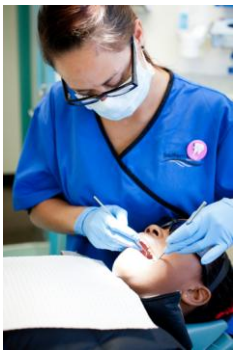
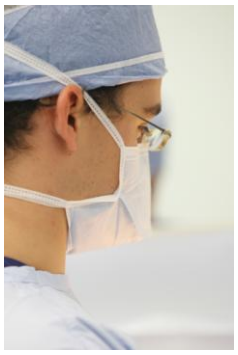
Better Health
Better Lives
Whanau Ora

Southern District Health Board

Annual Report 2012






Southern District Health Board

DIRECTORY

Current Board Members

Joe Butterfield	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 Current Board Membership of the 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

Sandra Cook
Kaye Crowther QSO
Paul Menzies
Tahu Potiki

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	
Mary Flannery	
Paul Menzies	

Clinical Advisory Committee

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

Appointments & Remuneration Advisory Committee

Joe Butterfield	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 Service/Deputy CEO
John Adams	Dean – Dunedin School of Medicine
Steve Addison	Executive Director Communications
Richard Bunton	Medical Director of Patient Services
Donovan Clarke	Kaiwhakahaere Hauora Māori (Executive Director, Māori Health)
Ian Macara	Chief Executive Officer, Southern Primary Health Organisation
Robert Mackway-Jones	Executive Director, Finance and Funding
Lynda McCutcheon	Executive Director Allied Health, Scientific & Technical
John Pine	Executive Director Human Resources
Leanne Samuel	Executive Director of Nursing & Midwifery
David Tulloch	Executive Medical Director

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Andy Burns
Audit New Zealand on behalf of the Auditor-General

Bankers

Westpac Business Banking
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PO Box 5345
DUNEDIN 9058

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FOREWORD FROM THE CHAIR AND CHIEF EXECUTIVE

Joe Butterfield – Chair

Carole Heatly– CEO

Southern DHB is entering a period of change as we seek to address the issues and challenges which we have faced in the past 12 months and plot a path towards becoming a more unified, high performing and financially sustainable district health board.

As we move through this process it is important that we continue to have the patient and community at the centre of everything that we do and that we focus on quality to ensure that our services are as safe as they can be.

If we are to achieve this we must complete the merger we began two years ago. We require district wide structures and clinical pathways if we are to realise the benefits of the merger and have embarked on a restructuring programme toward this. In May, we restructured our executive team and further restructuring is now taking place as we align the DHB.

This year's deficit has been unacceptably high and it is important that we move towards providing quality services within our allocated funding. To this end we are working towards finalising a deficit reduction programme which will see us return to a break even position in three years.

We have engaged Price Waterhouse Coopers (PWC) to assist us towards making the DHB more financially sustainable. PWC is working with us as we improve our financial reporting systems and undertake an ambitious cost savings programme.

This work is complemented by a focus on quality and performance as we put in place a new management structure, which includes dedicated quality and performance positions. These efforts will be further underpinned by new management clinical partnerships as we build on a culture that has the patient at the centre of everything that we do.

Much of this direction is being encompassed by what we are calling the Southern Way, a campaign to bring staff and stakeholders with us on this journey of positive change.

We would like to thank all our staff and community providers for their hard work throughout the year. Their professionalism and dedication has made a tremendous difference to our patients/ consumers, their families and the entire community.

Their roles are difficult and highly pressured and it is important that they get recognised for the important job that they do. DHBs are about people, those that we help and those that deliver our services and we will keep that very much in focus during the year ahead.

Joe Butterfield

Chairman

Carole Heatly

Chief Executive Officer

THE YEAR IN REVIEW

Year End result

The year end result was $13.2M against a budgeted deficit of $10.5m. This was a disappointing result and we have engaged with Price Waterhouse Coopers (PWC) to assist us to improve our financial reporting systems and to provide advice to help ensure that we are operating as efficiently as possible.

We must ensure that the DHB provides financially sustainable health and disability services to the community we serve and are working on a programme to reduce our deficit to zero over the next three years.

This includes an ambitious cost savings programme as well as restructuring to develop single directorates and clinical pathways as part of our journey towards becoming a more high performing DHB.

Strategic Plan

We made good progress towards completing our strategic plan and established our mission and values.

Our Vision is: Better Health, Better Lives, Whanau Ora.

Our Mission is: We work in partnership with people and communities to achieve their optimum health and wellbeing. We seek excellence through a culture of learning, inquiry, service and caring.

As part of this we have established the following priorities for our work:

- Patients are at the centre of everything that we do
- Create a high performance organisation with a focus on quality
- Become a single unified DHB
- Provide financially and clinically sustainable services to the community

New Chief Executive

Our new Chief Executive, Carole Heatly, began at the DHB in March 2012. Ms Heatly comes from the National Health Service (NHS) where she was the Chief Executive of the North Cumbria University Hospital NHS Trust in the UK, a position she had held since 2008.

Ms Heatly has a great deal of experience in the NHS and a background well suited to leading Southern DHB as we move to consolidate the organisation and further develop the services we provide the community.

Executive Restructure

The executive team was restructured in May as the first step in the process to complete the merger and properly align the DHB as a single district health board with single divisions and clinical pathways. The new executive structure was well received by our staff and the sector and there is a lot of support for this new direction.

Dunedin Joint Assessment

During the year the National Health Board Business Unit undertook a Joint Assessment of Dunedin Hospital with Southern DHB. The assessment found issues regarding the systems, processes and culture within the hospital and the wider DHB and a great deal of work has gone into addressing these and a lot of progress made.

Many of the issues are being worked through as part of our current restructuring programme which focuses on aligning directorates and focusing on single clinical pathways.

Wakatipu Health Services Expert Panel

The National Health Board Expert Panel looked at the configuration of health services within the Lakes District and made a number of recommendations which were well received by the Wakatipu community. These included the provision of a CT scanner for Lakes District Hospital.

The DHB has made good headway as it works through these recommendations and recently approved a plan which will provide CT scanners at both Dunstan and Lakes District Hospitals.

Dunstan has the most immediate need with a growing and aging population. We intend to work with the community and the Dunstan Hospital Trust to have a CT scanner put in place at Dunstan Hospital as soon as possible.

We have also identified an opportunity to work with a private provider on a diagnostic suite, including a CT scanner, for Queenstown as part of a public/private partnership and will work towards having a CT scanner in place there in two years' time.

The Lakes District and Central Otago has a growing population and this is a real opportunity to enhance the services provided to the community. Clinicians from both sites recognise the need for collaborative working to avoid unnecessary duplication and have been fully involved in the planning of these developments.

New Mental Health and Addiction Plan - Raise HOPE: Hapaia te Tumanako 2012-2015

Following a comprehensive planning process and public consultation, Southern DHB approved the Mental Health and Addiction Strategic Plan on 3 May 2012. The plan, called Raise HOPE: Hapaia te Tumanako 2012-2015, is the districts first long-term mental health plan and sets the strategic direction for improving mental health and addiction outcomes in the Southern community for the next three years.

The plan aims to improve the health of the community through better prevention of mental illness and addiction; intervening early in targeted and effective ways; locating support in the community and close to consumers; and improving cooperation across the sector with better quality and capability of services.

Community support for the plan was strong with significant positive feedback being given during the seven week consultation process.

Consultation on Southern DHB diabetes strategy

The Southern District Health Board in partnership with Southern PHO, Diabetes Otago and the local diabetes team is developing a diabetes strategy that will guide the direction of health services for diabetes for the next 10 years.

Diabetes is a chronic condition that affects around 10,000 people in the Southern district. Up to a further 5,000 people have diabetes but are as yet undiagnosed.

Early diagnosis and effective long term management of diabetes has major benefits for people and ensures they live longer, fuller lives. Keeping people well for longer also has cost benefits for the health system.

Consultation with people throughout Otago and Southland on the diabetes strategy was held during May with people being encouraged to attend the drop-in forums to tell us what diabetes services they believe will be needed in the future and how these could be delivered.

Ronald McDonald House

Ronald McDonald House South Island, in partnership with the Southern District Health Board, is to build a new facility for families at Southland Hospital.

The Ronald McDonald Family Room will be situated just metres from the children's and neonatal wards, and will allow parents and families to get rest and respite while still being close to their child.

Southland is a large area, and families are often a long way from home, so have to be accommodated in hotels. The Ronald McDonald Family Room will enable families to be on hand for their child at all times.

Ronald McDonald House South Island Trust will fund the construction of the Family Room, and the DHB will contribute to some of the running costs. The Family Room will be open by early next year.

Launch of Māori Health Directorate

Southern DHB launched the new Māori Health Directorate at Murihiku Marae in May to consolidate Māori health services within the DHB. The Directorate provides support and assistance to all health services and providers to work together to improve Māori health outcomes.

The Directorate enables better planning, co-ordination and delivery through the development of the Māori Health Plan and an improved reporting structure to measure outcomes.

Māori health and the DHB are now linked at a national, regional and local level, so we are better positioned to understand the needs of our Māori community and the ways to which we deliver services.

The establishment of the Directorate is a positive step forward for Māori health in the district and has come about following a long period of discussion and consultation about the needs of local Māori.

Positive feedback on home-based support proposal

Southern DHB's proposal to change the way home-based support services are provided received positive feedback following a month long consultation process.

The DHB was very pleased with the response of the public and stakeholders to the proposed changes. Over 85 percent of the people and groups who made submissions supported the six key outcomes of the proposal.

The submissions we received endorsed the new model of care and were particularly supportive of developing a care manager role for older clients with complex needs, who can be a key contact for older people and their families.

Under the proposal, home-based support will focus on maximising clients' independence and wellbeing, while providing better quality care. This model is more flexible, and can be better tailored to meet an individual's needs by, focusing on what people need to stay healthy and independent.

The proposal also ensures equitable access to care across the district, with clearer criteria, as well as being easier for older people to access and use.

The DHB will begin implementing the new model of care in September by seeking expressions of interest from potential providers of the new service. Changes in home-based support are not likely to start until the middle of next year, and will be introduced gradually to ensure clients have all the information they need about changes to the service.

Dental buses rolling out across the district

The DHB's new dental buses are starting to be seen around the district with seven expected to be operational by mid-2013.

The buses are part of a new model for delivering dental care to school-aged children with the mobile clinics and permanently staffed 'hubs' replacing the roving dental therapists moving between school dental clinics.

Children can be diagnosed and treated with a range of new technologies at the mobile clinics, possibly eliminating the need for to travel to a main centre.

Radiography and other new technology on the buses allows dental technicians to make good decisions about the need for treatment and future checkups.

The DHB is working on getting parents used to the new model of care that asks parents to come to the dental clinic with their children so that we can discuss treating and preventing cavities with them. This is a major change from the days when children would go to the dental therapist by themselves, get fillings and come back the following year for more.

Along with the new mobile clinics, a new electronic record system is being put in place, so that a child's records can be easily accessed, irrespective of which clinic they have previous visited, enabling better continuing care.

Southern DHB leads the way with electronic prescribing roll out

In a New Zealand first, an electronic prescribing pilot launched in Dunedin Hospital in 2010 is being rolled out across the whole Southern DHB.

The highly successful initiative, spearheaded by a team of DHB clinical and IT staff, saw a significant reduction in patient medication errors during its pilot that the system is now being introduced into all Southern DHB hospitals.

Funding for the project was approved by the Southern DHB and the rollout is being supported by an additional grant from the Health Quality and Safety Commission (HQSC).

The scheme, piloted in two wards in Dunedin Hospital, allowed doctors to prescribe medication electronically from specially designed software. This eliminated the risk of most common errors such as patient identification and illegible drug names.

The Southern DHB will be supporting the introduction of e-prescribing into other South Island hospitals through a regional medication safety group, which represents a level of collaboration between DHBs that has not occurred before.

Immunisation an example for other districts

The Southern DHB has achieved 95 percent immunisation coverage for 2-year-old children for the last two quarters, meeting the MoH Immunisation Health Target, and the commitment of the whole health sector to achieving good immunisation coverage is being used as an example for other districts.

National immunisation champion, Dr Pat Tuohy visited the DHB recently to see what processes were in place to achieve such good immunisation coverage.

The DHB is now well on its way to achieving and exceeding the next MoH target of 85 percent of all 8 month olds immunised.

B4 School Check reaching more children

The Southern DHB has the highest national average of all DHBs for children being assessed under the B4 School Check programme.

Since it started more than 9000 children in the Southern region have had their B4 School Check.

B4 School Check, a national initiative launched in 2008, is a health and development check for four-year-olds and is the final core (eighth) check in the Well Child Tamariki Ora Service Schedule. The check is designed to identify any health, behavioural, social or developmental concerns that may affect the child's ability to learn, such as hearing problems or communication difficulties.

The MOH target is 80 percent of the eligible population of four year olds in the Southern District, including 80 percent of the eligible high needs population.

Southern DHB has achieved 104 percent of the overall target for B4 School Checks, and 108 percent of the high needs target.

New fluoroscopy machine is quicker and better

A state-of-the-art fluoroscopy machine at Dunedin Hospital's radiology department is making a positive difference for both patients and staff.

The new machine is providing improved image quality, increasing the range of procedures staff can perform while reducing patients' exposure to radiation due to faster and better imaging.

The unit replaces an older model which was becoming increasingly inefficient and awkward for staff and patients to use.

The new machine is providing outstanding image quality, and is quicker and much easier to use. The machine is also wide enough to allow patients to remain in their own wheelchair instead of needing to be transferred to another chair.

Fluoroscopy is the diagnostic tool to get real time moving images of a patient's internal organs. Dunedin Hospital's fluoroscopy team sees about 30 patients a week.

Yellow envelope improves medical information handover

A yellow envelope is improving the way clinical handover information is communicated between Otago aged care providers and the Southern DHB.

The initiative, used by the older persons services at Dunedin Hospital and about 70 residential care facilities, provides a safer and effective transfer of medical information when a resident is moving between a care facility and the hospital.

The concept was introduced in November last year and the anecdotal feedback has been overwhelmingly positive.

The concept, costing $2000 a year, involves using a big bright yellow envelope in which medical documents, medicines and key information go with the patient when they return to their rest home after being in hospital.

More than 50 Smokefree champions

The Southern DHB is fortunate to have over 50 Smokefree Champions in many wards and departments.

These staff are a fantastic resource with up-to-date information about Nicotine Replacement Therapy and the ABC approach to smoking cessation – Ask about smoking status, offer Brief Advice, and recommend Cessation support.

The Champions attended a one-day train-the-trainer course approved by the Ministry of Health which enables them to share this information with their colleagues and to enrol non-prescribing health professionals as Quit Card providers.

Alternative Spinal Technique Available For Scoliosis

Southern DHB is now offering its patients an alternative spinal technique for Scoliosis. Dunedin surgeon Alan Carstens is using keyhole surgery to unlock people's spinal problems.

Mr Carstens is the only surgeon in the country able to perform endoscopic correction of scoliosis (a curved spine) and he provides the treatment at Dunedin Hospital, where he trained as an orthopaedic registrar. He recently returned to Dunedin Hospital following a year's fellowship in Brisbane, where he learned the specialist technique from leading orthopaedic surgeon Mr Geoff Askin.

The procedure is an excellent alternative to traditional open-spine surgery. With endoscopic surgery, small holes are used instead of large incisions which minimises blood loss, reduces scarring, allows for faster recovery times and less post-operative pain.

The operation has a huge impact on young lives. Patients with Scoliosis have a debilitating condition that has life-threatening implications, but by the end of their recovery and rehabilitation they are able to look forward to leading a normal healthy life.

BOARD MEMBERS

Joe Butterfield, F.C.A.

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 since 1983.

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.

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 Disability Support and Community and Public Health 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 1980's. 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 Consultant for 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 Advisory Committee and from 2007-10 served on the Iwi Governance, Hospital Advisory, Community and Public Health and Complaints Review 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 andwasa member of the Ministry of Health National Breast Feeding Advisory Committee.

She is also a member of the Invercargill City Council's Child Friendly City Initiative Committee,serves on the Advisory Panel for Number 10 Youth One Stop Shop, is a Member Invercargill South Rotary and the National Council of Woman. 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 four terms on the Otago District Health Board and then Southern DHB (his fifth 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 Disability Support and Community and Public Health Committees.

Malcolm has extensive governance and managerial experience in the education and business sectors, including current 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 Southland DHB's 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. He is also employed by Clutha Community Health Company Ltd as a Medical Advisor.

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 Committee in 2005, 2008 and since June 2010 has been a member of the Southern DHB Hospital Advisory Committee and the combined Community and Public Health and Disability Support Advisory Committees. He is also the Chair of Southern DHB's Clinical 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) and is an executive member of the Otago Division of the New Zealand Medical Association. 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.

THE SOUTHERN DHB

Southern DHB is responsible for the planning, funding and provision of publicly funded health care services to a population of approximately 304,000 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 58% of the population lives in Dunedin and Invercargill. The population is projected to increase by 2.8% by 2021, which is lower than the average growth projections in NZ, however the Central Otago and Queenstown Lakes Districts are projected to have considerable population growth and have high numbers of tourists and visitors. Consideration for providing health services for this growing population will be important in the future.

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 also 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)

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 tertiary, secondary, community, disability, and mental health care services to the Southern region.

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 includes:

- 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

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.

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. Southern DHB will continue to participate in the development of these strategies as they relate to improving the health status of Māori in the district.

Relationships between Murihiku and Araiteuru Rūnaka and Southern DHB were further strengthened in June 2011 with the DHB and Otago and Southlands seven Rūnaka signing a Principles of agreement.

The overall purpose of this agreement is to ensure all parties will 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.

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"

STATEMENT OF RESPONSIBILITY

FOR THE TWELVE MONTHS ENDED 30 JUNE 2012

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 2012, fairly reflect the financial position and operations of Southern DHB.

Joe Butterfield
Chairman
Date: 4 October 2012

Paul Menzies
Deputy Chairman
Date: 4 October 2012

Carole Heatly
Chief Executive Officer
Date: 4 October 2012

Robert Mackway-Jones
Executive Director
Finance and Funding
Date: 4 October 2012

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
Clinical Advisory Committee	Monthly
Disability Support Advisory Committee	Bi-Monthly
Hospital Advisory Committee	Monthly
Iwi Governance Committee	Monthly

Quality Improvement Programme

Southern DHB has embraced and developed quality and risk management programmes supporting ongoing accreditation status against Quality Health New Zealand (QHNZ) Standards.

The following quality principles are embedded into all Southern DHB activities:

- the patient/client comes first
- all work is part of a process
- quality improvement is ongoing
- prevention is achieved through planning
- quality happens through people

The quality improvement programme:

- fosters a quality structure which supports clinical and non-clinical systems improvements
- enhances reporting, feedback and communication amongst the service groups and the quality and risk management committee
- facilitated building of a clinical governance relationship across all clinical specialties and teams

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 the 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 2012
(In thousands of New Zealand Dollars)

	Note	2012 Actual	2012 Budget	2011 Actual
Revenue	1	820,425	816,966	802,008
Other operating income	2	14,011	9,222	10,247
Finance income	5a	2,176	2,231	2,080
Total income		**836,612**	**828,419**	**814,335**
Employee benefit costs	4	316,439	307,524	297,475
Depreciation and amortisation expense	7,8	20,087	20,458	19,397
Outsourced services		21,441	19,369	18,556
Clinical supplies		71,123	69,351	70,232
Infrastructure and non-clinical expenses		42,908	42,288	40,723
Payments to non-health board providers		360,707	363,640	350,824
Other operating expenses	3	3,019	2,611	3,650
Finance costs	5b	4,966	4,877	5,000
Capital charge	6	9,110	8,792	8,336
Total expenses		**849,800**	**838,910**	**814,193**
Share of profit/(loss) in associates	10	(49)	-	88
Surplus/(deficit) for the year	13	**(13,237)**	**(10,491)**	**230**
Other Comprehensive income				
Gains on property revaluations	13	-	-	-
Total other comprehensive income		-	-	-
Total Comprehensive income	22	**(13,237)**	**(10,491)**	**230**

Explanation of major variances against budget are provided in note 23

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2012
(In thousands of New Zealand Dollars)

	Note	2012 Actual	2012 Budget	2011 Actual
Equity at beginning of the year		**116,925**	**114,764**	**107,437**
Contribution from the Crown being the net assets transferred to Southern DHB from the Otago and Southland DHBs on 1 May 2010		-	-	-
Total comprehensive income		(13,237)	(10,491)	230
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	13	20,793	21,071	10,029
Other equity movements	13	-	-	(771)
Equity at end of the year		**124,481**	**125,344**	**116,925**

Accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2012

(In thousands of New Zealand Dollars)

	Note	2012 Actual	2012 Budget	2011 Actual
Assets				
Property, plant and equipment	7	277,518	291,441	257,960
Intangible assets	8	4,402	-	5,492
Investments in associates	10	277	238	326
Total non-current assets		**282,197**	**291,679**	**263,778**
Inventories held for distribution	9	4,265	4,370	4,605
Trade and other receivables	11	21,534	30,075	28,844
Cash and cash equivalents	12	39,772	11,596	37,294
Total current assets		**65,571**	**46,041**	**70,743**
Total assets		**347,768**	**337,720**	**334,521**
Equity				
Crown equity	13	53,603	155,616	32,810
Property revaluation reserves	13	85,362	86,314	85,362
Retained earnings / (losses)	13	(14,484)	(116,586)	(1,247)
Total equity		**124,481**	**125,344**	**116,925**
Liabilities				
Interest-bearing loans and borrowings	14	76,401	93,077	93,570
Employee benefits	15	16,095	14,545	14,698
Total non-current liabilities		**92,496**	**107,622**	**108,268**
Cash and cash equivalents	12	-	-	-
Interest-bearing loans and borrowings	14	29,453	4,229	8,144
Trade and other payables	16	47,446	47,229	47,072
Employee benefits	15	53,892	49,439	50,281
Custodial & special purpose funds		-	3,857	3,831
Total current liabilities		**130,791**	**104,754**	**109,328**
Total liabilities		**223,287**	**212,376**	**217,596**
Total equity and liabilities		**347,768**	**337,720**	**334,521**

Accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS

For the year ended 30 June 2012

(In thousands of New Zealand Dollars)

	Note	2012 Actual	2012 Budget	2011 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and patients		835,295	825,839	807,840
Cash paid to suppliers		(498,297)	(496,655)	(484,045)
Cash paid to employees		(311,649)	(311,477)	(295,015)
Cash generated from operations		**25,349**	**17,707**	**28,780**
Interest received		2,176	2,231	2,080
Interest paid		(5,032)	(4,741)	(4,697)
Net taxes refunded/ (paid) (goods and services tax)		745	(512)	413
Capital charge paid		(9,906)	(8,908)	(7,819)
Net cash flows from operating activities	12	**13,332**	**5,777**	**18,757**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		50	-	55
Acquisition of property, plant and equipment		(34,616)	(45,995)	(18,888)
Net appropriation from trust funds		-	-	231
Net cash flows from investing activities		**(34,566)**	**(45,995)**	**(18,602)**
Cash flows from financing activities				
Proceeds from equity injection		20,793	21,071	10,029
Drawdown (Repayment) of borrowings		2,919	(4,320)	(2,974)
Net cash flows from financing activities		**23,712**	**16,751**	**7,055**
Net increase in cash and cash equivalents		2,478	(23,467)	7,210
Cash and cash equivalents at beginning of year		37,294	35,063	30,084
Cash and cash equivalents at end of year	12	**39,772**	**11,596**	**37,294**

Accompanying notes form part of these financial statements

STATEMENT OF CONTINGENCIES AND COMMITMENTS

As at 30 June 2012
(In thousands of New Zealand Dollars)

Contingent Liabilities	2012 Actual	2011 Actual
Legal proceedings against Southern DHB	20	7
Personal grievances	-	-
	20	**7**

Southern DHB has been notified of six claims.

Contingent Assets	2012 Actual	2011 Actual
Legal proceedings by Southern DHB	-	-
	-	**-**

Southern DHB currently has no claims pending

As at 30 June 2012
(In thousands of New Zealand Dollars)

	2012 Actual	2011 Actual
Capital Commitments	**15,516**	**13,019**
Non-cancellable commitments - operating lease commitments		
Not more than one year	1,220	1,408
One to two years	560	560
Two to three years	289	189
Three to four years	166	43
Four to five years	107	0
Over five years	75	0
	2,417	**2,200**

Accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

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 NZIAS 1.

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

Basis of Preparation

Statement of Compliance

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

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

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

Amended standards adopted during the year

Standards, amendments, and interpretations issued that which are relevant to the DHB that were adopted during the year are:

FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments).

NZ IAS 1 Presentation of Financial Statements

NZ IFRS 7 Financial Instruments: Disclosures

The adoption of these standards did not result in any additional disclosures being required.

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 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IAS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods used in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. The DHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

As the External Reporting Board is to decide on a new accounting standards framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefit entities. This means that the financial reporting requirements for public benefit entities are expected to be effectively frozen in the short-term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

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 financial performance. 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
- work in progress.

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 financial performance. 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 financial performance.

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 financial performance 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 financial performance 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%

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

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 financial performance.

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 financial performance. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the statement of financial performance.

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 financial performance.

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

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 financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance 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 financial performance.

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 financial performance.

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

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 financial performance 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 financial performance 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

Crown funding

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

Goods sold and services rendered

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

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

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance 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 financial performance.

The interest expense component of finance lease payments is recognised in the statement of financial performance 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 financial performance, 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 financial performance 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 financial performance. 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.

NOTES TO THE FINANCIAL STATEMENTS

1 Revenue

	2012 Actual	2011 Actual
Health and disability services (MOH contracted revenue)	779,411	758,775
ACC contract	8,679	8,471
Inter district patient flows	23,312	26,275
Other revenue	9,023	8,487
	820,425	**802,008**

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.

2 Other operating income

	2012 Actual	2011 Actual
Gain on sale of property, plant and equipment	45	47
Donations and bequests received	1,171	671
Rental income	1,845	1,780
Other	10,950	7,749
	14,011	**10,247**

3 Other operating expenses

	Note	2012 Actual	2011 Actual
Impairment of trade receivables (doubtful debts)		269	715
Bad debts written off		72	50
Loss on disposal of property, plant and equipment		21	21
Audit fees (for the audit of financial statements)		162	162
Audit related fees (for assurance and related services)		-	-
Fees paid to other auditors for assurance and related services including internal audit		47	122
Board member fees	19	328	402
Operating lease expenses		2,117	2,175
Koha		3	3
		3,019	**3,650**

4 Employee benefit costs

	2012 Actual	2011 Actual
Wages and salaries	312,828	294,601
Increase/ (decrease) in employee benefit provisions	3,611	2,874
	316,439	**297,475**

5a Finance income

	2012 Actual	2011 Actual
Interest income	2,176	2,080
	2,176	**2,080**

5b Finance costs

	2012 Actual	2011 Actual
Interest expense	4,966	5,000
	4,966	**5,000**

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 30 December respectively. The capital charge rate for the period ended 30 June 2012 was 8 per cent. The amount charged during the period was $9,110 (2011: $8,336).

7 Property, plant and equipment

Cost	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant and equipment	Vehicles	Leased Assets	Work in progress	Total
Balance at 1 July 2010	25,263	199,078	116,983	259	15,765	1,821	**359,169**
Additions	-	214	3,635	-	685	14,551	**19,085**
Disposals	(32)	(16)	(7,244)	-	(1,094)	-	**(8,386)**
Transfers	-	3,334	3,534	455	15	(8,068)	**(730)**
Revaluations & impairment	-	(771)	-	-	-	-	**(771)**
Balance at 30 June 2011	**25,231**	**201,839**	**116,908**	**714**	**15,371**	**8,304**	**368,367**
Balance at 1 July 2011	25,231	201,839	116,908	714	15,371	8,304	**368,367**
Additions	-	522	6,824	10	596	30,528	**38,480**
Disposals	-	(6)	(6,268)	(55)	(1,665)	-	**(7,994)**
Transfers	-	10,040	7,473	23	-	(17,963)	**(427)**
Revaluations & impairment	-	-	-	-	-	-	**-**
Balance at 30 June 2012	**25,231**	**212,395**	**124,937**	**692**	**14,302**	**20,869**	**398,426**
Depreciation and impairment losses							
Balance at 1 July 2010	-	1,162	90,602	207	8,970	-	**100,941**
Depreciation charge for the year	-	6,912	8,041	53	2,818	-	**17,824**
Impairment losses	-	(41)	-	-	-	-	**(41)**
Reversal of impairment losses	-	-	-	-	-	-	**-**
Disposals	-	-	(7,223)	-	(1,094)	-	**(8,317)**
Transfers	-	-	117	8	(125)	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Balance at 30 June 2011	**-**	**8,033**	**91,537**	**268**	**10,569**	**-**	**110,407**
Balance at 1 July 2011	-	8,033	91,537	268	10,569	-	**110,407**
Depreciation charge for the year	-	7,176	8,677	47	2,569	-	**18,469**
Impairment losses	-	-	-	-	-	-	**-**
Reversal of impairment losses	-	-	-	-	-	-	**-**
Disposals		(6)	(6,251)	(46)	(1,665)		**(7,968)**
Transfers	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Balance at 30 June 2012	**-**	**15,203**	**93,963**	**269**	**11,473**	**-**	**120,908**
Carrying amounts							
At 1 July 2010	25,263	197,916	26,381	52	6,795	1,821	**258,228**
At 30 June 2011	**25,231**	**193,806**	**25,371**	**446**	**4,802**	**8,304**	**257,960**
At 1 July 2011	25,231	193,806	25,371	446	4,802	8,304	257,960
At 30 June 2012	**25,231**	**197,192**	**30,974**	**423**	**2,829**	**20,869**	**277,518**

7 Property, plant and equipment (continued)

Impairment

There were no impairment losses recognised in the 2012 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 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

The disposal of certain properties may be subject to the Ngai Tahu Claims Settlement Act 1995, or the provision of section 40 of the Public Works Act 1981.

8 Intangible assets

Cost	**Software**
Balance at 1 July 2010	11,720
Additions	1,233
Disposals	(77)
Balance at 30 June 2011	**12,876**
Balance at 1 July 2011	12,876
Additions	528
Disposals	-
Balance at 30 June 2012	**13,404**
Amortisation and impairment losses	
Balance at 1 July 2010	5,888
Amortisation charge for the year	1,573
Impairment losses	-
Reversal of impairment losses	-
Disposals	(77)
Balance at 30 June 2011	**7,384**
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**
Carrying amounts	
At 1 July 2010	5,832
At 30 June 2011	**5,492**
At 1 July 2011	5,492
At 30 June 2012	**4,402**

8 Intangible assets (continued)

Impairment

There were no impairment losses recognised in the 2012 year

9 Inventories held for distribution

	2012 Actual	2011 Actual
Pharmaceuticals	1,587	1,363
Surgical & Medical supplies	2,678	3,242
	4,265	**4,605**

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2012 was $4,265 (2011 $4,605).

The write-down of inventories held for distribution amounted to $0 for 2012, while reversals of write-downs were $0 for 2012 (2011: $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 2012	Balance Date
South Island Shared Service Agency Limited	Support the activites of DHBs' in providing: • health services planning and review, • provider and stakeholder management, • contract management, • project management, • contract audit and monitoring, and • financial analysis and planning	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%)

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

2011 Actual	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
South Island Shared Service Agency Limited	2,229	1,142	1,087	2,877	295
	2,229	1,142	1,087	2,877	295

10 Investments in associates (continued)

c) Share of profit of associate entities

	2012 Actual	2011 Actual
Share of profit/ (loss) before tax	(49)	88
Less: tax expense		-
Share of profit/ (loss) after tax	**(49)**	**88**

d) Investment in associate entities

	2012 Actual	2011 Actual
Carrying amount at beginning of year	326	238
Acquisition of new investments	-	-
Disposal of investments	-	-
Share of total recognised revenue and expenses	(49)	88
Dividends	-	-
Other movements	-	-
	277	**326**

11 Trade and other receivables

	2012 Actual	2011 Actual
Trade receivables from non-related parties	3,589	3,051
Ministry of Health receivables	912	2,082
Accrued income	15,540	21,622
Prepayments	1,493	2,089
	21,534	**28,844**

Trade receivables are shown net of provision for doubtful debts amounting to $1,695 arising from identified debts unlikely to be recovered (2011: $1,426).

12 Cash and cash equivalents

	2012 Actual	2011 Actual
Bank balances	9,706	3,838
Call deposits	30,053	33,442
Cash and cash equivalents	13	14
Bank overdrafts	-	-
Cash and cash equivalents in the statement of cash flows	**39,772**	**37,294**

Working capital facility

At 30 June 2012, the Southern DHB held no bank overdraft facilities.

12 Cash and cash equivalents (continued)

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

	Note	2012 Actual	2011 Actual
(Deficit) / surplus for the period		(13,237)	230
Add back non-cash items:			
Depreciation and assets written off		20,087	19,397
Share of profit/ (loss) after tax from associate companies	10	49	(88)
Other non cash items			
Increase/ (decrease) in fair value		623	338
Increase/ (decrease) in provision for doubtful debts		269	715
Add back items classified as investing activity:			
Net loss/ (gain) on disposal of property, plant and equipment		(24)	(26)
Movements in working capital:			
(Increase)/ decrease in trade and other receivables		7,042	(4,512)
(Increase)/ decrease in inventories		340	(403)
Increase/ (decrease) in trade and other payables		(6,825)	112
Increase/ (decrease) in employee benefits		5,008	2,994
Net movement in working capital		**5,565**	**(1,809)**
Net cash inflow/ (outflow) from operating activities		**13,332**	**18,757**

13 Capital and reserves

	Crown equity	Property revaluation reserve	Retained earnings	Total equity
Balance at 1 July 2010	22,781	86,314	(1,658)	107,437
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	10,736	-	-	10,736
Equity repayment to the crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	-	-	-
Transfers from revaluation of land and buildings on impairment		(771)	-	(771)
Transfers from revaluation of land and buildings on disposal	-	(181)	181	-
Surplus for the period	-	-	230	230
Balance at 30 June 2011	**32,810**	**85,362**	**(1,247)**	**116,925**
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**

During the year the accounting treatment for Research, Trust, and Custodial Funds was revised. Previously these funds were recorded as liabilities. In the current year these funds were recorded as revenue and those with conditions attached of $3.3 million have been ring fenced within retained earnings.

Equity is made up of	2012 Actual	2011 Actual
Equity	119,631	115,482
Restricted Equity	4,850	1,443
Total Equity	**124,481**	**116,925**

14 Interest-bearing loans and borrowings

	2012 Actual	2011 Actual
Non-current		
Secured loans	74,295	90,189
Unsecured loans	437	789
Finance lease liabilities	1,669	2,592
	76,401	**93,570**
Current		
Current portion of secured loans	27,599	5,100
Current portion of finance lease liabilities	1,408	2,599
Current portion of unsecured loans	446	445
	29,453	**8,144**

Secured loans

Southern DHB has a secured loan with the Crown Health Financing Agency.

The details of terms and conditions are as follows:

Interest rate summary	2012 Actual	2011 Actual
Crown Health Financing Agency	3.88% to 6.96%	3.65% to 6.96%

Repayable as follows:	2012 Actual	2011 Actual
Within one year	28,046	5,546
One to two years	10,806	38,045
Two to three years	6,976	10,806
Three to four years	16,720	6,976
Four to five years	625	16,720
Later than five years	40,554	20,004

Term loan facility limits	2012 Actual	2011 Actual
Crown Health Financing Agency	97,400	97,400
Term loan facility	-	-

Security and terms

The term loan is a secured loan.

The loan facility is provided by the Crown Health Financing Agency, which is part of the Treasury.

The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent Southern DHB cannot perform the following actions:

- 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 loan from the Crown Health Financing Agency were waived. However the Crown Health Financing Agency retains the right to reinstate the covenants at any time.

14 Interest-bearing loan and borrowings (continued)

Finance lease liabilities

Finance lease liabilities are payable as follows:

	Minimum lease payments 2012 Actual	Interest 2012 Actual	Principal 2012 Actual	Minimum lease payments 2011 Actual	Interest 2011 Actual	Principal 2011 Actual
Less than one year	1,618	159	1,459	2,910	268	2,642
Between one and five years	1,775	177	1,598	2,693	300	2,393
More than five years	-	-		176	4	172
	3,393	**336**	**3,057**	**5,779**	**572**	**5,207**

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

15 Employee benefits

	2012 Actual	2011 Actual
Non-current liabilities		
Liability for long-service leave	3,376	3,069
Liability for sabbatical leave	1,232	1,109
Liability for retirement gratuities	11,487	10,520
	16,095	**14,698**
Current liabilities		
Liability for long-service leave	3,183	3,169
Liability for sabbatical leave	132	113
Liability for retirement gratuities	2,154	2,045
Liability for annual leave	30,418	26,780
Liability for sick leave	250	257
Liability for continuing medical education	5,913	5,901
Salary and wages accrual	11,842	12,016
	53,892	**50,281**

16 Trade and other payables

	2012 Actual	2011 Actual
Trade payables due to associates	-	-
Trade payables to non-related parties	5,053	2,849
GST payable	6,842	6,098
Income in advance relating to contracts with specific performance obligations	1,614	1,168
Capital charge due to the Crown	-	796
Other non-trade payables and accrued expenses	33,937	36,161
	47,446	**47,072**

17 Operating leases

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:	2012 Actual	2011 Actual
Less than one year	1,220	1,408
Between one and five years	1,122	792
More than five years	75	0
	2,417	**2,200**

During the year ended 30 June 2012, $2,117 was recognised as an expense in the statement of financial performance in respect of operating leases (2011: $2,175).

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 14.7 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 Crown Retail Deposit Guarantee Scheme for deposits held with banks that have opted into the scheme provides a guarantee of $1million per depositor per guaranteed institution. Deposits beyond this level are not covered by this scheme.

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

Trade receivables	Gross Receivable	Impairment	Gross Receivable	Impairment
Not past due	2,741		3,604	(57)
Past due 0-30 days	931		719	(22)
Past due 31-120 days	788	(117)	766	(366)
Past due 121-360 days	496	(382)	470	(146)
Past due more than 1 year	1,240	(1,196)	1,000	(835)
Total	**6,196**	**(1,695)**	**6,559**	**(1,426)**

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

Trade receivables	2012 Actual	2011 Actual
Gross trade receivables	6,196	6,559
Individual impairment	(1,695)	(1,426)
Collective impairment	-	-
Net total trade receivables	**4,501**	**5,133**

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.

18 Financial instruments (continued)

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.

2012	Balance sheet	Contractual cash flow	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
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	-
Loan from associate	-	-	-	-	-	-	-
Unsecured bank facility	-	-	-	-	-	-	-
Trade and other payables	47,446	47,446	47,446	-	-	-	-
Bank overdraft	-	-	-	-	-	-	-
Total	**153,300**	**174,938**	**61,491**	**20,578**	**15,266**	**33,348**	**44,255**
Forward exchange contracts							
Inflow							
Outflow	153,300	174,938	61,491	20,578	15,266	33,348	44,255

2011	Balance sheet	Contractual cash flow	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
Secured loans	95,289	117,752	7,228	2,645	32,071	42,297	33,511
Unsecured loans	1,234	1,343	223	223	445	452	-
Finance lease liabilities	5,191	5,779	1,599	1,311	1,404	1,289	176
Loan from associate	-	-	-	-	-	-	-
Unsecured bank facility	-	-	-	-	-	-	-
Trade and other payables	47,072	47,072	47,072	-	-	-	-
Bank overdraft	-	-	-	-	-	-	-
Total	**148,786**	**171,946**	**56,122**	**4,179**	**33,920**	**44,038**	**33,687**
Forward exchange contracts							
Inflow							
Outflow	148,786	171,946	56,122	4,179	33,920	44,038	33,687

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.

	2012 Actual						
	Effective interest rate (%)	Total	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
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 Health Funding Agency *	3.88%	5,000	5,000	-	-	-	-
Crown Health Funding Agency *	4.90%	5,000	5,000	-	-	-	-
Crown Health Funding Agency *	6.96%	5,000	-	5,000	-	-	-
Crown Health Funding Agency *	6.11%	12,000	-	12,000	-	-	-
Crown Health Funding Agency *	4.28%	10,000	-	-	10,000	-	-
Crown Health Funding Agency *	5.75%	6,000	-	-	-	6,000	-
Crown Health Funding Agency *	6.55%	6,250	-	-	-	6,250	-
Crown Health Funding Agency *	4.75%	10,000	-	-	-	10,000	-
Crown Health Funding Agency *	4.40%	1,250	-	-	-	-	1,250
Crown Health Funding Agency *	4.34%	4,500	-	-	-	-	4,500
Crown Health Funding Agency *	4.40%	5,400	-	-	-	-	5,400
Crown Health Funding Agency *	5.22%	7,000	-	-	-	-	7,000
Crown Health Funding Agency *	5.06%	10,000	-	-	-	-	10,000
Crown Health Funding Agency *	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	-
Bank overdraft	N/A	-	-	-	-	-	-

* These assets/ liabilities bear interest at fixed rates

18 Financial instruments (continued)

Effective interest rates and repricing analysis

	2011 Actual						
	Effective interest rate (%)	Total	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
Cash and Cash Equivalents	2.50%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office *	0.00%	6,004	300	300	600	1,800	3,004
Crown health Funding Agency *	3.65%	4,500	4,500	-	-	-	-
Crown health Funding Agency *	3.88%	5,000	-	-	5,000	-	-
Crown health Funding Agency *	4.28%	10,000	-	-	10,000	-	-
Crown health Funding Agency *	4.90%	5,000	-	-	5,000	-	-
Crown health Funding Agency *	6.96%	5,000	-	-	5,000	-	-
Crown health Funding Agency *	6.11%	12,000	-	-	12,000	-	-
Crown health Funding Agency *	4.75%	10,000	-	-	-	10,000	-
Crown health Funding Agency *	5.06%		-	-	-	10,000	-
Crown health Funding Agency *	5.75%		-	-	-	6,000	-
Crown health Funding Agency *	6.55%		-	-	-	6,250	-
Crown health Funding Agency *	5.22%	7,000	-	-	-	-	7,000
Crown health Funding Agency *	6.42%	10,000	-	-	-	-	10,000
Finance lease liabilities*	3.34%-8.93%	5,207	1,440	1,202	1,265	1,128	172
Unsecured Bank Loans	0.00%	1,343	223	223	445	452	-
Bank overdraft	3.50%-5.42%	-	-	-	-	-	-

* 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 2012, 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 $1,005 (2011: $959).

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	Designated at fair value through profit & loss	Loans and receivables	Available for sale	Other amortised cost	Carrying amount Actual	Fair value Actual
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
Bank overdraft	12	-	-	-	-	-	-	-
2011								
Trade and other receivables	11	-	-	28,844	-	-	28,844	28,844
Cash and cash equivalents	12	-	-	37,294	-	-	37,294	37,294
Secured loans	14	-	-	95,289	-	-	95,289	93,435
Finance lease liabilities	14	-	-	5,191	-	-	5,191	5,089
Unsecured liabilities	14	-	-	1,234	-	-	1,234	961
Trade and other payables	16	-	-	47,072	-	-	47,072	47,072
Bank overdraft	12	-	-	-	-	-	-	-

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 2012 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2012 Actual %	2011 Actual %
Finance Leases	6.08%	9.25%
Loans and borrowings	2.42% - 4.27%	6.00%

19 Related parties

Ownership

Southern DHB is a crown entity in terms of the Crown Entities Act 2004and 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 $'000	
	2012 Actual	2011 Actual
Helen Algar	-	11
Peter Barron	-	11
Sajan Bhatia	-	-
Joe Butterfield	51	30
Louise Carr	-	11
Neville Cook	28	28
Sandra Cook	22	-
Kaye Crowther QSO	26	26
Mary Flannery	28	16
Karen Goffe	-	10
Susie Johnstone	-	12
Malcolm Macpherson	29	26
Fiona McArthur	-	11
Judith Medlicott	-	10
Paul Menzies	35	38
Errol Millar	-	24
Katie O'Connor	-	10
Tahu Potiki	26	24
Louise Rosson	-	10
Branko Sijnja	27	28
Richard Thomson	27	27
Tim Ward	29	28
Dot Wilson	-	11

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

19 Related parties (continued)

Compensations The key management remuneration is as follows:	2012 Actual	2011 Actual
Salary and short-term benefits	2,714	2,420
Superannuation	23	12
	2,737	**2,432**

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

The FTE associated with key personnel was 10.24 (2011: 10.10). In May 2012 the executive management team underwent a restructure. The information above represents the remuneration and FTE of the people on the management team for the period they were on the team.

Employee Termination Payments

Nine employees received remuneration in respect of the termination or personal grievance relating to their employment with Southern DHB. The total payments were $290,351 (2011: 17 employees totalling $359,173).

2012	2011
137	69
48	60
33	30
17	24
16	22
15	22
15	21
9	21
2	18
	16
	14
	14
	13
	10
	4
	1
	0

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 2012 were:

Total Remuneration and Other Benefits $000	Number of Employees	
	2012	2011
100 - 110	80	69
110 - 120	62	44
120 - 130	41	42
130 - 140	18	27
140 - 150	31	22
150 - 160	12	18
160 - 170	22	15
170 - 180	15	16
180 - 190	14	14
190 - 200	11	11
200 - 210	11	10
210 - 220	9	9
220 - 230	16	11
230 - 240	15	19
240 - 250	7	8
250 - 260	11	8
260 - 270	8	9
270 - 280	8	9
280 - 290	9	9
290 - 300	9	7
300 - 310	5	9
310 - 320	7	6
320 - 330	3	4
330 - 340	5	2
340 - 350	4	3
350 - 360	2	5
360 - 370	2	2
370 - 380	2	-
380 - 390	1	-
390 - 400	1	-
410 - 420	2	-
430 - 440	1	-
460 - 470	-	1
510 - 520	-	1
530 - 540	1	-
550 - 560	1	-
580 - 590	-	1
650 - 660	1	-
820 - 830	-	1

Of the 447 employees shown above 345 were medical/dental employees (2011: 326 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 639, compared with the actual total number of 447 (2011: 635 and 412).

The Chief Executive's employment began on 18 March 2012. Her remuneration and other benefits, either paid or accrued from that date are in the band $130-$140. The Remuneration for the former Chief Executive up until his resignation in September 2011 falls within the band $200-210.

19 Related parties (continued)

Transactions with Board Members and Key Management Personnel

	2012				2011			
Board and Exec Members	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
Richard Bunton								
Mainland Cardiothoracic Associates (D)	1,441	-	-	-	1,302	-	-	-
Joe Butterfield								
Corstophine Baptist Community Trust (F)	1,965	-	-	-	1,998	-	-	-
Polson Higgs (F)	3	-	-	-	-	-	-	-
Neville Cook								
Environment Southland	0		-		0	-	-	-
Invercargill Licencing Trust (B)		30	-	-	-	1	-	-
Sandra Cook								
Te Runanga O Ngai Tahu (Representative)	0	-	-	-	0	-	-	-
Kaye Crowther								
WHK (NZ) Ltd (E)	-	-	-	-	82	-	-	-
Royal New Zealand Plunket Society Southland (C)	131	3	-	2	9	-	-	-
Mary Flannery								
Bodkins/ AWS Legal, Alexandra (E)	1	-	-	-	-	-	-	-
Rural Otago Primary Health Organisation (T)		-	-	-	2,759	-	-	-
Malcolm Macpherson								
ACC (F)	2,038	9,915	-	667	2,236	9,741	-	1,086
Centennial Health (F)	29	-	-	-	28	-	-	-
Central Otago District Council - Mayor	Interest Ceased 2011				52	-	-	-
Otago Community Hospice (T)	2,632	3	-	0	2,485	2	-	-
Otago Polytechnic (B)	73	196	-	19	67	135	3	43
Paul Menzies								
Southern Primary Health Organisation (T)	58,989	190	1	60	Interest Commenced 2012			
Tahu Potiki								
Arai Te Uru Whare Hauora Ltd (D)	640	-	-	-	676	0	-	0
Environment Science and Research (B)	8	-	1	-	-	-	-	-
Te Runanga O Ngai Tahu (Representative)	0	-	-	-	1	-	-	-
Brian Rousseau								
South Island Shared Service Agency Limited (D)	150	103	-	-	728	147	-	-
Branko Sijnja								
Balclutha General Practitioners Limited (E)	38	-	-	-	58	-	-	-
Clutha Health First (B)	6,234	409	2	35	5,981	396	1	29
Southern Community Laboratories (D)	827	1,156	-	90	Interest Commenced 2012			
University of Otago (Rural Immersion Programme) (D)	11,966	3,105	66	225	10,244	3,191	682	219

19 Related parties (continued)

Board and Exec Members	2012 Purchased by Southern DHB	2012 Purchased from Southern DHB	2012 Owed by Southern DHB	2012 Owed to Southern DHB	2011 Purchased by Southern DHB	2011 Purchased from Southern DHB	2011 Owed by Southern DHB	2011 Owed to Southern DHB
Richard Thomson								
Dunedin City Council (Co)	714	-	-	-	795	-	93	-
Hawksbury Community Living Trust (C & T)		-	-	-	-	0	-	0
Healthcare Otago Charitable Trust (T)	4	-	-	-	7	30	-	-
Tim Ward								
Southern Institute of Technology (B)	11	234	2	-	6	228	-	225

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 Board and Committee attendances

Board Meeting Attendance Register

	7-Jul	5-Aug	2-Sep	6-Oct	10-Nov	15-Dec	2-Feb	1-Mar	5-Apr	3-May	7-Jun
Joe Butterfield (Chair)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Paul Menzies (Deputy Chair)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Neville Cook	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	A
Sandra Cook*			✔	✔	✔	✔	✔	✔	✔	✔	✔
Kaye Crowther	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Mary Flannery	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Malcolm Macpherson	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Tahu Potiki	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	A
Branko Sijnja	✔	✔	A	✔	✔	✔	✔	✔	✔	✔	✔
Richard Thomson	✔	✔	✔	✔	✔	✔	A	✔	✔	✔	✔
Tim Ward	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

*** Commenced 25 August 2011**

Key:

✔	Present
A	Apology
Ab	Absent
LOA	Leave of Absence Granted

20 Board and Committee attendances (continued)

Hospital Advisory Committee Attendance Register

	6-Jul	4-Aug	1-Sep	5-Oct	9-Nov	1-Feb	29-Feb	4-Apr	2-May	6-Jun
Paul Menzies (Chair)	✔	✔	✔	A	✔	✔	✔	✔	✔	✔
Neville Cook	A	✔	✔	A	✔	✔	✔	A	✔	✔
Malcolm Macpherson	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Tahu Potiki	NA	NA	NA	NA	NA	✔	A	✔	✔	A
Branko Sijnja	✔	✔	A	✔	✔	✔	✔	✔	✔	✔
Richard Thomson	✔	✔ VC	✔	✔	✔	A	✔	✔	✔	✔
Tim Ward	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Key:

✔	Present
A	Apology
✔ VC	Present via videoconference
NA	Not Appointed

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

	6-Jul	4-Aug	1-Feb	4-Apr	2-May	6-Jun
Malcolm Macpherson (Chair)	✔	✔	✔	✔	✔	✔
Neville Cook	A	✔	✔	A	✔	✔
Sandra Cook	NA	NA	✔	✔	✔	✔
Kaye Crowther	✔	✔	✔	✔	✔	✔
Mary Flannery	✔	✔	✔	✔	✔	✔

Key:

✔	Present
A	Apology
NA	Not Appointed

Audit & Risk Committee Attendance Register

	5-Aug	6-Oct	15-Dec	1-Mar	7-Jun
Tim Ward (Chair)	✔	✔	✔	✔	✔
Joe Butterfield	✔	A	✔	✔	✔
Mary Flannery	✔	✔	✔	✔	✔
Paul Menzies	✔	✔	✔	✔	✔

Key:

✔	Present
A	Apology
NA	Not Appointed

20 Board and Committee attendances (continued)

Iwi Governance Committee Attendance Register

	6-Jul	30-Aug	5-Oct	9-Nov	14-Dec	1-Feb	29-Feb	3-Apr	2-May	6-Jun	4-Jul
Sandra Cook	NA	NA	A	✔	A	✔	✔	A	✔	✔	A
Kaye Crowther	NA	NA	NA	NA	NA	✔	✔	✔	✔	✔	✔
Paul Menzies	✔	✔	✔	✔	✔	✔	A	✔	✔	✔	✔
Tahu Potiki	✔	✔	✔	A	✔	✔	A	✔ VC	✔	A	✔

Key:

✔	Present
A	Apology
NA	Not Appointed
✔ VC	Present via videoconference

Clinical Advisory Committee Attendance Register

	6-Jul	3-Aug	24-Aug	5-Oct	9-Nov	1-Feb	29-Feb	4-Apr	2-May	6-Jun
Branko Sijnja (Chair)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Key:

✔	Present
A	Apology

21 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 current 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 2012 has resulted in a deficit of $2.9 million for Mental Health services. Additionally Southern DHB has a brought forward under spend of $0.1 million, meaning that the brought forward deficit is $2.8 million.

22 Accounting estimates and judgements

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.

23 Explanation of financial variances from budget

The unfavourable variance in comprehensive income against budget for the year ended 30 June 2012 was $2.7m.

At a very high level, the following items (unfavourable variances shown as negatives) contribute to the overall variance:

- $4.2m of additional revenue, including ministry of health revenue, most of which has associated cost offset
- $3.9m of income related to a transfer of research trust and custodial funds previously recorded as liabilities
- $4.1m lower personal health costs, and includes lower payments to the PHO for SIA and health promotion funding.
- $0.8m of lower mental health costs, including lower than budgeted costs for community and residential beds
- ($6.4m) of additional medical salaries (net of outsourced medical personal) due to additional FTE, annual leave not taken to budget and overtime payments
- ($3.2m) of additional outsourced costs
- ($2.1m) of net increased Disability Support Services expenditure
- ($1.6m) of additional clinical supply costs
- ($1.4m) of additional infrastructure and non clinical costs
- ($1.0m) of higher administration salaries from higher FTE and other variations

24 Events after the balance date

There were no significant events after the balance date.

STATEMENT OF FORECAST SERVICE PERFORMANCE

The following reports on the achievement the DHB made against targets planned in the four output classes

1) Prevention Services

Prevention health services promote and protect the health of the whole population, or identifiable subpopulations, 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.

By improving environments and raising awareness, these services support people to reduce the major risk factors that contribute to the most prevalent long-term conditions and enable people to avoid, delay or reduce the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effectiveness when the aims are achieved. High need and at risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes. These services also ensure that threats to the health of the community are prevented from developing or spreading and that services are prepared for emergency events – such as pandemics or earthquakes.

The Southern DHB will seek to fund or provide outputs which will make a positive impact on the health and wellbeing of the Otago and Southland population.

Prevention Services			
Performance Measure	**Baseline 2009/10**	**Target 2011/12**	**Achievement 2011/12**
Health Promotion and Education Services			
The number of hospitalised smokers provided with help and advice to quit.	56%	95%	Not achieved with actual 86.7%, however, this was a significant increase in prior years results
The proportion of smokers identified in primary care and provide with help and advice to quit.	NA	90%	Not achieved result was 31.8%
The percentage of infants exclusively and fully breastfeed at 6 weeks.	68%	74%	Not achieved, with actual reducing to 66%
The percentage of infants exclusively and fully breastfeed at 6 months.	33%	33%	Not achieved, with actual at 29%
Statutory and Regulatory Services			
The proportion of compliant tobacco retailers identified from controlled purchase operations.	79%	85%	Achieved, with 91% compliant from controlled purchase operations
The proportion of compliant alcohol retailers identified from controlled purchase operations.	90%	95%	Not achieved with actual at 78%
The proportion of Communicable disease notifications investigated.	100%	100%	All notifications were investigated. Achievement 100%
The proportion of hazardous substances inspections and audits completed.	31.25%	10%	Achieved target with result of 20.4%

Prevention Services (continued)			
Performance Measure	**Baseline 2009/10**	**Target 2011/12**	**Achievement 2011/12**
Immunisation Services			
The percentage of children fully immunised at age 2.	93.6%	95%	Not achieved, but increased from previous years to 94.5%
The proportion of eligible young women completing the HPV vaccination programme.	57%	70%	Not achieved, but increased from prior years actual to 65%
The proportion of the total population aged over 65 having received a flu vaccination.	67.7%	70%	Not achieved with actual at 65.72%

2) Early Detection and Management

Early detection and management services cover a range of services provided across the continuum of care to maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated - particularly where people have multiple conditions requiring ongoing interventions or support. These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori and Pacific health services, pharmacy services, community radiology and diagnostic services and child oral health and dental services. A proportion of these services are demand driven, such as pharmaceuticals and diagnostics, and services are provided with a mix of public and private funding and may include co-payments for general practice services and some high-cost drugs.

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services; in Otago and Southland this demand is growing at a faster rate than the growth in our population.

Early detection and management services result in earlier identification of risk and health issues, providing an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. They also help to reduce the burden of long-term conditions by supporting people to better manage their conditions and avoid complications, acute illness and crises. These services also promote regular connection with health services, supporting people to maintain good health through earlier diagnosis and treatment and reducing complex intervention and unnecessary hospital admissions.

Providing flexible, responsive and needs-based services in the community, without the need for a hospital appointment, will reduce the overall rate of hospital admissions, particularly acute and unplanned admissions and will have a major impact on the sustainability of hospital and specialist services by freeing up specialist services for more complex and planned interventions and reducing the diversion of critical resources into managing acute demand.

Government expects that primary care will make a larger contribution to the health system as a point of continuity and improve access to a wider range of publicly funded services closer to home. The integration of services to meet Government expectations for 'better, sooner, more convenient health services' provides a unique opportunity to reduce duplication, waste and inefficiencies across the health system by ensuring the right person has access to the right services, in the right place and at the right time - irrespective of provider.

The Southern DHB will seek to fund or provide outputs which will make a positive impact on the health and wellbeing of the Otago and Southland population.

Early Detection and Management			
Performance Measure	**Baseline 2009/10**	**Target 2011/12**	**Achievement 2011/12**
Primary Health Care (GP) Services			
The percentage of the DHB population enrolled in a Primary Healthcare Organisation.	92.7%	93.5%	Achieved 93.9%
GP utilisation by high needs patients - the ratio of consults (doctor & nurse) of high needs and non-high needs patients.	1.11	1.11	1.08
The number of skin lesions removed in primary care (by a GP with special interest – GPSI) without the need for a hospital appointment.	550	550	Achieved with 697 lesions removed
Oral Health Services			
The number of eligible pre-school children enrolled in school and community oral health services.	13,658	16,300	Achieved with 16357 children enrolled
The percentage of eligible adolescents who access funded oral health services.	79.6%	85.0%	Not achieved with only 82% of eligible adolescents accessing services
Long-term Conditions Programmes			
The proportion of the eligible population (35-79) having a CVD risk assessment (fasting lipid/glucose test) every five years.	75.8%	77.0%	Not achieved with only 44.1% having assessments
The percentage of estimated people with diabetes who receive the free annual diabetes check.	63.9%	66.9%	Achieved with 98.53%
The proportion of people with diabetes who have satisfactory or better management, i.e. HBA1c < 8.	79.7%	81.0%	Not achieved with only 68% having reached the target
Pharmacy Services			
The number of DHB funded prescription items dispensed.	4,704,482	5,319,083	Not achieved, with 5,150,642 funded prescriptions dispensed
Population Based Screening Services			
The proportion of the eligible population (45-69) receiving breast screen examinations.	73.6%	73.6%	Not achieved actual was 70.8%
The proportion of the eligible population (25-69) receiving cervical cancer screens.	79%	80.0%	Not achieved with only 78.1% screened
The percentage of eligible children receiving Before School Checks (B4SC).	65.8%	76.0%	Achieved with 83%
Community Referred Tests and Diagnostic Services			
The proportion of ED/inpatient CT and MRI scans performed on the same day.	New measure	70%	Meet target with 79.47%
Laboratory test turnaround times: Biochemistry	<24 hours	<24 hours	Achieved
Laboratory test turnaround times: Immunology	<48 hours	<48 hours	Achieved
Laboratory test turnaround times: Haematology	<24 hours	<24 hours	Achieved
Laboratory test turnaround times: Cytology	<72 hours	<72 hours	Non Gynaecological achieved target
Laboratory test turnaround times: Histology	<72 hours	<72 hours	Achieved
Laboratory test turnaround times: Microbiology	<72 hours	<72 hours	Achieved

3) Intensive Assessment and Treatment

Intensive assessment and treatment services are services that are usually complex and 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.

An owner of hospital and specialist services the DHB provides an extensive range of intensive treatment and complex specialist services to its population and to the populations of other DHBs who do not provide some of the more complex and highly specialised tertiary services in their own regions. The DHB also funds some intensive assessment and treatment services for its population that are provided by other DHBs, private hospitals or private providers. A proportion of these services are driven by demand, such as acute and maternity services. However, others are planned services for which provision is determined by capacity and resource; clinical triage, national service coverage agreements and treatment thresholds determine access to these services.

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (i.e. removal of an obstructed gallbladder so that the patients does not have repeat attacks of abdominal pain/colic, increased risk of cancer and/or infection) or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services can also support improvements across the whole system, enabling people to be supported in the community with confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

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

Government has set clear expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care being delivered. The changes being made to meet Government expectations are providing unique opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

The Southern DHB will seek to fund or provide outputs which will make a positive impact on the health and wellbeing of the Otago and Southland population.

Intensive Assessment and Treatment			
Performance Measure	**Baseline 2009/10**	**Target 2011/12**	**Achievement 2011/12**
Specialist Services Mental Health Services			
Access rates to specialist mental health services for children and young people (0-19).	3.35%	3.31%	Achieved with 4.05%
Access rates to specialist mental health services for adults (20-64).	3.87%	3.63%	Achieved with 4.09%
The proportion of long-term mental health clients aged under 65 with current relapse prevention plans.		95.00%	Not achieved, with only 93.3%with current plans
Elective Services			
The number of medical and surgical First Specialist Appointments (FSA).		30,475	Achieved with 36,700 having FSA
Operating theatre cancellations by hospital after admission.		9%	Achieved with only 3.1% cancellations
Proportion of resourced theatre elective minutes used to total resourced theatre minutes.		85%	Achieved. 85.59%
The number of elective surgical services discharges (including dental and cardiology).		11,044	Not achieved, actual was 10,214
The number of elective surgical services caseweights (CWDs) delivered.		14,186	Achieved, with 14,923 elective caseweights delivered
The percentage of elective and arranged surgery undertaken on a day case basis (OS6).	57.7%	62%	Not achieved with 58% on a day case basis
The proportion of people receiving elective or arranged surgery on the day of admission (OS7).	83.1%	90%	Not achieved actual was 86.3%

Intensive Assessment and Treatment (continued)			
Performance Measure	**Baseline 2009/10**	**Target 2011/12**	**Achievement 2011/12**
Acute Services			
The percentage of people assessed, treated or discharged from ED at Dunedin Hospital in under six hours.	71.80%	95%	Not achieved, with actual at 84.78%. This however is an improvement on prior years.
The percentage of people assessed, treated or discharged from ED at Invercargill Hospital in under six hours.	81.9%	95%	Not achieved, however the result is an improvement on prior years at 91.3%
The acute readmission rate to hospital (OS8).	8.91%	8.50%	Not achieved 9.1%
The average length of stay in hospital (acute)(OS4).	4.15 days	4.15 days	Achieved actual was 3.94 days
Maternity Services			
The number of births in the DHB region.	3677	3,540	Achieved births were 3,555
Exclusive breastfeeding at discharge after birth.		75%	Achieved 81%
Assessment, Treatment and Rehabilitation Services			
Average length of stay in AT&R services.		16 days	Achieved actual was 14.3 days
Waiting time for referral until transfer into AT&R service	2 days	90% <1 day	Information not available

4) Rehabilitation and Support

Rehabilitation and support services provide people with the support and assistance they need to maintain 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 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) Services and include: domestic support, personal care, community nursing and community services provided in people's own homes and places of residence and also long and short-term residential care, respite and day services. Services are provided mostly for older people, mental health clients and for personal health clients with complex health conditions.

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

Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

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 staying active and positively connected to their communities. People whose needs are adequately met will also be less dependent on hospital and residential services and less likely to experience acute illness, crisis or deterioration of their conditions. Even when returning to, or maintaining, full health is not possible, timely access to responsive support services enables people to maximise function with the greatest independence.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. Effective and responsive delivery of support services will help to reduce demand for acute services and improve access to other services and interventions. It will also free up resources for investment into early intervention, health promotion and prevention services that will help people stay healthier for longer.

While living in Aged Residential Care is appropriate for a small proportion of our population, Southern DHB rates are above national averages. Living in Aged Residential Care has also been associated with a more rapid functional decline than 'ageing in place' and is a more expensive option. Resources could be better spent providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

Southern DHB has taken a 'restorative' approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and that the DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

The Southern DHB will seek to fund or provide outputs which will make a positive impact on the health and wellbeing of the Otago and Southland population.

Rehabilitation and Support			
Performance Measure	**Baseline 2009/10**	**Target 2011/12**	**Achievement 2011/12**
Needs Assessment and Services Coordination Services			
The percentage of clients reassessed within 12 months	10,700	70%	Due to the InteRAI implementation the information is incomplete, we are behind in reviews and have not met the 70% target
Palliative Care Services			
The number of people in ARC services assessed and being supported by the Liverpool Care Pathway.	NA	180	Information on the total number of people assessed and supported is not available. There are however a large number of providers trained in the Liverpool Care Pathway.
Rehabilitation Services			
The percentage of people referred to cardiac rehabilitation services after an acute event.	NA	70%	Not achieved with actual close at 69%
Home-Based Support Services			
The total hours of age related Domestic Assistance accessed by the over 65 population.	246,210	258,711	Not achieved 175,550
The total hours of age related Personal Care accessed by the over 65 population.	318,950	320,000	Achieved with hours 370813
Residential Care Services			
Utilisation of ARC beds by the over 65 population: Dementia.	240 beds	244 beds	252 beds
Utilisation of ARC beds by the over 65 population: Hospital level.	840 beds	845 beds	783 beds
Respite and Day Services			
The expenditure for the over 65 population accessing age related Respite Care.	$ 829,000	$ 899,000	Almost achieved with 863,210 spent
The expenditure for the over 65 population accessing Day Services.	$ 272,000	$ 459,000	Not achieved with 285,464 spent
The expenditure for the over 65 population accessing individualised home support.	$ 907,000	$ 1,844,000	Achieved with 2,102,375 spent

EXPENDITURE BY OUTPUT CLASS

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

	2012 Actual	2012 Budget
Income		
Prevention Services	8,200	9,108
Early Detection and Management Services	201,436	190,076
Intensive Assessment and Treatment	521,458	528,128
Rehabilitation and Support	105,568	101,107
Total income	**836,662**	**828,419**
Expenditure		
Prevention Services	8,200	9,108
Early Detection and Management Services	203,699	193,880
Intensive Assessment and Treatment	529,753	530,397
Rehabilitation and Support	108,198	105,525
Total expenditure	**849,850**	**838,910**
Share of profit/(loss) in associates	(49)	-
Surplus/(Deficit)for the year	**(13,237)**	**(10,491)**

Independent Auditor's Report

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

The Auditor-General is the auditor of 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 statement of service performance of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 18 to 48, that comprise the statement of financial position as at 30 June 2012, 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 statement of service performance of the Health Board on pages 49 to 54.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 18 to 48:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board's:
    - financial position as at 30 June 2012; and
    - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board on pages 49 to 54:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board's service performance for the year ended 30 June 2012, including:
    - its performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and

- its revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 18 October 2012. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

An audit also involves evaluating:

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

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

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

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 18 October 2012 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

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