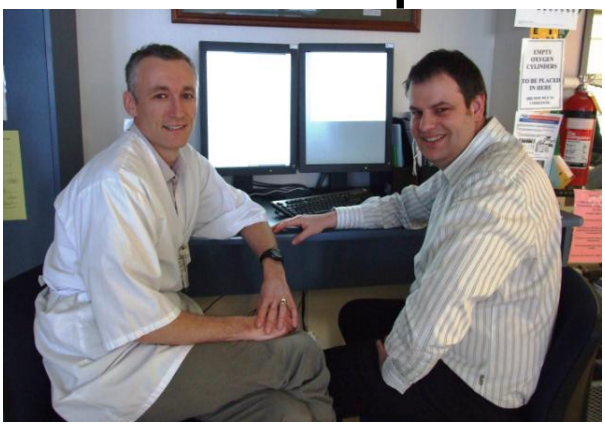
Better Health
Better Lives
Whanau Ora

Southern District Health Board

Annual Report 2013



Southern District Health Board

DIRECTORY

Board Members

Joe Butterfield MNZM	Chairman
Paul Menzies	Deputy Chairman
Neville Cook	
Sandra Cook	
Kaye Crowther QSO	
Mary Flannery	
Malcolm Macpherson	
Tahu Potiki	
Branko Sijnja	
Richard Thomson	
Tim Ward	
Stuart McLauchlan	Crown Monitor

The Membership of the Board Committees is as follows:

Hospital Advisory Committee

Paul Menzies	Chairman
Neville Cook	
Malcolm Macpherson	
Tahu Potiki	
Branko Sijnja	
Richard Thomson	
Tim Ward	

Iwi Governance Committee

Eleanor Murphy	Chair & Ōtākou Representative
Taare Bradshaw	Hokonui Representative
Sandra Cook	
Kaye Crowther QSO	
Kingi Dirks	Moeraki Representative
Peter Ellison	Puketeraki Representative
Paul Menzies	
Hana Morgan	Awarua Representative
Tahu Potiki	
Odele Stehlin	Waihōpai Representative
Ann Wakefield	Ōraka Aparima Representative

Community and Public Health Advisory Committee & Disability Support Advisory Committee (Joint Meetings)

Malcolm Macpherson	Chairman
Neville Cook	
Sandra Cook	
Kaye Crowther QSO	
Mary Flannery	

Audit and Risk Committee

Tim Ward	Chairman
Joe Butterfield MNZM	
Mary Flannery	
Paul Menzies	
Stuart McLauchlan	Crown Monitor

Clinical Advisory Committee (Disestablished Nov-12)

Branko Sijnja	Chairman
Richard Bunton	Medical Director of Patient Services
Michael Furlong	Elected Member, Senior Medical Staff, Otago
James Knight	Chair of General Medical Staff, Otago
Lynda McCutcheon	Executive Director Allied Health, Scientific & Technical
Roland Meyer	Elected Member, Senior Medical Staff, Southland
Andre van Rij	Representative, School of Medicine, University of Otago
Leanne Samuel	Executive Director of Nursing & Midwifery
Julian Speight	Chair of Senior Medical Staff, Southland
David Tulloch	Chief Medical Officer

Appointments & Remuneration Advisory Committee

Joe Butterfield MNZM	Chairman
Malcolm Macpherson	
Paul Menzies	
Richard Thomson	

Chief Executive Officer

Carole Heatly

Executive Management Team

Carole Heatly	Chief Executive Officer
Lexie O'Shea	Executive Director Patient Services/ Deputy CEO
Steve Addison	Executive Director Communications
Peter Beirne	Executive Director Finance
Richard Bunton	Medical Director of Patient Services
Donovan Clarke	Kaiwhakahaere Hauora Māori (Executive Director, Māori Health)
Sharon Kletchko	Executive Director Strategy, Integration & Funding
Ian Macara	Chief Executive Officer, Southern Primary Health Organisation
Lynda McCutcheon	Executive Director Allied Health, Scientific & Technical
John Pine	Executive Director Human Resources
Jim Reid	Acting Dean – Dunedin School of Medicine
Leanne Samuel	Executive Director of Nursing & Midwifery
David Tulloch	Chief Medical Officer

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Andy Burns
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Bankers

Westpac Business Banking
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PO Box 5345
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FOREWORD FROM THE CHAIR AND CHIEF EXECUTIVE

Joe Butterfield – Chair

Carole Heatly– CEO

During the past year we have made important gains across our entire spectrum of work. As a DHB we are becoming a more cohesive organisation as we build solid links between our role as a planner and funder of health and disability services and those as a provider.

We have made great progress in implementing the Southern Way. This campaign has focused the activities of the DHB as we have sought to ensure that we:

- Put patients at the centre of everything we do
- Create a high performing organisation with a focus on quality
- Become a single unified DHB
- Provide clinically and financially sustainable services to the community we serve

We have used the campaign to drive our forward planning and cost savings initiatives and to focus our communications internally and externally.

While our financial position continues to be a challenge and our deficit remains unacceptably high we believe we are on the right path to reduce our deficit in line with a pathway agreed with the National Health Board. This includes implementing a process of cultural change which will see us improve the quality of our services while reducing their cost.

As part of this drive we have implemented a new Quality and Performance framework and adopted the quadruple aim to assist us in our decision making. It sets out to balance decision making against the health needs of the population, the safety and care experience of patients, the delivery of care within budget and learning opportunities for current and future staff.

We have also implemented a new structure at the General Manager level of the organisation. This new structure established clinical managerial partnerships and strengthened clinical decision making.

We have begun a process to align and improve the remaining tiers of the organisation consistent with the principles of the Southern Way and the Quadruple Aim.

During the year our performance in meeting the Government's health targets has improved greatly.

In spite of significant challenges we met our elective surgery target, meaning more people were able to get the care they need.

While we are still not quite there with the target which measures waiting times in our emergency departments, we have made tremendous gains in this area and now see the vast majority of patients within the target. This has been thanks to the outstanding efforts of the dedicated staff who work in this area.

We would like to thank all our staff and community providers for their hard work throughout the year. The professionalism and dedication of these people makes a tremendous difference to our patients/consumers, their families and the entire community.

Joe Butterfield

Chairman

Carole Heatly

Chief Executive Officer

THE YEAR IN REVIEW

Year End Result

The year end result was a deficit $11.9m against a budgeted deficit of $10.9m.

We have in place an ambitious cost saving plan to ensure we achieve our target of moving out of a deficit position over the next three years.

New Cystic Fibrosis Clinic Puts Patients at Centre of Treatment

The Department of Respiratory Medicine at Southern DHB has initiated a new Adult Cystic Fibrosis (CF) Multidisciplinary Clinic to ensure that people living in the district who have CF experience the best possible care.

CF is a condition that can range in severity from relatively mild symptoms to a life threatening disease, and often sufferers have very complex health needs which may require intensive and pro-active management from numerous healthcare professionals. The new clinic means that patients no longer need to have separate appointments to see a physiotherapist, respiratory physiologist, dietitian, physician and specialist nurse, which would typically be held on different days. Now patients can see all of their care team members in a single site visit, making it easier and more convenient for patients to receive quality care.

The new clinic also puts patients physically at the "centre" of the clinic: with the cast of professionals rotating around the individual's own clinic room. This also means that staff will be able to come together easily to share expertise and identify opportunities for improvement as the service develops. Liaison with other healthcare professionals within the DHB is also expected to benefit from the resulting improvements to communications and record keeping. This new approach should also see a reduction in clerical staff workload, and improved data collection.

This development follows the recent publication of the "Standards of Care for Cystic Fibrosis in New Zealand" that sets a framework, and defines the core team for specialist CF care. It is seen as timely that the SDHB has developed a philosophy of care which places the patient at the centre and focuses on delivery of quality services that are both financially and clinically sustainable.

"We are very excited to be able to introduce this high quality service to our patients," commented Ben Brockway, Consultant and Senior Lecturer in Respiratory Medicine and Dunedin Public Hospital.

District Nurses First to get Mobile Technology

Southern DHB has become the first to introduce mobile technology to District Nurses. Southland Hospital District Nurses in early May started using tablets and specialist Agility software to manage workflow, scheduling and have real-time information about the patients they are visiting in the community.

District Nurse Janeece Cournane said "although it was a big adjustment from their paper-based itineraries, there are real benefits in being able to use tablets and the Agility system. It means we have the most up-to-date information when we visit patients, and we are able to add notes to the patient's file so that all nurses visiting that patient have the same information.

"It also means we can manage our workload better as a nurse who may have extra capacity on a particular day can assist another nurse who may be very busy, but still have access to all the patient information.

Nursing Leader Wendy Findlay said "it was exciting for Southland to be at the forefront of this programme. By being part of the pilot, our nurses can help shape how the Agility software will be developed in the future. The nurses are excited about the next stage of development, where they will be able to document further clinical information and have it available for them to access within the patient's own home. This will enable nurses to make more informed decisions and provide better quality care.

The implementation at Southland Hospital is phase two of a pilot programme, supported by Health Workforce New Zealand, which started with Gore District Nurses.

Leading the Way with Linen

Southern DHB is leading the way in providing input into a South Island Alliance (SIA) project on linen and laundry in conjunction with Health Benefits Ltd (HBL).

HBL is a government-owned company that has specifically been set up to help District Health Boards save money by reducing their administrative, support and procurement costs. A working group undertook a review of linen items at Dunedin Hospital recently across a range of categories, to look at opportunities for potential improvements and cost savings.

Charge Nurse Manager, Internal Medicine Ward, Margot Love has been using her ward as a "linen laboratory" and has been trying out new products or processes to improve hospital linen provision for patients, ensuring the linen is fit for purpose, individualised for the patient as well as delivering a saving in health dollars.

"A number of initiatives have been introduced as a result and more are planned to ensure that hospital linen is good quality, comfortable for patients, meets infection control standards and is financially sustainable," said Southern DHB Service Manager, Radiology, and Chair SIA Linen Workstream, Heather Fleming.

These include the introduction of blue polarfleece blankets to replace two other linen lines (air-cell blankets and quilts), gradually reducing the number of linen lines from approximately 105 down to 40 to 50, and standardising bed-making.

"As a result of the above, on the Dunedin site the disposable linen line delivered $60,000 savings by the end of the financial year, as all disposable facecloths have now been phased out and replaced with cloth ones."

Feedback has been really positive from both patients and staff. The standardisation of linen has made staff's job easier and the new linen is more user friendly and comfortable for the patient. "It's a win-win situation with a better system and significant financial savings for the Southern DHB," said Heather. "This is a lovely example of how some small changes can have significantly positive effects, such as patients enjoying better quality linen and the DHB saving money too.

Southern DHB celebrates outstanding immunisation coverage

Southern DHB has celebratied the achievement of the national immunisation health target for the third year in a row. To acknowledge the collaborative effort of the DHB and the primary health sector, Southern DHB presented certificates to general practices and child health organisations across the district.

Southern DHB programme leader of the Vaccine Preventable Disease Team Jillian Boniface said the immunisation programme's success was due to the dedication of all those involved in delivering immunisation services across the district.

"Reaching the target has been a team effort not just on the part of DHB staff, but in conjunction with GPs, practice nurses and child health organisations, who are at the front line, educating families, and promoting the importance of and delivering the vaccinations.

We work with the practices and families to encourage all vaccinations are given on time. This is the best way we can help to prevent the spread of the vaccine-preventable diseases, especially for the small babies and those people who are unable to be vaccinated. The team also supports families who may have delayed immunisations due to mild illnesses, busy lives or trouble getting to the family doctor."

The Southern DHB has already meet the new Ministry target of 85 percent of 8-month olds fully vaccinated for 2012/2013 and achieved the programme goal of 95% in the first year

"We have always had good coverage across all age groups as we have not focused solely on the 2-year-olds target," Mrs Boniface said. "We are already meeting the new target and with further refinement of our processes, we are confident we can achieve the ultimate target of 95 percent coverage for all age groups of children."

New liver diagnostic tool for Southern DHB

Southern DHB clinicians are excited by the improved care the new Fibroscan tool will enable them to offer patients who have, or are suspected of having, liver disease.

Fibroscan enables clinicians to diagnose and monitor liver health without having to resort to invasive procedures such as biopsies. Gastroenterology Clinical Leader Jason Hill explains, “Fibroscan is essentially measuring the stiffness of the liver, which is an indicator of the progression of liver diseases like hepatitis or cirrhosis. However, unlike previous techniques, using Fibroscan is painless, quick and easy. The scan only takes a few minutes, and patients are given the results straight away.” “This is a huge step forward for the quality of care we can offer patients as it will result in a significant reduction in the need to do liver biopsies, which are obviously more uncomfortable and time consuming for patients.”

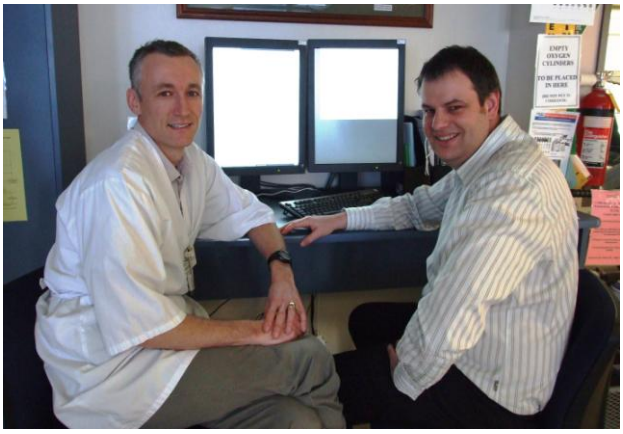
The Fibroscan is likely to reduce the number of liver biopsies by 50-60 percent and may be a more suitable option for a number of people, including those with bleeding disorders and children.

The Fibroscan device will be based in the Department of Gastroenterology at Dunedin Hospital, but is portable, so clinics will be able to be carried out at other Southern DHB sites in the future.

Southern Innovation Challenge Winner

Since winning the DHB’s first ever Southern Innovation Challenge at the end of 2012, Dr Matt Bailey and his colleagues in the ICU and IT Department have been busy putting the $10,000 prize money to good use!

Intensivist Dr Mat Bailey, IS developer Lance Elder and Associate (Charge) Nurse Manager Gordon Speed secured the prize money during the DHB’s ‘Dragon’s Den’ style contest, which asked staff to come forward with innovative and fresh ideas on improving the quality of service that is provided to patients.



Mat’s team won $10,000 to replace the current database software at Dunedin Hospital’s ICU with one that would deliver multiple benefits for ICU patients, particularly in the areas of safety and continuity of care.

Since winning the prize, the team have used the money to progress ahead on several related projects:

Database Upgrade Complete

The ICU database has been upgraded and operational for several months now, and its improved functionality has delivered numerous benefits for the team. The medical and nursing handover component, a new feature of the database, is now operational and is actively supporting staff to achieve effective and thorough handover procedures.

The improved ability to collate and report on patient data is also increasing the capacity for research within the unit and assisting with better monitoring of patients and their outcomes as part of practice review. While staff get to grips with the new technology, further improvements are being planned to the system for the near future which promise to deliver even more benefits for patients and the ICU team. Watch this space!

New Touchscreen Tablets to Support ICU Videoconferencing

The funding has also helped the ICU department to purchase touchscreen mobile tablets for Dunedin and Invercargill Hospital ICUs which will enable fast, effective videoconferencing communications to take place between the staff and patients at each ICU ward. The technology is now in place and the team are planning to commence working with the videoconferencing technology in the near future.

Improving X-Ray Results Communication in ICUs

The funding has also seen the purchasing of new large visual screens which will support staff to be alerted to incoming X-ray results for those staff working on night shifts. These new screens are designed to deliver the software which has been created to ensure that incoming x-ray results are not missed during shift changes/night shifts. The software is completed and the team are currently waiting on the installation of the screens before being able to launch the technology to staff.

Speaking about how the funding has supported the projects Dr Bailey said: “We are pleased to now have the database operational, and to be already seeing the return on our investment in technology across a number of areas. We look forward to being able to work with staff to utilise the other technology projects as they go live.

More At–Risk Kids Getting Health Support

More children in the Southern District are receiving the health and educational support they need thanks to the introduction of the Gateway Assessments initiative.

Gateway Assessments bring together a range of agencies to build a complete picture of what health or educational assistance a child may need, and how that support can be provided. Launched in this district in October, Gateway Assessments co-ordinators based at Southern DHB received 78 referrals in the first two months. Women’s, Children’s and Public Health Nursing Director Jane Wilson explains: “Already Gateway Assessments have resulted in a number of children being referred for further specialist care, such as audiology and oral health they may not have otherwise received.

“Sometimes the children entering Child, Youth and Family care have physical, mental or social health needs that have not been previously identified. We know that as this group of children often move around, they can have health concerns that may have been missed. Gateway Assessments mean we can be sure these children are healthy and receiving the educational support they need to thrive.

Established in the 2011 Budget, the project, which is led by Child, Youth and Family, has been rolled out across the country.

New ED Project Targets Reduction in Hazardous Drinking

A new intervention “Project Ease Up” is being rolled out by Southern DHB through Dunedin and Southland Hospitals, to identify potential hazardous drinking behaviour and support follow-up treatment through primary care.

From 22 July 2013 all patients attending the Dunedin and Southland Emergency Departments (ED) have been asked a single question as part of the standard pre-screening procedure. Women are asked how often they consume more than four standard drinks in one sitting, and for men that figure will be increased to six standard drinks. If a patient answers that they do so on a monthly, weekly or daily basis then they are identified as being at risk of hazardous drinking and informed that they are drinking more than the recommended levels. The patient will be given a leaflet on hazardous drinking with local contact details of where they can seek support and referred to their GP/primary care via the ED discharge letter for follow up.

The Southern PHO and Public Health South will be working together to set up training opportunities for GPs and practice nurses to deliver the screening and brief intervention based on a newly developed ABC (Ask, Brief advice, and Counselling for reduction in alcohol consumption) training package developed by the National Health Promotion Agency.

The intervention is in response to the growing awareness of the role that alcohol plays in the demand for health services, as Southern DHB Public Health Registrar Susan Jack explains: “Alcohol is our favourite recreational drug however its consumption has a major impact on the district’s health services. For example it is causally related to over 60 medical conditions and approximately 1000 deaths a year are attributed to alcohol – both from chronic diseases and also from injuries sustained when under the influence of alcohol.

“Around 25% of people in the district are estimated to be hazardous drinkers, that’s the highest amount for any DHB in New Zealand so it’s a priority for Southern that we try and support a reduction in consumption. This new project will be a real help in assisting clinicians to easily address alcohol-related presentations at ED and improve the identification of hazardous drinkers, whilst also giving patients direct access to services that may support them to reduce their consumption.

Mobile Breast Screening Goes Digital

A new mobile breast screening unit is on the road in Southern DHB rural areas, newly equipped with a digital mammography machine. Women who are over 80km from a fixed breast screening site are offered this service.

The new digital mammography machine, which has replaced an old analogue X-RAY unit, uses state-of-the-art digital technology enabling pictures to be processed within minutes. It has the ability to send pictures back overnight to the radiologists in the main centres of Dunedin Hospital and Southland Hospital to be read and reported the following day.

Digital mammography imaging cuts down screening times and reduces the need to recall women should the pictures need retaking as images are available immediately. With digital, the image can be checked on screen instantly before the woman leaves the unit. If images are not of sufficient quality, or, if a different view is needed, they can be taken again while the woman is still there.

Previously a film had to be processed which took about three days. The films had to be couriered back in cassettes to the main centres for processing and, if there was blurring or other problems with the picture quality the women would have to be called back for a second screening. If this happened, women in rural areas often had difficulty in making the second trip. This also means that the Medical Radiation Technologists are no longer having to work with chemical solutions to process the films.

Older Patients Supported to Leave Hospital Sooner

A new comprehensive health service is to be delivered by Southern DHB which will allow patients over 65 years of age to leave Dunedin Hospital earlier than usual, to receive monitoring, support and rehabilitation in their own homes.

From 1 July 2013, the Early Discharge and Rehabilitation Service for Older People (EDRS) will deliver community-based integrated health services at home to patients who are medically stable but would otherwise have to remain in hospital, or who have high risk of readmission in the immediate future.

The new service will facilitate the safe transition of patients back to their own homes, where they will receive ongoing monitoring and same day visits, as required. For those patients requiring additional support food parcels can be provided for the first 24 hours, as well as safe transport home. The fully integrated service has been made possible through having an interdisciplinary team consisting of a Clinical Nurse Specialist, Registered and Enrolled Nurses, a Social Worker, Occupational Therapists, Physiotherapists, Rehabilitation Assistants and a Clinical Psychologist, working together to support the patients early return home. As well as supporting early discharge, the new integrated service will also ensure ongoing medical and rehabilitation support services are delivered including community rehabilitation, stroke education and falls assessment.

Over the last 18 months the EDRS has been piloted with older patients in medical, orthopaedic wards and the Dunedin Hospital Emergency Department, under the project name "Gibson Community Rehabilitation Service." The service name has been changed to better reflect the new functions included in the comprehensive service.

Following the success of the pilot the service will now be extended to include all Dunedin Hospital wards from 1 July 2013. Talking about the new service Southern DHB's Clinical Nurse Specialist Eileen Richardson commented: "This is a challenging yet exciting time for the team. There is enormous potential to make a real difference in service provision for older people, by providing the opportunity to return home sooner with comprehensive and flexible support tailored to meet their individual needs."

Quality Improvement Strategy targets World-Class Performance

Southern DHB launched a new quality improvement strategy designed to drive organisational performance to world-class levels.

The strategy, which works across all areas of the DHB, brings together internationally proven quality improvement and performance excellence systems whilst being tailored to meet the unique needs of the DHB's staff, providers and patients.

The "Quality Improvement and Performance Excellence Strategy" has a four-fold aim:

- To improve the health of the DHB's population and reduce inequalities (population health)
- To improve the safety and care experience of its patients (experience of care)
- To improve the delivery of care within budget (cost per capita)
- To improve learning opportunities for current and future staff (teaching and learning)

Together these aims set a balanced platform that will guide future decision making and planning, and ensure an aligned strategic focus across the organisation.

The comprehensive strategy incorporates six "Dimensions of Quality"; these are elements of a healthcare system that have been identified as the areas that need to improve in order to deliver "right care, right resource, in right place at right time". They focus on improving work at the clinical interface and include the following elements: patient safety, effectiveness, patient centeredness, timeliness, efficiency and equity.

A framework which is widely used in the New Zealand public and private sector (the Baldrige Framework) will be applied to help staff focus their activities and ensure quality improvement and performance outcomes. It includes project management, problem solving, quality accounting and measurement methodologies that will work together to provide an effective, integrated approach.

A dedicated unit is being established to drive the new strategy through the DHB, including two new Director positions: Director of Performance and Director of Quality. Quality Improvement facilitators will be assigned to take responsibility for delivery of the directorate-specific activities and workstream leaders will lead key projects across the five directorates.

The strategy is being rolled out across the organisation to introduce staff to the methodologies and tools that will support them to improve their quality and performance measures, and the first area to be focused on will be patient safety.

The new strategy is part of the DHB's ongoing commitment to achieving its "Southern Way" vision of becoming a high performing, unified organisation which places patients at the centre of every decision it makes, and provides financially and clinically sustainable services to the community it serves.

"The roll-out of this strategy marks an exciting time for staff and patients of the DHB, as it gives us a clear road map for how we can continue to improve the quality and performance of the service we provide for all our communities, whilst ensuring that we continue to be deliver a sustainable service," commented Carole Heatly, CEO Southern DHB.

BOARD MEMBERS

Joe Butterfield, MNZM, FCA, FInstD, CMILT

Chairman

Joe Butterfield is a chartered accountant who has spent his working life as a partner/director of the accounting firm Footes Ltd Chartered Accountants (and its predecessors) to which he is now a consultant.

Joe, who is from Timaru, has a strong interest in health and welfare matters. He was Chairman of South Canterbury District Health Board (SCDHB) from 2000-2009, until he stood down after his term had expired. He was a member of Health South Canterbury (the predecessor to SCDHB) and served as its Chairman from 1996 until 2000. He has also served on the Ministry of Health National Capital Committee and District Health Boards New Zealand.

As well as roles in health and finance, Joe has extensive experience in the transport and agricultural sector and has held directorships in companies including Intercity Holdings Ltd and its subsidiaries, Ritchie's Transport Holdings, the Port of Timaru and the South Canterbury Regional Development Board. Joe is also a Fellow of the NZ Institute of Directors and a Chartered Member of the Institute of Logistics and Transport.

Paul Menzies, LLB

Deputy Chairman (Southland Constituency)

Paul Menzies is a Winton-based lawyer who has been a partner at Menzies Forrest Marshall Solicitors from 1983 until 2012 and is now a consultant to that firm.

Paul, an elected member of the Board since 2001, was appointed as Chair of Southland DHB on 10 March 2009, and Deputy Chair of Southern DHB on 10 December 2010 following the merger of Otago and Southland DHBs.

He has served on a number of public and private sector boards and committees over the years. Positions include previous Chair of the Southland Hospital Advisory Committee (HAC) from 2001-2010, Otago DHB HAC member from 2001-2007 and current Chair of the Southern DHB HAC. Paul is a past President of the Southland Law Society and was appointed Chairman of Rugby Southland in 2011. He is also a trustee on the Southern PHO Board.

Neville Cook, MBA

Elected Member (Southland Constituency)

Neville Cook was a member of the NZ Police for 36 years, retiring as District Commander of the Southland District in 1999. He practiced as a financial advisor for three years and later as a public event organiser until 2004 when he took over management of the Readings Cinema Complex in Invercargill. He has a Master's degree in Business Administration (1998).

Neville was originally appointed to the Southland DHB Board in 1998 as a community representative. He was reappointed by the Minister of Health for a further term, but later successfully stood for election. He has also served as Chair of the DHB's Disability Support Advisory Committee, then was made a member of the joint Community and Public Health and Disability Support Advisory Committees, has served on the Hospital Advisory and Audit and Risk Committees and has been Deputy Chair of Southland DHB.

Neville was District Governor for Rotary in 2000 for the Southern area and has been actively involved with DARE and Victim Support organisations since their inception in the 1980s. Neville is currently a member of the Invercargill Licensing Trust, the Invercargill Licensing Trust Foundation and a Councillor for Environment Southland.

Sandra Cook LLB

Appointed Member

Sandra Cook is Otautau based and is affiliated to the Iwi of Ngāi Tahu. She is currently employed as Principal Advisor for the Office of the CEO of Te Rūnanga o Ngāi Tahu. Sandra, who holds a Bachelor of Laws (LLB) has been actively involved with Ngāi Tahu and Māori affairs since 1995. Her roles have included providing legal and policy advice on the protection of the customary rights of Ngāi Tahu as the co-manager of the Settlement Implementation Unit (which later became the Legal and Risk Services Unit) Whānui within the Ngāi Tahu organisation. She also was employed as an external consultant to a variety of clients such as Government Departments, Te Rūnanga o Ngāi Tahu, other Iwi organisations and private commercial companies.

Sandra has significant local health governance experience, including having served as a Director for the Takitimu Primary Health Organisation (PHO), as a member and then Chairperson of the Murihiku PHO Māori Governance Group and was a ministerial appointment on the Primary Health Organisation Community Council.

Kaye Crowther QSO

Elected Member (Southland Constituency)

Kaye is a Retirement and Agency Services and Trust Account Manager for Crowe Horwath, formerly WHK Southern, Invercargill, with over 40 years' experience in Estate, Trust and Financial Services together with 35 years' experience in the health and social sectors. Kaye has been an elected member of the Southland DHB Board since 2007 and was re-elected to the Southern DHB Board in 2010. She is also a member of Southern DHB's Community and Public Health and Disability Support Advisory Committees and Iwi Governance Committee and has also served on the Hospital Advisory Committee, and Complaints Review and Sentinel Events committees.

Kaye is a past New Zealand President and Board member of the Royal NZ Plunket Society (Inc) (1996-2007), council member of Water Safety New Zealand and was a member of the Ministry of Health National Breast Feeding Advisory Committee.

Kaye is a Trustee for Number 10 Youth One Stop Shop, President of Invercargill South Rotary Club and a member of National Council of Women. Kaye was awarded the Queens Service Order (QSO) for services to Children and the Community in 2008.

Mary Flannery, LLB

Elected Member (Otago Constituency)

Mary Flannery is an Alexandra-based lawyer who has been an Associate for Bodkins Alexandra since 2004. She and her husband Wes also run a sheep and cattle farm in the Ida Valley, Central Otago.

Mary has been involved in health services at a governance level in Central Otago for the past 12 years. She has been a trustee of the Rural Otago Primary Health Organisation and Immediate Past Chairperson of Central Otago Health Incorporated, the sole shareholder of the company that runs Dunstan Hospital. This is Mary's first term as an elected Board member of Southern DHB.

As well as health, Mary has governance experience in the community and educational sectors, as a former member of the Vincent Community Board (an amalgamation of the Earnscleugh-Manuherikia and Alexandra Community Boards) for nine years and as Chairperson of the Poolburn School Board of Trustees.

Malcolm Macpherson, BSc, Post Grad Dip Sci, PhD

Elected Member (Otago Constituency)

Malcolm Macpherson has spent more than twenty years working on community health issues as a trust member, district councillor, and former mayor of Central Otago District Council (2001-2010). He spent a period as Communications Officer for Healthcare Otago.

Malcolm served three terms on the Otago District Health Board and then Southern DHB (his fourth term). He has also been a member of the Otago Hospital Advisory Committee, Rural Consultative Subcommittee and chaired the Central Otago Rural Health Advisory Group. He has served on the Otago/Southland combined Disability Support Advisory Committee and now chairs Southern DHB's combined Community and Public Health and Disability Support Advisory Committees

Malcolm has extensive governance and managerial experience in the education and business sectors, including membership of the Otago Polytechnic Council, Central Lakes Trust (owner of Pioneer Generation), and the Otago Community Hospice board. He is a shareholder of Medco Properties Ltd (owners of the Alexandra Medical Centre) and director of Centennial Health Ltd. He is president of Central Stories Museum and Art Gallery, Chairman of the Jolendale Park Charitable Trust and a member of the Roxburgh Gorge Trail Charitable Trust.

Tahu Potiki

Appointed Member

Tahu Potiki is Otago based and is affiliated to the Iwi of Kai Tahu and Kati Mamoe. He has spent many years working in Māori development and was the CEO of Te Rūnanga o Ngāi Tahu for six years. In this role he was responsible for the overall strategic leadership of the tribe's corporate operations. Tahu also has a background in Māori Health and worked as a qualified social worker for many years.

Tahu has served on four South Island District Health Boards (DHBs), including as a Ministerial appointment on both the Otago and Southland DHBs, before being appointed to the Southern DHB Board. He has also been a member of Southland and Otago DHBs' Hospital Advisory and Audit Finance and Risk Committees and is a member of Iwi Governance Committee (IGC).

Tahu is a Board member of the Māori Television Service, New Zealand Council for Educational Research, Relationship Services NZ and Environmental Science and Research. He is also the Ōtākou representative to Te Rūnanga o Ngāi Tahu.

Branko Sijnja, MBChB, Dip Obst, FRNZCGP, FNZMA, PGDipRPHP

Elected Member (Otago Constituency)

Dr Branko Sijnja has worked in rural hospitals and has been a General Practitioner in Balclutha for over 30 years. He practices part-time at Balclutha General Practitioners Ltd and is a Director of the Otago University's Rural Medical Immersion Programme, training medical students to work in rural New Zealand.

This is Branko's third term on the DHB Board, the first two with Otago DHB and then Southern DHB following the merger. He has been a member of the Otago DHB's Community and Public Health Advisory Committee in 2005, 2008 and since June 2010 has been a member of the Southern DHB Hospital Advisory Committee.

Branko has a long involvement in the reform and delivery of health services (primary and secondary) at a local and national level. He is a Board member of the Clutha Community Health Company Ltd, Clutha Health Incorporated (which owns Balclutha's Hospital Clutha Health First). He has also served on various Ministry of Health Steering Committees and Reference Groups.

Richard Thomson BA (hons), MA, and Dip.Clin. Psych

Elected Member (Otago Constituency)

Richard is a Dunedin-based businessman who owns and runs the Acquisitions national chain of retail stores. Prior to this he was a lecturer in psychological medicine at the Dunedin School of Medicine, Otago University. He has also worked in private practice as a clinical psychologist.

Richard has been an elected member of the Otago DHB, now Southern DHB, for the past 11 years. He spent seven of these as Chair of the Otago DHB and has chaired most Board committees, including the Otago DHB Community and Public Health, Disability Support and Hospital Advisory Committees. Richard is also an elected member of the Dunedin City Council, a trustee of the Healthcare Otago Charitable Trust and is Chairperson of the Hawksbury Community Living Trust.

Richard is a strong advocate for health issues. He played a key role, alongside the Southland DHB Chair, in the progressive coming together of the Otago and Southland DHBs.

Tim Ward, B Com, C A (PP)

Appointed Member

Tim Ward has been a partner (Business Advisory and Tax) at Chartered Accountancy Firm BDO New Zealand Ltd since 1987 and has both private and public sector governance experience.

Tim was appointed to the Southland DHB Board by the Minister of Health in September 2009 and was then appointed to the Southern DHB Board in December 2010. He has been a member of the DHB's Hospital Advisory and Audit, Finance and Risk Committees since 2009. Tim was also Chairman of the Spicer and Oppenheim National Partnership for a three year term that concluded at the time of the merger to form BDO. He has also been a member of BDO's National Management Board until he retired from this position in April 2008.

Other positions include membership of the Institute of Chartered Accountants, the role of Proprietor's Appointee to the Verdon College Board of Trustees since 1991 and membership of the Southern Institute of Technology's Business Consultative Group. Tim was a Minister's appointee to the council of Southern Institute of Technology (SIT) in April 2010 and stood down from membership of the advisory group at the time of that appointment.

Board and Committee attendances

Board Meeting Attendance Register

	5-Jul	2-Aug	6-Sep	4-Oct	8-Nov	13-Dec	8-Feb	7-Mar	11-Apr	2-May	6-Jun
Joe Butterfield (Chair)	A	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Paul Menzies (Deputy Chair)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Neville Cook	✔	✔	✔	✔	✔	A	✔	✔	✔	✔	✔
Sandra Cook	A	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Kaye Crowther	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Mary Flannery	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Malcolm Macpherson	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Tahu Potiki	✔	✔	A	✔	✔	A	✔	✔	A	Ab	✔
Branko Sijnja	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Richard Thomson	✔	✔	✔	✔	✔	A	✔	✔	A	✔ VC	✔
Tim Ward	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Key:

✔	Present
A	Apology
Ab	Absent
✔ VC	Present via videoconference

Hospital Advisory Committee Attendance Register

	4-Jul	1-Aug	5-Sep	3-Oct	7-Nov	7-Feb	6-Mar	10-Apr	1-May	5-Jun
Paul Menzies (Chair)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Neville Cook	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Malcolm Macpherson	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Tahu Potiki	✔	✔	✔	A	✔	A	✔	A	Ab	A
Branko Sijnja	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Richard Thomson	✔	✔	✔	✔	✔	✔	A	A	✔ VC	✔
Tim Ward	✔	✔	✔	✔	A	✔	✔	✔	✔	✔

Key:

✔	Present
A	Apology
✔ VC	Present via videoconference
Ab	Absent

Audit & Risk Committee Attendance Register

	18-Jul	2-Aug	14-Aug	5-Sep	4-Oct	8-Nov	13-Dec	7-Mar	2-May	6-Jun
Tim Ward (Chair)	✔	✔	TC	✔	✔	✔	✔	✔	✔	✔
Joe Butterfield	✔	✔	TC	✔	✔	✔	✔	✔	✔	✔
Mary Flannery	✔	✔	TC	✔	✔	✔	✔	✔	✔	✔
Paul Menzies	✔	✔	TC	✔	✔	✔	✔	✔	✔	✔

Key:

✔	Present
TC	Teleconference

Disability Support Advisory Committee and Community & Public Health Advisory Committee Meeting Attendance Register

	1-Aug	3-Oct	12-Dec	7-Feb	1-May	5-Jun
Malcolm Macpherson (Chair)	✔	✔	✔	✔	✔	✔
Neville Cook	✔	✔	✔	✔	✔	✔
Sandra Cook	A	✔	✔	✔	✔	✔
Kaye Crowther	✔	✔	✔	✔	✔	✔
Mary Flannery	✔	✔	✔	✔	✔	✔

Key:

✔	Present
A	Apology

Iwi Governance Committee Attendance Register

	4-Jul	1-Aug	5-Sep	3-Oct	7-Nov	12-Dec	7-Feb	6-Mar	1-May
Sandra Cook	A	A	✔	✔	✔	✔	✔	✔	✔
Kaye Crowther	✔	✔	✔	✔	✔	✔	✔	✔	✔
Paul Menzies	✔	✔	✔	✔	✔	✔	✔	✔	✔
Tahu Potiki	✔	✔	✔	A	Ab	✔	A	Ab	Ab

Key:

✔	Present
A	Apology
Ab	Absent

Clinical Advisory Committee Attendance Register

	1-Aug	
Branko Sijnja (Chair)	✔	Committee disbanded in November 2012

Key:

✔	Present
A	Apology

THE SOUTHERN DHB

Southern DHB is responsible for the planning, funding and provision of publicly funded health care services to an estimated population of 308,410 people throughout the Southern DHB catchment area.

The statutory (New Zealand Public Health & Disability Act 2000 - NZPHD Act 2000) purpose of Southern DHB is to:

- Improve, promote and protect the health of its population
- Promote the integration of health services across primary and secondary care services
- To reduce health outcome disparities
- Manage national strategies and implementation plans
- Develop and implement strategies for the specific health needs of the local population.

Southern DHB encompasses the Territorial Local Authorities (TLAs) of the Central Otago District Council, the Clutha District Council, the Dunedin City Council, the Invercargill City Council (ICC), the Southland District Council (SDC), the Gore District Council (GDC), the Queenstown Lakes District Council (QLDC) and the Waitaki District Council.

The population profile shows that 60% of the population lives in Dunedin and Invercargill. Our population is projected to increase gradually (5.3% over 15 years) but there are two important trends that will impact on future health needs and services.

a) There is going to be a big rise in the number of people over the age of 65 years, and especially 80 years plus. However there is going to be a decrease in children and youth and working age adults.

b) There is wide variation in projected population changes across the district; Dunedin, Queenstown, and Central Otago having a growing population, and Invercargill, Waitaki, Gore, and Balclutha have negative growth projections.

The Board

The Board provides governance to overall Southern DHB operations. Southern DHB's Board consists of seven elected members (four from the Otago constituency and three from the Southland constituency) and three members appointed by the Minister of Health. The Minister appoints the Board Chair and Deputy Chair.

The Board has three committees who play an advisory and monitory role and are established under the NZPHD Act 2000:

- Community and Public Health Advisory Committee (CPHAC)
- Disability Support Advisory Committee (DSAC)
- Hospital Advisory Committee (HAC)

In addition the Board has established four committees that advise on delegated portfolios:

- Audit, and Risk (A&R) Committee
- Iwi Governance Committee
- Appointments and Remuneration Advisory Committee
- Clinical Advisory Committee (CAC) – disestablished November 2012

Southern DHB consists of three distinct arms, each charged with specific functions and accountability.

Governance Arm

The Governance Arm is responsible for the development of policy and strategy. In addition, this Arm is accountable for ensuring that the needs of the population are identified and services are prioritised accordingly. Through the Delegation of Authority, policy matters pertaining to operational management are designated to the Chief Executive Officer (CEO), who in turn is supported by an Executive Management Team (EMT).

Provider Arm

The Provider Arm of Southern DHB provides, secondary, community, disability, and mental health care services to the Southern region and tertiary services to the Southern region and New Zealand

The DHB operates the following hospitals:

- Dunedin Hospital
- Lakes District Hospital (Queenstown / Frankton)
- Southland Hospital (Invercargill)
- Wakari Hospital (Dunedin).

The services provided by these hospitals include:

- Acute services

  Acute services are for illnesses that have an abrupt onset. It is usually of short duration, rapidly progressive, and in need of urgent care

- Emergency Services

  Emergency Departments are operated at Dunedin Hospital and Southland Hospital which have the main admitting specialties available to provide definitive care for most patients who require admission.

- Elective Services

  Elective services (booked surgery) are for patients who do not require immediate hospital treatment.

  Our DHB is committed to meeting the government's expectations around elective services, particularly the key principles underlying the electives system:

  clarity – where patients know whether or not they will receive publicly funded services

  timeliness – where services can be delivered within the available capacity, patients receive them in a timely manner; and

  fairness – ensuring that the resources available are directed to those most in need.

- Non admitted Services

  Generally known as outpatient services, the DHB provides a wide range of specialties to ensure patient referrals are managed within appropriate timeframes and contribute to the outcome that people with early conditions are treated and managed earlier with illness progression reduced.

Funder Arm

The Funder Arm of the DHB has the following functions:

- Manage the strategic planning and funding of services including undertaking health needs assessment
- Manage a funding budget by prioritising and allocating funding within National, South Island and local purchasing and pricing frameworks
- Monitoring provider compliance to quality and performance standards and contract requirements
- Relationship and contract management of providers

Partnership with Iwi – Tuhono ki te Iwi

Tena koutou e ka rangatira o tena marae o tena marae, mauria mai ou kete matauraka, he whangai ki te iwi, nau mai whakatau mai, tena tatou katoa.

The NZPHD Act 2000 outlines the responsibilities Southern DHB has in honouring the principles of the Treaty of Waitangi. The DHB acknowledges the special relationship between Iwi and the Crown and as a Crown agent recognises it has responsibility to assist the Crown in fulfilling its obligations under the Treaty of Waitangi. Relationships between Murihiku and Araiteuru Rūnaka and Southern DHB were further strengthened through the Principles of Relationship.

In June 2011, the Principles of Relationship document was signed by Southern DHB's Board Chairman and Ka Rūnaka leaders which has assisted in advancing the focus and growth of Maori health across the district. The overall purpose of this agreement is to ensure all parties work together in good faith to safeguard and improve health outcomes for Māori in Otago and Southland, as well as promoting the mutual interests of all parties in achieving this goal.

As an organisation, Southern DHB commits to adhere to the principles and objectives outlined in the Māori Health Strategy – He Korowai Oranga and the Māori Health Action Plan – Whakatātaka. These documents provide a high level national perspective that assist to deliver to the Southern DHB Māori Health Plan 2013/14, focused on improving the health status of Māori in the district.

Mauri ora ki a tatou katoa

VISION & MISSION

The Southern DHB Vision and Values

Vision

"Better Health, Better Lives, Whanau Ora"

Mission

"Working in partnership with people and communities to achieve their optimum health and wellbeing, and seeking excellence through a culture of learning, inquiry, service and caring"

Southern Way

Patients are at the centre of everything we do

Create a high performing organisation with a focus on quality

Become a single unified DHB

Provide financially and clinically sustainable services to the community we serve

STATEMENT OF RESPONSIBILITY

FOR THE TWELVE MONTHS ENDED 30 JUNE 2013

The Board and management of Southern DHB accept responsibility for the preparation of the financial statements and the statement of service performance and the judgements used in them.

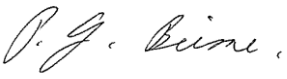
The Board and management of Southern DHB accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting. In the opinion of the Board and management of Southern DHB, the financial statements for the year which ended on 30 June 2013, fairly reflect the financial position and operations of Southern DHB.

Joe Butterfield
Chairman
Date: 31 October 2013

Paul Menzies
Deputy Chairman
Date: 31 October 2013

Carole Heatly
Chief Executive Officer
Date: 31 October 2013

Peter Beirne
Executive Director Finance
Date: 31 October 2013



GOVERNANCE AND ACCOUNTABILITY STATEMENT

Role of the Board

The Board's governance responsibilities include:

- Communicating with Ministers and stakeholders to ensure their views are reflected in Southern DHB's planning
- Delegating responsibility for the achievement of specific objectives to the Chief Executive Officer (CEO)
- Monitoring the organisation's progress towards achieving objectives
- Reporting to stakeholders on plans and progress made towards fulfilling those plans; and
- Maintaining effective systems of internal control

Structure and Philosophy of Southern DHB

Board Membership

The Board is made up of elected and appointed members. All Board members are required to act in the best interests of the District Health Board. Members acknowledge that the Board must stand unified behind its decisions and individual members have no separate governing role outside the boardroom.

Operations

The Board has appointed a single employee, the CEO, to manage overall operations. All other employees have been appointed by the CEO. The Board directs the CEO by delegating responsibility and authority for the achievement of objectives through setting policy.

Division of Responsibility between the Board and Management

Key to the efficient running of Southern DHB is having a clear division between the roles of the Board and management. The Board concentrates on setting policy, approving strategy, and monitoring progress towards meeting objectives. Management implements policy and strategy. The Board has clearly distinguished these roles by ensuring the delegation of responsibility and authority to the CEO is concise and complete.

Connection with Stakeholders

The Board acknowledges its responsibility for keeping in touch with stakeholders and acknowledges the expectations of the Minister of Health and Associate Ministers of Health.

Board Committees

The Board has several standing committees to focus in detail on particular issues. Each committee has been delegated governance responsibility to advise the Board on policies and monitor the DHB's progress towards meeting its objectives. Committees do not get involved in day-to-day operational matters. The Board and its standing committees (including the statutory, permanent advisory committees) are:

Committee	Meets
Southern DHB Board	Monthly
Audit and Risk Committee	Bi-Monthly
Community and Public Health Advisory Committee	Bi-Monthly
Disability Support Advisory Committee	Bi-Monthly
Hospital Advisory Committee	Monthly
Iwi Governance Committee	Monthly

Performance Excellence and Quality Improvement

During the past year southern DHB has made important gains in relation to quality activities. The Southern Way programme has focused the activities of the DHB as we have sought to ensure that we:

- Put patients at the centre of everything we do;
- Create a high performing organisation with a focus on quality;
- Become a single unified DHB; and
- Provide clinically and financially sustainable services to the community we serve.

The Southern Way helped to implement a process of change which helped improve the quality of our services while reducing cost.

A pivotal aspect of the change and quality improvement has been the development and implementation of the Performance Excellence and Quality Improvement Strategy.

The strategic plan recognises that we aim to do better with the provision of healthcare in our district, and sets out a strategy to not only improve but for the Southern DHB to excel. It identifies four components to an effective strategy:

1. The Fourfold Aim – a set of four goals based on the Institute for Healthcare Improvement triple aim but includes the additional goal which recognises the critical importance on constant teaching and learning in any healthcare organisation, as well as our regional and national role as provider of high quality healthcare education, research and scholarship.
2. A set of six dimensions of quality, taken from Crossing the Quality Chasm, which was first published in 2001, focuses our quality and patient safety activities.
3. A set of performance excellence criteria, based on the Baldrige Performance Excellence structure.
4. A proven approach to quality improvement, project and programme management, performance management and measurement, and reporting to our community.

These four components taken together give us a goal, a set of criteria against which to measure quality, an operational structure to link these into the management and performance of the organisation, and a way to achieve that performance.

A number of successful quality activities were undertaken over the 2012/13 period. The Certification Audit was carried out in February with the excellent outcome of being re-certified for 3 years. Southern DHB also participated in a trial of the new DHB certification audit process, the information from the trial informing the new way certification is carried out across other DHBs.

Patient Safety has been a key focus with the roll out of the national programme on patient safety. The programme includes surgical site infection prevention, falls prevention, Central Line Associated Bacteraemia and hand hygiene. Patient safety boards were implemented as a way of making the programme transparent to our patients/clients and staff, and formed the basis of measurement and reporting 'from the bedside to the Board'.

Risk Management

The Board acknowledges it is ultimately responsible for the management of risks to Southern DHB. The Board has charged the CEO through its risk management policy with establishing and operating a risk management programme in line with the "Guidelines for Managing Risk in the Australian and New Zealand Public Sector SAA/NZSHB 143:1999."

Southern DHB's risk management programme aims to identify issues and manage risks within the DHB's financial and clinical constraints. Southern DHB has adopted effective strategies for handling risk to protect patients, families, staff and the organisation to the best of its ability.

Risk management mainly involves the quality of management and operational systems, clarification of individual roles and responsibilities and providing a healthy, safe and secure environment for patients, families and staff.

The risk management programme involves:

- a risk management team, which advises managers and the overall organisation about the development of risk management strategies and links into other health providers
- core policies, procedures and guidelines, including identifying staff's training needs
- ensuring guidelines and practices identify risks and manage them in a timely manner
- identifying the implications of amended and new laws to ensure compliance

Accountability

The Board holds monthly meetings to monitor progress towards its strategic objectives and ensure Southern DHB is operating in line with its policies.

Conflicts of Interest

The Board has an Interests Register and ensures Board members are aware of their obligations to declare any potential conflicts of interest. The Executive Management Team also has an Interests Register.

Internal Audit

While many of the Board's functions have been delegated, the overall responsibility for maintaining effective systems of internal control ultimately rests with the Board. Internal controls include the policies, systems and procedures set up to ensure the Board's specific objectives are achieved. The Board and management acknowledged their responsibility by signing the Statement of Responsibility.

Southern DHB has an internal audit function which monitors its systems of internal control and the quality and reliability of financial and other information reported to the Board. Internal Audit is independent of management and reports its findings to the Audit and Risk Committee. Internal Audit liaises closely with the external auditors, who review systems of internal control to the extent necessary for its audit.

Legislative Compliance

The Board acknowledges its responsibility to ensure the organisation complies with all laws. The Board has delegated responsibility to the CEO for a programme to systematically identify compliance issues and to ensure staff are aware of the relevant legal requirements.

Human Resources Employment Relations/Good Employer Objectives

The DHB's human resources (staff) are its most valuable asset.

Workforce development and strong organisation health are central to our DHB to ensure that we provide high quality effective services and meet the continued challenges of the health needs of our community.

Southern DHB is committed to developing a workforce profile and understanding the needs and expectations of its workforce. We are committed to promoting leadership opportunities and a positive culture for our organisation.

Southern DHB remains fully supportive of collaborative workforce activity through Health Workforce New Zealand. Southern DHB will also be progressing a number of local initiatives based on the potential to add value, while recognising that investment in workforce development is inherently medium to longer term.

Under the Crown Entities Act 2004, the DHB has to report whether it is meeting its Good Employers objectives. Southern DHB has several policies which relate to the "Good Employer" Framework promoted by the Human Rights Commission. The following table demonstrates policy coverage under this framework

Framework Area	DHB Policy and Activity
Leadership, Accountability and Culture.	Southern DHB has a clinical governance framework to ensure appropriate engagement for management and clinical staff pertaining to quality and safety of services. The DHB's Executive Management Team promotes the organisation's visions and values and encourages staff involvement in decision making which affects them, through formal change management protocols.
Recruitment, Selection and Induction.	A suite of Equal Employment Opportunity policies are complemented by an orientation programme for new staff.
Employee Development, Promotion and Exit.	The DHB has annual performance and development reviews for staff. Considerable funds are committed to staff education and development each year. The DHB promotes quality and innovation through workforce development, which includes having annual awards and scholarships.
Flexibility and Work Design.	The DHB has numerous part-time staff, some "job-shared" roles and tries to be flexible about staff's on-site and off-site commitments. The DHB employs around 4,500 staff (around 3,600 Full Time Equivalents during the year).
Remuneration, Recognition and Conditions.	Southern DHB's Human Resources aims to contribute to the development of an organisation which shares common values and ensures staff are recognised and valued in ways meaningful to them, because that is key to recruiting and retaining a highly skilled workforce.
Harassment and Bullying Prevention.	Southern DHB has adopted a zero tolerance stance towards harassment and bullying, supported by appropriate policies which include a Code of Conduct and Integrity policy.
Safe and Healthy Environment.	Dedicated Health and Safety staff take a proactive approach, through an accredited Accident Compensation Corporation partnership programme. A strong culture of workplace safety and consultation networks continues, including elected health and safety representatives on committees throughout the DHB. Southern DHB has strong and proactive management of health and safety issues. Southern DHB continually seeks to improve its ability to understand, measure and prevent incidents. The organisation also has an independent contracted employee assistance programme supported by staff mentors and advisors if needed.

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2013

	Note	2013 Actual $000	2013 Budget $000	2012 Actual $000
Revenue	2	839,075	839,414	820,425
Other operating income	3	8,419	7,574	14,011
Interest income		2,211	2,220	2,176
Total income		**849,705**	**849,208**	**836,612**
Employee benefit costs	5	323,413	322,734	316,439
Depreciation and amortisation expense	7,8	14,122	15,038	20,087
Outsourced services		19,013	18,330	21,441
Clinical supplies		73,253	73,004	71,123
Infrastructure and non-clinical expenses		41,795	42,695	42,908
Other district health boards		34,981	34,884	34,942
Payments to non-health board providers		336,886	336,241	325,765
Other operating expenses	4	2,944	2,366	3,019
Interest expense		5,330	5,036	4,966
Capital charge	6	9,602	9,858	9,110
Total expenses		**861,339**	**860,186**	**849,800**
Share of surplus /(deficit) in associates	10 c	(255)	-	(49)
Surplus/(deficit) for the year	13	**(11,889)**	**(10,978)**	**(13,237)**
Other Comprehensive income				
Gains on property revaluations	13	-	-	-
Total other comprehensive income/ (expense)		-	-	-
Total Comprehensive income/ (expense)	21	**(11,889)**	**(10,978)**	**(13,237)**

Explanation of major variances against budget are provided in note 21

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2013

	Note	2013 Actual $000	2013 Budget $000	2012 Actual $000
Equity at beginning of the year		**124,481**	**124,479**	**116,925**
Total Comprehensive income/ (expense)		(11,889)	(10,978)	(13,237)
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	13	16,943	22,467	20,793
Other equity movements	13	(847)	-	-
Equity at end of the year		**128,688**	**135,968**	**124,481**

Accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2013

	Note	2013 Actual $000	2013 Budget $000	2012 Actual $000
Assets				
Property, plant and equipment	7	286,566	297,509	277,518
Intangible assets	8	8,663	15,246	4,402
Investments in associates	10 d	-	328	277
Total non-current assets		**295,229**	**313,083**	**282,197**
Inventories held for distribution	9	4,817	4,265	4,265
Trade and other receivables	11	23,026	23,929	21,534
Cash and cash equivalents	12	27,242	24,056	39,772
Total current assets		**55,085**	**52,250**	**65,571**
Total assets		**350,314**	**365,333**	**347,768**
Equity				
Crown equity	13	70,546	76,070	53,603
Property revaluation reserves	13	84,515	85,362	85,362
Accumulated surpluses/ (deficits)	13	(26,373)	(25,464)	(14,484)
Total equity		**128,688**	**135,968**	**124,481**
Liabilities				
Interest-bearing loans and borrowings	14	93,959	75,056	76,401
Employee benefits	15	15,469	16,095	16,095
Total non-current liabilities		**109,428**	**91,151**	**92,496**
Interest-bearing loans and borrowings	14	11,749	28,853	29,453
Trade and other payables	16	43,560	47,742	47,446
Employee benefits	15	56,889	61,619	53,892
Total current liabilities		**112,198**	**138,214**	**130,791**
Total liabilities		**221,626**	**229,365**	**223,287**
Total equity and liabilities		**350,314**	**365,333**	**347,768**

Accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS

For the year ended 30 June 2013

	Note	2013 Actual $000	2013 Budget $000	2012 Actual $000
Cash flows from operating activities				
Cash receipts from Ministry of Health and patients		845,375	844,854	835,295
Cash paid to suppliers		(512,957)	(507,679)	(498,297)
Cash paid to employees		(320,724)	(316,823)	(311,649)
Cash generated from operations		**11,694**	**20,352**	**25,349**
Interest received		2,211	2,220	2,176
Interest paid		(5,330)	(5,112)	(5,032)
Net taxes refunded/ (paid) (goods and services tax)		(2,649)	2,672	745
Capital charge paid		(4,870)	(7,128)	(9,906)
Net cash flows from operating activities	12	**1,056**	**13,004**	**13,332**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		102	-	50
Acquisition of property, plant and equipment		(28,104)	(48,320)	(34,616)
Net cash movement in investments		22	-	-
Net cash flows from investing activities		**(27,980)**	**(48,320)**	**(34,566)**
Cash flows from financing activities				
Proceeds from equity injection		16,943	22,464	20,793
Drawdown (Repayment) of borrowings		(2,549)	(2,865)	2,919
Net cash flows from financing activities		**14,394**	**19,599**	**23,712**
Net increase in cash and cash equivalents		(12,530)	(15,717)	2,478
Cash and cash equivalents at beginning of year		39,772	39,773	37,294
Cash and cash equivalents at end of year	12	**27,242**	**24,056**	**39,772**

Accompanying notes form part of these financial statements

STATEMENT OF CONTINGENCIES AND COMMITMENTS

Schedule of Contingencies

As at 30 June 2013

Contingent Liabilities	2013 Actual $000	2012 Actual $000
Legal proceedings against Southern DHB	-	20
Personal grievances	-	-
	-	**20**

Southern DHB has not been notified of any claims.

Contingent Assets	2013 Actual $000	2012 Actual $000
Legal proceedings by Southern DHB	-	-
	-	**-**

Southern DHB currently has no claims pending

Schedule of Commitments

As at 30 June 2013

	2013 Actual $000	2012 Actual $000
Capital Commitments	**15,603**	**15,516**

	2013 Actual $000	2012 Actual $000
Non-cancellable commitments - operating lease commitments		
Not more than one year	1,101	1,220
One to two years	838	560
Two to three years	588	289
Three to four years	164	166
Four to five years	37	107
Over five years	47	75
	2,775	**2,417**

Accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1 Statement of accounting policies for the year ended 30 June 2013

Reporting Entity

Southern District Health Board (Southern DHB) is a Health Board established by the New Zealand Public Health and Disabilities Act 2000. Southern DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Southern DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

Southern DHB is a public benefit entity, as defined under NZ IAS 1.

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

The financial statements for the DHB are for the year ended 30 June 2013, and were approved by the Board on 31 October 2013.

Basis of Preparation

Statement of Compliance

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

Functional and presentation currency

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand.

Measurement base

The assets and liabilities of the Otago and Southland DHBs were transferred to the Southern DHB at their carrying values which represent their fair values as at 30 April 2010. This was deemed to be the appropriate value as the Southern District Health Board continues to deliver the services of the Otago and Southland District Health Boards with no significant curtailment or restructure of activities. The value on recognition of those assets and liabilities has been treated as capital contribution from the Crown.

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value, financial instruments classified as available-for-sale, land and buildings and investment property, and certain borrowings.

Non-current assets held for sale are stated at the lower of carrying amount and fair value less costs to sell.

The preparation of financial statements in conformity with NZ IFRS 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.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted.

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

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

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

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

Critical accounting estimates and assumptions

Management discussed with the Audit Committee the development, selection and disclosure of Southern DHB's critical accounting policies and estimates and the application of these policies and estimates.

Critical accounting judgements in applying the Southern DHB's accounting policies

In preparing these financial statements Southern DHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results.

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations or future events that are believed to be reasonable under the circumstances.

During the year the DHB reviewed the estimate of the useful lives for Clinical and IT Assets. A large number of Assets had their lives amended, based on the estimate of remaining life. The result of this review was a reduction in Depreciation for the year of $3.4 million for Clinical Assets and $2.1 million for IT Assets.

Significant Accounting Policies

Associates

Associates are those entities in which Southern DHB has significant influence, but not control, over the financial and operating policies.

The financial statements include Southern DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When Southern DHB's share of losses exceeds its interest in an associate, Southern DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Southern DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Foreign Currency Transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of comprehensive income. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget Figures

The budget figures are derived from the statement of intent as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

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 fixture and fittings
- computer equipment
- vehicles
- library books

Owned assets

Except for land and buildings, 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.

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive income. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of comprehensive income.

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

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.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of comprehensive income is calculated as the difference between the net sales price and the carrying amount of the asset.

Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions

The cost of an item of property, plant and equipment is recognised as an asset if, and only if, it is probable that future economic benefits or service potential associated with the item will flow to Southern DHB and the cost of the item measured reliably.

In most instances, an item of property, plant and equipment is recognised at its cost. Where an asset is acquired at no cost, or for nominal cost, it is recognised at fair value as at date of acquisition.

Leased assets

Leases where Southern DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

Subsequent costs

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 Southern DHB. All other costs are recognised in the statement of comprehensive income as an expense as incurred.

Depreciation

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	15 to 80 years	1.25-6.67%
Plant and Equipment	5 to 15 years	6.67-20%
Computer Equipment	3 to 10 years	10-33%
Motor Vehicles	5 years	20%
Library Books	2 to 10 years	10-50%

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

The residual value of assets is reassessed annually, and adjusted if applicable, at each financial year-end.

Intangible assets

Intangible assets that are acquired by Southern DHB are stated at cost less accumulated amortisation and impairment losses. Intangible assets with finite lives are subsequently recorded at cost less any amortisation.

Amortisation

Amortisation is charged to the statement of comprehensive income 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:

Type of asset	Estimated life	Amortisation rate
Software	3 to 10 years	10-33%

Investments

Investments in debt and equity securities

Financial instruments held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the statement of comprehensive income.

Other financial instruments held by Southern DHB are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the statement of comprehensive income. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the statement of comprehensive income.

Financial instruments classified as held for trading or available-for-sale investments are recognised / derecognised by Southern DHB on the date it commits to purchase / sell the investments.

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.

Inventories

Inventories are stated at the lower of cost, on a first in first out basis and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost.

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 Southern DHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Impairment

The carrying amounts of Southern DHB's assets other than investment property, inventories and inventories held for distribution 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 comprehensive income.

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

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of comprehensive income.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. 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.

For non-cash generating assets that are not part of a cash generating unit, value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a discount rate that reflects current market rates and the risks specific to the asset.

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

Reversals of impairment

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

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of comprehensive income.

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

Interest-bearing and Interest-free borrowings

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

Employee Benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

Long service leave, sabbatical leave and retirement gratuities

Southern DHB's net obligation in respect of long service 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 obligation is calculated by AON New Zealand Ltd, using accepted actuarial principles and complies with all requirements of NZ IAS. The discount rates adopted are in accordance with NZ IAS 19.

Annual leave, conference leave, sick leave and medical education leave

Annual leave, conference leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount Southern DHB expects to pay. Southern DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Provisions

A provision is recognised when Southern DHB has a present legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring

A provision for restructuring is recognised when Southern DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits to be derived by Southern DHB from a contract are lower than the unavoidable cost of meeting its obligations under the contract.

Trade and other payables

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

Insurance

ACC Partnership Programme

Southern DHB belongs to the ACC Partnership Programme whereby Southern DHB accepts the management and financial responsibility of work related illnesses and accidents of employees. Under the ACC Partnership Programme Southern DHB is effectively providing accident insurance to employees and this is accounted for as an insurance contract. The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to the balance sheet date for which Southern DHB has responsibility under the terms of the Partnership Programme.

The liability for claims reported prior to balance date has been determined by assuming that the future experience for each current claim is consistent with historical claim information since the commencement of the programme. The liability for injuries or illnesses that have occurred up to balance date, but not yet reported or not enough reported, has been determined by reference to historical information of the time it takes to report injury or illness.

The value of the liability is measured at the present value of the future payments for which Southern DHB has responsibility using a risk free discount rate. The value of the liability includes a risk margin that represents the inherent uncertainty of the present value of the expected future payments.

Revenue relating to service contracts

Southern DHB 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 Southern DHB, 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.

Income tax

Southern DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

MOH revenue

The DHB is primarily funded through revenue received from the MoH, which is restricted in its use for the purpose of the DHB meeting its objectives.

Revenue from the MoH is recognised as revenue when earned.

ACC contract revenue

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

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Southern DHB region is domiciled outside of Southern. The MoH credits Southern DHB with a monthly amount based on estimated patient treatment for non- Southern residents within Southern. An annual washup occurs at year end to reflect the actual number of non- Southern patients treated at Southern DHB.

Interest income

Interest income is recognised using the effective interest method.

Rental income

Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of services

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

Donations and bequests

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of comprehensive income on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of comprehensive income over the lease term as an integral part of the total lease expense.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Net financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, interest received and receivable on funds invested calculated using the effective interest rate method, dividend income and gains and losses on hedging instruments that are recognised in the statement of comprehensive income.

The interest expense component of finance lease payments is recognised in the statement of comprehensive income using the effective interest rate method.

Non-current assets held for sale

Immediately before classification as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZIFRS. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in the statement of comprehensive income, even when the asset was previously revalued. The same applies to gains and losses on subsequent re-measurement.

Custodial/Trust and Bequest Funds

Donations and bequests to Southern DHB are recognised as revenue when control over assets is obtained. A liability, rather than revenue, is recognised where fulfilment of any restrictions attached to those assets is not probable. Those donations and bequests with restrictive conditions are appropriated from retained earnings to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds it is recognised in the statement of comprehensive income and an equivalent amount is transferred from the trust funds component of equity to retained earnings.

Financial Instruments

Southern DHB is party to financial instruments as part of its normal operations. Financial instruments are contracts which give rise to assets and liabilities or equity instruments in another equity. These financial instruments include bank accounts, short-term deposits, investments, interest rate swaps, debtors, creditors and loans. All financial instruments are recognised in the balance sheet and all revenues and expenses in relation to financial instruments are recognised in the statement of comprehensive income. Except for those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

Cost of Service Statements

The cost of service statements, as reported in the statement of objectives and service performance, reports the net cost of services for the outputs of Southern DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost Allocation

Southern DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information.

Criteria for Direct and Indirect Costs

“Direct costs” are those costs directly attributable to an output class. “Indirect costs” are those costs which cannot be identified in an economically feasible manner with a specific output class. Indirect costs are therefore charged to output classes in accordance with prescribed Hospital Costing Standards based upon cost drivers and related activity/usage information.

2 Revenue

	2013 Actual $000	2012 Actual $000
Health and disability services (MOH contracted revenue)	801,490	779,411
ACC contract	8,932	8,679
Inter district patient flows	19,363	23,312
Other revenue	9,290	9,023
	839,075	**820,425**

Revenue for health services includes all revenue received from the Crown (via the Ministry of Health), Accident Rehabilitation and Compensation Insurance Corporation (ACC), and other sources.

3 Other operating income

	2013 Actual $000	2012 Actual $000
Gain on sale of property, plant and equipment	52	45
Donations and bequests received	466	1,171
Rental income	1,814	1,845
Other	6,087	10,950
	8,419	**14,011**

4 Other operating expenses

	Note	2013 Actual $000	2012 Actual $000
Impairment of trade receivables (doubtful debts)		144	269
Bad debts written off		30	72
Loss on disposal of property, plant and equipment		49	21
Audit fees (for the audit of financial statements)		166	162
Audit related fees (for assurance and related services)		-	-
Fees paid to other auditors for assurance and related services including internal audit		79	47
Board member fees	19	341	328
Operating lease expenses		2,133	2,117
Koha		2	3
		2,944	**3,019**

5 Employee benefit costs

	2013 Actual $000	2012 Actual $000
Wages and salaries	320,416	312,828
Increase/ (decrease) in employee benefit provisions	2,997	3,611
	323,413	**316,439**

6 Capital charge

Southern DHB pays capital charge to the Crown twice yearly. This is based on closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the period ended 30 June 2013 was 8 per cent. The amount charged during the period was $9.60 million (2012: $9.11 million).

7 Property, plant and equipment

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant and equipment	Vehicles	Library books	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 2011	25,231	201,839	132,279	714	-	8,304	**368,367**
Additions	-	522	7,420	10	-	30,528	**38,480**
Disposals	-	(6)	(7,933)	(55)	-	-	**(7,994)**
Transfers	-	10,040	7,473	23	-	(17,963)	**(427)**
Revaluations & impairment	-	-	-	-	-	-	**-**
Balance at 30 June 2012	**25,231**	**212,395**	**139,239**	**692**	**-**	**20,869**	**398,426**
Balance at 1 July 2012	25,231	212,395	139,239	692	-	20,869	**398,426**
Additions	-	4,151	11,227	30	32	14,214	**29,654**
Disposals	(73)	-	(10,143)	(22)	-	-	**(10,238)**
Transfers	-	18,228	6,800	784	-	(28,885)	**(3,073)**
Revaluations & impairment	-	(904)	-	-	-	-	**(904)**
Balance at 30 June 2013	**25,158**	**233,870**	**147,123**	**1,484**	**32**	**6,198**	**413,865**
Depreciation and impairment losses							
Balance at 1 July 2011	-	8,033	102,106	268	-	-	**110,407**
Depreciation charge for the year	-	7,176	11,246	47	-	-	**18,469**
Impairment losses	-	-	-	-	-	-	**-**
Reversal of impairment losses	-	-	-	-	-	-	**-**
Disposals	-	(6)	(7,916)	(46)	-		**(7,968)**
Transfers	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Balance at 30 June 2012	**-**	**15,203**	**105,436**	**269**	**-**	**-**	**120,908**
Balance at 1 July 2012	-	15,203	105,436	269	-	-	**120,908**
Depreciation charge for the year	-	7,615	5,429	144	1	-	**13,189**
Impairment losses	-	-	-	-	-	-	**-**
Reversal of impairment losses	-	-	-	-	-	-	**-**
Disposals	-	-	(6,674)	(22)	-		**(6,696)**
Transfers	-	-	-	-	-	-	**-**
Revaluations	-	(102)	-	-	-	-	**(102)**
Balance at 30 June 2013	**-**	**22,716**	**104,191**	**391**	**1**	**-**	**127,299**
Carrying amounts							
At 1 July 2011	25,231	193,806	30,173	446	-	8,304	**257,960**
At 30 June 2012	**25,231**	**197,192**	**33,803**	**423**	**-**	**20,869**	**277,518**
At 1 July 2012	25,231	197,192	33,803	423	-	20,869	277,518
At 30 June 2013	**25,158**	**211,154**	**42,932**	**1,093**	**31**	**6,198**	**286,566**

The net carrying amount of assets held under finance leases is $3.73 million (2012 $2.83 million) for plant and equipment

7 Property, plant and equipment (continued)

Impairment

There were no impairment losses recognised in the 2013 year

Revaluation

Current Crown accounting policies require all Crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with Treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings of the former Otago and Southland District Health Boards was carried out as at 30 April 2010 by Tony Chapman, an independent registered valuer with Chapman Consultancy and a member of the New Zealand Institute of Valuers. That valuation conformed to International Valuation Standards and was based on an optimised depreciation replacement cost methodology. The valuer was contracted as an independent valuer. The land and buildings were transferred to Southern DHB at these values.

Restrictions

Some of the land owned by Southern DHB is subject to Waitangi Tribunal claims. In addition, the disposal of certain properties may be subject to the Ngai Tahu Claims Settlement Act 1998, and/or the provision of section 40 of the Public Works Act 1981.

8 Intangible assets

	Software
Cost	**$000**
Balance at 1 July 2011	12,876
Additions	528
Disposals	-
Balance at 30 June 2012	**13,404**
Balance at 1 July 2012	13,404
Additions	5,318
Disposals	(124)
Balance at 30 June 2013	**18,598**
Amortisation and impairment losses	
Balance at 1 July 2011	7,384
Amortisation charge for the year	1,618
Impairment losses	-
Reversal of impairment losses	-
Disposals	-
Balance at 30 June 2012	**9,002**
Balance at 1 July 2013	9,002
Amortisation charge for the year	933
Impairment losses	-
Reversal of impairment losses	-
Disposals	-
Balance at 30 June 2013	**9,935**
Carrying amounts	
At 1 July 2011	5,492
At 30 June 2012	**4,402**
At 1 July 2012	4,402
At 30 June 2013	**8,663**

Impairment

There were no impairment losses recognised in the 2013 year

9 Inventories held for distribution

	2013 Actual $000	2012 Actual $000
Pharmaceuticals	1,128	1,587
Surgical & Medical supplies	3,689	2,678
	4,817	**4,265**

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2013 was $4.817 million (2012 $4.265 million).

The write-down of inventories held for distribution amounted to $0 for 2013, while reversals of write-downs were $0 for 2013 (2012: $0 and $0). No inventories are pledged as security for liabilities but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

10 Investments in associates

Southern DHB has the following investments in associates:

a) General information

Name of entity	Principal activities	Interest held at 30 June 2013	Balance Date
South Island Shared Service Agency Limited	South Island Shared Service Agency Limited is a non operating company	30%	30 June

SISSAL is no longer operating and will be held as a non-operating company. The functions of SISSAL are being conducted by South Island DHB's under an agency arrangement.

b) Summary of financial information on associate entities (100%)

2013 Actual ($000)	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
South Island Shared Service Agency Limited	-	-	-	1	(850)
	-	-	-	1	(850)

2012 Actual ($000)	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
South Island Shared Service Agency Limited	944	20	924	1,035	(163)
	944	20	924	1,035	(163)

c) Share of profit of associate entities

	2013 Actual $000	2012 Actual $000
Share of surplus/ (deficit) before tax	(255)	(49)
Less: tax expense		
Share of surplus/ (deficit) after tax	**(255)**	**(49)**

10 Investments in associates (continued)

d) Investment in associate entities

	2013 Actual $000	2012 Actual $000
Carrying amount at beginning of year	277	326
Acquisition of new investments	-	-
Disposal of investments	(22)	-
Share of total recognised revenue and expenses	(255)	(49)
Dividends	-	-
Other movements	-	-
	-	**277**

e) Share of associates' contingent liabilities and commitments

	2013 Actual $000	2012 Actual $000
Contingent liabilities	-	-
Contracted capital commitments	-	-
Other contracted commitments	-	-

11 Trade and other receivables

	2013 Actual $000	2012 Actual $000
Trade receivables from non-related parties	3,089	3,589
Ministry of Health receivables	2,591	912
Accrued income	15,707	15,540
Prepayments	1,639	1,493
	23,026	**21,534**

Trade receivables are shown net of provision for doubtful debts amounting to $1.84 million arising from identified debts unlikely to be recovered (2012: $1.70 million).

12 Cash and cash equivalents

	2013 Actual $000	2012 Actual $000
Bank balances	-	9,706
Call deposits	-	30,053
Cash and cash equivalents	15	13
Demand Funds with HBL	27,227	-
Cash and cash equivalents in the statement of cash flows	**27,242**	**39,772**

Working capital facility

At 30 June 2013, the Southern DHB held no bank overdraft facilities.

Southern DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Southern DHB that equates to $36.18 million.

12 Cash and cash equivalents (continued)

Reconciliation of (deficit)/ surplus for the year with net cash flows from operating activities

	Note	2013 Actual $000	2012 Actual $000
(Deficit) / surplus for the period		(11,889)	(13,237)
Add back non-cash items:			
Depreciation and assets written off		14,122	20,087
Share of (surplus) / deficit after tax from associate companies	10 c	255	49
Other non cash items			
Increase/ (decrease) in fair value		88	623
Increase/ (decrease) in provision for doubtful debts		144	269
Add back items classified as investing activity:			
Net loss/ (gain) on disposal of property, plant and equipment		(3)	(24)
Movements in working capital:			
(Increase)/ decrease in trade and other receivables		(1,636)	7,042
(Increase)/ decrease in inventories		(552)	340
Increase/ (decrease) in trade and other payables		(1,775)	(6,825)
Increase/ (decrease) in employee benefits		2,302	5,008
Net movement in working capital		**(1,661)**	**5,565**
Net cash inflow/ (outflow) from operating activities		**1,056**	**13,332**

13 Capital and reserves

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2011	32,810	85,362	(1,247)	116,925
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	21,500	-	-	21,500
Equity repayment to the crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	-	-	-
Transfers from revaluation of land and buildings on impairment	-	-	-	-
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Deficit for the period	-	-	(13,237)	(13,237)
Balance at 30 June 2012	**53,603**	**85,362**	**(14,484)**	**124,481**
Balance at 1 July 2012	53,603	85,362	(14,484)	124,481
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	17,650	-	-	17,650
Equity repayment to the crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	-	-	-
Transfers from revaluation of land and buildings on impairment	-	(802)	-	(802)
Transfers from revaluation of land and buildings on disposal	-	(45)	-	(45)
Deficit for the period	-	-	(11,889)	(11,889)
Balance at 30 June 2013	**70,546**	**84,515**	**(26,373)**	**128,688**

In 2012 the accounting treatment for Research, Trust, and Custodial Funds was revised. Prior to this these funds were recorded as liabilities. From 2012 onwards these funds were recorded as revenue and those with conditions attached were ring fenced within retained earnings.

13 Capital and reserves (continued)

Equity is made up of	2013 Actual $000	2012 Actual $000
Equity	123,603	119,631
Restricted Equity	5,085	4,850
Total Equity	**128,688**	**124,481**

14 Interest-bearing loans and borrowings

	2013 Actual $000	2012 Actual $000
Non-current		
Secured loans	90,765	74,295
Unsecured loans	249	437
Finance lease liabilities	2,945	1,669
	93,959	**76,401**
Current		
Current portion of secured loans	10,600	27,599
Current portion of finance lease liabilities	943	1,408
Current portion of unsecured loans	206	446
	11,749	**29,453**

Secured loans

Southern DHB has secured Crown loans with the Ministry of Health.

The details of terms and conditions are as follows:

Interest rate summary	2013 Actual	2012 Actual
Crown loans - fixed interest	2.61% to 6.55%	3.88% to 6.96%

Repayable as follows:	2013 Actual $000	2012 Actual $000
Within one year	10,806	28,046
One to two years	12,976	10,806
Two to three years	16,720	6,976
Three to four years	625	16,720
Four to five years	16,600	625
Later than five years	44,954	40,554

Term loan facility limits	2013 Actual $000	2012 Actual $000
Crown loans	97,400	97,400
Term loan facility	-	-

15 Interest-bearing loan and borrowings (continued)

Security and terms

The Crown Loans are secured by a negative pledge. Southern DHB cannot perform the following actions without the Ministry of Health's prior written consent;

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any of its assets except disposals at full value in the ordinary course of business.

From November 2007 all covenants in application over the Crown loans were waived. However the Ministry of Health retains the right to reinstate the covenants at any time.

Finance lease liabilities

Finance lease liabilities are payable as follows:

	Minimum lease payments 2013 Actual $000	Interest 2013 Actual $000	Principal 2013 Actual $000	Minimum lease payments 2012 Actual $000	Interest 2012 Actual $000	Principal 2012 Actual $000
Less than one year	1,270	313	957	1,618	159	1,459
Between one and five years	2,512	621	1,891	1,775	177	1,598
More than five years	1,384	376	1,008	-	-	
	5,166	**1,310**	**3,856**	**3,393**	**336**	**3,057**

Under the terms of the lease agreements, no contingent rents are payable.

15 Employee benefits

	2013 Actual $000	2012 Actual $000
Non-current liabilities		
Liability for long-service leave	3,085	3,376
Liability for sabbatical leave	1,237	1,232
Liability for retirement gratuities	11,147	11,487
	15,469	**16,095**
Current liabilities		
Liability for long-service leave	3,302	3,183
Liability for sabbatical leave	137	132
Liability for retirement gratuities	2,341	2,154
Liability for annual leave	32,150	30,418
Liability for sick leave	221	250
Liability for continuing medical education	6,018	5,913
Salary and wages accrual	12,720	11,842
	56,889	**53,892**

16 Trade and other payables

	2013 Actual $000	2012 Actual $000
Trade payables due to associates	-	-
Trade payables to non-related parties	3,872	5,053
GST payable	4,192	6,842
Income in advance relating to contracts with specific performance obligations	892	1,614
Capital charge due to the Crown	4,731	-
Other non-trade payables and accrued expenses	29,873	33,937
	43,560	**47,446**

17 Operating leases

Leases as lessee	2013 Actual $000	2012 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1,101	1,220
Between one and five years	1,627	1,122
More than five years	47	75
	2,775	**2,417**

During the year ended 30 June 2013, $2.133 million was recognised as an expense in the statement of comprehensive income in respect of operating leases (2012: $2.117 million).

18 Financial instruments

Exposure to credit, interest rate and currency risks arise in the normal course of Southern DHB's operations.

Credit risk

Financial instruments, which potentially subject the health board to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The health board places its cash and short-term deposits with high-quality financial institutions and the health board has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 34.5 per cent). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

	2013		2012	
Trade receivables	Gross Receivable $000	Impairment $000	Gross Receivable $000	Impairment $000
Not past due	4,531		2,741	
Past due 0-30 days	618	(5)	931	
Past due 31-120 days	328	(16)	788	(117)
Past due 121-360 days	418	(232)	496	(382)
Past due more than 1 year	1,624	(1,586)	1,240	(1,196)
Total	**7,519**	**(1,839)**	**6,196**	**(1,695)**

18 Financial instruments (continued)

In summary, trade receivables are determined to be impaired as follows:

Trade receivables	2013 Actual $000	2012 Actual $000
Gross trade receivables	7,519	6,196
Individual impairment	(1,839)	(1,695)
Collective impairment	-	-
Net total trade receivables	**5,680**	**4,501**

At the balance sheet date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset, including derivative financial instruments, in the statement of financial position.

Liquidity risk

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

The following table sets out the contractual cash flows for all financial liabilities and for derivatives that are settled on a gross cash flow basis.

2013	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured loans	101,365	122,677	2,552	12,552	16,926	42,281	48,366
Unsecured loans	455	477	143	63	126	145	-
Finance lease liabilities	3,888	5,165	723	547	916	1,595	1,384
Trade and other payables	43,560	43,560	43,560	-	-	-	-
Total	**149,268**	**171,879**	**46,978**	**13,162**	**17,968**	**44,021**	**49,750**
Inflow	-	-	-	-	-	-	-
Outflow	149,268	171,879	46,978	13,162	17,968	44,021	49,750

2012	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured loans	101,894	123,176	12,889	19,670	14,259	32,103	44,255
Unsecured loans	883	923	223	223	206	271	-
Finance lease liabilities	3,077	3,393	933	685	801	974	-
Trade and other payables	47,446	47,446	47,446	-	-	-	-
Total	**153,300**	**174,938**	**61,491**	**20,578**	**15,266**	**33,348**	**44,255**
Inflow	-	-	-	-	-	-	-
Outflow	153,300	174,938	61,491	20,578	15,266	33,348	44,255

Interest rate risk

Interest rate risk is the risk that the fair value of a financial instrument will fluctuate or, the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

Southern DHB adopts a policy of ensuring that interest rate exposure will be managed by an appropriate mix of fixed rate and floating rate debt.

18 Financial instruments (continued)

Effective interest rates and repricing analysis

In respect of income-earning financial assets and interest-bearing financial liabilities, the following table indicates their effective interest rates at the balance sheet date and the periods in which they reprice.

	2013 Actual						
	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and Cash Equivalents	2.50%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office *	0.00%	4,804	300	300	600	1,800	1,804
Crown loans *	4.28%	10,000	-	10,000	-	-	-
Crown loans *	2.61%	6,000	-	-	6,000	-	-
Crown loans *	6.55%	6,250	-	-	6,250	-	-
Crown loans *	2.94%	6,000	-	-	-	6,000	-
Crown loans *	4.75%	10,000	-	-	-	10,000	-
Crown loans *	5.75%	6,000	-	-	-	6,000	-
Crown loans *	6.42%	10,000	-	-	-	10,000	-
Crown loans *	3.37%	5,000	-	-	-	-	5,000
Crown loans *	3.44%	10,000	-	-	-	-	10,000
Crown loans *	4.34%	4,500	-	-	-	-	4,500
Crown loans *	4.40%	1,250	-	-	-	-	1,250
Crown loans *	4.40%	5,400	-	-	-	-	5,400
Crown loans *	5.06%	10,000	-	-	-	-	10,000
Crown loans *	5.22%	7,000	-	-	-	-	7,000
Finance lease liabilities*	3.46%-11.41%	3,857	557	401	677	1,214	1,008
Unsecured Bank Loans	0.00%	477	143	63	126	145	-

* These assets/ liabilities bear interest at fixed rates

18 Financial instruments (continued)

Effective interest rates and repricing analysis

	2012 Actual						
	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and Cash Equivalents	2.50%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office *	0.00%	5,404	300	300	600	1,800	2,404
Crown loans *	3.88%	5,000	5,000	-	-	-	-
Crown loans *	4.90%	5,000	5,000	-	-	-	-
Crown loans *	6.96%	5,000	-	5,000	-	-	-
Crown loans *	6.11%	12,000	-	12,000	-	-	-
Crown loans *	4.28%	10,000	-	-	10,000	-	-
Crown loans *	5.75%	6,000	-	-	-	6,000	-
Crown loans *	6.55%	6,250	-	-	-	6,250	-
Crown loans *	4.75%	10,000	-	-	-	10,000	-
Crown loans *	4.40%	1,250	-	-	-	-	1,250
Crown loans *	4.34%	4,500	-	-	-	-	4,500
Crown loans *	4.40%	5,400	-	-	-	-	5,400
Crown loans *	5.22%	7,000	-	-	-	-	7,000
Crown loans *	5.06%	10,000	-	-	-	-	10,000
Crown loans *	6.42%	10,000	-	-	-	-	10,000
Finance lease liabilities*	3.34%-8.93%	3,057	844	616	709	888	-
Unsecured Bank Loans	0.00%	923	223	223	206	271	-

* These assets/ liabilities bear interest at fixed rates

Foreign currency risk

Foreign exchange risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates.

Southern DHB is exposed to foreign currency risk on sales, purchases that are denominated in a currency other than NZD. The currencies giving rise to this risk are primarily United States and Australian Dollars.

Capital management

Southern DHB's capital is its equity, which comprises Crown equity, reserves, and retained earnings. Equity is represented by net assets. Southern DHB manages its revenues, expenses, assets, liabilities and general financial dealings prudently in compliance with the budgetary processes.

Southern DHB's policy and objectives of managing the equity is to ensure Southern DHB effectively achieves its goals and objectives, whilst maintaining a strong capital base. Southern DHB policies in respect of capital management are reviewed regularly by the governing Board.

There have been no material changes in Southern DHB's management of capital during the period.

Sensitivity analysis

In managing interest rate and currency risks Southern DHB aims to reduce the impact of short-term fluctuations on Southern DHB's earnings. Over the longer-term, however, permanent changes in foreign exchange and interest rates would have an impact on earnings.

At 30 June 2013, it is estimated that a general change of one percentage point in interest rates would increase or decrease Southern DHB's operating result by approximately $1.013 million (2012: $1.005 million).

18 Financial instruments (continued)

Classification and fair values

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

	Note	Held for trading $000	Designated at fair value through profit & loss $000	Loans and receivables $000	Available for sale $000	Other amortised cost $000	Carrying amount Actual $000	Fair value Actual $000
2013								
Trade and other receivables	11	-	-	23,026	-	-	23,026	23,026
Cash and cash equivalents	12	-	-	27,242	-	-	27,242	27,242
Secured loans	14	-	-	101,365	-	-	101,365	104,560
Finance lease liabilities	14	-	-	3,888	-	-	3,888	4,249
Unsecured liabilities	14	-	-	455	-	-	455	455
Trade and other payables	16	-	-	43,560	-	-	43,560	43,560
2012								
Trade and other receivables	11	-	-	21,534	-	-	21,534	21,534
Cash and cash equivalents	12	-	-	39,772	-	-	39,772	39,772
Secured loans	14	-	-	101,894	-	-	101,894	110,126
Finance lease liabilities	14	-	-	3,077	-	-	3,077	3,117
Unsecured liabilities	14	-	-	883	-	-	883	883
Trade and other payables	16	-	-	47,446	-	-	47,446	47,446

Estimation of fair values analysis

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

Interest-bearing loans and borrowings

Fair value is calculated based on discounted expected future principal and interest cash flows.

Finance lease liabilities

The fair value is estimated as the present value of future cash flows, discounted at market interest rates for homogenous lease agreements. The estimated fair values reflect change in interest rates.

Trade and other receivables/payables

For receivables / payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables / payables are discounted to determine the fair value.

Interest rates used for determining fair value

The entity uses the government yield curve as of 30 June 2013 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2013 Actual %	2012 Actual %
Finance Leases	5.49%	6.08%
Loans and borrowings	2.55% - 5.14%	2.42% - 4.27%

19 Related parties

Ownership

Southern DHB is a crown entity in terms of the Crown Entities Act 2004 and is owned by the Crown.

Identity of related parties

Southern DHB has a related party relationship with its subsidiaries, associates, joint venture and with its board members, directors and executive officers.

Board members' authorised remuneration, either paid or accrued, during the period was:

	Board Members Fees	
	2013 Actual $000	**2012 Actual $000**
Joe Butterfield	53	51
Neville Cook	29	28
Sandra Cook	26	22
Kaye Crowther QSO	27	26
Mary Flannery	29	28
Malcolm Macpherson	30	29
Paul Menzies	37	35
Tahu Potiki	26	26
Branko Sijnja	27	27
Richard Thomson	27	27
Tim Ward	30	29
	341	**328**

The remuneration paid relates solely to Board members' role on the Board and various statutory committees.

Key management team remuneration

The executive management remuneration is as follows:	**2013 Actual $000**	**2012 Actual $000**
Salary and short-term benefits	2,427	2,714
Superannuation	31	23
	2,458	**2,737**

The compensations above excludes amounts paid to board members as these are separately shown

The FTE associated with executive personnel was 9.5 (2012: 10.24). The information above represents the remuneration and FTE of the people on the executive management team for the period they were on the team.

Employee Termination Payments

Ten employees received remuneration in respect of the termination or personal grievance relating to their employment with Southern DHB. The total payments were $236,007 (2012: 9 employees totalling $290,351).

2013 $000	**2012 $000**
64	137
40	48
35	33
32	17
20	16
16	15
13	15
13	9
3	2
2	-

19 Related parties (continued)

Employee Remuneration

The number of employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2013 were:

Total Remuneration and Other Benefits $000	Number of Employees	
	2013	2012
100 - 110	92	80
110 - 120	51	62
120 - 130	51	41
130 - 140	31	18
140 - 150	29	31
150 - 160	17	12
160 - 170	17	22
170 - 180	13	15
180 - 190	21	14
190 - 200	14	11
200 - 210	12	11
210 - 220	16	9
220 - 230	11	16
230 - 240	17	15
240 - 250	12	7
250 - 260	8	11
260 - 270	13	8
270 - 280	5	8
280 - 290	7	9
290 - 300	13	9
300 - 310	10	5
310 - 320	5	7
320 - 330	3	3
330 - 340	8	5
340 - 350	3	4
350 - 360	3	2
360 - 370	3	2
370 - 380	1	2
380 - 390	3	1
390 - 400	2	1
410 - 420	-	2
420 - 430	1	-
430 - 440	1	1
450 - 460	1	-
500 - 510	1	-
510 - 520	1	-
530 - 540	-	1
550 - 560	-	1
650 - 660	-	1

Of the 496 employees shown above, 376 were medical/dental employees (2012: 345 employees were medical/dental). If the remuneration of part-time employees was grossed-up to a Full Time Equivalent (FTE) basis, the total number with FTE salaries of $100,000 or more would be 692, compared with the actual total number of 496 (2012: 639 and 447).

The Chief Executive's remuneration and other benefits, either paid or accrued are in the band $430-$440.

19 Related parties (continued)

Transactions with Board Members and Key Management Personnel

	2013				2012			
Board and Exec Members	Purchased by Southern DHB $000	Purchased from Southern DHB $000	Owed by Southern DHB $000	Owed to Southern DHB $000	Purchased by Southern DHB $000	Purchased from Southern DHB $000	Owed by Southern DHB $000	Owed to Southern DHB $000
Richard Bunton								
Mainland Cardiothoracic Associates (D)	1,253	-	-	-	1,441	-	-	-
Royal Australasian College of Surgeons (C)	4	-	-	-	6	-	-	-
Joe Butterfield								
Corstorphine Baptist Community Trust (F)	1,755	-	-	-	1,965	-	-	-
Polson Higgs (F)	-	-	-	-	3	-	-	-
Neville Cook								
Environment Southland	1	-	-	-	0		-	
Invercargill Licencing Trust (B)	3	5	-	-		30	-	-
Sandra Cook								
Te Runanga o Ngai Tahu (Representative)	0	-	-	-	0	-	-	-
Kaye Crowther								
Royal New Zealand Plunket Society Southland (C)	89		(2)	-	131	3	-	2
Number 10, Youth One Stop Shop (T)	75	-	-	-	-	-	-	-
Mary Flannery								
Bodkins/ AWS Legal, Alexandra (E)	0	0	-	-	1	-	-	-
Sharon Kletchko								
Southern Cancer Network (A)	-	203	-	167		Not Employed 2012		
Nelson Marlborough DHB (E)	894	1,344	28	70		Not Employed 2012		
Malcolm Macpherson								
ACC (F)	1,617	10,369	-	898	2,038	9,915	-	667
Centennial Health (F)	27	-	-	-	29	-	-	-
Otago Community Hospice (T)	2,553	5	-	-	2,632	3	-	0
Otago Polytechnic (B)	43	237	0	51	73	196	-	19
Lynda McCutcheon								
University of Otago (A)	9,933	3,374	254	172		Interest Commenced 2013		
Paul Menzies								
Southern Primary Health Organisation (T)	53,971	145	2	21	58,989	190	1	60
Number 10, Youth One Stop Shop (F)	75	-	-	-		Interest Commenced 2013		
Tahu Potiki								
Arai Te Uru Whare Hauora Ltd (D)	569	-	-	-	640	-	-	-
Environment Science and Research (B)	22	-	2	-	8	-	1	-
Te Runanga o Ngai Tahu (Representative)	0	-	-	-	0	-	-	-
Leanne Samuel								
Southern Institute of Technology (B)	8	11	0	4	11	234	2	-

19 Related parties (continued)

	2013				2012			
	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB
Board and Exec Members								
Branko Sijnja								
Balclutha General Practitioners Limited (E)	2	-	-	-	38	-	-	-
Clutha Health First (B)	5,654	398	1	46	6,234	409	2	35
Southern Community Laboratories (D)	915	1,303	-	177	827	1,156	-	90
University of Otago (Rural Immersion Programme) (D)	9,933	3,374	254	172	11,966	3,105	66	225
Richard Thomson								
Dunedin City Council (Co)	585	-	-	-	714	-	-	-
Hawksbury Community Living Trust (C & T)	-	1	-	-	-	-	-	-
Healthcare Otago Charitable Trust (T)	102	-	-	-	35	-	-	-
Tim Ward								
Southern Community Laboratories (D)	915	1,303	-	177	827	1,156	-	90
Southern Institute of Technology (B)	8	11	0	4	11	234	2	-

C = Chairperson; DC = Deputy Chairperson; B = Board members; CEO = Chief Executive Officer; E = Employee; A = Associated with organisation; S = Shareholder; D = Director; Co = Councillor; F = Family member or spouse; T = Trustee

20 Mental Health Ringfence

The Mental Health blueprint is a model that proposes levels of funding required for effective Mental Health Services. Within the context of the blueprint model the Mental Health ringfence policy is designed to ensure that funding allocated for Mental Health is expended in full for mental health services. The Mental Health ringfence is calculated by taking the expenditure base in the previous year, adding specific 'blueprint' funding allocations and adding a share of demographic funding growth plus a share of any inflationary growth funding. Any underspend resulting in a surplus within the service must be reinvested in subsequent periods.

During the 2011/12 year there was a change in the ring-fence calculation to include community dispensed anti-psychotic drugs, and primary mental health initiatives. Also, the mental health specific demographic rate is now used in calculating the demographic component of the ring-fence, rather than the District Health Boards' (DHBs) average demographic rate.

The year ended 30 June 2013 has resulted in a deficit of $1.0 million for Mental Health services. Additionally Southern DHB has a brought forward over spend of $1.3 million (adjusted for primary mental health initiatives revenue of $1.5m in 2011/12), meaning that the carry forward overspend is $2.3 million.

21 Explanation of financial variances from budget

The unfavourable variance in comprehensive income against budget for the year ended 30 June 2013 was $0.9m.

At a high level the following contributed the overall variance (unfavourable variances shown as negatives)

- $2.4m of Management Admin Salaries due to budget contingencies not utilised
- $1.5m of Mental Health expenditure not incurred due to unfilled FTE positions
- $1.4m impact of employee actuarial valuation of employee entitlements
- $0.9m of additional revenue, most of which has costs associated with it including Electives incentive revenue, Health Workforce NZ and ACC revenue
- $0.9m of lower clinical and IT depreciation charges
- $0.5m of impact from research account revenues and expenditures
- ($0.3m) of unfavourable palliative care expenditure
- ($0.5m) of unfavourable patient travel and accommodation expenses
- ($0.6m) of unfavourable Microsoft licensing costs
- ($0.8m) of unfavourable laboratory testing costs
- ($1.0m) of unfavourable implants & prosthesis expenditure
- ($1.1m) of nursing salary cost variation
- ($1.3m) of unfavourable community pharmaceuticals expenditure
- ($1.3m) of unfavourable home support cost.
- ($1.6m) of Outsourced Clinical Services costs

22 Events after the balance date

There were no significant events after the balance date.

STATEMENT OF SERVICE PERFORMANCE

1. Improving Health Outcomes for Our Population

What are we trying to achieve?

DHBs are responsible for supplying health and disability services to meet the needs of their populations. This section presents an overview of how we are succeeding in improving the health and wellbeing of our population and that of the wider South Island. There is no single measure for our desired outcomes or for the impact of the work we do. Rather, we use population health indicators as proxies to demonstrate the outcome or impact being sought.

The South Island DHBs have identified **three** strategic outcomes and a core set of associated performance measures, at a population level, which will demonstrate whether we are making a positive change in the health of our collective population. These are long-term outcome measures (5-10 years in the life of the health system) and as such, we are aiming for a measureable change in the health status of the South Island population over time, rather than a fixed target.

Outcome 1: People are healthier and take greater responsibility for their own health.

> The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing.

Outcome 2: People stay well and maintain their functional independence.

> The development of primary and community-based services that provide early diagnosis and treatment and support people to better manage enduring health conditions, reduce the complications of disease and injury and maintain functional independence in their own homes and communities.

Outcome 3: People recover from complex illness and/or maximise their quality of life.

> The development of systems and models of care that free up secondary and specialist services to provide timely and appropriate complex care and advice to reduce the progression of illness, better support people's functional capacity and improve people's quality of life.

Against each of these desired regional outcomes, we have identified areas where individual DHB performance will have an impact on achievement and collectively agreed a core set of related medium-term (3-5 years) performance measures. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'main measures', and each South Island DHB has set local measures to evaluate their performance over the next three years.

1.1 Longer-Term Outcome Measures

Outcome 1: People are healthier and take greater responsibility for their own health

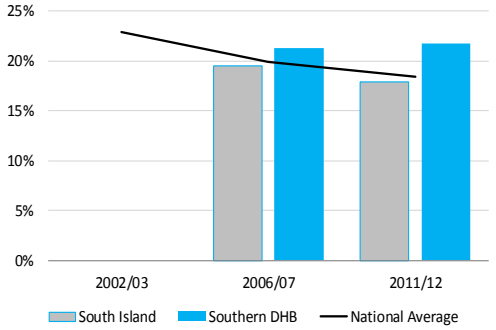
A reduction in smoking rates

The results of the latest New Zealand Health Survey undertaken in 2011/12 show a slight increase in the number of smokers in Southern DHB from 2006/7 (21.3%) to 2011/12 (21.8%).

This is inconsistent with the rest of the South Island (17.9%) and New Zealand (18.4%) where there have been measurable reductions.

In the past two years there has been a 10% increase in the number of youth who have never smoked which is anticipated to lead to a reduction in smokers.

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



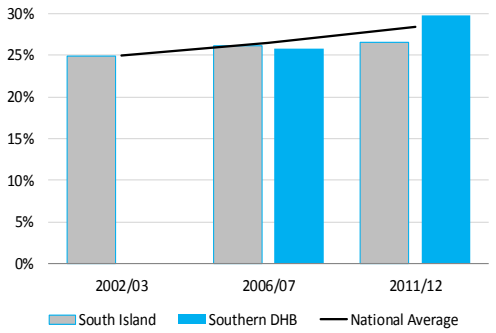
Data sourced from national NZ Health Survey.[1]

A reduction in obesity rates

The results of the latest New Zealand Health Survey undertaken in 2011/12 show a marked rise in obesity rates in Southern.

Whilst in line with national and international trends, this has seen Southern move from below in 2006/07 to above in 2011/12 for both South Island and national rates.

Long-term Outcome Measure: The percentage of the population (15+) who are obese.[2]



Data sourced from national NZ Health Survey.[1]

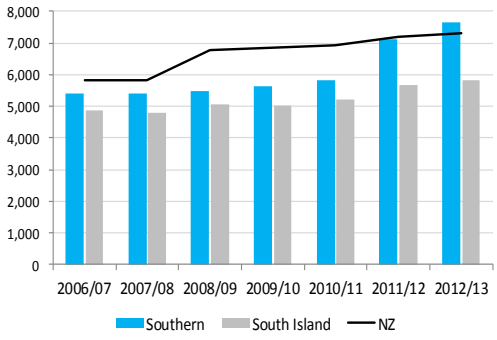
Outcome 2: People stay well and maintain their functional independence

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

The rate of acute medical admissions to hospital has increased over the past two years.

Analysis is being undertaken alongside the current development of the health needs assessment to better understand this trend. There are a number of possible contributors which are linked to the management of ambulatory sensitive conditions in the community.

The Age-Standardised Rate of Acute Medical Admissions to Hospital, Per 100,000 People



Data sourced from National Minimum Data Set.

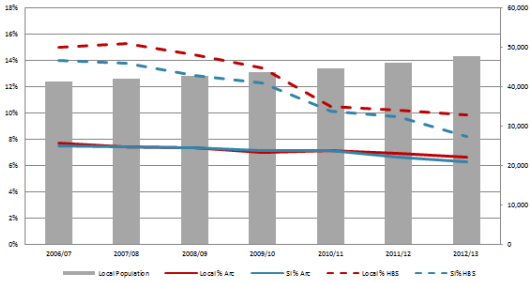
[1] The NZ Health Survey was completed by the Ministry of Health in 2003/04, 2006/07 and 2010/11; the latest survey results were released in 2013. It is based on a small sample population survey which is extrapolated.
[2] 'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.

An increase in the proportion of the population 65+ supported to maintain functional independence

DHBs across the South Island, including Southern DHB, have moved to a more restorative approach for home and community support services (HCSS). This better matches the support to actual client need and is reflected in the smaller percentage of people receiving HCSS for Southern DHB.

Fewer people are entering Aged Residential Care (ARC) which is an indicator that people are retaining their functional independence.

The Percentage of the Population (65+) in ARC and those receiving Home Based Support (HBS) Services



Data sourced from Client Claims Payment System provided by South Island Alliance Programme Office (SIAPO).

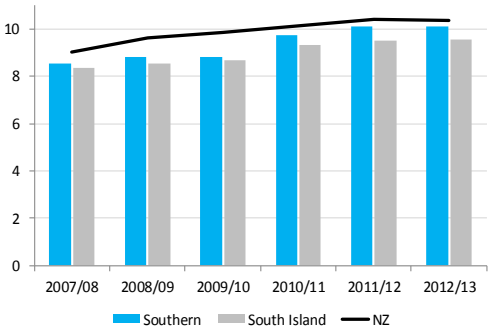
Outcome 3: People recover from complex illness and/or maximise their quality of life

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

Southern DHB inpatient readmission rates have remained steady over the past year (10.09%) and continue to be lower than the rest of New Zealand (10.34%).

This has been achieved with an average length of stay under the New Zealand average and indicates people are receiving quality care while in hospital and the necessary support when back in their homes.

The rate of acute inpatient readmissions to hospital within 28 days of discharge from hospital.



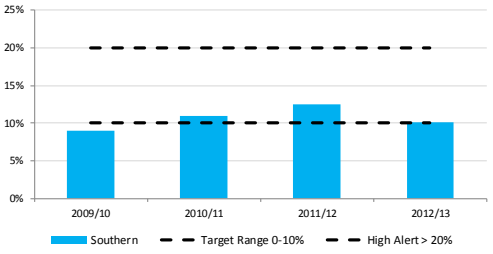
Data sourced from Ministry of Health[3] and Southern DHB.

A reduction in acute (unplanned) inpatient readmissions to hospital and specialist services –Mental Health

Southern DHB acute mental health inpatient readmissions have reduced this year and are now at 10% - the good practice target agreed through the national mental health KPI benchmarking project.

This improvement will be related to services undertaking a significant project to improve post-discharge community care (KPI19 of the national mental health benchmarking project), and therefore reduce the need for readmission.

The rate of acute (unplanned) inpatient readmissions to mental health services within 28 days of discharge.



Data sourced from Ministry of Health[3]and Southern DHB.

[3] This measure is based on the national DHB performance indicator OS8.

1.2 Medium-Term Impact Measures

We have identified a series of measures that impact on our longer-term outcomes. These are areas that the DHB can influence change. Targets have been set to help evaluate the progress and effectiveness of our activities.

1.2.1 People are healthier and take greater responsibility for their own health

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

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.

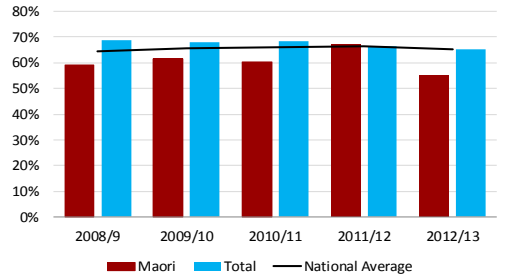
More Babies are fully and exclusively breastfed

The percentage of six-week old babies who are fully or exclusively breastfed has decreased slightly to 65.1%.

Māori breastfeeding rates remain lower than those of the total population.

Percentage of babies fully/exclusively breastfed at 6 weeks

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	68.4%	66.6%	65.1%	74%
Māori	60.2%	67.3%	55.4%	74%



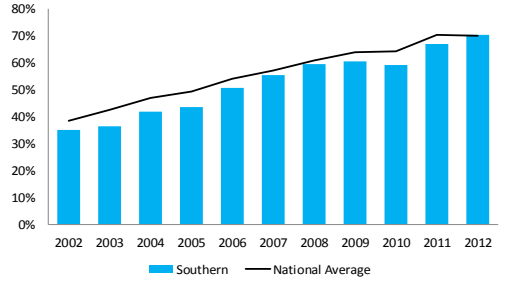
Data sourced from Plunket via the Ministry of Health.[4]

Fewer young people take up tobacco smoking

Fewer young people in Southern are taking up smoking. Locally there has been significant gains in reducing the uptake of smoking amongst young people and at 70.4% Southern is now on a par with national rates.

Percentage of 'never smokers' among Year 10 students

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	59.3%	66.9%	70.4%	63%
NZ	64.3%	70.4%	70.1%	-



Data sourced from national Year 10 ASH Survey.[5]

[4] Data is reported annually on calendar years for the national DHB performance indicator SI7.
[5] The ASH survey (run by Action on Smoking and Health) provides a point prevalence data set and is reported annually on calendar years.

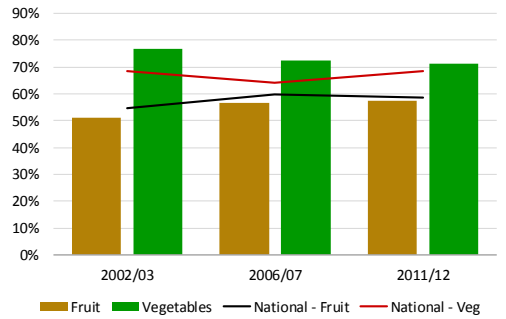
Adults have healthier diets

There has been a 4.6% increase of people having two or more servings of fruit per day to 57.4% but this continues to be below the national rate (58.5%).

The percentage of people consuming three or more servings of vegetables (71.5%) was similar to the previous survey in 2006/07 and continues to be above the national rate (68.4%).

Percentage of the population having the recommended servings of fruit &vegetables

	Actual 06/07	Actual 11/12	Target 12/13
Fruit 2+	52.8%	57.4%	61.5%
Veg 3+	72.4%	71.5%	73.5%



Data sourced from the national NZ Health Survey.[1]

1.2.2 People stay well and maintain their functional independence

Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and supporting them to better manage illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness. They also support people to regain their functionality after illness and to remain healthy and independent.

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

More Children have good oral health

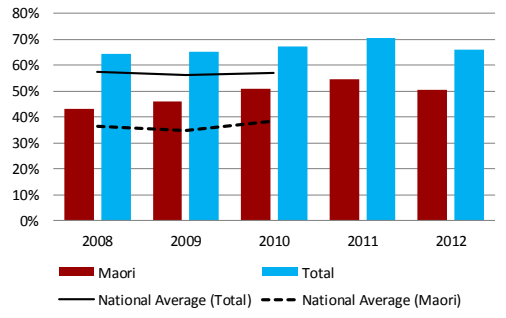
The overall percentage of children aged 5 years who are caries-free (no holes or fillings) has dropped slightly over the past year to 66.0%.

The new community based oral health service is enrolling more children at an earlier age, and as a result more children with poor oral health are receiving checks and treatment.

With more children enrolled and engaged, there is now greater opportunity to promote life style behaviours to reduce tooth decay such as brushing teeth and good nutrition.

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

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	67.2%	70.3%	66.0%	70%
Māori	51.0%	54.5%	50.5%	70%



Data sourced from Ministry of Health.[6]

[6] Oral health data is reported annually for the school year (calendar year) and is based on the national DHB performance indicator PP11.

People better manage their long-term conditions

The latest confirmed results for 2012/13 are not yet available.

The percentage of the Southern population identified with diabetes with HbA1c ≤64mmol/mol.				
	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	95%	79%	NA	81%
Māori	78%	68%	NA	81%

Data sourced from Southern PHO.[7]

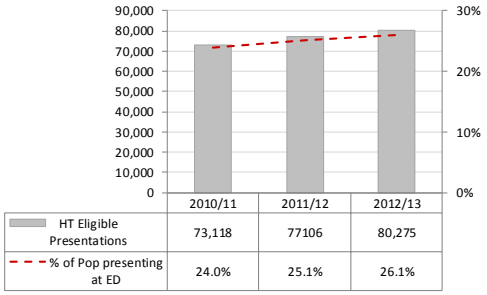
More People access care appropriate to their needs

The number of people and the percentage of the population presenting to emergency departments (ED) continues to increase.

People should be accessing care in the community in the first instance where appropriate. There may be some correlation with the rate of acute admissions has also increased.

Analysis is being undertaken alongside the current development of the health needs assessment to better understand this trend. There are a number of possible contributors which are linked to the management of ambulatory sensitive conditions in the community.

The percentage of the Southern population presenting at ED.				
	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	24.0%	25.1%	26.1%	21.5%



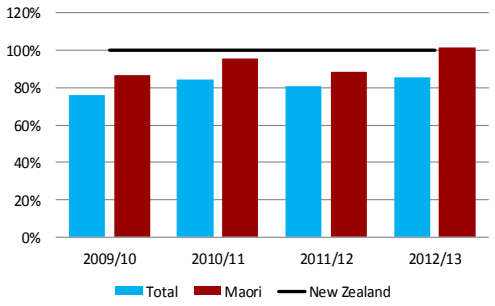
Data sourced from Southern DHB.[8]

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

Ambulatory Sensitive Hospitalisations (ASH) is a measure for conditions that if managed well, could be treated without the need for hospital treatment. ASH rates are used as an indicator to the responsiveness of primary care services.

Overall the Southern population continues to have good access to primary care services. The ASH rates continue to fluctuate but remain at or below the national rate (measured as 100%).

The ratio of admissions for the Southern population compared to national (0-74 years).				
	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	84%	80%	85%	<95%
Māori	95%	88%	101%	<95%



Data sourced from the Ministry of Health.[9]

[7] Diabetes data is reported one quarter in arrears via the national PHO Performance - 'satisfactory' is defined as having HbA1c ≤ 64%.
[8] 'Admitted' is defined by the Ministry of Health national ED Health Target.
[9] 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.

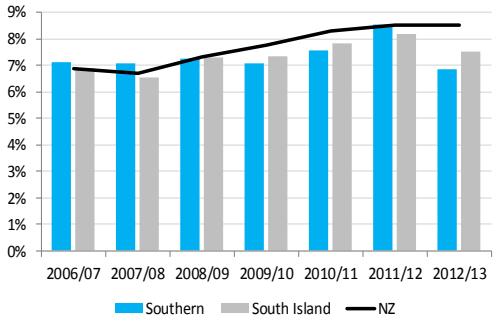
More older people maintain functional independence

At 6.9%, the percentage of Southern population aged 75 years and over being admitted to hospital as a result of a fall is well below the national rate.

There is increased focus on falls prevention to improve the outcomes for elderly who have had, or are at risk of falls and the associated complications.

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

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	7.6%	8.5%	6.9%	7.3%
South Is.	7.8%	8.2%	7.5%	-



Data sourced from NMDS.

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

Expectation

Clinicians, in collaboration with patients and their families, make decisions with regards to complex treatment and care. Not all decisions result in interventions to prolong life, but may focus on patient care such as pain management or palliative services to improve the quality of life. For those who do need a higher level of intervention, timely access to high quality complex services improves health outcomes by restoring functionality, slowing the progression of illness and disease and improving the quality of life.

The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter waiting lists and wait times are also 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 to earlier in the path of illness.

More People receive timely emergency care

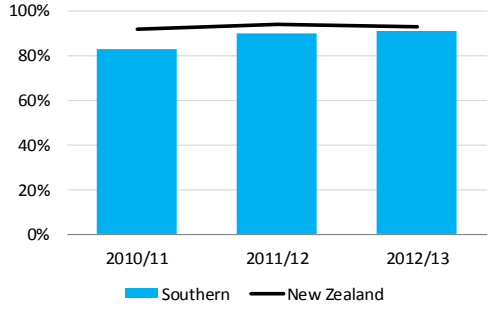
Southern DHB has made significant improvements over the past two years and is now very close to achieving the Health Target of at least 95% of people presenting at the emergency department (ED) being admitted or discharged with 6 hours.

Despite an increase in the number of people attending ED, there has been increased performance in the 2012/13 year with the introduction of observation units, along with initiatives to reduce bed-block.

Primary care and community based services continue to provide urgent care and after hours services which reduce the pressure on ED. The DHB has also invested additional funding for afterhours nurse-led telephone triage services that help direct people in need of care to the most appropriate service.

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

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	83%	90%	91%	95%
NZ	92%	94%	93%	95%



Data sourced from the Southern DHB.[10]

[10] This measure is based on the national DHB Health Target 'Shorter stays in Emergency Departments'.

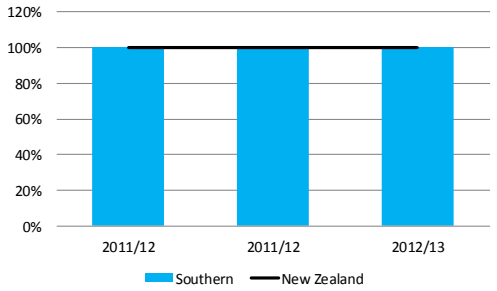
More People receive timely cancer services

All people commenced radiation therapy within four weeks of the decision to treat.

This is a significant achievement with the geographical spread of the district and the increasing demand for oncology services.

The percentage of patients who receive radiation therapy treatment within four weeks of the decision to treat.

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	100%	100%	100%	100%
NZ	100%	100%	100%	100%



Data sourced from the Southern DHB.[11]

More People receive timely access to elective services

Southern DHB continues to provide very good access to First Specialist Assessments (FSA) and subsequent commitments to provide treatment.

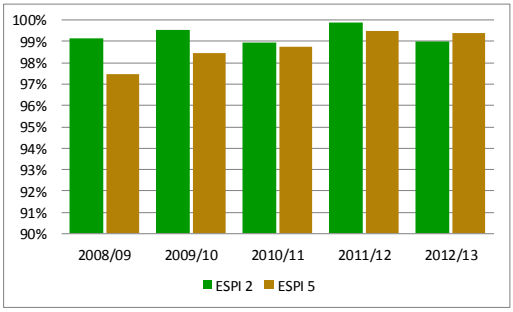
- 99% of people were provided with an FSA within 5 months of referral
- 99.4% of people given a commitment to treat received their treatment with 5 months.

The percentage of people in Southern provided with a FSA within 5 months of referral (ESPI 2).

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	99.0%	99.9%	99.0%	100%

The percentage of people in Southern given a commitment to treatment and treated within 5 months (ESPI 5).

	Actual 10/11	Actual 11/12	Actual 12/13	Target 12/13
Total	98.7%	99.5%	99.4%	100%



Data sourced from individual DHBs.[12]

[11] This measure is based on the national DHB Health Target 'Shorter waits for Cancer Treatment'.
[12] The Elective Services Patient Flow Indicators (ESPIs) are measures of system performance, for which DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available for these measures.

2. Statement of Service Performance 2012/13

2.1 Measuring Our Performance

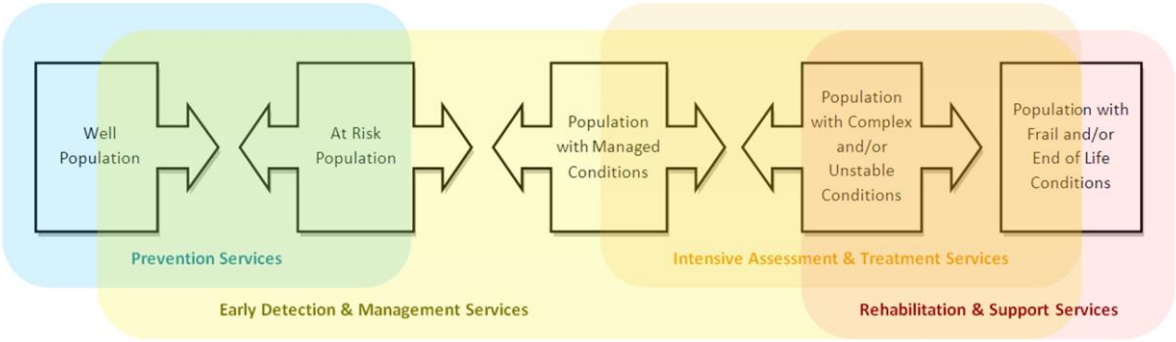
Over the long-term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in Otago and Southland, the decisions we make about which services will be delivered have a significant impact on our population and, if coordinated and planned well, will improve the efficiency and effectiveness of the whole Southern health system.

One of the functions of this document is to demonstrate the effectiveness of the services we have funded or provided on behalf of our population. In this section we evaluate our performance by providing the results against the forecast of our planned outputs (what services we planned to fund and provide in the previous year) as stated in the Statement of Intent (SOI).

In order to present a representative picture of overall DHB performance, outputs have been grouped into four '*output classes*' that are a logical fit with the stages of the continuum care and are applicable to all DHBs. Our Statement of Service Performance uses a mix of measures of timeliness, coverage, volume and quality - all of which help us to evaluate different aspects of our performance against the targets we set.

Figure 1: Scope of DHB operations – output classes against the continuum of care

our outputs cover the full continuum of care for our population.



Wherever possible, we have included previous year's baseline data to support evaluation and provide context to our performance for the current year. Measures that relate to new services have no baseline data.

2.2 2012/13 Performance Overview

The health targets provide a high level indicator of how the local health system is performing. Overall the DHB has improved its performance against all of the health targets.

For the long-standing targets the DHB has exceeded or substantially met these targets; under 6 hours in ED, electives, cancer treatment, and providing advice to smokers to quit in hospital.

For the newer measures which relate mainly to primary care, the addition of the 8 month target for immunisation has been met and demonstrates the good systems and processes are in place. Good progress has been made towards the supporting smokers that interface with primary care services to quit, and increasing heart and diabetes checks. Further improvement is required to achieve these targets.

Shorter stays in Emergency Departments

Target: 95%

Result:91.5%

SHORTER STAYS IN EMERGENCY DEPARTMENTS

The ED performance across Dunedin and Invercargill hospitals for 2012/13 (91.5% in quarter 4) continues to trend upwards but still falls short of the target "95% of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours."

Across the district there has been an effort to increase awareness across the whole hospital of the target, greater engagement of areas outside of ED, beds being available on the wards and an improvement in the use and administration of observation beds are all contributing to an improved performance.

Target:10,113

Result:10,270

IMPROVED ACCESS TO ELECTIVE SURGERY

The electives target was achieved with 10,270 elective procedures completed in 2012/13.As at 30 June 2013 no patients were waiting longer than 5 months for surgery.

Completing the increased volume of procedures and fulfilling these in a timelier manner with the reduced target time (from 6 months to 5 months) is a great achievement. This is the result of improved efficiencies such as better theatre utilisation and more people receiving their surgery on the day of admission.

Target: 100%

Result: 100%

SHORTER WAITS FOR CANCER TREATMENT

The DHB has achieved the 100% target of people referred for radiation or chemotherapy beginning treatment within four weeks of a first specialist assessment (FSA). This is an outstanding achievement with the target times reducing from 6 weeks to 4 weeks and has resulted in a faster and much more efficient and responsive service.

Target: 85%

Result: 95%

INCREASED IMMUNISATION

2012/13 was the first full year of targeting immunisations by 8 months of age. The DHB alongside Southern PHO and general practice met the government's expectation of 95% for the programme, exceeding the 85% target for 2012/13. This is an outstanding result and was built on the excellent systems and processes already in place for childhood immunisations.

Hospital Target:95%

Result: 96.4%

Primary Target: 90%

Result: 56%

BETTER HELP FOR SMOKERS TO QUIT

The 96% of smokers seen in public hospitals receiving advice and help to quit exceeds the programme goal of 95%.

Increasing the percentage of smokers seen in primary care receiving advice and help to quit is still a work in progress with 56% achieved in quarter 4. This is a 24% increase over the previous 12 months, and new initiatives being put in place will see this increase further.

Southern DHB is not able to report on the third part of the target at this stage due the data capture process still being implemented. The third measure is "progress towards 90% of pregnant woman who identify as a smoker at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit".

Target: 75%

Result: 63%

MORE HEART AND DIABETES CHECKS

The 63% of eligible people who received a 'heart and diabetes check' achieved is short of the targeted 75% by June 2013, but there has been measurable progress from the 44% in the previous year. This result is similar to all New Zealand DHBs (67%) with only three DHBs achieving the 75% target.

Southern DHB acknowledges the work and effort that Southern PHO and general practice has done to significantly improve the number of people receiving heart and diabetes checks.

Real progress was made in the second half of the year as a result of initiatives. Improved identification of eligible people and improved risk stratification were introduced and have become embedded into primary care.

2.3 Prevention Services

Prevention health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and population-based immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population.

Health Promotion and Education Services

These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes that support people to maintain wellness or assist them to make healthier choices. Change is indicated by rates of positive or negative behaviours (such as smoking rates).

DHB Performance

Helping smokers to quit has been a big focus during 2012/13 with many more people being offered advice and support to quit while receiving health services in our hospitals and primary care.

There was a significant increase in the percentage of identified smokers being offering advice and support to smokers to quit in primary care. This has been achieved through initiatives such as GP champions, coordinators visiting and assisting practices, and up skilling staff with group-based smoking cessation training. The local primary care performance (56%) is on a par with the national rate (57%). The big shift towards primary care offering smokers quit advice contributed to the drop in numbers accessing Quitline however overall, a greater number of people are accessing quit advice and support.

Health Promotion and Education Services Performance Measures					
Measure		**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Smokers receive advice and support to quit smoking in hospital. [13]		87%	96%#	95%	
Smokers receive advice and support to quit smoking in primary care.		32%	56% #	90%	
Smokers seeking quit advice from Quitline services. [14]		4886	3598	5000	
Infants exclusively and fully breastfeed at 6 weeks. [15]	Total	67%	65%	74%	
	Māori	67%	55%	74%	
Infants exclusively and fully breastfeed at 6 months.	Total	29%	28%	28%	
	Māori	22%	15%	28%	

- Where quarterly data gives a better indication of trend this has been graphed and is shown with the lighter coloured formatting.

[13]The coverage of services where providers routinely check smoking status as a clinical 'vital sign' and provide brief advice and offer quit support to current smokers. Brief advice is effective a prompting quit attempts and long term quit success.
[14]The number of calls made to Quitline reflects the quantity of people taking self-responsibility by seeking further cessation advice and hence the effectiveness of the smoking cessation health promotion messages, advice and support being delivered. The data is for the calendar year i.e. Jan- Dec.
[15]The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period.

Statutory Regulation

These services sustainably manage environments to support people and communities to make healthier choices and maintain health and safety. They include: compliance monitoring with liquor licensing and smoke environment legislation, assurance of safe drinking water, proper management of hazardous substances and effective quarantine and bio-security procedures.

DHB Performance

The Public Health Unit continues to deliver a high quality services that meets and exceeds the compliance targets set by the Ministry of Health. The high percentage of retailers compliant with the relevant legislation not only reflects the monitoring work that goes on, but also the excellent work in developing a good understanding of the legislation by retailers and their obligations in providing safer and healthier environments.

The activity measuring compliance with the Sale of Liquor Act and new Sale and Supply of Liquor Act shows a pleasing increase on 2011/12 results, with the target being achieved in 2012/13. This is mirrored by the positive trend for compliance among Tobacco retailers visited in 2012/13 with the Smokefree Environments Act continues, with a strong increase on the 2011/12 result.

Statutory Regulation Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Tobacco retailers are compliant with current legislation.[16]	91%	97%	85%	
Alcohol retailers are compliant with current legislation. [16]	78%	97%	95%	
The proportion of Communicable disease notifications investigated. [17]	100%	100%	100%	
The proportion of hazardous substances inspections and audits completed. [17]	100%	100%	100%	

[16]The proportion of compliant retailers identified through controlled purchase operations is seen as a measure of the quality of the information, training and advice services provided to retailers.
[17]The timeliness of public health services.

Population Based Screening

These services are mostly funded and provided through the National Screening Unit and help to identify people at risk of illness and pick up conditions earlier. They include breast and cervical cancer screening and antenatal HIV screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.

DHB Performance

The DHB continues to provide responsive population based screening programmes. Many of the various programmes targets have been met or exceeded. Of particular note is the exceptional performance of the Before Schools Check Service. At over 90% for both total population and higher needs children, this represents a significant contribution to identifying and meeting the health needs of children.

Population Based Screening Performance Measures					
Measure		**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The proportion of the eligible population (45-69) receiving breast screen examinations. [18]		71%	74%	≥70%	
Women are re-screened between 20 and 24 months from their previous breast screen examination. [19]		70%	NA[20]	≥75%	-
The proportion of the eligible population (25-69) receiving cervical cancer screens. [21]		78.1%	79%	≥80%	
The percentage of eligible children receiving Before School Checks (B4SC). [22]	Total	83%	91%	≥80%	
	Quintile 5	87%	92%	≥80%	

[18] Screening coverage is a good indicator of the effectiveness of preventive services. The national breast screening target is 70%.
[19] Quality of the screening programme to maximise the detection of small localised cancers.
[20] Confirmed results for 2012/13 were not available at the time this report was prepared.
[21] Screening coverage is a good indicator of the timeliness and effectiveness of preventive services. The national cervical cancer screening target is 80%.
[22] Provides an indication of the coverage of B4SC and the effectiveness of the service. The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development, giving him/her the best possible start for school and later life.

Immunisation Services

These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated and successful service.

DHB Performance

The DHB continues to have a high performing immunisation service. This has been achieved by a whole of sector approach with a well-coordinated and functioning programme involving general practice, PHO, public health, and the DHB. This is demonstrated by meeting the programme goal for immunising children at 8 months of age in the first year.

Immunisation Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Children fully immunised at age 8 months. [23]	-	95%#	85%	
Children fully immunised at age 2 years. [23]	95%	95%#	≥95%	
Children (aged 8 months) 'reached' by immunisation services. [24]	-	96%	99%	-
Children (aged 2) 'reached' by immunisation services.	99%	98%	98%	
Eligible young women (12-18 years) engaged in the HPV vaccination programme. [25]	65%	68%	70%	
People aged over 65 having received a flu vaccination. [26]	66%	69%	69%	

- Where quarterly data gives a better indication of trend this has been graphed and is shown with the lighter coloured formatting.

[23]The coverage provides an indication of the effectiveness of primary care and immunisation outreach services in reaching a vulnerable group in the population.
[24]This reflects the quality of immunisation services in 'reaching' the parents of eligible children and providing advice and support to enable parents to make informed choices for their children. Reached' is defined as those children fully immunised, as well as those who have declined immunisations, have opted off the National Immunisations Register (NIR) or are on catch up schedules.
[25]The measure is based on year 8 girls who have completed the 3 dose HPV vaccinations. The reported data is the cohort born in 1999 and is for the year to Dec 2012.
[26]The coverage rate provides an indication of the effectiveness of primary care in reaching a vulnerable group in the population.

2.4 Early Detection and Management

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

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

Primary Health Care (GP) Services

These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary health care professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.

DHB Performance

One of the key strategic goals of the DHB is for patients to receive care closer to home. One of the options to achieve this is to provide more services in primary care and support people to stay well and reduce the overall rate of admissions to hospitals. This has seen an investment of new services into primary care and in some instances a change how care may be delivered. This has required some adjustment by both patients and providers.

Access to primary care services continues to be very good for the total population (aged 0-74 years) in relation to the rest of the country. However the Ambulatory Sensitive Hospitalisation (ASH) rates [30] for children (aged 0-4 years) has now increased above that seen elsewhere.

There continues to be an increase in services available in primary care to make services more accessible and meet patient need. The increasing number of people accessing brief intervention for mild mental health, and skin lesion General Practitioner with Special Interest (GPSI), indicates that these services are being utilised.

Primary Health Care (GP) Services Performance Measures					
Measure		**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The percentage of the DHB population enrolled in a Primary Healthcare Organisation. [27]		93.9%	92.5%	95%	
The number of skin lesions removed in primary care (by a GP with special interest – GPSI) without the need for a hospital appointment. [28]		697	830*	600	
The number of people receiving a brief intervention from the primary mental health service. [29]		3,694	3,923	3,800	
Ambulatory Sensitive Hospital Admission rates for children aged 0-4 years are reduced. [30]	Total	103	115	102	
	Māori	96	110	102	
Ambulatory Sensitive Hospital Admission rates for population aged 0-74 years are reduced.	Total	78	85	<95	
	Māori	67	72	<95	

[27] Coverage provides an indication on the access to primary care services. The national PHO enrolment target is 95%.
[28] GPSIs are an example of a traditional hospital based service being delivered in the community and closer to home.
[29] An indicator of the coverage of brief intervention services with the aim is to provide early intervention and help people to reduce the likelihood of developing enduring conditions.
[30] A number of admissions to hospital are seen as preventable through appropriate early intervention and these admissions provide an indication of the quality of primary care services; access and effectiveness and an improved interface between primary and secondary services.

Oral Health

These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.

DHB Performance

The DHB has invested significant resources over the past 5 years into developing new models of care supported by new community based fixed and mobile oral health clinics across the district. The new model of care has a strong emphasis on early enrolment; children are now enrolled from birth. This has seen a rise in the number of eligible preschool children enrolled in school and community oral health services over this time but the total number has plateaued over the past year as the total number enrolled children approaches the total number of eligible children. It is pleasing to note the DHB has for the first time reached the national target of 85% of eligible adolescents accessing funded oral health services.

Oral Health Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Eligible preschool children enrolled in school and community oral health services. [31]	16,357	16,007	16,500	
The percentage of eligible adolescents who access funded oral health services. [32]	82%	85%	85%	

Long-Term Conditions management

These services are targeted at people with high health need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission.

DHB Performance

There were significant developments with evolving and new programmes aimed at long-term conditions introduced during 2012/13. There was a renewed emphasis on the cardiovascular disease (CVD) checks (which also are part of the 'more heart and diabetes checks' health target) which saw a 19% increase over the year. The DHB's CVD risks assessment results (62.8%) are similar to the national result (67%).

The biggest change was the introduction of the diabetes care improvement package (DCIP). This replaced the original one a year 'get checked' and is now a comprehensive package of nine checks that targets all aspects of diabetes care. This has seen a major investment by the PHO to develop and roll-out to practices. Now that it is starting to become embedded, we anticipate improved results in coming years.

[31]Quantity of children enrolled provides an indication of the volume and size of the service. Targets were set as part of the oral health business case and aligns with the goal of increased reach of services.
[32]Coverage and effectiveness of oral health services in reaching adolescents.

Long-Term Conditions management Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The proportion of the eligible population (35-79) having a CVD risk assessment in the last five years. [33]	44%	62.8%[#]	75%	
The percentage of estimated people with diabetes who receive an annual diabetes check. [34]	99%	NA[35]	90%	
The proportion of people with diabetes who have satisfactory or better management. [36]	68%	NA[35]	81%	

- Where quarterly data gives a better indication of trend this has been graphed and is shown with the lighter coloured formatting.

Community Referred and Delivered Services

These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. To improve performance, we will target improved primary care access to diagnostics to improve clinical referral processes and decision-making.

DHB Performance

Laboratory services continue to be provided in a timely way. This is a well embedded service that has performed as expected. As part of a quality improvement initiative and based on good practice, the turnaround times for histology have been increased (now 12 hours longer).

Community Referred and Delivered Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Laboratory test turnaround times: Biochemistry [37]	<24 hours	<24 hours	<24 hours	
Laboratory test turnaround times: Immunology	<48 hours	<48 hours	<48 hours	
Laboratory test turnaround times: Haematology	<24 hours	<24 hours	<24 hours	
Laboratory test turnaround times: Histology	<72 hours	<84 hours	<72 hours	
Laboratory test turnaround times: Microbiology	<72 hours	<72 hours	<72 hours	

[33]The coverage rate provides an indication of the effectiveness of primary care in providing core services to an at risk group in the population. The Minister of Health has set the expectation that 75% of eligible people will have received a CVD risk assessment by June 2013; 90% by June 2014.
[34] Diabetes annual reviews changed significantly from July 2012 where they moved from a single check each year to a more comprehensive check involving nine components which could be undertaken over a period of time. The nine components are required for the measure to be recorded as completed.
[35] Confirmed results for 2012/13 were not available at the time this report was prepared.
[36]Indicates the quality of primary care services in managing people with diabetes. Defined as having an HBA1c ≤ 64 mmol/mol.
[37]Good laboratory services improve the timeliness of effective diagnosis.

2.5 Intensive Assessment and Treatment

Output Class Description

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

As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

Specialist Mental Health Services

These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation rates are monitored across ethnicities and age groups to ensure service levels are maintained and to demonstrate responsiveness.

DHB Performance

Access to specialist mental health services continues to be above, or very close (within 0.2%) to target. Data improvements mean that we are now better able to consider access to primary care and non-government organisation (NGO) services alongside this measure, giving more context to this result. Local and national policy has an expectation of improved access across the entire sector, especially in primary and NGO, and this is increasingly the focus of our attention when we consider how to improve access for the Southern population.

There has been a stronger focus in 2012/13 on improving the percentage of service users who have a current relapse prevention plan. Significant performance improvements have been seen in a number of child and youth services, by improving administrative processes and monitoring.

Specialist Mental Health Services Performance Measures					
Measure		**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Access rates to specialist mental health services for children and young people (aged 0-19 years). [38]	Total	4.05%	3.49% [39]	≥3.31%	
	Māori	3.95%	3.73% [39]	≥3.31%	
Access rates to specialist mental health services for children and young people (aged 20-64 years). [38]	Total	4.09%	3.61% [39]	≥3.63%	
	Māori	7.79%	7.26% [39]	≥5.52%	
The percentage of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment for two years or more, who have a current relapse prevention plan. [40]	Total	93.7%	94.5%[39]	95%	
	Māori	98.1%	98.1% [39]	95%	
The percentage of children and young people who have been receiving secondary care for one year or more, who have a current relapse prevention plan. [40]	Total	91.5%	93.5% [39]	95%	

[38] An indication of the timeliness, accessibility and responsiveness of mental health services.
[39] There are some data irregularities in the quarter 4 data which had not been clarified at the time of the report being written. Quarter two data has been used as an indicator for the performance over the year.
[40] An indication of the quality of mental health services; clients with enduring serious mental illness are expected to have an up-to-date relapse prevention plan identifying early warning signs for the services user and their families. It identifies what the service users can do for themselves and what the service will do to support the service users. Relapse prevention/resiliency planning has been shown to be a key component of service delivery that allows the medium to longer-term impacts of a serious mental illness to be minimised, improving outcomes for clients.

Specialist Mental Health Services Performance Measures					
Measure		**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
	Māori	94.4%	86.4% [39]	95%	
The percentage of people referred for non-urgent mental health or addiction services are seen within three weeks. [41]		-	62% [39]	65%	-
The percentage of people referred for non-urgent mental health or addiction services are seen within 8 weeks. [41]		-	90% [39]	75%	-

Elective Services

These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).

DHB Performance

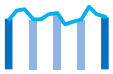
The number of people receiving elective surgery increased further in 2012/13. This was achieved whilst improving timeliness and improving or maintaining quality indicators. The electives target was achieved with 10,270 elective procedures completed in 2012/13. Additionally as at 30 June 2013 no patients were waiting longer than 5 months for surgery. This is the result of improved efficiencies such as:

- better theatre utilisation with the productive operating theatre programme (TPot) making a big contribution to improved performance.
- more people receiving their surgery on the day of admission. This has been achieved across all specialties and has been a particular focus of the Enhanced Recovery After Surgery (ERAS) colorectal programme and other quality projects to make improvement in this dimension.

Outpatient 'Did Not Attend' (DNA) rates have continued to decrease. Southern DHB has reduced DNA rates over the past three years using initiatives such as a text reminder system, spot audits on DNAs and follow-up with patients by the appropriate speciality.

Elective Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The number of medical and surgical First Specialist Assessments (FSA).	36,700	34,565	36,834[42]	
Theatre utilisation - proportion of resourced theatre minutes used to total resourced theatre minutes. [43]	85.6%	86.1%[#]	88%	
The number of elective surgical services discharges (including dental and cardiology).	10,214	11,750	11,214	
The number of elective surgical services caseweights (CWDs) delivered.	14,923	14,948	14,738	
The percentage of elective and arranged surgery undertaken on a day case basis. [44]	58%	58%[#]	59.6%	

[41] An indication of the timeliness of access to mental health services. The Ministry has set a 3 year target of 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks.
[42] The target for the number of FSAs was renegotiated with the NHB after the start of the year.
[43] A measure of the quality of systems and processes in maximising operating theatre efficiencies and productivity.
[44] Timeliness of elective services in a way that minimises the time and pre/post-operative inconveniences that can impact.

Elective Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The proportion of people receiving elective or arranged surgery on the day of admission. [45]	86%	90%#	95%	
Average elective and arranged inpatient length of stay (days) is maintained. [45]	3.25	3.79#	4.02	
Outpatient 'Did Not Attend' (DNA) rates are reduced. [46]	8.8%	8.2%#	8.0%	
Rate of inpatient pressure injuries. [47]		NA [48]	0.68%	-
Rates of central line associated bacteraemia (CLAB). [49]	0	0	2	

- Where quarterly data gives a better indication of trend this has been graphed and is shown with the lighter coloured formatting.

Acute Services

These are services for illnesses that have an abrupt onset, are often of short duration and progress rapidly, for which the need for care is urgent (they may or may not lead to hospital admission). Hospital-based services include emergency departments, short-stay acute assessments and intensive care services. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of services.

DHB Performance

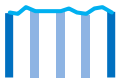
The Dunedin and Southland Hospital Emergency Departments have given significant effort and commitment to improving their performance where people are assessed, treated or discharged from ED in under six hours. Despite an increase in the number of people attending ED, there has been increased performance in the 2012/13 year with the introduction of observation units, along with initiatives to reduce bed-block.

Moving people through ED has to be balanced with also providing quality care. The acute readmission rate to hospital has been supported by initiatives such as the Early Support Discharge Programme. This has seen a steady decline in readmissions since March 2013. This programme now has extended hours so we expect to see continued improvement.

The DHB's acute inpatient average length of stay in hospital continues to meet the target during the past two years (<4.25 days).

Acute Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
People are assessed, treated or discharged from ED in under six hours. [50]	89.9%	91.5%#	95%	

[45] A measure of the quality of hospital systems and productivity where patients receive a more convenient level of care and resources are used in a more cost effective manner.
[46] An indicator of the quality of outpatient services. Timely and convenient appointments will contribute to lower DNA rates.
[47] Pressure injury/ulcers are preventable adverse events and are used as key quality indicators of patient care.
[48] Confirmed results for 2012/13 were not available at the time this report was prepared.
[49] Rates of CLAB in hospitals reflect the quality of infection control procedures. CLAB is a national safety improvement measure standardised across all DHBs.
[50] An indicator of the timeliness of ED services and the effectiveness of hospital systems.

Acute Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The acute readmission rate to hospital. [51]	9.1%	9.5%#	9.1%	
The acute inpatient average length of stay in hospital (days). [52]	3.94	4.00#	<4.25	

- Where quarterly data gives a better indication of trend this has been graphed and is shown with the lighter coloured formatting.

Maternity Services

These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.

DHB Performance

The number of births in the district have trended downwards as expected in line with national and local population projections. The birthing facilities across the district all continue to be 'baby friendly' accredited, aimed at providing mother and baby with a good start including assistance in establishing breastfeeding before going home.

Maternity Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The number of births in the DHB region. [53]	3,555	3,503	<3,720	
New mothers have established breastfeeding on discharge from hospital. [54]	83%	83%	85%	
Baby friendly hospital accreditation is maintained. [55]	100%	100%	100%	

Assessment, Treatment and Rehabilitation Services (AT&R)

These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments, (where appropriate) is indicative of the responsiveness of services.

DHB Performance

Average length of stay (LOS) for inpatient Assessment, Treatment and Rehabilitation Services **(**AT&R) services across all 3 Southern DHB services average 18.7 days for calendar year 2012 (range 16.8 days to 25.0 days).The reduction in LOS is a national and international trend for rehab as patients receive more services in the community. Other reason for reduced LOS is due to increased options for Home Care Support Services. For 2012 Southern DHB AT&R LOS was 3.9 days lower than the benchmark LOS of all other NZ AT&R services.

[51] An indication the quality of care received in hospital and post-discharge.
[52] An indication the timeliness and quality of care received in hospital. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of service provision.
[53] Southern district is forecast to have a declining birth-rate by Statistics NZ.
[54] An indication of the quality and effectiveness of initiatives promoting breastfeeding.
[55] A measure of the quality of services and facilities for mother and baby.

Assessment, Treatment and Rehabilitation Services (AT&R) Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Average length of stay (days) for inpatient AT&R services.[56]	-	18.7	16.0	-
Waiting time for referral until transfer into AT&R service.	-	NA[57]	Establishing a baseline in 2012/13	-
Proportion of admissions into AT&R made by direct community referral.[58]	-	NA[57]	10%	-

2.6 Rehabilitation and Support

Output Class Description

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

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

Needs Assessment and Services Coordination Services (NASC)

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

DHB Performance

The past 12-18 months has seen the introduction of InterRAI, a new standardised clinical assessment tool used for determining the support needs of patients. Over five and a half thousand people had an assessment completed; most importantly was the significant increase in the number of people receiving reassessments. This is important for the person receiving services are matched to need and for the system in that limited resources are allocated to people

Needs Assessment and Services Coordination Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Number of people 65 years and over provided with a Clinical Assessment of need. [59]	-	5,565	New measure	-
Percentage of eligible clients provided with a clinical assessment/reassessment of need within 14 working days from receipt of referral. [60]	-	NA [61]	40%	-

[56] An indication of the quality and effectiveness of AT&R services
[57] Implementation of this measure was never established due to unforeseen incompatibilities between reporting systems.
[58] Access is improved and the measure provides an indication of the timeliness to AT&R with direct community referral. Keeping people in their own homes where appropriate promotes independence, leads to better outcomes and supports the government's policy of *better, sooner, more convenient.*
[59] Measures the quantity of older people receiving a Comprehensive Clinical Assessment. InterRAI is a comprehensive geriatric assessment tool used to ensure consistency in assessing the needs of older people and has been rolled out across the DHB during 2011/12.
[60] Measures the timeliness of NASC service to provide a comprehensive Clinical Assessment of need.
[61] Implementation of this measure was never established due to unforeseen incompatibilities between reporting systems.

Needs Assessment and Services Coordination Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
People 65 years and over receiving long-term HBSS clients having a Clinical Assessment review within the previous 12 months. [62]	-	60.2%[#]	40%	
Percentage of eligible clients having a plan of care completed within 10 working days from date of assessment or reassessment. [63]	-	78%	80%	-
The percentage of mental health clients with a reassessment within the previous 12 months. [64]	-	NA [65]	95%	-

- Where quarterly data gives a better indication of trend this has been graphed and is shown with the lighter coloured formatting.

Palliative Care Services

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

DHB Performance

The Liverpool Care Pathway is an internationally recognised tool to improve the quality of care at the end of life. This has been progressively introduced to the two hospices, aged residential care facilities, and some hospital wards. The results for 2012/13 show a good uptake of the Liverpool Care Pathway.

Palliative Care Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
People in hospice services are assessed and being supported by the Liverpool Care Pathway. [66]	-	73%	90%	-
ARC facilities are trained to provide the Liverpool Care Pathway. [67]	-	70%	75%	-

Rehabilitation Services

These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupation therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to these services.

DHB Performance

People are referred to cardiac rehabilitation services after an acute event. The timing of the changes to the model of care for cardiac rehabilitation did not occur as planned thus results are similar to last year. The work to increase referrals is to be undertaken this year particularly at Dunedin Hospital, and is proposed to include discharges from Internal Medicine.

[62] An indication of the timeliness of NASC services.
[63] Measures the timeliness of NASC service to provide a coordinated plan of care to meet client needs. Care plans following clinical assessment of need will lead to more coordinated care and better quality outcomes.
[64] Measures the coverage and timeliness of services which are responsiveness to changing mental health needs.
[65] Confirmed results for 2012/13 were not available at the time this report was prepared.
[66] An indication of the quality of palliative care services where an approved care pathway is used. Integrated care pathway delivering best practice care to dying patients and their families / whānau in the last days and hours of life irrespective or diagnosis or care setting.
[67] An indication of coverage and accessibility to the Liverpool Care Pathway.

Rehabilitation Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
People are referred to cardiac rehabilitation services after an acute event. [68]	69%	68%	70%	❚❚
People are referred to mental health community support after discharge from inpatient services. [69]	66%	NA [70]	65%	-

Home-Based Support Services

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

DHB Performance

2012/13 saw the planning for the introduction of a restorative model of home and community support services (HCSS) commencing 1 July 2013. A comprehensive process involving extensive consultation and subsequent competitive selection of providers (through a robust request for proposal (RPF)) took longer than originally anticipated. The planned HCSS measures were not in place in time to report for 2012/13.

Home-Based Support Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Number of eligible complex clients receiving home and community support services (HCSS) per head of population aged over 65 years.[71]	-	NA [72]	Establishing a baseline in 2012/13	-
Number of eligible non-complex clients receiving HCSS per head of population aged over 65 years.	-	NA [72]	Establishing a baseline in 2012/13	-
Percentage of clients receiving services within 48 hours of receipt of referral.	-	NA[72]	50%	-
Percentage of HCSS clients with goals based 'restorative' care plans.[73]	-	NA[72]	25%	-
Percentage of HCSS support workers who have completed minimum training requirements. [74]	-	NA[72]	50%	-

[68] Provides an indication of the coverage of cardiac rehabilitation services.
[69] Provides an indication of the coverage of mental health community support services.
[70] Confirmed results for 2012/13 were not available at the time this report was prepared.
[71] These three targets are key quality indicators that will be introduced with new service specifications. Indicate the timeliness and responsiveness of providers to support and meet client needs. SDHB introduced a revised HCSS service in mid-2013 in line with 'restorative' principles of care; Overtime SDHB would expect to see a proportional increase in the number of complex clients being supported with HCSS to live independently in the community.
[72] The establishment of the new home and community support service took longer than originally planned and this data was not collected during 2012/13.
[73] An indication of effective coverage of new 'restorative' Home and Community Support Service.
[74] Key quality indicator in revised HCSS service specifications.

Residential Care Services

These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support.

DHB Performance

The utilisation of rest home level beds continues to realign down towards the South Island per capita rate. This is a pleasing result as the preference is to support older people in their own homes where possible. This result has been brought about through improved assessments with the introduction of InterRAI and better coordinated home and community support services.

2012/13 also saw the introduction of InterRAI into residential care facilities which is a key quality improvement initiative in the development of individualised care plans for residents.

Residential Care Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
Number of Rest Home Bed Days per capita of the population aged over 65 years. [75]	9.3	8.29	9.0	
Percentage of residential care facilities using InterRAI assessment tool. [76]	-	21%	10%	-

Respite and Day Services

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

DHB Performance

The utilisation of respite care was closer to assessed need for respite care. This will have been assisted by the introduction of InterRAI assessment tool (see page 70) in addition to access to respite beds.

The dementia day programme did not eventuate as planned due to the longer than anticipated time to establish the HCSS. This programme will now be implemented in 2013/14.

Respite and Day Services Performance Measures				
Measure	**Actual 2011/12**	**Actual 2012/13**	**Target 2012/13**	**Trend**
The ratio of number of days of respite care allocated to number of days used. [77]	74%	83%	78%	
The total number of eligible clients accessing Dementia Day Activity Programmes. [78]	-	0	20	-

[75] The level of rest home level care compared to other districts indicates the coverage and quality of services to safely support independent community living. Measures equity of access to services across the SI based on standardised eligibility criteria. The average rest home bed days per capita for the South Island in 2011/12 was 8.33 bed days.
[76] Measures the coverage of the utilisation of comprehensive clinical assessment tools in age residential care facilities. There is the expectation that more aged residential care facilities will utilise InterRAI to develop care plans.
[77] An indication of the quality service allocation and the ability of clients to access services. The higher the ratio would indicate that more appropriate allocation is being made and people are able to access respite care when required.
[78] An indicator of the quantity of people accessing the new Dementia Day Activity Services to support independent living. Services to assist in maintaining functional independence - older people are supported in their homes/communities when it's safe and cost effective.

EXPENDITURE BY OUTPUT CLASS

The following table shows revenue and expenditure by the four output classes

	2013 Actual	2013 Budget
Income		
Prevention Services	12,272	13,612
Early Detection and Management Services	199,221	201,167
Intensive Assessment and Treatment	535,457	530,950
Rehabilitation and Support	103,010	103,479
Total income	**849,960**	**849,208**
Expenditure		
Prevention Services	12,272	13,612
Early Detection and Management Services	202,098	203,352
Intensive Assessment and Treatment	540,871	537,205
Rehabilitation and Support	106,353	106,017
Total expenditure	**861,594**	**860,186**
Share of profit/(loss) in associates	(255)	-
Surplus/(Deficit) for the year	**(11,889)**	**(10,978)**

Independent Auditor's Report

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

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

We have audited:

- the financial statements of the Health Board on pages 21 to 48, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 49 to 73 that comprises the statement of service performance, which includes outcomes.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 21 to 48:

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

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators) rely on information from third-party health providers, such as primary health organisations and South Link Health. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 49 to 73:

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

Our audit was completed on 31 October 2013. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Our audit of the financial statements involved evaluating:

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

Our audit of the performance information involved evaluating:

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

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

Andy Burns
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand