	2015/16	2016/17	2017/18		
		Plan	Plan	Plan	Plan		
KEY ACTIONS - with brief description*	DELIVERABLES - timing					Specify linkage to Financial Performance Forecasts **	DHB's assessment (high/medium/low) and reasons for risk of non implementation
Centre of Excellence Health of Older Persons Project	Implementation of recommendations from Cente of Excellence concept plan	107				Additional investment to support development service delivery for ageing population	Medium
Child and Youth Integrated Model of Care	Integrated Model of Care	50				Improved coordination in the delivery of services to Children and Youth	Low
Laundry Service Review	Efficienies following laundry operation review	(13)	(13)	(13)	(13)	-Increase in commercial customer pricing -Reduction in costs and wastage	Medium
Replacement of Legacy Patient Administration System (PAS)	CORE PAS developed and delivered to Model Community by Orion, SCDHB implementation 2018	235	214	290	2,238	As per Regional Business Case approved by NHITB	Medium
eMedicines Reconciliation (eMR) with eDischarge Summary	Implement eMR following on from ePA, ePM Q4 2014/15	1,079	356	-	-	Includes all eMedicines programmes, ePrescribing and Administration management, ePharmacy, eReferrals, eMaternity, eMed reconciliation, eLabs/ordering	Low
Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)	Implement regional solution 2014/15	29	-	-	-	Deploy the Regional HCS Mental Health module, Portal Upgrade, deployment of CWS across the rest of the region.	Medium
National Patient Flow	To implement the National Patient Flow project which will track and report on the patient journey	52	-	-	-	Phase 1 National Data Collection (Referrals to First Specialist Assessment) live 1 July 2014. Project scoping, requirements gathering for Phase 2 commenced	Low
Self-Care Portal	To implement a Self Care Patient Portal that helps patients be involved in their care	90	-	-	-	Reviewing portals available including Regional concept	High - Regional proof of concept for technical solution will take 6 months to develop pilot. Parameters/governance around this will require consultation
	TOTAL	1,629	557	277	2,225		

2.4 Financial Risks

All DHBs face pressure from additional expenditure which must be managed within the allocated funding.

Management of expenditure pressure will require considerable restraint, and focused exploration of productivity improvements.

SCDHB will manage staff numbers to appropriate levels and implement changes to service configuration. Efforts will be prioritised within DHB's service priorities and demographics.

On top of these risks there are a number of specific risks to the financial projections contained in this plan. They include:

- Industrial Settlements – The majority of Industrial Agreements will be settled in the 2013/14 financial year within financial parameters and the total cost, including progression already provided for in existing agreements will be managed within a combination of funding or additional efficiencies or productivity gains. The NZNO MECA expiring in February 2015 may pose a challenge for it represents a large component of our workforce and employee expectations tend to mirror the improvement in the national economy.
- Inter District Flows – The Funding Envelope identified the level expected for Inter District Flows. This is based on historical patterns and the updated price.
- Asset Revaluations – A provision has been made for a 10% increase in the revaluation of land and buildings, along with the work to be carried out on Kensington and the Gardens Block the consequential flow on impact for depreciation and capital charge has not been included.
- Demand Pressures – The plan is based on delivering to the agreed price volume schedules. There are risks on both the Funder and Provider side of the Annual Plan. Specifically the risks are:
    - HBL costs/savings/timings around workstreams;

- National Costing Collection & Pricing Programme (NCCP) related work including an overall review of PBFF over next 18 months including secondary and tertiary adjusters by the Ministry of Health;
- Talbot Park revenue and costs;
- Employee entitlement valuations;
- Land and Building revaluations;
- 2013 census population base changes; and
- Changes in depreciation and capital charge as a result of site redevelopment work.

- The HBL Indicative Case(s) for Change will require investment from the sector, this is significant across the various programmes and at this stage SCDHB has planned for a net cost in 2014/15 and then a net gain in the following two years. There is a risk on the timing of the investment vs. gain in any one financial year, particularly where business cases are compelling across the sector but may disadvantage individual DHBs.
- The Facility Master Plan is currently being updated to determine scope of work required to maintain the hospital site for 15-20 years. Related seismic strengthening remains a risk until this work is complete. The plan allows for the interim capital expenditure of $3.9M for the strengthening and refurbishment of the Gardens Block due to be completed in 2014/15. The outcome of Facility Master Plan review could identify that $16M currently earmarked for this work is not sufficient, or the work may need to happen in conjunction with a major facility redevelopment.
- Procurement and Supplies – The plan assumes supplies costs are tightly controlled and savings delivered by national, regional and district based procurement initiatives. Exchange rates and other supplier cost pressures are a risk to these assumptions.
- Information Systems Strategic Plan – SCDHB will continue to support the regional and national initiatives to replace and develop systems. The funding included in the capital expenditure section of the plan is indicative of the projects that will be completed under the regional plan with the major focus on the replacement of the patient administration system.

2.5 Fixed Assets

The Board considers the appropriateness of the valuation of its land and buildings each year in June. No impact on capital charge, as a result of any requirement to adopt a new valuation, has been provided in either income or expenditure.

SCDHB is well within its banking covenants.

Disposal of Land
SCDHB will ensure that disposal of land transferred to, or vested in it pursuant to the Health Sector (Transfers) Act (1993) will be subject to approval by the Minister of Health. The DHB will ensure that the relevant protection mechanisms that address the Crown's governance obligations in relation to Māori sites of significance and that the requirements of section 40 of the Public Works Act are addressed. Any such disposals will be [planned in accordance with s42 (2) of the NZPHD Act 2000. No land disposals have been planned in 2014/15 and out years.

Business Cases
SCDHB is completing a single stage business case for the redevelopment of parts of Timaru Hospital. The business case follows the approval by the Capital Investment Committee of the Strategic Assessment. The business case will be completed in the 2014/15 financial year.

2.6 Capital Expenditure

Capital expenditure is provided in two components:

- General Capital Expenditure

It should be noted that any delays in 2013/14 capital expenditure will be carried forward into 2014/15.

$000s	2013/14	2014/15	2015/16	2016/17	2017/18
Buildings , Plant & Equipment excl Clinical	1,701	1,735	1,770	1,805	1,841
Clinical Equipment	-	-	-	-	-
IT/IS	117	118	119	121	122
Vehicles	200	200	200	200	200
Total General	2,018	2,053	2,089	2,126	2,163

- Special Capital Projects

  Special capital projects are targeted funding which is not available for redistribution should these projects not proceed. Explicit approval for each of these items is required before proceeding.

$000s	2013/14	2014/15	2015/16	2016/17	2017/18
Infrastructure	200	200	200	200	200
ISSP	1,101	2,454	246	246	1,927
Facility & Seismic Aprroved		3,900			
Facility & Seismic Unaprroved			8,000	8,100	
Radiology		900			
Total Special	1,301	7,454	8,446	8,546	2,127
Total Capex	3,319	9,508	10,525	10,651	4,258

2.7 Method of Capital Prioritisation

SCDHB funds capital expenditure for its Provider Arm only.

SCDHB sets the capital budget, which is informed by the budgeting process, including a bottom-up list of requests.

The capital budget is compiled from prioritised bottom-up requests and management knowledge. Prioritisation is based on clinical, quality or compliance driven need or financial justification to which various thresholds/hurdles apply depending on the nature and quantum of the proposed investment.

2.8 Funding Source

All capital expenditure will be from internally generated funds or existing debt facilities already in place with the Crown Health Financing Agency.

2.9 Debt and Equity

SCDHB has no additional borrowing facility or equity requirements during the three years of this financial plan, unless the Facility Master Plan is advanced due to the seismic strengthening work not being able to proceed due to the building being occupied.

The DHB plans to draw down against existing facilities to meet its requirements for the Capital Plan.

To minimise its funding costs SCDHB will maintain a high debt-to-equity ratio while remaining within its banking covenants and maintaining flexibility in its ability to drawdown debt.

Schedule of Debt and Equity Movements

$000s	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan
New Debt Drawdown - DMO	0	0	0	0
Debt Repayment DMO	0	0	0	0
Equity Movements FRS3 Depreciation funding repayment	(200)	(200)	(200)	(200)
- Net Result	(200)	(200)	(200)	(200)

Changes in Lenders, Limits and Borrowing Arrangements
All debt facilities except overdraft are with the Debt Management Office (DMO). The DMO advised on 14 November 2007 that it waived the requirement on the DHB to comply with financial covenants and annual ratio compliance certificates. There have been no other changes to arrangements and none are planned.

SCDHB joined the HBL Banking and Treasury arrangements during 2012/13 and continues to be a party to this arrangement. Where the DHB can attain a preferential rate for term deposits outside this arrangement it has retained the right to do so.

2.10 Statement of Significant Accounting Policies

2.10.1 Reporting Entity

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, the Financial Reporting Act 1993 and the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013.

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.

2.10.2 Reporting period

The reporting period for these prospective financial statements is for the year ended 30 June 2015.

2.10.3 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 are SCDHB's first full NZIFRS prospective financial statements and NZIFRS 1 has been applied.

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

2.10.4 Basis of Preparation

The prospective financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that land and buildings are stated at their fair value.

The preparation of financial statements in conformity with NZIFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. The Prospective Financial Statements are updated annually.

The Prospective Financial Statements include actual audited financial results for the year ended 30 June 2013.

These prospective financial statements have been prepared in compliance with FRS-42: Prospective Financial Statements.

2.10.5 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 Prospective Financial Statements:

1. 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.

2. Taxation

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

3. Donations and Bequest Funds

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

4. 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.

5. 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 financial performance.

6. 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.

7. 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; and
- 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 financial performance 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 Financial Performance.

Fixed assets vested from the Hospital and Health Service

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

8. Revaluation of Land and Buildings

Land was revalued as at 31 January 2014 to fair value and buildings were revalued as at 31 January 2014 to fair value. Fair value is determined by an independent registered valuation advisor and based upon market evidence for land and net replacement cost for 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. Consideration of the current valuations to determine that they have not materially changed is conducted in January each year. The results of 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 financial performance. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the statement of financial performance will be recognised first in the statement of financial performance up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

Additions to property, plant and equipment between valuations are recorded at cost.

9. Disposal of Fixed Assets

When a fixed asset is disposed of, any gain or loss is recognised in the Statement of Financial Performance and is calculated as the difference between the sale price and the carrying value of the fixed asset.

10. 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.

11. 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.

12. 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 financial performance on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Software	2 to 10 years	50-10%

13. 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.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance sheet date and was estimated at the date of transition.

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 financial performance.

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.

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 financial performance.

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.

14. Investments in Equity Securities

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

15. 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.

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 financial performance as incurred.

Defined benefit schemes

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

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

16. 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 Financial Performance.

17. 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 principle outstanding to determine the interest expense each period.

18. 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.

19. 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 financial performance over the period of the borrowings on an effective interest basis.

20. Trade and Other Payables

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

21. 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.

22. 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 Financial Performance. 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 Financial Performance.

    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 Financial Performance.

23. Standards issued but not yet effective.

    None.

24. Changes in Accounting Policies

    SCDHB has adopted New Zealand equivalents to International Financial Reporting Standards (NZ IFRS) with effect from 1 July 2006.

These prospective financial statements have been prepared in accordance with NZIFRS.

CHAPTER 3: STEWARDSHIP

3.1 Quality & Safety

The DHB continues its commitment to embedding and integrating its clinical governance structures, allowing time for the combined Clinical Board to bed in and become known within the organisation. Following the completion of a review of the activities of the Clinical Board reporting committees, structures will be further developed.

At a national level, we will continue to engage with the Health, Quality and Safety Commission work programmes and priorities (with a particular focus on the Patient Safety Campaign work, and developments in capturing patient experience).

With a view to clinical governance SCDHB will continue to actively participate in the activities of the South Island Service Level Alliance for Quality and Safety. This Alliance was "formed to lead advice and make recommendations to support and coordinate improvements in safety and quality in health care for the South Island DHBs; identify and monitor initiatives that support improvements in national health and safety indicators; report on safety and quality, including performance against national indicators; and share knowledge about and advocate for safety and quality".[14] The Alliance's key focus areas for 2014 - 2017 are: 1.Open for Better Care (Patient Safety Campaign); 2.Incident Management; 3.Quality Systems and Indicator Framework; 4.Consumer Participation.

SCDHB continues to hold the chair of the National Quality Managers group and has close links with the Health Quality and Safety Commission, with membership on bodies such as the Patient Safety Campaign Advisory Group.

3.2 Risk Management

SCDHB's Risk Management Policy functions as the framework to support the risk management programme within the DHB: it reflects the Risk Management Principles and Guidelines AS/NZS ISO 31000:2009. The DHB will explore ways it can continue to strengthen its risk management processes specifically in relation to hierarchy of risk, (including service level risk) and expanding its risk identification to capture those involving the potential risk of patient harm.

3.3 Compliance with Legislation

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 and Amendment Act 2013, 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, the Financial Reporting Act 1993 and the Crown Entities Act 2004 and Amendment Act 2013.

As required by the DHB Operating Policy Framework the SCDHB will comply with all relevant legislation and regulation in all activities and will meet the requirements of the Crown Entities Act 2004 and Amendment Act 2013.

The DHB secondary services Provider arm and Talbot Park both hold current certification.

[14] *South Island Regional Health Services Plan 2014 - 2017*

3.4 Managing our Workforce within Fiscal Restraints

SCDHB supports and actively participates in national collective bargaining to ensure sector, organisational and professional needs are considered and remuneration and other terms and conditions are developed within fiscal constraints which in turn lead to performance improvement, productivity enhancement and effective employee engagement.

We will continue to participate in workforce profiling and the development of strategies and actions in relation to vulnerable workforces. Some medical specialties, sonographers, orthotists and mental health roles have been identified in this regard.

SCDHB will continue to support national/regional initiatives to improve the recruitment, deployment and retention of staff and support the use of common technology, coordination of HR processes and development of key HR metrics which will inform business planning processes.

We support the development and implementation of a Leadership and Management Framework and will evaluate the benefit of joining the Health Workforce Curriculum Partnership with education and training providers.

We will continue to support and advance the work of HBL as it identifies new service delivery models, technology, processes and policies which will improve efficiency and contain costs.

Finance, Procurement and Supply Chain Shared Services teams have developed detailed operating models, shared policies and over arching agreements and are engaging with DHBs in the implementation phases. SCDHB will continue to support the Food and Laundry, National Infrastructure Platform and HRMIS projects as they continue to develop.

3.5 Strengthening our Workforce

We are committed to a workforce strategy which provides a healthy environment, supportive work culture and ensures that every employee has the capacity and capability to deliver to current and future health care needs of our community.

SCDHB will continue to work with our Regional Training Hub Director and will participate in the various national initiatives to deliver workforce plans which will reflect core baseline data, utilise service demand forecasting and meet workforce requirements regarding hard to staff positions.

To strengthen professional leadership across allied and technical professions we will participate in the regional allied health professional leadership/educator advanced practice roles project and evaluate the establishment of an allied health professional forum.

The aging population and aging workforce are issues which drive our planning and strategy development with more than 40% of staff 50 years old or older. In view of this we have progressed a project to determine the factors which affect the retention, productivity and motivation of the older workforce. Our DONMAH also chairs the Nursing project group 'Sustaining the Workforce' which will provide recommendations in regard to improved utilisation of nurses and encourage the active contribution of older nurses as long as possible.

3.6 Safe and Competent Workforce

Children's Worker Safety Checking

SCDHB will support the development and implementation of plans and procedures by the 20 DHBs for recruiting workers in the children's workforce regarding safety checking. New employees in our core children's workforce will be screened in accordance with the requirements of the Vulnerable Children's Bill from 1 July 2014 and the checking of the existing core children's workforce will be phased in over the following

three years. The DHB will ensure that safety checking information is available for provision to the Director General (s38) to meet the requirements in the Vulnerable Children's legislation.

3.7 Organisation Health

We want to ensure that we build on the positive organisation culture as reflected in our most recent staff survey which showed an overall improvement in relation to previous results. Senior managers will give direction and focus to various projects and engage with staff for further improvement.

3.8 Health 4 You

We are continuing the pro-active approach to employee health by providing a variety of initiatives to empower staff to understand and improve their health. The targeted areas are improved nutrition, encouraging physical activity and workplace resilience. The subsidised gym memberships and other free or low cost contracted activities such as the provision of fitness programmes delivered on site by local fitness providers will continue. In out years we will continue with our holistic approach and include activities with a social context e.g. team building and activities which build employee resilience.

3.9 Health and Safety

We maintain a safe and healthy environment by participating in the ACC Workplace Safety Management Practices Programme and are participating in ACC's Employer Centric Services programme to benefit from specialised advice and coordinated injury prevention and claims management. SCDHB will also strengthen the integration and collaboration of stakeholders relating to Health and Safety and apply the guidelines of good governance for managing health and safety risks.

3.10 Care Capacity and Demand Management

SCDHB joined the Care Capacity Demand Management (CCDM) programme supported by the Safe Staffing Health Workplace Unit and in partnership with the unions. The CCDM programme is designed to assist the matching of service demand with service capacity to ensure the right number and skill mix of staff meet patient needs. An information technology system to measure patient acuity has been successfully implemented which will provide the necessary data to support the CCDM programme.

South Canterbury DHB Workforce (July 2013)

Average age - 47 years		
Gender Mix	**Female** **Male**	84.02% 15.98%
Largest Ethnic Group	**NZ European**	63.40%
Hours of work	**Full time** **Part time/casual**	32.24% 67.76%

Professional Grouping	FTE
Allied Health	100.45
Nursing	296.43
Medical	55.79
Support	44.56
Management and Admin	112.04
Total	**609.27**

3.11 Workforce Development

SCDHB remains actively engaged in national activity through Health Workforce NZ (HWNZ) and regional activity through participation in the South Island Regional Training Hub (SIRTH). SIRTH is one of four national training hubs established through a HWNZ initiative and "functions to create a training and education network within the region that facilitates the coordination and delivery of education and training to all health professionals".[15]

While necessary to develop support for our aging workforce it is equally important that more local young people are effectively engaged and attracted to health careers with a focus on undergraduate qualifications. To address this need SCDHB implemented the Incubator Programme at six High Schools and participated in career choice events. We are progressively increasing the number of schools participating in the programme and are creating paid work experience for students who are participating in tertiary health education.

It is also important that we ensure all health professional graduates are supported in their first year of practice and to facilitate this we will develop a Learning and Development Framework with particular emphasis on development of an Allied Health and Technical new graduate programme, transitioning to an interdisciplinary framework.

To enable the national understanding of the skill mix, competencies, education and training needs of the mental health workforce we will participate in the Te Pou and Matua Raki workforce stocktake of adult mental health and addiction services.

We support the principles of equal opportunity and therefore will be promoting career opportunities for Maori and Pacific Island youth and continue to actively engage with the Kia Ora Hauora Maori Health Careers Programme locally. SCDHB will continue the partnership with Maori stakeholders and be guided by Te Waipounamu Maori Health Workforce and other national plans.

SCDHB will support the development of a framework for the implementation of allied health assistant training and development and participate in the regional pilot for rehabilitation assistant training.

Following the stock take of qualifications/training of health care assistants and orderlies we will be working with individuals to facilitate the creation of potential career paths in conjunction with Careerforce. This work will also meet collective contractual agreement requirements.

SCDHB will continue to engage with staff by providing some career planning guidance to medical, nursing and allied health employees taking the 70/20/10 model of medical education funding into account.

The Health Workforce New Zealand supported pilot for our GP registrar training is continuing with one GPEP2 level registrar rotating at the teaching practices.

The new role of Associate Director of Allied Health has been established and implemented and is making a positive contribution to the development of the allied health workforce.

[15] *South Island Regional Health Services Plan 2014 - 2017*

3.12 Building Capability

SCDHB has committed to working regionally as part of the South Island Information Systems Service Level Alliance (SIISSLA) to invest in new information systems. Planning has an emphasis on clinical systems and supports the National Health IT Plan by developing, implementing and maintaining appropriate information systems aligned to both its Regional Service Plan and Annual Plan.

SCDHB Share of Regional/National Projects

$000s	2013/14	2014/15	2015/16	2016/17	2017/18 +	Total
PAS(Patient Administration System) - Total	205	235	214	290	2,238	3,183
e-Pharmacy	-	300		-	-	300
e-Prescribing & Administration	6	401				407
e-Medicine Reconciliation		55	-			55
e-Medicine Management			356			356
e-Referrals (DHB)	124	5				129
Regional Shared Care Record (eSCRV)	-	264	52	-		316
e-Maternity	-	201	-			201
IT - RL6	-	35				35
IT - eOrdering Shared Radiology/Labs	117	117				234
IT - National Patient Flow	17	52				70
IT - Clinical Workstation	6	29				35
IT - Provation	-	94	-			94
IT - Mosaic	-	20	-			20
IT - Commuity ePrescribing		70				70
IT - Self-care Portal		90				90
IT - FPSC	298	436				734
IT - Concept Projects/Unspecified						933
	774	**2,404**	**622**	**290**	**2,238**	**7,261**

There are a number of national projects which the SISSLA are awaiting further information in order to prioritise against the current programme of work. Therefore this document does not include any assumptions on investment, operation costs and benefits for the following systems:

- HRMIS – national via HBL;
- FPSC – national via HBL
- National Infrastructure – national via HBL; and
- National Patient Flow.

Regional

The South Island is to review, and change the way health care is delivered to consumers enabling a sustainable and integrated service to be provided over the coming years. This goal is to improve support for community services, better access by GPs, to DHB clinical and patient information and to provide greater integration and visibility across the continuum of care for both care teams and users of the health service.

3.13 Information Communication Technology - Support information and data– Daptiv programme

Patient Administration System (PAS) - The National Health IT Board (NHITB) is driving the development of regional information systems including the integration of Patient Administration with clinical systems.

Finance procurement & supply chain – Support the programme's information requests and the procurement transition from 1 July 2015. Currently SCDHB is not scheduled to transform to the new Finance and Supply model until 2016.

3.14 Clinical Technology/Communication

The DHB will support the following initiatives:

- Continue to support the use of new IS capability including connection to the clinical portal by providing staff with technology and devices that enable maximum engagement including computers on wheels (cows), ipads, tablets and smart phones;
- Increasing use of WIFI to relay medical images to data repositories;
- The introduction of a new intranet at SCDHB in the first six months of 2014/15 will enable more accessible internal communication and information sharing across the DHB; and
- Use of South Island wide network (WAN) to provide secure communication between DHBs for example secure email.

3.15 National Health Committee (NHC)

The South Island DHB's will work with the NHC via the Strategic Planning and Integration Team who will take on the role of the Regional Prioritisation Networks and work with NHC to understand the implications and resource requirements in supporting the following NHC initiatives:

- the burden of disease review programme by engaging with and providing advice on the burden of disease documents;
- the NHC work programme for sector referral round by referring technologies that are driving fast-growing expenditure to the NHC for prioritisation and assessment where appropriate;
- the NHC work programme for the development of recommendations and implementation strategies by providing expert clinical opinion to working and advisory groups on health technology assessments where possible and by not introducing emerging technologies where the NHC has recommended that these technologies should not be introduced;
- the NHC identification of notional savings work programme by providing expert business opinion to working and advisory groups on health technology assessments where possible;
- the NHC health innovation partnership work programme by providing clinical research time to design and run field evaluations where possible; and
- the NHC development of regional prioritisation networks work programme by referring technologies that are driving fast-growing expenditure and that have not been prioritised for assessment at the national level, to the Regional Prioritisation Network where appropriate.

3.16 Health Promotion Agency (HPA)

The DHB will support the following HPA initiatives:

- national health promotion activities around the health targets;
- work undertaken by the HPA on preventing foetal alcohol spectrum disorder; and
- compliance with requirements of the Sale and Supply of Alcohol Act 2012, including enabling the Medical Officer of Health to comply with their specific responsibilities and duties outlined under the Act.

3.17 PHARMAC

The DHB will support the following PHARMAC initiatives:

- commencing its interim procurement role for hospital medical devices, including committing to implement new national medical device contracts, when appropriate; and
- progressing its hospital pharmaceuticals management function.