Southern District Health Board
Piki Te Ora

Annual Report

Quality and Performance Account

2016/17

Owning our Future

Ref E90

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2016/17
Key highlights

Launched HealthOne – a shared patient records system to improve service and safety

Over 600 employees attended Speak Up programme as part of Southern Future

Further roll-out of telehealth, enabling those in rural areas to avoid travelling for some specialist appointments

Investment in leadership, including appointment of CEO

Opened new Education Centre (Southland), Audiology Suite (Wakari)

Financial position continues to improve, finishing 2016/17 year slightly ahead of budget

Planning for upgrade of Lakes District Hospital. ICU and gastroenterology facilities in Dunedin are underway. Planning has progressed on the new hospital in Dunedin

Community Health Council established, to ensure patients' voices are at centre of what we do

Increased funding for CT scans in rural hospitals thereby reducing the need for people to travel to Dunedin or Invercargill

18% increase in children and youth who have accessed specialist mental health services with a current transition (discharge) plan

99% people on long term Home and Community Support Services received a Comprehensive Clinical Assessment in the past 12 months

99%

Significant increase in the number of referrals to the Southern Stop Smoking Service

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This Southern District Health Board Annual Report 2016/17 is presented to the House of Representatives pursuant to section 150(3) of the Crown Entities Act 2004.

Contents

From the Commissioner & Chief Executive

2016/17 has been another year of significant change at Southern DHB, as we work towards sustainably meeting the health needs of our community.

For us, sustainability means balancing important priorities outlined in this report – improving the health outcomes for our community (see pages 14 to 53) and enhancing patients' experience and quality of care (pages 55 to 61), while building the organisational resilience, including the sustainability of our workforce, and living within our means that will enable quality care to be delivered into the future (pages 64 to 73).

The importance of quality and safety to the achievement of our goals is a reason why this year's Annual Report also contains our Quality Account, on page 56.

Accomplishing all our organisation's goals is a significant task, and the opportunities for improvement are immense.

The past year has built on the direction established by the Commissioner team since its appointment by the Minister of Health in June 2015. We updated our Owning our Future work plan, aimed at ensuring clarity on the critical areas of focus for Southern DHB, and identifying the 'enablers' that will help us meet these goals. We are pleased in this annual report to highlight the achievements that have been made, and the areas where continued focus is necessary.

However, sustaining some of the improvements that had been made during our first year – where we saw improvements across all the Minister's health target areas, for example – has been challenging. There have been important successes, including progress in meeting the target for providing faster cancer treatment and implementing the new Raising Healthy Kids target. However, other areas have troubled us, including meeting our elective surgery targets and achieving shorter stays in the Emergency Department.

The solutions to these issues are not easy. Some steps have been made to address capacity issues, such as extending the hours for our operating theatres, and supporting projects to further optimise theatre time, in an effort to reduce the time some patients need to wait for surgery.

However, we need to go further. Reducing waiting times in the Emergency Department, for example, requires a whole of system approach that incorporates supporting our people to stay well in their homes, and ensuring adequate support through primary and community-based services. Taking decisive steps to enhance primary care will be a central focus for the coming year.

The past year has also required us to confront major service challenges in ophthalmology and urology, where our systems and processes were unable to meet demands. The impact on patients has been unacceptable, and addressing the situation has required us to consider all aspects of the services, from our administrative processes, to the capacity of the service and developing more sustainable models of care.

This underlines the importance of continuing to invest in our systems and processes. We are pleased to be able to report substantial progress in these areas, and believe this will place us in a stronger position to deliver health services to our communities in the future.

A fundamental priority has been ensuring we have the right leadership to drive our progress in the future. We appointed Chris Fleming to the permanent position of CEO in February, and he is leading further changes to our operational structure. These will increase focus on critical strategic areas – including integration with primary care, and clinical quality and safety – and reduce complexity in decision-making. Alongside this is ongoing investment in our Southern Future programme of work, promoting collaboration and innovation at all levels of the organisation.

All of these changes need to be grounded in the needs of patients and the community. We were delighted this year to establish a Community Health Council to ensure the voice of patients and the community remains at the centre of what we do, and are grateful to those who made themselves available for this important work. The CEO and Commissioner team have held community forums across the district to continue to hear directly from those we serve, and invite the public to attend the open sections of the Commissioner meetings where they have the opportunity to ask questions directly of the Commissioner and executive teams.

We've also focused on much-needed investments in our infrastructure. We have now launched HealthOne, a South Island-wide shared patient records system, so a number of health providers can access important, life-saving information about patients. We have further developed our telehealth services so some patients can avoid travelling for some specialist appointments. Behind the scenes is work to improve our data

gathering and reporting systems, to improve the information we have to make important organisational decisions.

The challenges surrounding some of our facilities have been well highlighted, and considerable progress has been made to improve these in the past year. A new education centre was opened in Southland, a new MRI scanner was installed in Dunedin. We celebrated the opening of the new Audiology Unit at Wakari Hospital, and work to upgrade our ICU/HDU and gastroenterology facilities is underway. Plans are in place to refurbish and improve Lakes District Hospital in Queenstown, with a particular focus on enhancing the emergency and diagnostic services of this facility. And, of course, we have focused on the planning for the redevelopment of Dunedin Hospital.

Ultimately, of course, health care is delivered by people, and improving the work environment at Southern DHB and supporting our teams has remained an important priority. We have invested in additional clinical roles to support increasing the number of ICU beds, and nursing leadership to support initiatives to enhance our ward processes as part of the 'Releasing Time to Care' programme. As part of our Southern Future programme of work we have held engagement days for our senior medical and administration teams respectively, and continued to progress initiatives such as the Southern Innovation Challenge, Speak Up workshops and Skills for Change programme to promote communication and collaboration at Southern DHB. We have also learned more about the experiences and priorities for our workforce in the staff satisfaction survey, which signalled a number of improvements over the past year.

And we are learning to live within our means. Our financial position continues to improve, finishing 2016/17 year slightly ahead of budget. We were especially pleased to achieve this financial result while also continuing to invest in important areas to support the long-term sustainability of the DHB.

There is a lot more work to do, and building systemic solutions that will support patient care in the long term will continue to be our focus.

The nature of our challenge is that it cannot be accomplished by any one person or team – rather it is the collective efforts of all our staff and partners delivering care across our vast district that will, and do, make a difference to our patients every day.

We thank our 4500 staff, our colleagues in WellSouth Primary Health Network, the rural trust hospitals, NGOs, education and Iwi, for everything they do.

And we appreciate also the ongoing support from our volunteers, sponsors, donors and the community as we continue to build a strong health system in the south.

We look forward to continuing our work together.

Nga mihi

Kathy Grant
Commissioner

Chris Fleming
Chief Executive Officer

Statement of Responsibility

For the 12 months ended 30 June 2017

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

The Commissioner team 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 Commissioner team and management of Southern DHB the financial statements and statement of service performance for the year ended 30 June 2017 fairly reflect the financial position and operations of Southern DHB.

Chris Fleming
Chief Executive Officer
30 October 2017

Kathy Grant
Commissioner
30 October 2017

Better Health, Better Lives, Whānau Ora

At Southern DHB, our goal is to support everyone across our district to live well and access the right care when they need it, by delivering high quality, patient-centred and equitable health services to our diverse communities.

Our Story

The Southern district is New Zealand's most scenic, demanding and inspiring environment.

Kai Tahu, Kati Mamoe and Waitaha thrived on the kaimoana in its coastal bays, and travelled through the district in quest of greenstone. Immigrants found gold in its rivers and hills, established farms in its farthest reaches and built cities based on dreams of opportunity and equality.

Fundamental to this vision has been access to education and health care, which together has led to a world-leading medical school at the University of Otago, and nursing and allied health programmes at Otago Polytechnic and Southern Institute of Technology.

This is a part of the world where people take care of each other. We look out for each other and help one another succeed.

We are hardworking, resourceful and capable, and have established ways of caring for each other across our communities.

Here, Southern DHB has grown from bringing together the health infrastructure from across the district.

Our shared goal is to work together, to support everyone across our district to live well, and access the right care when they need it, by delivering high quality, patient-centred and equitable health services to our diverse communities.

Collectively, we deliver services to our people across the widest geographic area of any DHB.

To achieve this, we work with primary and community health providers, iwi organisations, education providers and rural trust hospitals in Dunstan, Balclutha, Gore, Oamaru and Ranfurly, while living our values of being kind, open, positive and working in partnership with our community.

We are diverse, inclusive, caring and professional – and have a total commitment to providing the highest quality of care to the people who trust us to serve them.

Partnership with Iwi

E ngā iwi, e ngā mana, e ngā kārangatanga maha o te tai tonga, tēnā koutou katoa.

The Treaty of Waitangi is an important founding document for New Zealand and, as an agent of the Crown, the DHB is committed to fulfilling its role as a Treaty partner. The New Zealand Public Health & Disability Act 2000 outlines the responsibilities Southern DHB has in honouring the principles of the Treaty of Waitangi. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure). The DHB and Māori have a shared role in implementing health strategies for Māori, and on 31 May 2011 Murihiku and Araiteuru Rūnaka and Southern DHB signed a collective Principles of Relationship agreement to provide the framework for ongoing relations between Southern DHB and Kā Rūnaka.

Kā Rūnaka is made up of a representative from each of the seven Rūnaka whose takiwā is in the Southern DHB:

- Te Rūnanga o Awarua
- Waihōpai Rūnaka
- Ōraka Aparima Rūnaka
- Hokonui Rūnaka
- Te Rūnanga o Ōtākou
- Kāti Huirapa Rūnaka ki Puketeraki
- Te Rūnanga o Moeraki.

Both parties work together in good faith to address Māori health inequities and improve the health and wellbeing of our Southern population. These goals are integrated into the Southern Strategic Health Plan – Piki te Ora, and underpin the annual Southern Māori Health Plan.

Mauri ora ki a tātou katoa.

Our Purpose

Southern DHB is responsible for the planning, funding and provision of publicly funded health care services.

The statutory (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
- Reduce health outcome disparities
- Manage national strategies and implementation plans
- Develop and implement strategies for the specific health needs of the local population.

This is achieved through:

- Our specialist hospital and mental health services delivered from Southland Hospital (Invercargill), Lakes District Hospital (Queenstown), Dunedin Hospital (Dunedin) and Wakari Hospital (Dunedin), and outpatient clinics across the district
- Contracts with a range of primary and community health providers. These include Primary Health Organisations (general practices), pharmacies, laboratories, aged residential care facilities, Pacific Islands and Maori Health providers, non-governmental mental health services, rural hospitals and primary maternity facilities.

Governance

The governance function is responsible for ensuring that the needs of the population are identified, services are prioritised accordingly, and that appropriate policies and strategies are developed to achieve the organisation's purpose. To deliver this, the operational management of the DHB is designated to the Chief Executive Officer, through the Delegation of Authority Policy, who in turn is supported by an Executive Leadership Team. Southern DHB is governed by a Commissioner, Kathy Grant, who was appointed by the Minister of Health Jonathan Coleman on 18 June 2015, and supported by Graham Crombie and Richard Thomson as Deputy Commissioners. The Commissioner team is advised by the Hospital Advisory Committee, Disability Support Advisory Committee/ Community and Public Health Advisory Committee, Finance Audit and Risk Committee and Iwi Governance Committee.

The Commissioner's term will continue until elections to the Southern District Health Board resume in late 2019.

We are the DHB in New Zealand with the largest geographical area

62,356km²

Our life expectancy at birth is **81 years**, slightly lower than the New Zealand average

The Southern district has a population of **320,640** residents, the majority living in Dunedin and Invercargill

There were a total of **3,420** babies born in the Southern DHB last year with the majority of these occurring at Dunedin Public Hospital and Southland Hospital

Our Population

12,756
elective procedures

81,124
presentations to Emergency Departments

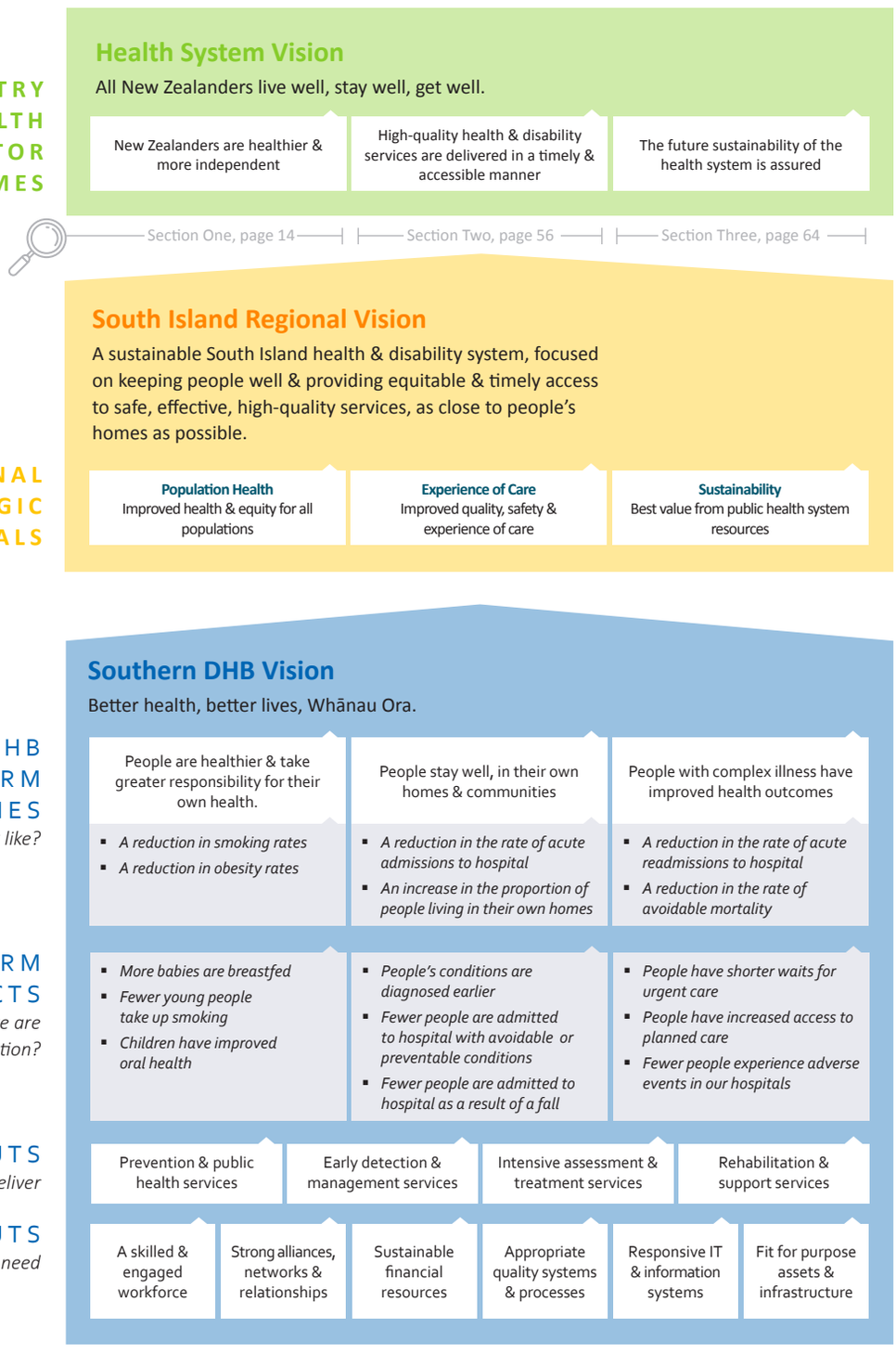
Ethnically the Southern district is predominantly **European, at 82%.** 10% are Māori, 6% Asian and 2% Pacific

Our population is slightly older when compared to the national average **53,040** people are aged 65 and over

4,633 staff employed at Southern DHB

Our Performance Story

Southern DHB's journey to delivering the best possible health outcomes for the district is guided by our vision, purpose and strategic plans, built on a common foundation of our organisational values and aligned with national and South Island regional priorities. Within this, our Owning our Future plan articulates areas of focus and investment needed to achieve our shared goals.



Te Tiriti O Waitangi

We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Māori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

Owning Our Future

Southern District Health Board
Piki Te Ora

Southern Future
It's up to us

What will success look like?

A quality and patient focused health system supported by our community, and built on strong staff engagement

Southern Strategic Health Plan Priorities

- A coherent Southern Health system of care
- A system built on a foundation of population health, and primary and community care
- Secure sustainable access to specialised services
- Strengthened clinical engagement and quality improvement
- Enhanced system capability and capacity
- Living within our means

Southern Māori Health Strategy

- Māori Health and Well-being Outcomes
- Māori Workforce and Provider Development
- Culturally Responsive Services

Alignment with NZ Health Strategy

✔ **Achieved** ↗ **In Progress** – **Not Achieved**

Enablers

Organisational Capability

✔ Appointment of CEO
✔ Organisational Development Integration
↗ Clinical Leadership Framework
✔ Project Management Office established

Information for our Business

✔ Common Data Definitions
✔ Business Insight Tools
↗ Electronic Radiology referrals for primary care
✔ Effective utilisation of Business Intelligence (BI) to support decision-making

Communication

✔ Community Health Council established
↗ Development of a range of multimedia engagement tools e.g. two-way interactive web presence
✔ Engagement forums and other ongoing listening opportunities

Quality and System Improvement

✔ System Improvement Framework
✔ Patient Flow and Production Planning
↗ Embedding Health Pathways
✔ Implementation of HealthOne
✔ Releasing Time to Care

Key Performance Targets

Lift Performance

– Performance achievement in top half of DHBs and PHOs for all key ministerial targets

Capital

✔ Supporting the Southern Partnership Group to meet the timelines for the Dunedin Hospital redevelopment
✔ Supporting the role of the Clinical Leadership Group
✔ Progressing the upgrade of Lakes District Hospital
✔ Commissioning of MRI in Dunedin
✔ Commissioning of new Education Centre in Southland

Model of Care Implementation

↗ Significant progress in implementing sustainable models of care in Long-term Conditions, Health of Older People, Urgent Care, Mental Health and Radiology

District Wide Services

✔ Care closer to home with significant progress in developing a district network of care: Telemedicine, Radiology, Outpatients
✔ Supporting Locality Network progress

Finance

✔ Agree and achieve 2016/17 budget.
✔ Agree 2017/18 budget
✔ Focus on sustainability and move towards break-even position 2019/20

Southern Future

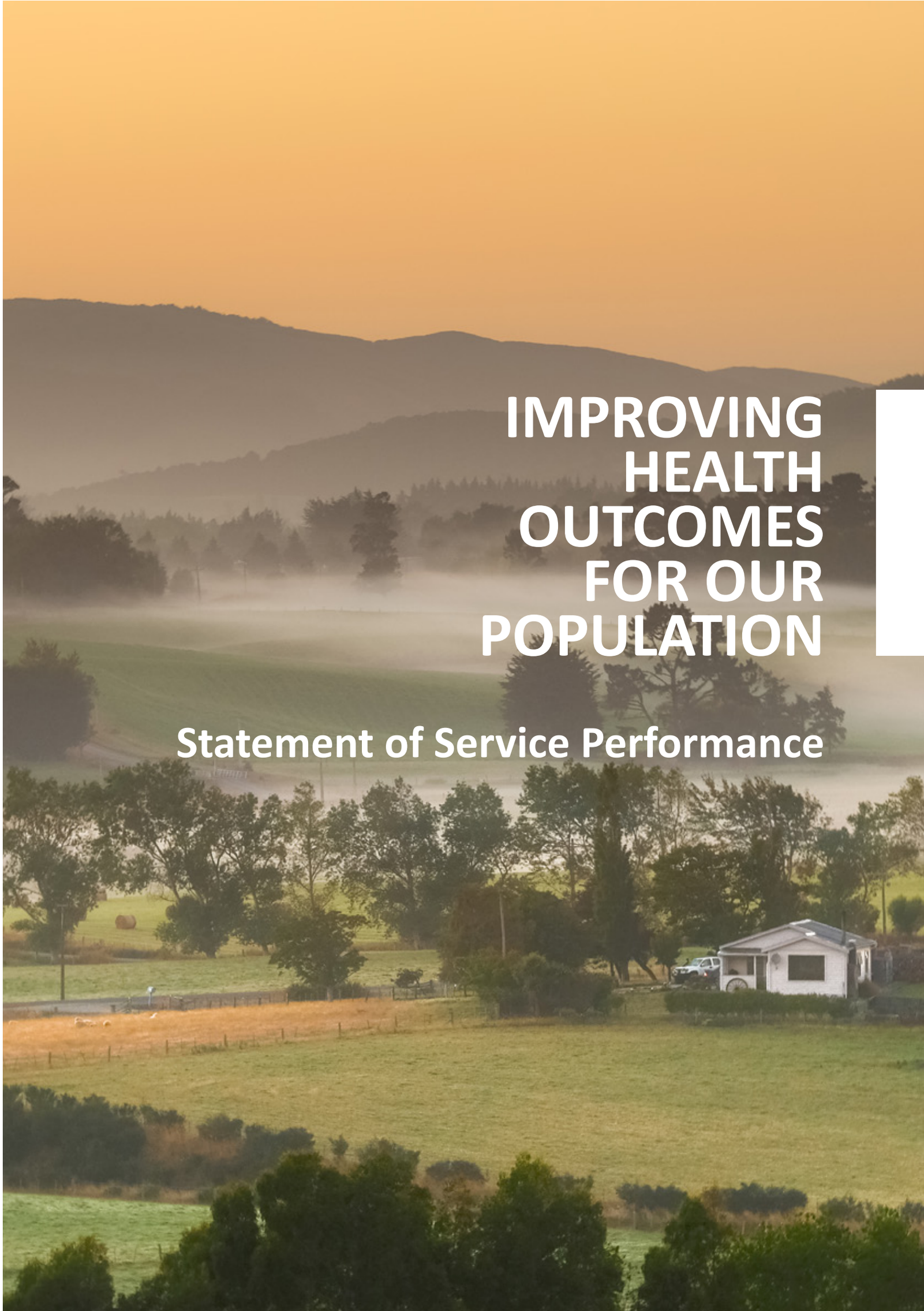
✔ Progress in addressing the identified 7 + 7 improvement priorities for patients and whānau, and staff and colleagues

Kind - Manaakitanga
Looking after our people: we respect and support each other. Our hospitality and kindness foster better care

Open - Pono
Being sincere: we listen, hear and communicate openly and honestly, and with consideration for others. Treat people how they would like to be treated

Positive -Whaiwhakaaro
Best action: we are thoughtful, bring a positive attitude and are always looking to do things better

Community - Whanaungatanga
As family: we are genuine, nurture and maintain relationships to promote and build on all the strengths in our community



IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

Statement of Service Performance

Statement of Service Performance

The Statement of Service Performance (SSP) presents a view of the range and performance of services provided for our population across the continuum of care.

As a DHB we aim to make positive changes in the health status of our population over the medium to longer term. As the major funder and provider of health and disability services in the Southern district, the decisions we make about the services to be delivered have a significant impact on our population. If coordinated and planned well, these will improve the efficiency and effectiveness of the whole Southern health system.

There are two series of measures that we use to evaluate our performance: outcome and impact measures which show the effectiveness over the medium to longer term (3-5 years); and output measures which show performance against planned outputs (what services we have funded and provided in the past year).

Improving Health Outcomes for Our Population

There is no single measure that can demonstrate the impact of the work we do, so we use a mix of population health and service access indicators as proxies to demonstrate improvements in the health status of our population.

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

The three strategic outcomes outlined in the Annual Plan 2016/17 with associated outcome and impact measures are shown below.

	Outcome 1	Outcome 2	Outcome 3
Outcome	People are healthier and take greater responsibility for their own health	People stay well in their own homes and communities	People with complex illness have improved health outcomes
Outcome Measures	• A reduction in smoking rates • A reduction in obesity rates	• A reduction in acute medical admissions to hospital • An increase in the proportion of people living in their own homes	• A reduction in the rate of acute readmissions to hospital • A reduction in the rate of avoidable mortality
Impact Measures	• More babies are breastfed • Fewer young people take up tobacco smoking • More children are caries free	• People wait no more than 6 weeks for scans (CT or MRI) • A reduction in avoidable hospital admissions • A reduction in number of people admitted to hospital due to a fall	• People presenting to ED are admitted, discharged or transferred within 6 hours • People receiving their specialist assessment or agreed treatment in under 4 months • Fewer people experience adverse events in hospital

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

Why is this important?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes, cardiovascular disease and cancer. These are major causes of poor health, premature mortality and are putting increasing pressure on health services.

The likelihood of developing long-term conditions increases with age, and with an ageing population, the burden of long-term conditions will grow. These conditions are also more prevalent among Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and well-being. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our communities and whānau.

How have we measured our success?

The key outcome measures that demonstrate how the DHB is meeting these outcomes are:

- reducing the number of people smoking in our population
- reducing obesity rates.

The impact measures that contribute to these outcomes are:

- more babies being breastfed
- more children are caries free (no holes or fillings)
- fewer young people taking up smoking.

How did we perform?

To date we have been able only to source data for the percentage of children who are caries free. This has shown improvement for five year olds overall, but a reduction for Māori children.

The change in timing or source of the data for the other four measures will mean the results will be available at a later date.

Outcome: Smoking

New Zealand has comprehensive tobacco control policies and programmes, yet smoking remains the leading modifiable risk factor for many diseases, such as cancer, respiratory disease and stroke. In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, housing, education and health.

Southern's smoking rate continues to decline but remains above the national average. Approximately 37,000 people are recorded as smokers in the Southern population.

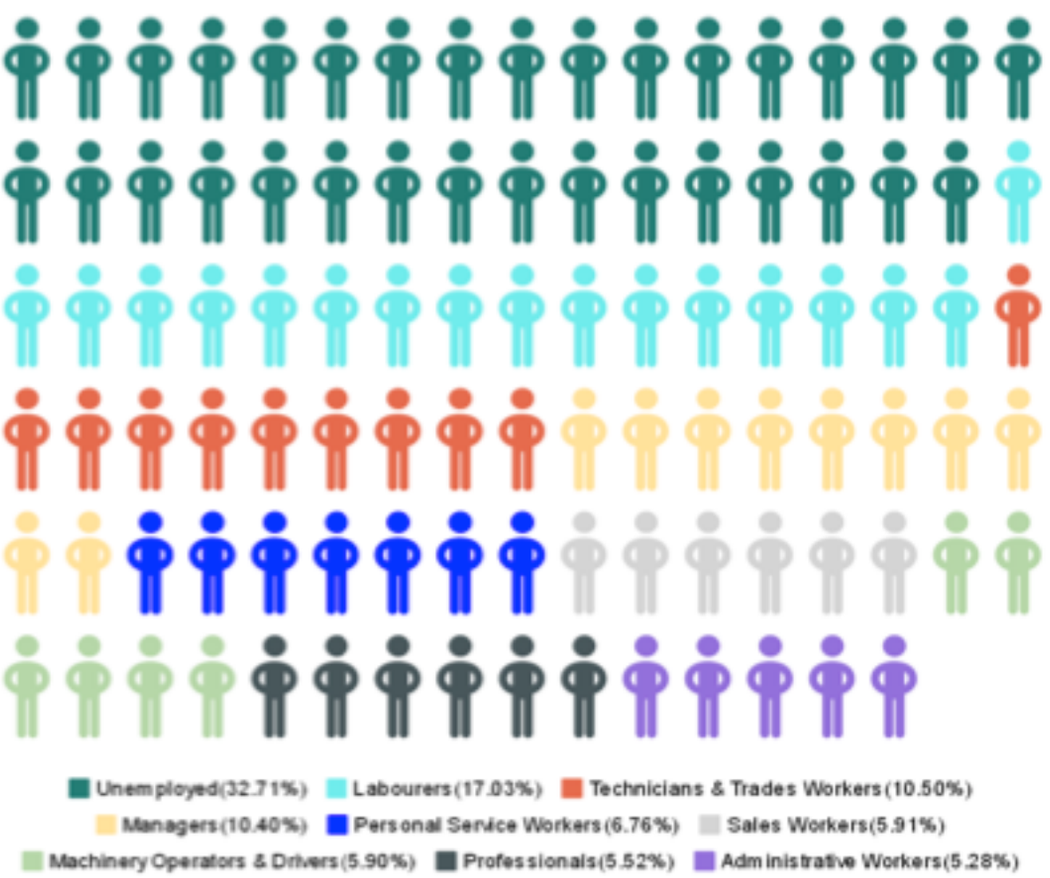
We have continued to focus on assisting people to quit smoking. Over the past year 85 per cent of smokers in primary care and 90 per cent of smokers in hospital settings have been provided with smoking ABC - **A**sked their smoking status, provided with **B**rief advice and offered **C**essation support. Enrolments in our Southern Stop Smoking Service continue to rise with over 2,900 referrals into this programme over the last year.

Percentage of the population (15+) who smoke[1]

	2011/12	2011/13	2011/14	2011/15	2011/16
Southern DHB	21.8%	21.5%	19.8%	Not available[2]	Not available[2]
New Zealand	18.4%	18.0%	17.7%	Not available	Not available

Data sourced from national NZ Health Survey[1].

A third of smokers in Southern are unemployed 1/3



[1]The New Zealand Health Survey data for 2015 and 2016 has not been released yet (30 August 2017).
[2]The New Zealand Health Survey historically was undertaken every five years (2006/7 & 2011/12). It is now undertaken on a rolling basis and results are collated over a period of years. The column headings show the years that the data was collated.

Outcome: Obesity

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Obesity impacts on quality of life and is a significant risk factor for many long-term conditions, including cardiovascular disease, diabetes, respiratory disease and some cancers. Supporting our population to achieve healthier body weight through improved nutrition and physical activity levels is fundamental to improving their health and well-being and to preventing and better managing long-term conditions and disability at all ages.

Southern DHB is participating in the national healthy food and drink project for DHBs to improve the food and beverages offered in our facilities.

We have invested in a number of programmes to tackle obesity in our district, including Green Prescription (GRx) and Active Families. Health professionals can refer clients or people can self-refer themselves to GRx or Active Families for support to increase their physical activity. Support staff assist clients, families and whānau to set achievable goals so they can be independently active. They are also supported to make healthy food choices and encouraged to attend local exercise classes and education sessions.

This year we have developed a framework for healthy weight for children 0-5 years old. During 2017/18 we will develop and disseminate consistent messages for healthy living across all aspects of the life course (pregnancy, baby, childhood, adulthood). Messages will be focused around:

- healthy foods and healthy eating
- portion sizes
- breastfeeding
- promoting the use of and understanding of the Health Star Rating system
- healthy sleeping patterns (particularly with Lead Maternity Carers (LMCs), General Practice and Early Childhood Centres).

Southern DHB supports healthy public policies, such as improving the built and food environments in which people live and work.

Where lifestyle and diet modifications have not proved sufficient, we are also working to improve access to bariatric surgery.

Percentage of the population (15+) who are obese[1]

	2011/12	2011/13	2011/14	2011/15	2011/16
Southern DHB	29.8%	28.9%	29.4%	Not available[2]	Not available[2]
New Zealand	28.4%	29.9%	29.7%	Not available	Not available

Data sourced from National NZ Health Survey[2].

[1]The New Zealand Health Survey data for 2015 and 2016 has not been released yet (30 August 2017).
[2]The New Zealand Health Survey historically was undertaken every five years (2006/7 & 2011/12). It is now undertaken on a rolling basis and results are collated over a period of years. The column headings show the years that the data was collated.

Our whole family has changed

When Savannah was referred to Active Families by her GP, her referral described a young girl whose weight was causing her joint and muscle pain.

Savannah and her mum also talked with Active Families about their busy lifestyle – how they used to be active together – and about Savannah's food anxiety leading her to be constantly looking for food and 'hoovering' her food very quickly at mealtimes.

Initially the family chose to work on making weekend family activities a priority, adjusting serving sizes of meals, and trying vegetable snacks to see Savannah through until dinnertime. Savannah also wanted to try to choose one physical activity each day in her own time.

Savannah particularly enjoyed making her own Portion Plate which she still uses, including to educate the rest of her family about portion sizes. The practical cooking classes gave Savannah further confidence with food, and since joining Active Families her food anxiety has almost disappeared.

Not only is Savannah more active now – so is the rest of her family. They enjoy weekend outings and have taken part in the Department of Conservation 'Kiwi Guardians' programme.

Says Andrea, "Our whole family has changed as a direct result of being involved with Active Families."

Walking the talk

Southland Hospital Dietician Claire Cannon is making some positive changes by providing the option of an 'active meeting' for her patients.

Claire manages patients with type 1 and type 2 diabetes and encourages her patients to be active and avoid sitting for long periods of time.

"I realised I was providing this advice, but we were sitting in an office the whole time. I thought it would be nice to go for a walk instead.

"It's less formal and we are in a neutral environment, so the patient feels comfortable and we both get to enjoy the outdoors."

Walks can last anywhere from 15 to 40 minutes, depending on the appointment and the patient's preference.

Claire says the response to this healthy alternative has been really positive. "Most patients are pleasantly surprised. It's amazing what some fresh air can do – for both the patient and myself."

Impact Indicator: Breastfeeding

Breastfeeding helps lay the foundation for a healthy life, contributing positively to infant health and well-being and potentially reducing the likelihood of obesity later in life. An increase in breastfeeding rates is seen as a proxy indicator of the success of health promotion and engagement activity, appropriate access to support services and a change in both social and environmental factors influencing behaviour and supporting healthier lifestyle choices.

There are a range of services available to encourage and support women in the Southern district to breastfeed including breastfeeding peer support services, smartphone applications BURP and Feedsafe[3].

A new online newborn enrolment form will be launched in 2017 and includes enrolment with General Practice, PHO, WellChild, immunisation and oral health services. This will provide opportunities for mothers to be offered support and advice from the many health services to which they are connected with a newborn baby.

Percentage of babies fully/exclusively breastfed at 6 weeks

	2014/15	2015/16	2016/17	
	Actual	Actual	Target	Actual
Southern DHB	70%	75%	>70%	Not available[4]
Southern DHB Māori	65%	70%	>70%	Not available
New Zealand	66%	74%	>70%	Not available

Data Source: Plunket via the Ministry of Health[5]

82%

of mothers have established breastfeeding at discharge following birth (see page 47)

[3] Feedsafe is a new smartphone app containing information on breastfeeding and alcohol, to help mothers to make informed choice around drinking and breastfeeding.
[4] The Ministry stopped reporting these indicators through the Well Child-Tamariki Ora Framework for all DHBs in 2017. Southern DHB is investigating other options to source this data.
[5] Provider data is not able to be combined for this measure so only performance data from the largest provider (Plunket) is presented. This covers the majority of mothers. However, the smaller local WellChild/Tamariki Ora providers (not included) primarily target Māori and Pacific mothers with their data. Therefore results for these ethnicities may be under-stated. The standard is set nationally as part of the WellChild Quality Framework.

Impact Indicator: Oral Health

Oral health is an integral component of lifelong health and impacts a person's self-esteem and quality of life.

Good oral health not only reduces unnecessary hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and health outcomes.

Southern DHB provides free oral health care for children from birth to 17 years. A focus of the oral health service is to ensure that all eligible children are enrolled and seen on time. The service has recognised that many children are missing out on accessing dental services and is working to address this. Ensuring children and their whānau are able to access oral health services in a timely manner is essential.

69%

of 5-year-olds have no holes or fillings

Good access to care will increase the likelihood of improved oral health, which is measured as the percentage of children aged five years who are caries free (have no holes or fillings). Over time the number of children without caries is increasing but there remains an equity gap for Māori.

Southern DHB continues to offer family appointment bookings, as well as providing services over the school holidays. Services have extended hours in Dunedin and Invercargill over the summer months.

The newborn enrolment form will also ensure automatic enrolment of all newborns into five key health services, including community oral health services.

Percentage of 5-year-olds who are caries free

	2014	2015	2016	
	Actual	Actual	Target	Actual
Southern DHB	64%	60%	>70%	69%
Southern DHB Māori	52%	64%	>70%	58%
New Zealand	59%	Not available	>70%	Not available[6]

Data Source: Ministry of Health Oral Health Team. Data is for the calendar year (Jan-Dec)

Medium Term Indicator: Reduced Smoking

Most people who smoke will begin by 18 years of age, and the highest prevalence of smoking is among younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up smoking.

A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Percentage of Year 10 students who have 'never smoked'

	2014	2015	2016	
	Actual	Actual	Target	Actual
Southern DHB	79%	80%	78%	Not available[7]
New Zealand	77%	79%	78%	Not available

Data Source: ASH Year 10 Survey

[6] The collated oral health data for all New Zealand DHBs is no longer available through the WellChild Tamariki Ora Quality Framework.
[7] Data from the ASH survey was not available at 27 September 2017.

Delirium initiative delivers better outcomes for elderly patients

Pictured: Esmé Thompson explains to Associate Charge Nurse Megan Livingstone-Young how the children from Roslyn Kindergarten made 'squishy balls' for the ward to use with patients with delirium

Patients over 65 years of age who are admitted to Dunedin Hospital will be safer, receive a better standard of care and have reduced risk of falls, thanks to a new package of care initiated by ward staff.

Delirium is an acutely disturbed state of mind characterised by restlessness, illusions and incoherence and some 10 to 40 per cent of hospital patients over 65 years of age are estimated to have the condition.

"We were seeing a significant number of patients being admitted showing the signs of delirium or developing the condition during their stay," explains Associate Charge Nurse Megan Livingstone-Young. "We know those patients are at a greater risk of suffering injury or needing a longer hospital stay and also have poorer health outcomes, so we wanted to do more to improve the way we supported these patients whilst in our care."

In late 2016, a new delirium identification and management package was implemented. Since then all patients who are admitted to the ward aged 65 years or older are screened for delirium using a consistent method both on admission and during every shift for the first five days of their stay.

Where a patient screens positive for delirium, staff ensure the environment is set up to minimise confusion and keep the patient safe. This might include using large clocks to show the date and time, orientation boards to remind patients where they are and using specialised beds which can be lowered to prevent a patient from falling out of bed and hurting themselves.

The ward staff have also introduced a 'distraction trolley' stocked with items that can be used for sensory stimulation, designed to engage the senses and provide comfort for patients who might be agitated, confused or distressed.

Getting orthopaedic patients on their feet faster

Shorter hospitals stays, lower use of rehabilitation facilities and high patient satisfaction are among the benefits of new hip and knee replacement surgery protocols put in place at Southern DHB.

Results of an 18-month trial of the Enhanced Recovery After Surgery (ERAS) protocols at orthopaedic wards of Dunedin and Southland hospitals were reported in the international journal *Orthopaedic Nursing*.

Authored by Southern DHB Orthopaedic Surgeon David Gwynne-Jones, Clinical Coordinator Ginny Martin, and Programme Manager Orthopaedic Pathway Programme Chris Crane, the paper looks at the recovery of 528 patients, compared to 507 in the historic control group, and found new measures helped improve patient recovery and reduced the length of time they had to stay in hospital.

"Through the introduction of ERAS, our patients now expect to arrive on the morning of their surgery and be out of bed, standing and walking that evening," explains Associate Professor Gwynne-Jones. "While ERAS principles are well established, our trial showed that it was effective even when implemented across the service – not just among a select group of patients – and for hospital patients with high average Body Mass Index (BMI) or who have very severe osteoarthritis and multiple co-morbidities."

Following the introduction of the programme, the average length of stay fell from 5.6 days to 4.3 days for hip replacement patients, and from 5.7 to 4.8 days for knee replacement patients. Unlike some overseas studies, there was limited use of step-down or rehabilitation beds, with 98% of patients discharged home.

Professor Gwynne-Jones said the multidisciplinary approach, team work and openness to change have been essential to the programme's success.

Outcome 2.
People Stay Well In Their Own Homes and Communities

Why is this important?

When people are supported to stay well and can access the care they need closer to home and in the community, they are less likely to need hospital-level or long-stay interventions. This not only leads to better patient experience and health outcomes for our communities, whānau and patients but also reduces pressure on our hospitals and frees up health resources.

Studies show countries with strong community and primary care services have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes at a lower cost than countries with services that focus more heavily on a specialist level response.

Health services also play an important role in supporting people to regain functionality after illness and to remain healthy and independent for longer. Even when returning to full health is not possible, access to responsive, needs-based pain management and palliative services (closer to home and family) can help to improve the quality of people's lives.

How have we measured our success?

The key outcome measures that demonstrate how the DHB is meeting these outcomes are:

- the rate of acute medical admissions to hospital
- the percentage of our population living in their own home.

The impact measures that contribute to these outcomes are:

- the percentage of people waiting no more than six weeks for their scans (CT or MRI)
- the reduction in the number of avoidable hospital admissions
- the reduction in the percentage of population over the age of 75 years admitted to hospital as a result of a fall.

How did we perform?

Following on from 2015/16, the positive trends have continued for 2016/17. This indicates that the investments and changes to primary and community services are having the desired effects, although there are significant opportunities for improvement. We are supporting more people to stay in their own homes for longer. Acute admissions to hospital have stabilised, and avoidable hospital admissions for Māori have reduced.

Outcome: Acute Medical Admissions

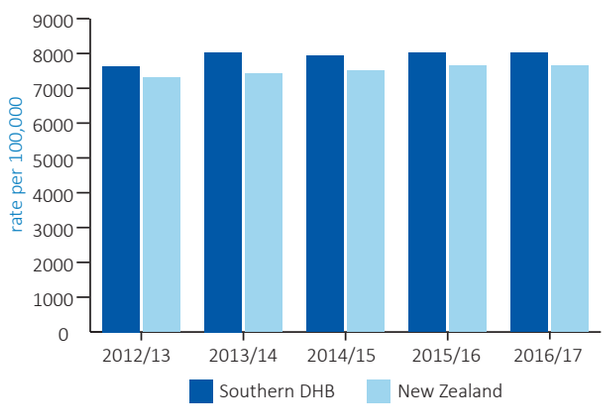
Lower acute admission rates can be used as a proxy indicator of improved conditions management. They can also be used to indicate the accessibility of timely and effective care and treatment in the community.

Southern DHB continues to remain static and above the national average for the number of acute admissions and this increasing demand on hospital services creates pressure on the whole health system. Reducing acute admissions will have a positive effect by enabling more efficient use of specialist resources that would otherwise be taken up by reacting to demand for urgent care.

The Internal Medicine Assessment Unit (IMAU) will be opened at Dunedin Hospital in September 2017 and is expected to take some pressure off the Emergency Department (ED), meaning reduced waiting times for patients. The majority of patients the IMAU will receive are likely to be older patients with multiple medical conditions from the ED, who often require further investigations and care, but not emergency treatment.

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

	2012/13	2013/14	2014/15	2015/16	2016/17
Southern DHB	7,634	8,030	7,923	8,028	8,023
New Zealand	7,298	7,428	7,516	7,644	7,638



Data sourced from National Minimum Data Set.

81,124
presentations to Emergency Departments across the Southern district

Outcome: People Living at Home

Studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and are positively connected to their communities. As rest home level occupancy continues to decrease despite an increase in the number of older people living in the Southern District, planning behind supporting people to live independently in their own homes is showing positive results.

We are seeing a gradual increase (0.5 per cent in 2016/17) in the proportion of older people supported in their own homes. This can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

In the coming years we are expecting to see more people enter hospital and dementia level care services, as they live longer in their own homes.

87%

of people aged 75+ live in their own home

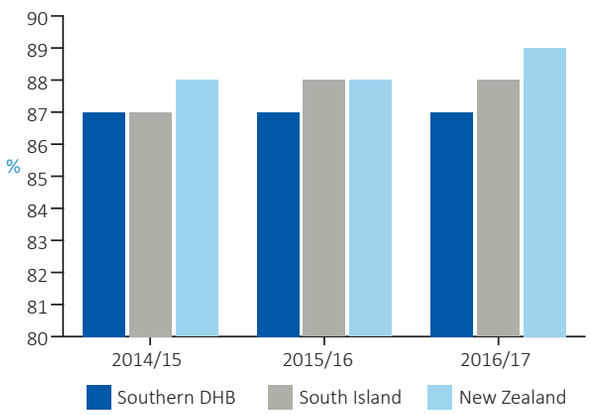
4th year

of delivering restorative Home and Community Support Services through an alliance

Life expectancy at birth was 81 years, slightly lower than the New Zealand average

Percentage of the population (75+ years) living in their own home

	2014/15	2015/16	2016/17
Southern DHB	87%	87%	87%
South Island	87%	88%	88%
New Zealand	88%	88%	89%



Medium Term Indicator: Earlier Diagnosis

Diagnostics are an important part of the health-care system and timely access by improving clinical decision-making enables early and appropriate intervention, improving quality of care and outcomes for our population.

The radiology service continues to experience increasing levels of urgent acute demand which is negatively impacting on timeliness. Southern DHB did not meet its targets for patients receiving either CT or MRI scans within 42 days of their referral being accepted.

In order to improve access for patients we plan to extend hours of operation, improve utilisation of CT resources across Southern DHB (including additional CT scanners based in rural hospitals), recruit and train key radiology staff and establish a clinically-led radiology demand workgroup to better plan for these services.

Percentage of people waiting no more than 6 weeks for their CT scan

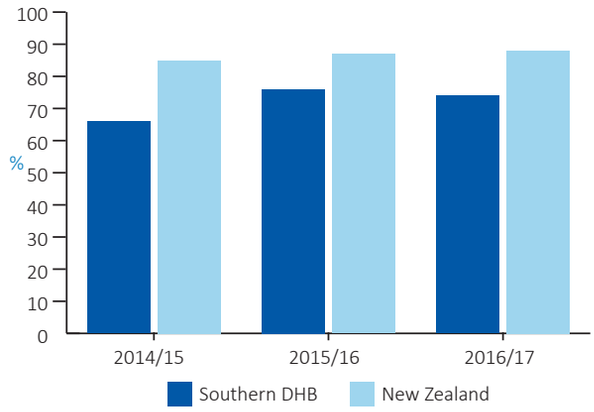
	2014/15	2015/16	2016/17	
	Actual	Actual	Target	Actual
Southern DHB	66%	76%	95%	74%
New Zealand	85%	87%	95%	88%

Percentage of people waiting no more than 6 weeks for their MRI scan

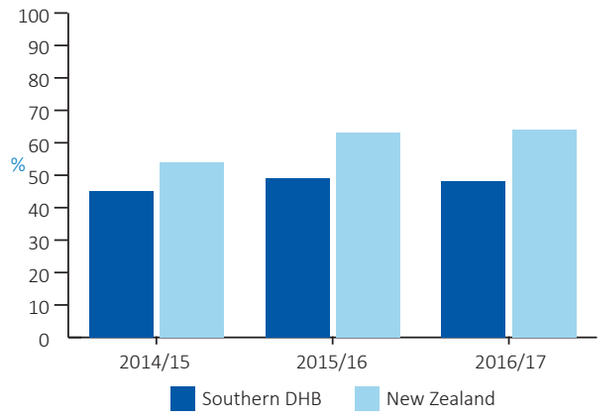
	2014/15	2015/16	2016/17	
	Actual	Actual	Target	Actual
Southern DHB	45%	49%	85%	48%
New Zealand	54%	63%	85%	64%

Data Source: Ministry of Health Performance Reporting PP29[8]

Percentage of CT scans within 6 weeks



Percentage of MRI scans within 6 weeks



74%

of people waited no more than six weeks for their CT scan

[8] This indicator is based on the national performance indicator PP29 and covers waiting time for CT and MRI scans.

Medium Term Indicator: Avoidable Hospital Admissions

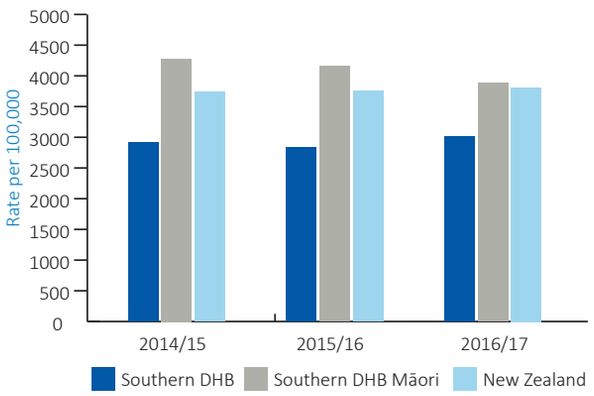
Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

Lower avoidable hospital admission rates, measured as Ambulatory Sensitive Hospitalisation (ASH) rates, are seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system. Total ASH rates have increased slightly in Southern, as they have across New Zealand. The rationale for this is not fully understood but could be related to increased demand for urgent care and Emergency Department (ED) attendances. The ASH rate for Māori in Southern is now equal to the New Zealand total ASH rate, however there is still an equity gap within the local population.

Avoidable hospital admission rates per 100,000 for the population aged 45-64 (ASH - SI1)

	2014/15	2015/16	2016/17	
	Actual	Actual	Target	Actual
Southern DHB	2,914	2,828	2,844	3,014
Southern DHB Māori	4,278	4,164	2,844	3,882
New Zealand	3,732	3,761	Not available	3,811

Data Source: Ministry of Health Performance Reporting SI[9]



[9] This indicator is based on the national performance indicator SI1 and covers hospitalisations for a range of conditions which are considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis.

Medium Term Indicator: Falls Prevention

Approximately 22,000 New Zealanders (aged over 75) are hospitalised annually as a result of injury due to a fall. Compared to people who do not fall, these people experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.

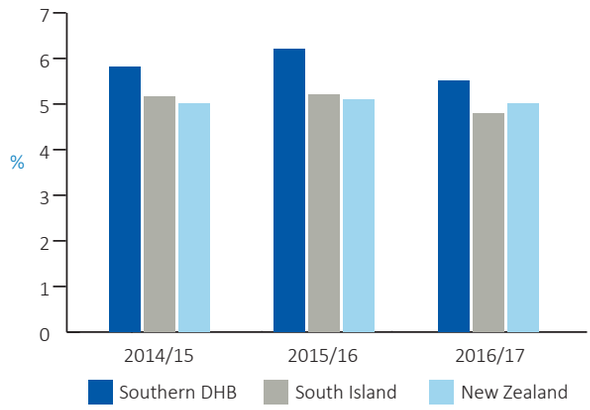
Lower falls rates can therefore be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided. WellSouth and Southern DHB have a whole of system view around falls, and this is a major contributor to the reduced fall rate in Southern to 5.5 per cent.

In the last year we have:

- continued to have a strong multi-sector Falls Governance Group which provides strong leadership around our programme of action
- undertaken a series of education sessions across the district with Age-Related Residential Care (ARRC) providers
- participated in the Hip Fracture Registry in Dunedin and Invercargill
- commenced work around developing our in-home based programme of strength and balance exercises for highest risk people. This programme will also allow people to have their home safety assessed to prevent further incidences
- extended the Fracture Liaison Service, which provides assessment and treatment for osteoporosis through WellSouth
- continued to support and encourage people to attend group community strength and balance exercise programmes managed through Age Concern.

Percentage of population (75 years and over) admitted to hospital as a result of a fall[10]

	2014/15	2015/16	2016/17	
	Actual	Actual	Target	Actual
Southern DHB	5.81%	6.20%	5.0%	5.50%
South Island	5.17%	5.20%	5.0%	4.80%
New Zealand	5.00%	5.10%	-	5.00%



Data Source: National Minimum Data Set

[10] This measure has been reset to reflect updated national ICD code definitions, so results differ to those previously published. 2014/15 results also reflect the updated 75+ population in line with the 2013 Census. The target for 2015/16 does not align with the updated definitions.

170
people referred to the Fracture Liaison Centre

75
people attended ARRC falls prevention education sessions focused on quality improvement

311
hip fracture ACC claims in 2016

Outcome 3.
People with Complex Illness Have Improved Health Outcomes

Why is this important?

For people who need a higher level of intervention, timely access to quality specialist care and treatment is crucial in supporting recovery or slowing progression of illness. This leads to improved health outcomes with restored functionality and a better quality of life.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services. They also impact on the wider health system in general by reducing acute demand, unnecessary presentations to the Emergency Departments and the need for more complex intervention.

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.

How have we measured our success?

The key outcome measures that demonstrate how the DHB is meeting these outcomes are:

- the rate of acute readmissions to hospital within 28 days of discharge
- the rate of mortality for people aged under 65 years.

The impact measures that contribute to these outcomes are:

- the percentage of people waiting at ED for less than six hours
- the percentage of people receiving their specialist assessment or agreed treatment in under four months
- rate of falls in hospital.

How did we perform?

We continue to keep people well in the community as demonstrated by the stable hospital readmission rate, which is below the rate seen across New Zealand. Falls are reducing in hospital. The long-term trend for avoidable mortality is also showing improvement.

Timeliness to access some services such as the Emergency Department and elective surgery is an ongoing challenge and as a DHB we know we have to improve in these areas.

Outcome: Acute Readmissions

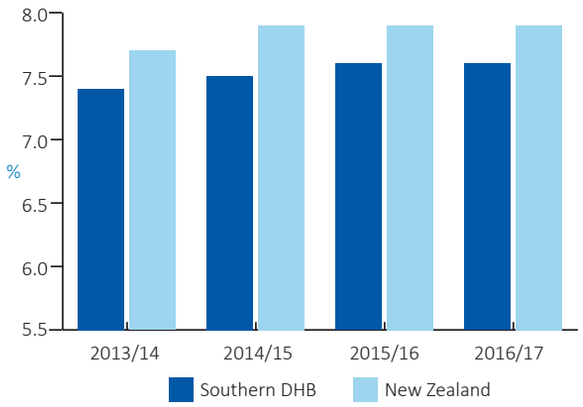
Unplanned hospital readmissions are largely (though not always) related to the quality of care provided to the patient.

As well as reducing public confidence and driving unnecessary costs, patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system. Southern DHB has maintained a steady readmission rate, and continues to perform better than the New Zealand readmission rate.

The key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge. Therefore, they are a useful marker of the quality of care being provided and the level of integration between services.

The rate of acute readmissions to hospital within 28 days of discharge

	2013/14	2014/15	2015/16	2016/17
Southern DHB	7.4%[10]	7.5%[10]	7.6%	7.6%[11]
New Zealand	7.7%[10]	7.9%[10]	7.9%	7.9%



Data Source: Ministry of Health Performance Data OS8

Outcome: Mortality Rates

Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

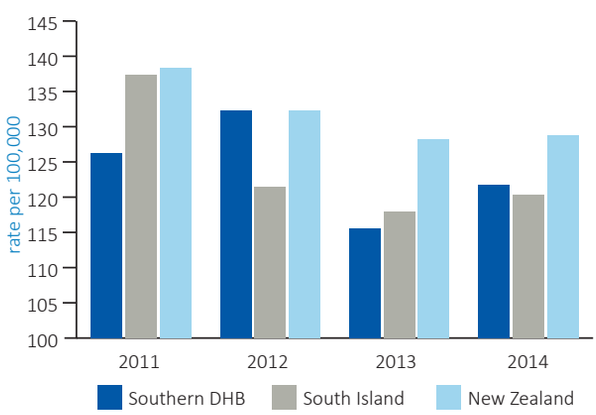
Southern has seen an overall reduction in preventable mortality since 2011, and continues to have lower mortality rates than the rest of New Zealand.

A reduction in avoidable mortality rates can be used as a proxy indicator of responsive specialist care and improved access to treatment for people with complex illness.

Note: there is a delay in mortality data as the cause of death has to be established for all reported deaths. Data is currently only available to 2014.

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

	2011	2012	2013	2014
Southern DHB	126.3	132.3	115.5	121.7
South Island	137.3	121.4	117.9	120.3
New Zealand	138.4	132.3	128.2	128.8



Data sourced from MoH Mortality Collection.

[11] This measure has been reset to reflect updated national ICD code definitions, so results differ to those previously published. 2014/15 results also reflect the updated 75+ population in line with the 2013 Census. The target for 2015/16 does not align with the updated definitions. The rates for prior years have been restated to the standardised rates of acute readmissions which aligns to the Statement of Intent

Medium Term Indicator: Waits for Urgent Care

Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

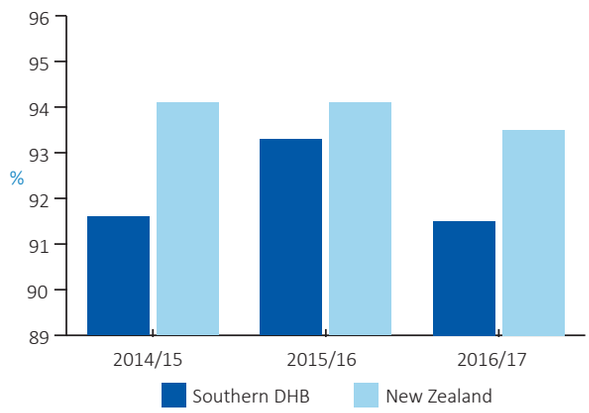
Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.

Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Increasing numbers of people attending EDs in the Southern district continue to place pressures on the system. The Internal Medicine Assessment Unit (IMAU) will be opened at Dunedin Hospital in September 2017 and is expected to take some pressure off the Emergency Department. The majority of patients the IMAU will receive are likely to be older patients with multiple medical conditions from the Emergency Department, who often require further investigations and care, but not emergency treatment.

Percentage of people presenting at ED who are admitted, discharged or transferred within 6 hours

	2014/15	2015/16	2016/17	
	Actual	Actual	Target	Actual
Southern DHB	91.6%	93.2%	95%	91.5%
New Zealand	94.1%	94.1%	95%	93.5%



Data Source: Individual DHB Patient Management Systems[12]

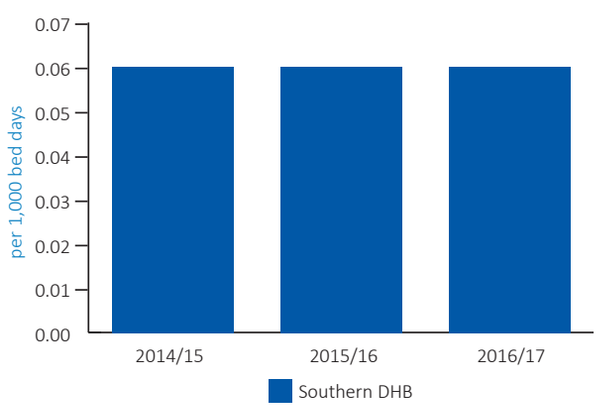
Medium Term Indicator: Adverse Events

The rate of falls is important, as patients who experience a fall while in hospital are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence and increased risk of institutional care. Fewer adverse events (such as falls) provide an indication of the quality of services and systems and improve outcomes for patients in our services.

The number of adverse events remains very low but the ultimate goal is no adverse events and zero patient harm.

Rate of SAC Level 1 and 2 falls in hospital (per 1,000 inpatient bed-days)[13]

	2014/15	2015/16	2016/17	
	Actual	Actual	Target	Actual
Southern DHB	0.06	0.06	0.05	0.06



Data Source: Individual DHB Quality Systems[13]

[12] This indicator is based on the national DHB Health Target 'Shorter Stays in ED' introduced in 2009.
[13] The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood.

Medium Term Indicator: Access to Planned Care

Planned services (including specialist assessment and elective surgery) are an important part of the health-care system and improve people's quality of life by reducing pain or discomfort and improving independence and well-being. Timely access to assessment and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

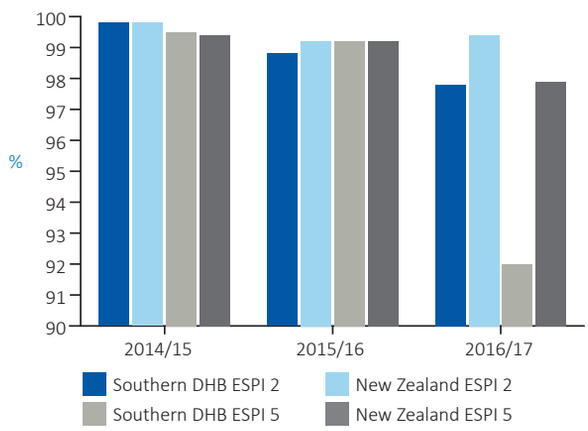
Delivering timely access to some treatments has been challenging for all DHBs in 2016/17, particularly for Southern DHB and especially for elective surgery. The solutions to these issues are not easy. Some steps have been made to address capacity issues, such as by extending the hours for our operating theatres, and supporting projects to further optimise theatre time, in an effort to reduce the time some patients need to wait for surgery.

People receiving their specialist assessment/treatment within four months shows how responsive the system is to the needs of our population. Patients have a much better chance of recovering and getting on with their lives where they are diagnosed, treated, and return home in a timely manner.

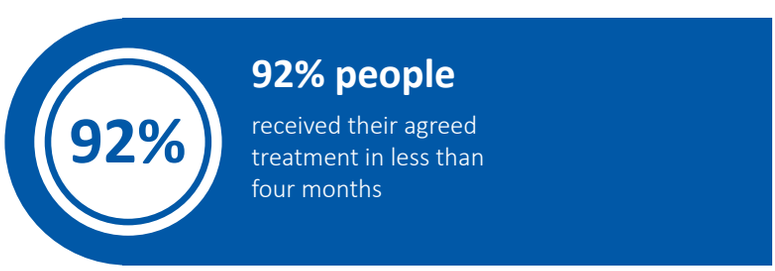
Percentage of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in under four months

	2014/15	2015/16	2016/17	
ESPI 2	Actual	Actual	Target	Actual
Southern DHB	99.8%	98.8%	100%	97.8%
New Zealand	99.8%	99.2%	100%	99.4%

	2014/15	2015/16	2016/17	
ESPI 5	Actual	Actual	Target	Actual
Southern DHB	99.5%	99.2%	100%	92.0%
New Zealand	99.4%	99.2%	100%	97.9%



Data Source: Ministry of Health Quickplace Data Warehouse[14]



[14] The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs are provided with individual performance reports from the Ministry of Health on a monthly basis.

National Health Targets

During the 2016/17 year Southern DHB saw variable performance across the health targets. Some of these targets involve work being undertaken in primary care with our health partners.

Shorter stays in Emergency Departments

95 per cent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

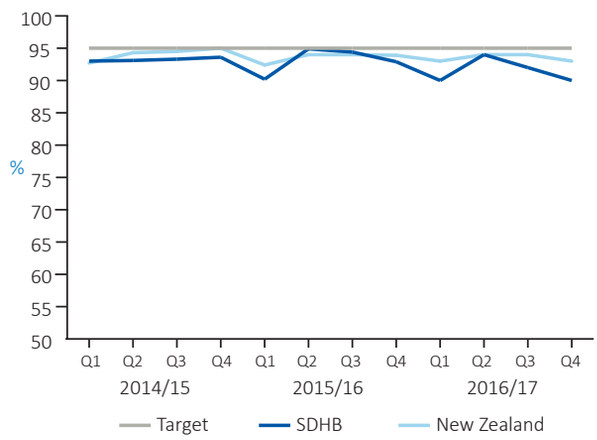
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
SDHB	90%	94%	92%	90%
NZ	93%	94%	94%	93%

The number of people accessing the Emergency Departments continues to increase. This is putting increased pressure on existing staff and resources to consistently manage patients in a timely way.

To reduce the number of people turning up at the Emergency Department, a number of initiatives have been implemented or are planned. An eight-bed Internal Medical Admission Unit (IMAU) is scheduled to open at Dunedin Hospital in September 2017.

In partnership with WellSouth Primary Health Network (PHN), we are establishing a community based Acute Demand Service. This is targeted at the most vulnerable people, and through acute care plans provide access to alternative acute care options.

Figure 1: Shorter stays in Emergency Departments



Improved Access to Elective Surgery

Nationally, DHBs will deliver an increase in the volume of elective surgery by an average of 4,000 per year. Southern will deliver at least 12,921 elective procedures in 2016/17.

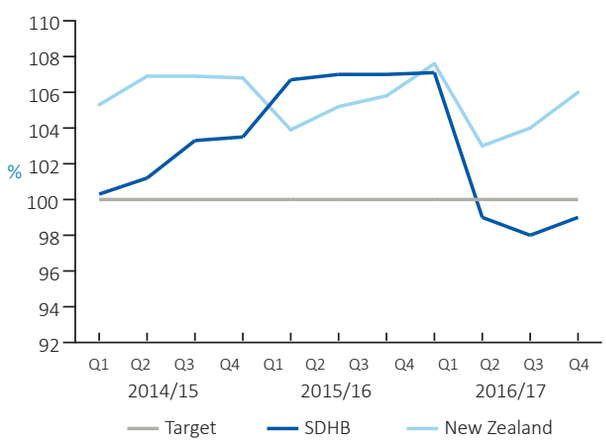
	Q1	Q2	Q3	Q4
Target	100%	100%	100%	100%
SDHB	105%	99%	98%	99%
NZ	105%	103%	104%	106%

A total of 12,756 elective procedures were completed in 2016/17. This is against a target of 12,921.

Some steps have been made to address capacity issues, such as by extending the hours for our operating theatres, and supporting projects to further optimise theatre time, in an effort to reduce the time some patients need to wait for surgery.

Production and Operations Planning (POP) is Southern DHBs new approach being used to plan electives service delivery for 2017/18. The process looks at DHB resources, and what models are needed to deliver the elective services agreed with the Ministry of Health.

Figure 2: Improved access to elective surgery



Faster Cancer Treatment

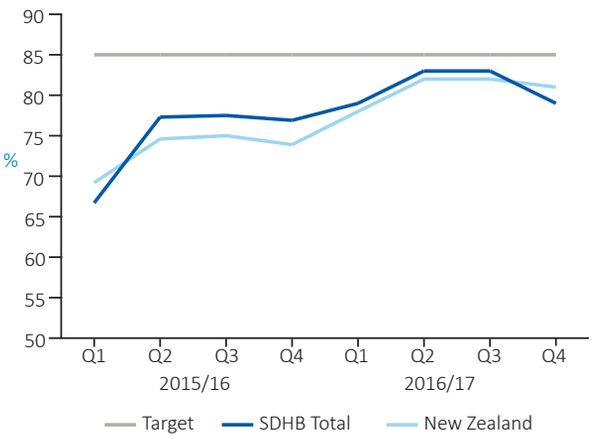
85 per cent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

	Q1	Q2	Q3	Q4
Target	85%	85%	85%	85%
SDHB	79%	83%	83%	79%
NZ	78%	82%	82%	81%

Southern DHB continues to show improvement on the percentage of patients receiving their first cancer treatment within 62 days, but this is still below the 85 per cent target.

Managing patients across the system has shown areas for improvement. The DHB is in the process of establishing a system whereby patients who do not receive treatment within 62 days can be identified earlier and a protocol to assist in their management of care is developed.

Figure 3: Faster cancer treatment



Increased Immunisation

95 per cent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

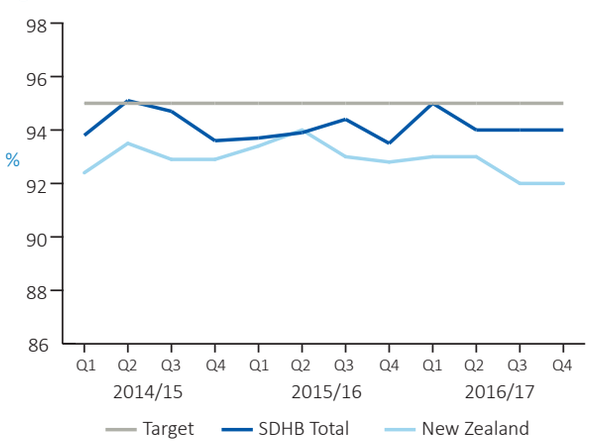
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
SDHB	95%	94%	94%	94%
NZ	93%	93%	92%	92%

Southern DHB continues to deliver a high performing immunisation service. This has been achieved by a whole of sector approach with a well-coordinated and functioning programme involving general practice, WellSouth Primary Health Network (PHN), public health and the DHB.

Southern DHB is assured that they are tracking every child; final coverage results are impacted by the small number of parents of children who have declined one or all of the events in the Immunisation Schedule.

Southern remains one of the higher performing DHBs for this target.

Figure 4: Increased immunisation



Better Help for Smokers to Quit - Primary

90 per cent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking.

	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
SDHB	83%	75%	73%	85%
NZ	87%	86%	87%	89%

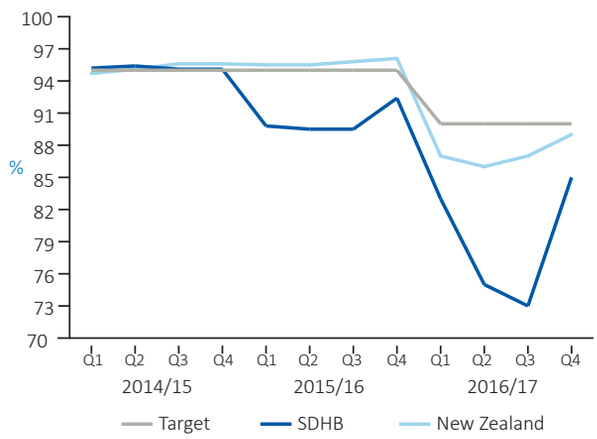
Southern DHB has made significant progress in the last quarter towards meeting the 90 per cent target.

There was a change to the period of recall down to 15 months in 16/17 and this is reflected in the significant drop in Quarter 2. Processes for recall have been refined to ensure people are recalled within the 15 months. This is reflected in the Quarter 4 results.

Initiatives such as WellSouth call centre and the HealthCloud reporting tool are expected to support this health target over the coming year.

Southern DHB's cessation support indicator is 33.1 per cent. This compares favourably with the national result for this indicator of 31.9 per cent. This indicator shows the percentage of current smokers who have been given or referred to cessation support services in the last 12 months.

Figure 5: Better help for smokers to quit - Hospital



Better Help for Smokers to Quit - Maternity

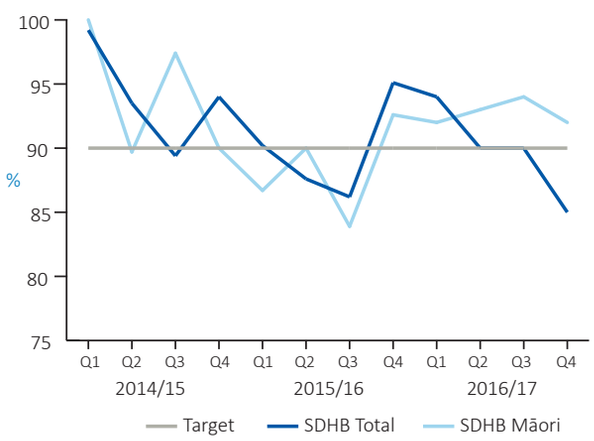
Progress towards 90 per cent of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered brief advice and support to quit smoking.

	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
SDHB	94%	90%	90%	85%
NZ	92%	93%	94%	92%

The maternity Better Help for Smokers to Quit target was achieved in three of the quarters in the past year.

The DHB continues to work with Lead Maternity Carers (LMCs) on recording smoking status and referrals to cessation services, and to ensure the correct health pathways are followed to our Southern Stop Smoking Service.

Figure 6: Better help for smokers to quit - Maternity



Raising Healthy Kids

95 per cent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017.

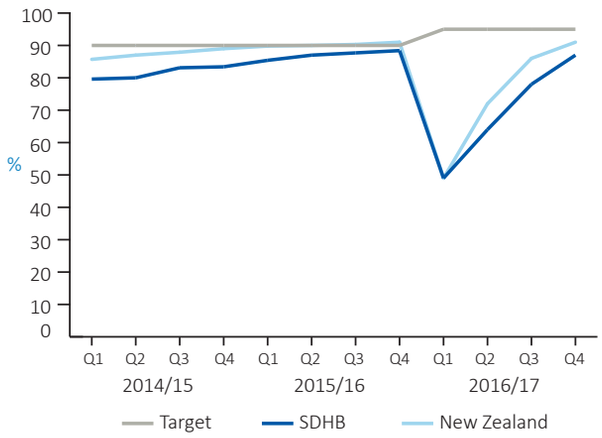
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
SDHB	49%	64%	78%	87%
NZ	49%	72%	86%	91%

Raising Healthy Kids is a new health target for 2016/17.

Southern DHB has shown significantly improved progress against this target over the past year, as we work towards achieving the target 95 per cent by December 2017.

There are now pathways and systems in place to better make and manage referrals.

Figure 7: Raising healthy kids



Outputs – Short-Term Performance Measures

In order to present a representative picture of performance, outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum of care and are applicable to all DHBs. These are:

- Prevention
- Early Detection and Management
- Intensive Assessment & Management
- Rehabilitation and Support.

Identifying a set of appropriate measures for each output class can be difficult. We do not simply measure 'volumes'. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'.

We use this grading system for the 2016/17 Statement of Service Performance to assess performance against each indicator in the Output Measures section. A rating has not been applied to demand driven indicators.

Criteria		Rating	
On target or better		Achieved	●
95-99.9%	0.1%-5% away from target	Substantially achieved	●
90-94.9%	5.1%-10% away from target	Not achieved, but progress made	●
<90%	>10% away from target	Not achieved	●

Cost of Service Statement

Table 1: Revenue and expenditure by the four output classes 2016/17

	2016/17 Actual $000	2016/17 Budget	2016/17 Variance $000
Revenue			
Prevention Services	9,217	9,606	(389)
Early Detection and Management Services	188,700	195,183	(6,483)
Intensive Assessment and Treatment	607,748	599,589	8,159
Rehabilitation and Support	128,610	126,671	1,939
Total Income	**934,275**	**931,049**	**(3,226)**
Expenditure			
Prevention Services	9,217	9,606	389
Early Detection and Management Services	188,975	197,454	8,479
Intensive Assessment and Treatment	629,023	616,679	(12,344)
Rehabilitation and Support	128,930	129,309	379
Total Expenditure	**956,145**	**953,049**	**(3,096)**
Share of profit/(loss) in associates	-		-
Surplus/(Deficit) for the year	**(21,870)**	**(22,000)**	**130**

Appropriations

Under the Public Finance Act, the DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by the DHB for the financial year 2016/17 is $818.6 million which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 14 to 53.

Output Class: Prevention

Prevention health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

These services include education programmes and services to raise awareness of risky 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.

Immunisation Services

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

Immunisation can prevent a number of diseases and is a cost effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people.

How did we perform?

Southern DHB continues to provide a high performing immunisation service with 94 per cent of children aged 8 months immunised against common vaccine-preventable diseases. This has been achieved by a whole of sector approach with a well-coordinated and functioning programme involving general practice, WellSouth, public health, and the DHB. Southern DHB is assured that they are tracking every child and final coverage results are impacted by the small number of parents of children who have declined one or all of the events in the Immunisation Schedule.

The DHB have been working to support families and whānau with improved knowledge about key entitlements for all newborn babies and enrolment in key health services. Automatic enrolment will occur into oral health services, newborn hearing and immunisation services and families will nominate their GP and Well Child Tamariki Ora (WCTO) provider. The newborn enrolment form will be launched in October 2017.

Table 2: 2016/17 Performance Results for Immunisation Services

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
Percentage of children fully immunised at 8 months (Health Target)	Total	94%	94%	95%	94%	🟡
	Māori	91%	94%	95%	92%	🟡
Percentage of children fully immunised at 2 years	Total	95%	95%	95%	95%	🟢
	Māori	93%	96%	95%	95%	🟢
Percentage of children fully immunised at 5 years	Total	Not available	91%	95%	92%	🟡
	Māori	Not available	92%	95%	93%	🟡
Percentage of children (aged 8 months) 'reached' by immunisation services	Total	97%	98%	99%	98%	🟡
Percentage of children (aged 2 years) 'reached' by immunisation services	Total	98%	99%	99%	99%	🟢
Percentage of eligible girls fully immunised with 3 doses of HPV Vaccine[15]	Total	-	-	70%	67%[16]	🟡
	Māori	-	-	70%	72%[16]	🟢
Percentage of people aged over 65 having received a flu vaccination	Total	65%	Not available[17]	75%	Not available[18]	🔴
	Māori	61%	Not available	75%	Not available	🔴

[15]The measure for the coverage of HPV vaccination changed in 2015/16 so prior years are not comparable. Data is for the 2016 calendar year.
[16]Fewer people consented to the HPV vaccination in 2016 for unknown reasons. The HPV programme changed from January 2017 to two doses (down from 3 doses) and boys are now eligible.
[17]Data not available in 2015/16 due to a change in reporting systems.
[18]Due to a change in reporting systems we are unable to gather the complete 2016 data. Flu vaccination data was made available from NIR from 1 July 2016. Data prior to 1 July 2016 was from the PHO Performance Management System which is no longer accessible.

Health Promotion and Education Services

Prevention services include health promotion to help prevent the development of disease, and statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases. Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt. Brief advice works by triggering a quit attempt rather than by increasing the chances of success of a quit attempt. Evidence shows that by encouraging and supporting more smokers to make quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and a reduction in the risk of smoking-related diseases.

Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and well-being, and potentially reducing the incidence of obesity later in life.

How did we perform?

It has been challenging for Southern DHB to achieve and maintain the smoking health targets over the last year. Not consistently maintaining the health target in the hospital setting highlights issues with embedding ABC and recording this on the patient records into routine business.

In primary care a WellSouth call centre was established to update smoking status of PHO enrolled smokers. In 2016/17 HealthCloud Reporter has been installed in the majority of general practices across the Southern district and this will allow WellSouth to benchmark practices against each other to compare performance and allow the development of league tables for health targets.

There were significant changes to smoking cessation services in 2016. A single Southern Stop Smoking Service (SSSS) was established by Nga Kete Matauranga Pounamu in mid-2016 and receives referrals from multiple providers. There have been focused efforts from the health system to increase volume and quality of referrals to the SSSS. SSSS have held meetings with general practices, LMCs and secondary care staff, and developed a website and promotional material. SSSS shares referral information with the DHB and WellSouth as part of an evaluation framework.

The pēpi-pod programme continues to be supported for vulnerable infants. This provides a safe space for infants every time and place they sleep. This is a public health response to the higher risk of Sudden Unexpected Death in Infancy (SUDI) for babies who are more vulnerable due to exposure to smoking, especially in pregnancy, being born before 37 weeks or weighing less than 2500 grams, or in family environments where use of alcohol and drugs are prevalent.

Table 3: 2016/17 Performance Results for Health Promotion and Education Services

Measure		2014/15	2015/16	2016/17		
		Actual	Actual	Target	Actual	
Percentage of smokers receiving advice and support to quit smoking in hospital	Total	95%	92%	95%	90%	●
	Māori	95%	95%	95%	93%	●
Percentage of Primary Health Organisation smokers who receive advice and support to quit smoking	Total	74%	88%	90%	85%	●
	Māori	77%	88%	90%	89%	●
Percentage of pregnant smokers being offered advice and support to help quit smoking	Total	94%	90%	90%	85%	●
	Māori	90%	88%	90%	86%	●
Percentage of pregnant women who are smokefree at 2 weeks postnatal	Total	-	87%	95%	Not available[19]	
	Māori	-	70%	95%	Not available[19]	
Infants exclusively or fully breastfed at 6 weeks	Total	70%	75%	75%	Not available[19]	
	Māori	65%	70%	75%	Not available[19]	
Infants exclusively or fully breastfed at 3 months	Total	-	57%	60%	Not available[19]	
	Māori	-	47%	60%	Not available[19]	
Infants receiving breast milk at 6 months	Total	61%	65%	65%	Not available[19]	
	Māori	51%	57%	65%	Not available[19]	

[19]Reporting on these indicators ceased through Well Child-Tamariki Ora Framework for all DHBs in 2017. SDHB is investigating other options to access this data.

Statutory Regulation

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

How did we perform?

The DHB has met two of the three measures outlined in the 2016/17 annual plan. The fourth measure is no longer applicable as Public Health South no longer undertakes hazardous substance inspections.

Table 4: 2016/17 Performance Results for Statutory Regulation

Measure	2014/15	2015/16	2016/17		
	Actual	Actual	Target	Actual	
Tobacco retailers are compliant with current legislation	95%	99%	85%	88%[20]	●
Alcohol retailers are compliant with current legislation	96%	98%	95%	89%[21]	●
The proportion of communicable disease notifications investigated	100%	100%	100%	99%	●
The proportion of hazardous substances inspections and audits completed	100%	Not available	100%	Not available[22]	

Population-Based Screening

Breast cancer is the most common cancer in New Zealand women, and the third most common cancer overall. One in nine New Zealand women will be diagnosed with breast cancer in their lifetime, three quarters of whom are aged 50 years and over. For women aged 50 to 65 years, screening reduces the chance of dying from breast cancer by approximately 30 per cent, (National Screening Unit, 2014). Breast screening is provided to reduce women's morbidity and mortality from breast cancer by identifying cancers at an early stage, allowing treatment to be applied.

Cervical screening is eligible for women aged 25 to 69 years. A cervical smear test looks for abnormal changes in cells on the surface of the cervix. Some cells with abnormal changes can develop into cancer if they are not treated. Treatment of abnormal cells is very effective at preventing cancer.

B4 School Checks are a MoH specified national programme and include the Tamariki Ora/Well Child checks done prior to a child turning five. The B4 School Check identifies any health, behavioural or developmental problems that may have a negative impact on the child's ability to learn and participate at school.

How did we perform?

Southern DHB has remained relatively stable with coverage for these measures. The screening rate for Māori women for breast and cervical screening has increased slightly, although it remains below the rate for all women.

Southern DHB is working alongside WellSouth and Pacific Radiology to enable women to have a one-stop consultation for breast and cervical screening. Providing the service in this way is more convenient and patient focused and will allow better alignment of these services for women.

Some progress has been made to ensure eligible Māori women are up to date with their cervical screening and reducing the gap between total population and Māori. However, Māori and Asian women still have lower levels of cervical screening coverage, which are below the target.

Southern achieved 81.3 per cent for Pacific women through working in partnership with community agencies and the communities we engage with, general practices, and Pacific Islands Trusts, to remove barriers and improve health literacy.

The steering groups for breast and cervical screening are to be amalgamated and this will minimise duplication and provide clear direction and monitoring of performance measures.

The percentage of children receiving their B4 School Check continues to exceed its target. The B4 School Check is a free health and development check for all four-year-olds, and is undertaken by DHB public health nurses.

[20]A total of 36 retailers were tested by controlled purchase operations with an 88% compliance rate. How the rate is calculated has been changed and prior years have been restated using the updated methodology.
[21]89% of alcohol premises visited during controlled purchase operations did not sell alcohol to the volunteer.
[22]Public Health South no longer do hazardous substance inspections. The requirements for hazardous substance audits have also changed and this measure is no longer able to be reported on.

Table 5: 2016/17 Performance Results for Population-Based Screening

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
Percentage of eligible women (50-69 years) who have had a BSA mammogram breast screen examination in the past 2 years (MHP).	Total	73%	74%	70%	75%	●
	Māori	62%	65%	70%	67%	●
Percentage of eligible women (25-69 years) who have had a cervical screening event in the past 36 months (MHP).	Total	79%	79%	80%	79%	●
	Māori	59%	61%	80%	63%	●
The percentage of eligible children receiving Before School Checks (B4SC).	Total	100%	94%	90%	91%	●
	Quintile 5[23]	100%	99%	90%	94%	●

Output Class: Early Detection and Management

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

Providers of these services include general practice, community and Māori and Pacific health services, pharmacy, diagnostic imaging, laboratory services, child and youth oral health services.

Oral Health

Oral health is an integral component to lifelong health and impacts a person's comfort in eating and ability to maintain good nutrition, self-esteem and quality of life. Good oral health not only reduces unnecessary hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and health outcomes.

Research shows that improving oral health in childhood has benefits over a lifetime. Good oral health in children indicates early contact with health promotion and prevention services, which will hopefully be lifelong good oral health behaviours.

The measure indicates the accessibility and availability of publicly-funded oral health programmes, which will in turn reduce the prevalence and severity of early childhood caries, and improve oral health of primary school children.

How did we perform?

A new model of care for dental health promotion was introduced five years ago. This model of care has, at its core, the principle of working in partnership with children's whānau/parents/caregivers to achieve improved oral health outcomes. This is a longer term strategy and is expected to yield positive results over the medium to longer term, particularly in the area of reducing caries.

Overall, Southern DHB has not met its oral health targets that were set out in our Annual Plan. The oral health service has carried a high number of vacancies in the number of dental therapists and health promotion team, which has had a significant effect on the level of achievement against the targets for the 2016/17 period.

The DHB has set up an online enrolment form to make it easier for people moving into the district to enrol electronically. A combined newborn enrolment process is also about to commence where a single process will enrol newborn children in five different services.[24]

The service has established some key medium to long-term strategies for improving progress against these measures which include:

- introducing the newborn enrolment form in October 2017, to ensure automatic enrolment into oral health services for all newborns
- developing a good understanding of which geographical parts of our DHB have lower rates of enrolment for children and adolescents and plans to increase enrolment
- improving the maintenance of year 1 to 8 lists using school information to improve the quality of data
- continuing to make it easier for families/whānau to access our oral health services by offering family appointments
- continuing to provide services over the school holidays as well as extended hours in the Dunedin and Invercargill areas over the summer months.

[23]Quintile 5 relates to most deprived (20%) in our population based on the Deprivation Index.
[24]New born enrolment includes oral health, general practice, PHO, immunisation, and WellChild Tamariki Ora.

Table 6: 2016/17 Performance Results for Oral Health

Measure		2014	2015	2016		
		Actual	Actual	Target	Actual	
The number of eligible preschool children enrolled in school and community oral health services (PP13)	Total	15,486	15,075	18,000	14,927	●
	Māori	2,174	2,325	3,300	2,353	●
The percentage of eligible preschool children enrolled in school and community oral health services (PP13a & MHP)	Total	82%	80%	95%	81%	●
	Māori	61%	65%	95%	65%	●
The number of eligible children from Year 1 to Year 8 enrolled in school and community oral health services (PP13)	Total	27,971	28,218	28,000	29,121	●
	Māori	3,629	3,892	5,108	4,213	●
The percentage of eligible adolescents who access funded oral health services (PP12)	Total	82%	75%	85%	73%	●
The percentage of children caries-free at five years of age (PP11)	Total	64%	60%	70%	69%	●
		52%	64%	70%	58%	●

Note: All oral health data is reported on a calendar year.

Long-term Conditions Management

Long-term conditions are the leading cause of hospitalisations, account for most preventable deaths and are estimated to consume a major proportion of our health funds.

Cardiovascular disease (CVD) is still the leading cause of death in New Zealand, and many of these deaths are premature and preventable. While some risk factors for cardiovascular disease are unavoidable, such as age or family history, many risk factors are avoidable, such as diet, smoking and exercise. Increasing the percentage of people having a CVD Risk Assessments (CVDRA) ensures these people are identified early and can therefore be managed appropriately.

How did we perform?

WellSouth continues to prioritise CVDRA for Māori men aged 35 to 44 years but Southern DHB is yet to reach the 95 per cent target for more heart and diabetes health checks. The DHB has commenced a St John Ambulance referral system for any patients they treat and leave at home who are in the priority group for CVDRA.

WellSouth continues to offer the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme for patients with Type 2 Diabetes. A total of 805 people went through this programme in the last year. The 'Walking Away' from diabetes programme is for patients identified with pre-diabetes. This is a structured group education module for people who are at high risk of developing Type 2 diabetes and cardiovascular disease.

The Long Term Conditions Network has developed the 'Do the Right Thing' programme to replace CarePlus. This programme puts the enrolled patient population through a Risk Prediction algorithm, and utilises a range of assessment tools to help determine the types of support patients may require to best support their long-term conditions.

Linked to better management of long-term conditions is having care plans and options for when people become acutely unwell. This has led to the development of the Acute Demand Management Services (ADMS) Programme, with a preliminary focus on Chronic Obstructive Pulmonary Disease (COPD). ADMS includes a number of programmes of work, such as ambulance diversion, primary options for acute care (POAC), community rehabilitation/wrap around services and acute care teams, which are geared to holding or reducing the growth in demand on ED services.

The measure for high risk patients receiving an angiogram within three days of admission was achieved, as was the measure of patients undergoing coronary angiography who present with acute coronary syndrome. The closer management of service capacity with demand for the service was a factor in achieving the targets for both of these measures.

Table 7: 2016/17 Performance Results for Long-Term Conditions Management

Measure		2014/15	2015/16	2016/17		
		Actual	Actual	Target	Actual	
The proportion of the eligible population (45-79) having a CVD risk assessment in the last five years (PP20 & MHP)	Total	83%	88%	90%	86%	●
	Māori	76%	82%	90%	82%	●
Percentage of eligible patients (15-74 years) with good or acceptable glycaemic control of ≤64mmol/mol (PP20)	Total	53%	53%	79%	37%[25]	●
	Māori	47%	46%	79%	36%[25]	●
Percentage of stroke patients thrombolysed (PP20)	Total	6%	3%	6%	5%	●
Percentage of high-risk patients receiving an angiogram within three days of admission (PP20)	Total	82%	79%	70%	83%	●
Percentage of patients presenting with Acute Coronary Syndrome (ACS) who undergo coronary angiography, have completion of ANZAC QI data collection within 30 days (PP20)	Total	95%	99%	95%	99%	●
		95%	100%	95%	95%	●

Community Referred Testing and Diagnostics

These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment.

Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management. Improving access to diagnostics will improve patient outcomes in a range of areas:

- Cancer pathways will be shortened with better access to a range of diagnostic modalities
- Emergency Department (ED) waiting times can be improved if patients have more timely access to diagnostics
- Access to elective services will improve, both in relation to treatment decision-making, and also improved use of hospital beds and resources.

How did we perform?

Southern DHB continued to meet its target for patients receiving radiotherapy or chemotherapy within four weeks which follows the trend of the past three years. Ongoing quality improvement work to reduce waiting times is making a significant difference.

Southern DHB continues to show improvement on the percentage of patients receiving their first cancer treatment in 62 days or less, but this is still below the 85 per cent target. The DHB is in the process of establishing a system whereby patients who do not receive treatment within 62 days can be identified earlier and a protocol to assist in their management of care is developed.

The radiology service continues to experience increasing levels of urgent acute demand which is negatively impacting on timeliness. Southern DHB did not meet its targets for patients receiving either CT or MRI scans within 42 days of their referral being accepted. In order to improve access for patients, plans have been developed which include:

- Extended hours of operation
- Improved utilisation of CT resource across the whole Southern DHB catchment including increased utilisation of CT based at rural hospitals
- Recruitment and training of key radiology staff
- The establishment of a clinically-led radiology demand workgroup to better plan for high tech imaging services.

[25]Changes to models of care and payment for diabetes management has seen an unintended drop in reporting on glycaemic control.

Table 8: 2016/17 Performance Results for Community Referred Testing and Diagnostics

Measure	2014/15	2015/16	2016/17		
	Actual	Actual	Target	Actual	
Percentage of accepted referrals for coronary angiography receiving procedure within 90 days (PP29)	100%	92%	95%	99%	●
Percentage of patients, ready for treatment, waiting less than four weeks for radiotherapy or chemotherapy (PP30)	100%	100%	100%	100%	●
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks (Health Target)	66%	77%	85%	79%	●
The percentage of accepted referrals for CT scans receiving procedure within 42 days (PP29)	66%	76%	95%	74%	●
The percentage of accepted referrals for MRI scans receiving procedure within 42 days (PP29)	45%	49%	85%	48%	●

Primary Health Care Services

Primary health care services are offered in local community settings by teams of General Practitioners, registered nurses, nurse practitioners and other primary care professionals. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.

Early detection in a primary care setting could lead to successful treatment, or a delay or reduction in the need for secondary and specialist care. These services are expected to enable more people to stay well in their homes and communities for longer.

How did we perform?

The PHO enrolment has not been met, primarily due to the numbers of students who access health services via student health services, which are not part of the PHO. This, however, does mask some of the gaps elsewhere. Māori enrolment has increased but is still well short of the 95 per cent target. People enrolling with the PHO means access to general practice services is improved. The newborn enrolment form will enable automatic enrolment to five key health services[26] and is expected to improve the number of newborn enrolments.

The primary care based General Practitioners with Special Interest (GPSI) skin lesion service run by WellSouth continues to exceed the 1,200 funded procedures. Work is currently underway on reviewing this programme to determine a feasible way to increase volumes in primary care, and reduce the number of skin lesion procedures done in hospitals.

The rates for Ambulatory Sensitive Hospital (ASH) admissions (avoidable hospitalisations) continues to improve for children 0-4 years old. The rate for Māori aged 45-64 years is also showing a declining trend (improvement), whilst acknowledging a slight increase in non-Māori rates. This could be attributed to multiple factors such as the GP/ Pharmacy Voucher programme, Te Kakano clinics held in community settings, 'free under 13 years' care for GP consultations and access to after hours care.

The installation of HealthCloud Reporter in general practices is enabling a more robust measurement/ performance framework at practice and practitioner level.

Linked to better management of long-term conditions is having care plans and options for when people become acutely unwell.. This has led to the development of the Acute Demand Management Services (ADMS) Programme, with a preliminary focus on COPD. ADMS includes a number of programmes of work, such as ambulance diversion, primary options for acute care (POAC), community rehabilitation/wrap around services, acute care teams, which are geared to holding or reducing the growth in demand on ED services.

WellSouth is continuing work with Invercargill Urgent Doctors Service to build increased capacity for sustainable urgent and after-hours services.

[26]Single enrolment for WCTO, oral health, WellSouth, newborn hearing, NIR

Table 9: 2016/17 Performance Results for Primary Health Care Services

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
The percentage of the DHB population enrolled in a Primary Health-care Organisation (PHO)	Total	93%	93%	95%	92%	●
	Māori	86%	81%	95%	83%	●
The number of skin lesions removed in primary care (by a GP with special interest – GPSI) without the need for a hospital appointment	Total	1,133	1,778[27]	1,200	1,229	●
Ambulatory Sensitive Hospital (ASH) admission rates (per 100,000) for children aged 0-4 years are reduced (SI1)[28]	Total	6,332	5,578	-	5,465	
	Māori	7,104	6,871	-	5,331	
Ambulatory Sensitive Hospital (ASH) admission rates (per 100,000) for the population aged 45-64 years are maintained (SI1)[28]	Total	2,914	2,828	<2,844	3,014	●
	Māori	3,732	3,761	4,000	3,882	●
The number of people receiving a brief intervention from the primary mental health service	Total	4,384	4,735	4,000	7,418	●

Output Class: Intensive Assessment and Management

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

Southern DHB provides a range of intensive treatment and complex specialist services to its population. 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 which the DHB must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Elective Services – Inpatient and Outpatient

These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. Elective services are an important part of the health system, as they improve a patient's quality of life by reducing pain or discomfort and improving independence and well-being. Timely access to elective services is a measure of the effectiveness of the health system. Meeting standard intervention rates for a variety of types of surgery means that access is fair, and not dependent upon where a person lives.

How did we perform?

Southern DHB achieved above the target for First Specialist Appointments (FSA), however, the total number of elective surgical discharges (including dental and cardiology) of 14,361 was just short of the target of 14,405. Likewise for the electives health target, a total of 12,756 elective procedures were completed in 2016/17. This is against a target of 12,921.

The solutions to delivering the increasing number of required electives are not easy. Some steps have been made to address capacity issues, such as by extending the hours for our operating theatres, and supporting projects to further optimise theatre time, in an effort to reduce the time some patients need to wait for surgery.

Changes occurring in 2017/18 include:

- implementing a new production planning process which will allow for more accurate planning and phasing of elective surgical activity during the course of 2017/18
- increasing theatre capacity through lengthening the theatre day and adding an additional weekend theatre
- increasing staffing resources to facilitate these actions.

[27]In 2015/16 WellSouth funded additional skin lesions above the 1,200 funded by Southern DHB.
[28]Ambulatory Sensitive Hospital (ASH) admissions are seen as preventable through appropriate early intervention in primary care. Data is to September 2015 and is produced 6-monthly by the Ministry of Health. Targets are set against national total population ASH rates.

Table 10: 2016/17 Performance Results for Elective Services - Inpatient and Outpatient

Measure	2014/15	2015/16	2016/17		
	Actual	Actual	Target	Actual	
The number of medical and surgical First Specialist Appointments (FSA)	38,443	38,662	35,693	37,071	●
Theatre utilisation - proportion of resourced theatre minutes used to total resourced theatre minutes	81%	87%	88%	90%	●
The number of elective surgical services discharges (incl. dental and cardiology)	Not available[29]	14,895	14,405	14,361	●
The number of elective surgical services discharges (excl. dental and cardiology) (Health Target)	11,039	13,324	12,921	12,756	●
The number of elective surgical services caseweights (CWDs) delivered	15,331	15,419	15,788	15,279	●
Average elective inpatient length of stay (days) is maintained (OS3)	-	1.54	1.55	1.49	●
Outpatient 'Did Not Attend' (DNA) rates are reduced	7.3%	7.5%	8%	6.8%	●

Acute Services

Acute and urgent services are vital services for communities due to the unforeseen and unplanned nature of many health related emergencies or events.

It is important to ensure those presenting at an Emergency Department (ED) with severe and life-threatening conditions receive immediate attention. EDs must have an effective triage system. There need to be accessible options for people to access urgent care in the community.

Long stays in EDs can contribute to overcrowding, negative clinical outcomes and compromised standards of privacy and dignity for patients.

How did we perform?

The number of people accessing EDs continues to rise in the Southern district and in turn puts pressure on people receiving timely care. Meeting the ED health target is an ongoing challenge and requires a system-wide approach.

Linked to better management of long-term conditions is having care plans and options for when people become acutely unwell. This has led to the development of the Acute Demand Management Services (ADMS) Programme, with a preliminary focus on COPD. ADMS includes a number of programmes of work, such as ambulance diversion, primary options for acute care (POAC), community rehabilitation/wrap around services, acute care teams, which are geared to holding or reducing the growth in demand on ED services.

A new allied health team has been introduced to ED in Dunedin to manage patients with non-urgent issues and get them back to home as soon as possible. Additionally the Internal Medicine Assessment Unit (IMAU) will be opened at Dunedin Hospital in September 2017 and is expected to take some pressure off the Emergency Department (ED). The majority of patients the IMAU will receive are likely to be older patients with multiple medical conditions from the ED, who often require further investigations and care, but not emergency treatment.

Table 11: 2016/17 Performance Results for Acute Services

Measure	2014/15	2015/16	2016/17		
	Actual	Actual	Target	Actual	
People are assessed, treated or discharged from the emergency department (ED) in under six hours (Health Target)	94%	93%	95%	90%	●
Number of people presenting at ED	77,811	80,062	<77,811	81,124	●
The acute inpatient average length of stay (days) in hospital (OS3)	-	2.3	2.4	2.4	●

[29] Changes to the definitions of surgical discharges were made for 2015/16. This means prior years' results are not comparable.

Maternity Services

These services are provided to women and their whānau through pre-conception, pregnancy, childbirth and postnatally. These services are provided in home, community and hospital settings by a range of health professionals. The DHB monitors volumes in this area to determine access and responsiveness of services.

How did we perform?

The number of births in the district continues to be relatively constant with minor variation from year to year. There was a slight increase in the number of births in 2016/17 which differs from the projections from Statistics New Zealand for decreasing birth numbers. There are nine birthing facilities across the Southern district.

New mothers are encouraged and supported to be breastfeeding prior to leaving birthing facilities and Southern has demonstrated improved breastfeeding rates through such initiatives as the Peer Breastfeeding Support Service in Otago and Southland. WellChild Tamariki Ora nurses and Lead Maternity Carers (LMCs) have been provided with Mama Aroha cards to support breastfeeding education for new mothers.

Each facility has a Baby Friendly Hospital coordinator to ensure accreditation standards are met across the district and the DHB has achieved this target again.

The Maternity Quality and Safety Framework supports the standards for the delivery of maternity services.

Table 12: 2016/17 Performance Results for Maternity Services

Measure		2013/14	2014/15	2015/16		
		Actual	Actual	Target	Actual	
The number of births in the DHB region	Total	3,277	3,352	<3,277	3,420	
	Māori	548	544	>548	559	
New mothers have established breastfeeding on discharge from hospital	Total	81%	84%	85%	82%	●
Baby friendly hospital accreditation is maintained	Total	100%	100%	100%	100%	●

Assessment, Treatment and Rehabilitation Services (AT&R)

These are services to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments, is indicative of the responsiveness of services.

Assessment Treatment and Rehabilitation (AT&R) functionality is measured by the FIM® instrument, which is a basic indicator for severity of disability. The functional ability of a patient changes during rehabilitation and the FIM® instrument is used to track those changes which are a key outcome measure in rehabilitation episodes.

How did we perform?

Our ATR services continue to do well against national figures for average length of stay and functional gain for the patients in the service.

In the past year, work has been completed to align the Dunedin Public Hospital and Wakari (ISIS) AT&R services into one service. The service now has a single Charge Nurse Manager, Allied Health Manager, and Clinical Leader. This has already shown to provide better outcomes for patients, with a reduction in the length of stay and an increase in functionality on discharge. Work is underway to align referral pathways into the service, and develop care pathways from acute into rehabilitation services (either via inpatient rehabilitation, or directly into the community).

Table 13: 2016/17 Performance Results for Assessment, Treatment and Rehabilitation Services (AT&R)

Measure		2013/14	2014/15	2015/16		
		Actual	Actual	Target	Actual	
Average LoS for inpatient AT&R services	<65 years	25.4	26.0	<28.3	27.1	●
	>65 years	18.6	16.7	<18.5	17	●
AT&R patients have improved functionality (FIM score) on discharge	<65 years	21.4	25.7	>24.2	25.2	●
	>65 years	17.4	17.6	>16.9	18.8	●

Specialist Mental Health Services

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

Relapse prevention plans identify clients' early relapse warning signs and outline what the client can do for themselves and what the service will do to support the client to enable them to stay healthy. Ideally, each plan will be developed with involvement of clinicians, clients and their significant others. The plan represents an agreement and ownership between parties.

How did we perform?

Access to specialist mental health services has been maintained at or above the target levels. There has been good improvement towards meeting the 95 per cent target in the number of children and youth who have a transition (discharge) plan.

Some of the challenges have been around extracting accurate data from PRIMHD[29], filling specialist roles and competing in a competitive workforce market. Our mental health services continue to experience an increase in the number of referrals that can occur in different areas of our large district.

Southern DHB will continue the implementation of Raise Hope - Hāpai te Tūmanako Stepped Care Action Plan in the coming year.

Table 14: 2016/17 Performance Results for Specialist Mental Health Services

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
Improving the health status of people (aged 0-19 years) with severe mental illness through improved access (PP6)	Total	3.84%	4.56%	3.75%	3.85%	
	Māori	3.76%	4.59%	3.75%	3.96%	
Improving the health status of people (aged 20-64 years) with severe mental illness through improved access (PP6)	Total	3.68%	4.12%	3.75%	3.60%	
	Māori	6.50%	7.55%	5.22%	6.93%	
The percentage of children and young people who have a current transition (discharge) plan (PP7)[30]	Total	37%	67%	95%	85%	●
The percentage of people (aged 0-19 years) referred for non-urgent Provider Arm mental health services are seen in a timely manner (PP8)	<3 weeks	79%	79%	80%	74%	●
	<8 weeks	95%	96%	95%	88%	●
The percentage of people (aged 0-19 years) referred for non-urgent addiction services (Provider Arm and NGO) are seen in a timely manner (PP8)	<3 weeks	81%	79%	80%	69%	●
	<8 weeks	96%	97%	95%	96%	●

Notable achievements over the year include:

- dedicated Māori mental health services based in both Otago and Southland contribute to high access rates for Māori

[29]PRIMHD requires all providers including both DHB and NGO to accurately record/code and upload data. Some NGO providers are still working on their IT infrastructure and systems to enable this to happen accurately and timely.

[30]Clients with enduring serious mental illness are expected to have an up-to-date transition (discharge) plan identifying early warning signs for the services' user and their families. It identifies what the service users can do for themselves and what the service will do to support the service users.

Output Class: Rehabilitation and Support

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

Southern has introduced a 'restorative' approach to home support, including individual packages of care that better meet people's needs. This may include 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 we monitor the effectiveness of these services, and that we use the InterRAI (International Residential Assessment Instrument) tool to ensure people receive equitable access to clinically appropriate support services that best meet their needs.

Needs Assessment & Service Co-ordination (NASC)

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

How did we perform?

We continue to deliver a restorative model for Home and Community Support Services (HCSS). Our model of care starts with an appropriate Comprehensive Clinical Assessment, which is critical to our ability to support older people in the community. Southern DHB Needs Assessors provide InterRAI[31] assessments for complex clients and our HCSS Alliance providers provide InterRAI assessments for non-complex clients.

The changes over the past few years to NASC services and the introduction of InterRAI have made a positive difference. The total number of people receiving InterRAI assessments continues to increase, and nearly all (99 per cent) people 65 years and over receiving long-term HCSS have had an assessment with an individual care plan in the past 12 months.

Table 15: 2016/17 Performance Results for Needs Assessment & Service Coordination (NASC)

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
Total number annual Comprehensive Clinical Assessments (InterRAI) provided for clients aged over 65 years	Total	3,117	4,393	>4,000	4,367	●
Percentage of people 65 years and over receiving long-term HCSS who had had a Comprehensive Clinical Assessment and an individual care plan (PP23)	Total	98%	99%	95%	99%	●

[31]InterRAI stands for international Resident Assessment Instrument and is a suite of standardised clinical assessment tools.

Home and Community Support Services

Home and Community Support Services (HCSS) are to support people to continue living in their own homes and to restore functional independence. An increase in the number of people being supported is indicative of increased capacity in the system.

How did we perform?

Southern has been delivering restorative HCSS through an Alliance for four years. We have continued to deliver more services to older people, and people with complex issues. There have been many changes in this area over the past year, with staff now receiving significantly better pay and working conditions through the Ministry of Health providing additional funding for in-between-travel payments, guaranteed hours and Pay Equity.

The number of support workers attaining a Level 2 qualification has been met and is expected to continue increasing with the introduction of Pay Equity, where pay rates are now formally linked to qualification levels. These changes will result in a more qualified and stable workforce, as well as keeping our older people as independent as possible in their own homes.

Table 16: 2016/17 Performance Results for Home and Community Support Services

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
Total number of eligible people aged over 65 years supported by home and community support services (HCSS)	Total	-	4,191	4,000	4,287	●
Number of eligible non-complex clients receiving HCSS per head of population aged over 65 years	Total	4%	4%	3.75%	3.9%	●
Percentage of HCSS clients aged over 65 years with goals-based care plans	Total	99.7%	97%	100%	100%	●
The percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Total	78%	70%	80%	80%	●
Percentage of Health of Older People (HOP) clients receiving HCSS who are complex	Total	49.5%	50.9%	55%	52%	●

Respite and Day Services

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

How did we perform?

Southern DHB uses respite care for our neediest older people and their whānau. There is good utilisation of allocated respite in aged residential care, which is generally reflective of appropriate allocations and good access to respite when required. Respite is used to give the primary carer a break from looking after an older person at home.

However, the data does not show the challenges in access to respite care for those with dementia. The occupancy rates for dementia beds has increased by seven per cent in the past year, resulting in fewer vacant beds to accommodate dementia respite. This will only be resolved once more capacity is built by the sector.

While there have been some challenges this year providing staff for some of our home-based dementia day activity programmes, these programmes have been extremely beneficial in providing some well-deserved time off for primary carers. We are looking to reassess our community day activity programmes services in the coming year to provide more dementia day activity in future years.

Table 17: 2016/17 Performance Results for Respite and Day Services

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
Ratio of number of days of respite care allocated to number of days used	Total	86%	86%	85%	93%	●
The total number of eligible clients accessing Dementia Day Activity Programmes	Total	27	49	>27	23	●
Number of eligible clients accessing Day Activity Programme[32]	Total	-	238	170	306	●

Rehabilitation Services

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

How did we perform?

Southern has made progress on two of the three measures for rehabilitation services. A review of people discharged from inpatient services and receiving a community mental health contact identified a number of issues, including: inaccurate data entry and person had been followed up; patients declined follow up; and in some instances follow-up did not occur. This will continue to be a priority project the district, regional and national Mental Health KPI programme.

2016/17 was the first full year for the Fracture Liaison Service (FLS) and more people than anticipated accessed this service. The inclusion of our Falls Pathway into the new tools to manage complex patients in primary care will allow better access to this service in the future.

The stroke service did not meet the National Stroke Guidelines with a requirement to have a Lead Stroke Nurse role. Therefore we were unable to report meeting the stroke unit or service requirements. A budget has been allocated for next year to employ dedicated Stroke Clinical Nurse Specialists on both the Southland and Dunedin Hospital sites.

Table 18: 2016/17 Performance Results for Rehabilitation Services

Measure		2014/15 Actual	2015/16 Actual	2016/17 Target	2016/17 Actual	
The number of people who are discharged from inpatient services, and who receive a community mental health contact in the 7 days immediately following discharge[33]	Total	84%	74%	73%	81%	●
Total number of people referred to the Fracture Liaison Service	Total	-	16	50	170	●
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Total	-	89%[34]	80%	-[35]	●

[32]This is a new measure introduced in 2015.
[33]Mental Health KPI 19.
[34]The percentage of patients admitted to a stroke unit is measured quarterly. This is the result from Quarter 4 (April-June).
[35]No Southern DHB hospital sites met the definition of an organised Stroke Unit in 2016/17 (as discussed with, and on the advice of, the South Island Stroke leaders group).

Age-Related Residential Care

These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days is seen as indicative of more people continuing to live in their own home, either supported or independently.

How did we perform?

There are minimal increases in the total number of people in aged residential care, despite an increase in the number of older people living in Southern DHB. People with more complex conditions are going into aged residential care; rest home level occupancy continues to decrease, and hospital level continues to increase. This demonstrates that the planning behind supporting people to live independently in their own homes is working and we continue to provide more services in the community.

The use of InterRAI LTCF (long-term care facility) Comprehensive Clinical Assessment has been among the best in New Zealand, with not only 100 per cent of facilities using InterRAI, but their compliance with assessments – being within 21 days of admission and six-monthly reassessments thereafter – has been excellent.

In 2017/18 we are implementing wrap-around services for older people based in primary care, which should identify issues that need support earlier, delaying or preventing the need for older people to require residential care.

Table 19: 2016/17 Performance Results for Age-Related Residential Care

Measure		2014/15	2015/16	2016/17		
		Actual	Actual	Target	Actual	
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	7.94	7.53	7.5	6.94	●
Percentage of residential care facilities using interRAI assessment tool	Total	98%	100%	100%	100%	●
Number of people in DHB subsidised aged residential care[36]	Rest home	1,151	1,135	<1,150	1,094	●
	Dementia	348	361	<350	388	●
	Hospital	1,091	1,108	<975	1,162	●
	Psychogeriatric	94	98	<85	93	●

[36]Measured as the number of unique individuals in June each year.

Palliative Care Services

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

How did we perform?

Otago Community Hospice and Southland Hospice have introduced training for 'Fundamentals of Palliative Care' education to our aged care facilities, where a number of older people spend their last days of life. The skills learned by staff are essential to providing excellent end-of-life care. All facilities have been introduced to *Te Ara Whakapiri – Principles and Guidance for the Last Days of Life: Guidance and Toolkit*.

Palliative innovations funding has been used to introduce palliative care nurse specialists to provide guidance, support, advice, education and working alongside staff in aged care facilities. Southland Hospice began their programme earlier as a pilot, supporting all facilities in Southland, while Otago Community Hospice has taken a more targeted intensive approach with a smaller number of facilities initially.

This was introduced in 2016 and there has been good progress towards the longer-term targets.

Table 20: 2016/17 Performance Results for Palliative Care Services

Measure		2014/15	2015/16	2016/17		
		Actual	Actual	Target	Actual	
Percentage of aged residential care facilities that have at least one staff member who has completed 'Fundamentals of Palliative Care' training programme.[37]	Total	New measure	New measure	90%	47%	●
Percentage of age related residential care facilities that have received support and guidance from a Hospice palliative care nurse specialist	Total	New measure	New measure	60%	41%	●

[37]The Fundamentals of Palliative Care is a 9 module learning package developed by Hospice New Zealand to support and educate people who are working with residents requiring a palliative approach.

IMPROVING PATIENT EXPERIENCES AND QUALITY OF CARE

Owning our future priorities

Includes:

- Community Health Council established
- HealthOne implemented
- Releasing Time to Care

Quality Account

Ensuring that we provide high quality, safe care that meets the needs of our diverse communities is of the highest importance to Southern DHB. We recognise the trust the community places in us to deliver care that is both excellent and safe, and we take this responsibility very seriously.

As part of meeting this commitment, New Zealand DHBs are expected to report to their communities on their quality and safety performance through the production of a Quality Account.

This year, Southern DHB has chosen to include this information within its Annual Report to reflect its critical role in understanding our overall performance as an organisation.

A summary will also be communicated to the wider public through community newspapers and our website.

This section of the report – Improving Patient Experiences and Quality of Care – includes the Serious Adverse Events reported at Southern DHB during 2016/17. It also outlines processes for gaining feedback from our patients and communities, and quality improvement initiatives.

Our performance against the national health targets and other outcome measures identified in our Annual Plan is detailed in the first section of this report: Improving Health Outcomes for our Population (page 14).

Further information about our work to develop an organisational culture based on collaboration and safety – with the goal of continually improving our services to patients – is outlined in the following section of this report: Organisational Resilience and Sustainability.

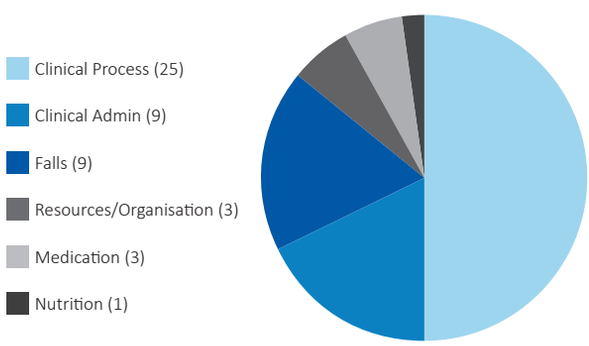
What have we learned from our serious adverse events?

Serious adverse events (SAEs) are reported by health and disability providers in accordance with the Health Quality & Safety Commission's national reportable events policy, and in general are those incidents which have resulted in a patient suffering serious harm or death.

In the 2015/17 year, there were 50 events that were classified as serious adverse events at Southern DHB. As in previous years, these are subject to a national annual process, with an annual report titled ***Learning from adverse events – adverse events reported to the Health Quality & Safety Commission***, which is to be released in November.

The information about SAEs is included in this Quality Account/ Annual Report to look specifically at what we have been working on in the past year, what we are able to learn as an organisation from the examination of this year's events, and what we can do to reduce the likelihood of similar events occurring in the future.

What were the main groups of SAEs in 2016/17?



The largest group of SAEs relates to clinical processes at 50 per cent (assessment, diagnosis, treatment, general care), followed by clinical administration at 18 per cent (handover, referral, discharge), falls at 18 per cent (serious harm from falls, for example a broken hip), resources/organisation at 6 per cent, medication error at 6 per cent (dispensing, prescribing or administration of medications) and nutrition at 2 per cent.

We have provided a summary of the main harms within these categories and the work to date and work planned to reduce these.

Ophthalmology

Last year we reported 30 ophthalmology cases; this year there are nine SAEs relating to ophthalmology. These are included in the clinical process and resource/organisation categories.

Addressing the unacceptable level of harm arising from challenges in this service has been an area of intensive focus for the DHB over the past year. The improvement work that had commenced in late 2015 was further developed in 2016/2017. It included the way in which we prioritise patients for appointments, a shift to a better facility that accommodated larger volumes of clinic visits, and establishing GPs and optometrists to work in a team with the specialist ophthalmologists and Clinical Nurse Specialist. Throughout this year we have continued to report

cases that we believe have been impacted by the delay in follow up so we can make sure we identify any further steps we must take to improve. A further update is provided on page 60.

Urology

There were two SAEs reported relating to delays in follow up for our patients in our Urology service. A further case related to a medication error, and another to an item that was retained during a surgical procedure. We will provide a full report next year on the external review of Urology services and the improvement programme of work.

Delay in acting on diagnostic results

A consistent way in which clinical staff record that they have viewed and acted on diagnostic test results is a challenge to all DHBs. Southern DHB has a variety of paper-based and electronic systems. When we have a variety of systems that we cannot audit, there is a risk to patient safety that some results may not be received or acted on appropriately. The electronic acknowledgment of laboratory and radiology test results (which is a way that medical staff record that a test result has been reviewed and that appropriate actions are put in place based on the result) was identified as an area where we could make considerable improvement. Over the past year we worked on a project to ensure that all results on our electronic system were reviewed and recorded as acknowledged. The project was successfully completed in December 2016.

A new electronic system Health Connect South (HCS) implemented in August 2016 is the new repository for laboratory and radiology results. The challenge for 2016/17 was to ensure that all results are electronically acknowledged on the new system. Paper-based reports have been removed ensuring there is only one record of the results that provide the information and record of acceptance which includes the vital follow up action. Service-level reporting and follow up with clinical staff has been established and we will continue to monitor this to ensure those using the system view the results, take the appropriate clinical action and record the acceptance on the new system.

Pressure injuries

Pressure injuries can occur when patients are being cared for in the community, residential care facilities and specialist hospitals. We have encouraged increased reporting of pressure injuries, included in the clinical processes, so that we can identify how best to target our improvement work.

In addition to gaining valuable information through this reporting, we have also joined with the Health Quality & Safety Commission to assess all levels of pressure injury harm with a consistent monitoring process. The pilot has commenced and we will continue to roll this out across all our wards/ units in our specialist hospitals. We plan to work collaboratively with ACC to source funding and support to establish a programme of improvement that will reduce the incidence of pressure injuries in all places of care within the DHB.

Falls

Rates of SAEs recorded relating to harm caused by falls remains similar to the previous year. A key improvement focus to minimise the number of serious harm falls is to ensure sound assessment and plans of care for our 'at risk' patients. This has seen our rates of assessment and plans move from being among the lowest in New Zealand to now joining the middle group of DHBs' performance, and sitting just below the target. Central to this has been a rethink of our approach to managing delirium, making a significant difference to patients at risk of this condition (see story on page 21 of this report). This improvement work will be ongoing in 2017/18 as part of the Releasing Time to Care programme (see page 59).

Medication errors

We continue to have SAEs related to medication, with three recorded this year. This too is an area of focus for our ongoing Releasing Time to Care programme of work.

Deteriorating patients – recognition and response

One SAE related to our recognition of and response to a patient whose condition was deteriorating. This is an internationally recognised area of avoidable harm. Early in 2017/18, work will commence to further examine our clinical systems and processes to understand opportunities for improvements in this area, linking in with the Health Quality & Safety Commission. Part of our work will be to encourage increased reporting, including near-miss events. We will provide an update in 2017/18 on our progress to date.

Hearing from our patients

Community Health Council established

Patients, families and whānau across the Southern district have a stronger voice in health services with the establishment of a Community Health Council this year.

The nine-member council is comprised of representatives from around the district with diverse backgrounds, ages, health and social experiences. They bring expertise in community development, education and health care, including Māori health, mental health and women's health.

The Council's role includes ensuring the community has a voice in health service planning, delivery and strategies, across primary, community and hospital-level services. This includes increasing opportunities for engagement and participation, and considering areas such as improving feedback processes and communications channels.

Their work complements contributions from consumer and patient representatives across our services, from mental health and addictions to maternity services.

Back Row: Ian Macara, Martin Burke, Ilka Fedor, Bronnie Grant, Dr Nigel Millar, Russell MacPherson. Front Row: Takiwai Russell-Camp, Lesley Gray, Paula Waby, Sarah Derrett and Kelly Takurua

Engaging with our communities

Community engagement opportunities are held regularly to ensure we continue to hear the priorities and perspectives of our communities. This has included public forums across the district with the Commissioner and Chief Executive. The public are also invited to open sessions at Commissioner meetings, and have the opportunity to submit questions. In addition, consultation processes relating to specific services – such as primary maternity services and developing models of care for the Waitaki District – have continued throughout the year.

Are you listening to me?

A health play inspired by a true life Southern DHB patient experience has offered staff the opportunity to reflect and collaborate with other health professionals to encourage best practice inter-professional approach with our patients.

The play was the idea of Southern Innovation Challenge 2016 applicants Noelle Bennett and Kaye Cheetham who were supported to make the play happen.

It was created using the verbatim theatre technique delivered by professional actors and helped staff see the world through a patient's eyes.

"By showcasing experiences through the patient's eyes we demonstrated how travelling through our health system feels from their perspective," said Ms Bennett.

"We're really pleased with the positive feedback, especially that it helps staff to consider ways in which to live the Southern DHB values of open, positive, kind and community, and also to focus on the organisation's improvement priorities to improve our patient experience."

Participants said:

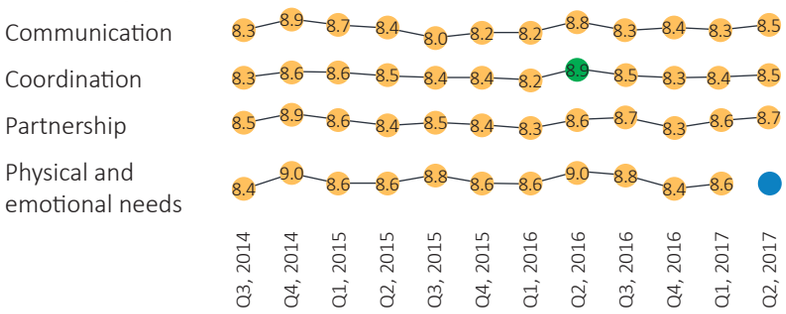
"Very powerful stories.... Every person at the DHB should come to this!"

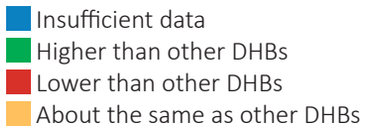
"It helps me reflect on my own practice and keep my clients at the centre of my interactions."

Patient experience survey

Compared with NZ Average

Score out of 10 by domain





Adult inpatient experience survey, Health Quality & Safety Commission, New Zealand

Results from the Health Quality and Safety Commission survey shows the experiences of inpatients at Southern DHB is largely consistent with other DHBs. There remain opportunities for improving patients' experiences by ensuring greater consistency in delivering our best care.

Improving feedback systems

In order to gain a clearer picture of patients' experiences, and identify areas for improvement, the Feedback Systems module has now been implemented within Safety1st, the electronic information system that stores the feedback we receive from our patients. The process for generating reports from this system is being developed in consultation with the Community Health Council. These aim to provide valuable information for targeting improvements within service areas, and to enable the wider organisation to identify areas of focus and measure the impact of its initiatives. We look forward to providing a summary of this in next year's annual report.

Releasing More Time to Care

A staff-led programme continues to empower clinical teams to streamline processes, so they can free up more to spend more time with their patients. Over the past year the DHB has progressively rolled out the 'Releasing Time to Care' programme across wards in Dunedin, Southland and Lakes District Hospitals. As the programme has gathered momentum, knowledge and experience has grown and been shared across wards, contributing to successful team efforts involving nursing, medical, allied health and administrative staff.

The Shift Handover module saw the nursing handover move from the office to the bedside which aims to improve patient safety and communication. As well as receiving very positive feedback from patients, the change also saves time for nurses, which can be spent on direct patient care.

The Admission and Discharge module involves wards mapping a typical patient journey from the emergency department to discharge, to ensure patients' journeys are as streamlined as possible. Included within this module was the 'Sit Up, Get Dressed, and Keep Moving' initiative, supporting patients to become more active as quickly as possible, and when safe to do so, to avoid the potential negative impact of being bed-bound while in hospital.

"Bedside handover ensures that key information about a patient and their care is shared between staff going off shift, those coming onto the next shift, and the patient is also encouraged to be part of the conversation. This really puts the patient's voice at the centre of their care."

Southern DHB Releasing Time to Care Charge Nurse Manager, Jen Gow.

Supporting service recovery - ophthalmology

A concerning number of serious adverse events within our ophthalmology service led to an external review and redesign of the service, and significant reductions in waiting times for patients.

The service had experienced a significant increase in the number of patients with chronic sight-threatening eye disease requiring assessment and treatment, such as diabetic retinopathy, glaucoma and macular degeneration. The increase in demand was driven by new treatments becoming available, offering benefits for conditions that were previously difficult or impossible to treat. However, they require frequent follow up appointments and the DHB's systems of care and treatment delivery in ophthalmology was unable to keep up with this increase in demand.

As a result of the external review and quality improvement project, changes to the service included:

Increasing capacity

- engaging locum specialists, and employing an additional ophthalmologist
- employing an in-house optometrist
- training registered nurses to become Avastin injectors

Changes to models of care

- Patients referred to GPs for repeat scripts
- Health-care assistants performing visual acuity assessments
- Optometrists and nurses providing assessments and treatments where clinically appropriate

Improving systems

- Utilising acuity tool and clinically assessed 'do not delay' patient groups to better identify high-risk patients
- Review of patient flow.

HealthOne means safer care

The launch of a shared patient records system, HealthOne, to hospitals, GPs and pharmacies across the Southern district provided an important step toward better, safer care for patients.

From September 2016, authorised health-care providers such as GPs, community nurses, pharmacists and hospital clinicians across the Southern district gained access to relevant health information when treating patients, including conditions, medications, allergies and test results.

For patients this means less need to repeat themselves or remember the details of their conditions and treatment. The availability of information could also be lifesaving in an emergency.

HealthOne is a secure system that respects patient privacy. It was already live across Canterbury and West Coast DHBs, and has since been launched in Nelson Marlborough DHB. This means patients can receive the benefits of clinicians having shared access to information across the South Island.

Fracture clinic redesign a success

The treatment of minor fractures has become a much easier process and major cost-saving exercise thanks to the ongoing redesign of the fracture clinic process.

Southland Hospital Emergency Department Clinical Nurse specialists Olivia Murray and Lara Gleeson have been spearheading the project, with the support of Orthopaedics Clinic Leader Mr Paul Rae, after winning $4000 at the Southland Innovation Awards in 2015.

The redesign has so far streamlined treatment and referral options, reduced long wait times in clinics, and reduced the workload for orthopaedic doctors and fracture clinic staff. The total cost saving for 2016 was $30,152.

“We are thrilled with the progress,” says Olivia. “The process has drastically improved our patient care by reducing the need for casting and splints, and fracture clinic staff can spend more quality time with injuries that require a consultant and follow-up.”

Improving the MRI experience

“We entered the 2016 Southern Innovation Challenge as we wanted to improve the MRI experience for kids and their families by watching a movie. MRI scans can be long, noisy and often a frightening procedure. We now have all the equipment up and running and have successfully scanned our first little girl while she watched Shrek on DVD.”

Jill Oliver, Charge MRI Technologist, Radiology Department

Makeover for Paediatric outdoor space

The Dunedin Hospital Rotary Children’s Ward outdoor space has received a multi-sensory makeover, so patients can enjoy a variety of engaging activities in the fresh air.

“The objective of the new space was to invigorate and make it more inviting,” says Rotary Children’s Ward Charge Nurse Manager Shirley Bell. “This has been achieved by creating different zones and filling it with plants, furnishing and technology.”

Rotary Children’s Ward Relieving Play Specialist Garry Goh had the original vision for the space, which included the introduction of multi-sensory effects.

“We have planted herbs to engage the olfactory and gustatory senses and a wind chime for the auditory senses, which, if you listen carefully, plays a gentle tune of a famous hymn,” says Garry. “The next addition is to place sensor speakers hidden in the plants that will play native bird songs when activated.”

Since the makeover, the outdoor space has been well used by parents and their children, including the sofa suite in the ‘green zone’ for restful lunches and chatting, and the basketball hoop for teenage patients.

ORGANISATIONAL RESILIENCE AND SUSTAINABILITY

Owning our future priorities

- Supporting the Southern Partnership Group to meet the timelines for the Dunedin Hospital redevelopment
- Supporting the role of the Clinical Leadership Group
- Progressing the upgrade of Lakes District Hospital
- Commissioning of MRI in Dunedin
- Commissioning of new Education Centre in Southland
- Significant progress in implementing sustainable models of care in Long-term Conditions, Health of Older People, Urgent Care, Mental Health and Radiology
- Care closer to home with significant progress in developing a district network of care: Telemedicine, Radiology, Outpatients
- Supporting Locality Network progress
- Agree and achieve 2016/17 budget
- Agree 2017/18 budget
- Focus on sustainability and move towards break-even position 2019/20
- Progress in addressing the identified 7 + 7 improvement priorities for patients and whānau, and staff and colleagues.

Strengthening our culture

Southern Future was a programme of work launched last year to reflect Southern DHB's priority to build a strong internal culture that promotes innovation, communication and collaboration. As well as improving Southern DHB as a place to work, the programme reflects international evidence that a positive staff experience leads to higher quality, safer care. The past year has seen a number of initiatives to progress this important priority.

Staff engagement survey

Southern DHB's staff engagement survey in early 2017 results highlighted an improving work environment, while clarifying areas for further attention. Improvements were reported across the areas that were surveyed in 2016, including recommending Southern DHB as a place to work, staff being generally friendly and openness to new ideas. In 2017, a number of additional questions were also asked, using a Health Round Table survey shared by nine other DHBs around New Zealand. The results provide clarity in the areas where efforts are best directed to make the greatest difference for our staff, colleagues and, ultimately, patients.

Staff survey results:

- 2153 staff participated in the survey, approximately half of the workforce at the DHB.
- Overall Southern DHB rated between 5th to 8th out of 10 for different sections and questions, when compared with the other DHBs that participate in the survey.
- Improvements were reported on seven of the eight questions from last year's survey, with the greatest gains made in:
  - Staff working here display a positive attitude
  - Staff are generally friendly and welcoming
  - New ideas to improve the way we work are encouraged
- The areas requiring the most focus for improvement are:
  1. Leaders' communication (some improvement on previous year's results)
  2. Resolution of staff performance issues quickly
  3. Bullying in our workplace
  4. Having the tools and resources to do my job properly (including workloads).

Staff empowered to 'Speak Up', 'Get Dotted' and share experiences

Aimed at creating a safety culture that promotes professional behaviours, accountability and alignment with the Southern DHB's values and behaviours, the Speak Up programme was launched this year, with approximately 600 people participating in the programme.

The sessions focused on the Southern Future values and behaviours, and provided staff the opportunity to ask questions and share their experiences in the workplace. Above the line (acceptable) and below the line (not acceptable) behaviours were articulated, and approaches for responding to these explored.

"We want to work as a team to create a culture of encouraging positive values and behaviours and empowering staff to speak up when they feel challenged by negative behaviour."

Operations Manager Janeen Holmes, Lakes District Hospital

This work has been supported by the popular and effective 'Get Dotted' workshops, helping people recognise their own particular communication style and from there, understand the impact their communication style may have on others they come in contact with.

Since it was first offered in November 2015, more than 900 staff have completed the programme.

Get Dotted Facilitator Amy Scott runs a session in Dunedin

Staff are also sharing their stories and celebrating successes through the Southern Future e-newsletter, on digital screens across the DHB, and through social media – enabling ways in which we live our values and make a difference to staff and patients to be highlighted. Regular staff forums are further enabling key directions to be shared and discussed, while the senior medical officers and administrators symposia held over the past year have offered further opportunities for staff to learn from one another's experiences.

New orientation process launched

Ensuring staff are introduced to Southern DHB's values, culture and priorities has also been the focus of a revised orientation process for all new employees. Launched at the beginning of 2017, the programme begins with a mihi with the Executive, Senior Managers and Line Managers, followed by a morning tea, welcome from the CEO, and a presentation on values, priorities and directions for the future. Staff from the Māori Health Directorate facilitate all new staff to reflect on our interwoven contributions to health, represented by the flax puti puti created by each participant. Staff also undertake online modules relating to critical areas and are required to complete the new welcome process within six weeks of their start date.

"The new process offers interesting and relevant content for our new staff, with time put aside to enjoy some kai and get to know each other."

Southern DHB Learning and Development Advisor Vicie Hodge

Southern Innovation Challenge

The Southern Innovation Challenge continues to be a popular event, with a total of 27 entries from across the DHB. The 'Dragon's Den' style contest called for innovation and fresh thinking to identify new ways of improving the quality of service provided to patients.

First place was awarded to the Orthopaedic and Surgical Outpatient teams at Southland Hospital for their innovative idea of the 'Carpel Tunnel Funnel – One Stop Shop Carpal Tunnel Surgery in the Outpatient Clinic'. This means patients requiring carpel tunnel release surgery have their first consultation with a specialist and their surgery all in the same day resulting in fewer visits to the hospital and less waiting time. The teams, who have already successfully piloted the 'One Stop Shop', were awarded $5,000.

Other innovations ranged from better information for preparing patients for surgery, a web-based enrolment form for oral health patients and a video teaching pre-schoolers safe sleep practices for babies.

"The idea fits perfectly with the DHBs values, the seven priorities for patients, and the seven priorities for staff," said Southern DHB Executive Director People, Culture and Technology, Mike Collins. "It values patients' time, as it provides our staff more time to focus on patients, and above all, is a great example of liberating innovation."

2016 Southern Innovation Challenge winners, from Southland Hospital's Orthpaedic and Surgical Outpatients teams, Jo Clark, Paul Rae and Jo Hunter

Developing leadership

Reshaping leadership structures

A significant change process was initiated this year to ensure the leadership of the organisation was appropriate to deliver the health needs of our population. A leadership structure was outlined, aiming to increase focus on integration with primary care, clinical quality and safety, and reduce complexity in decision-making. It also aims to build the priorities identified through the Southern Future programme of work, including calls from patients and the community for more seamless and integrated health-care services.

Key changes included:

- Establishing two core operational teams of:
  - o Specialist Services
  - o Strategy, Primary and Community
- Distributing Corporate Service responsibilities across the roles of
  - o Finance, Procurement and Facilities
  - o People, Culture and Technology
  - o Quality Improvement and Governance Support
- Aligning Nursing leadership to be broadly site-specific, with Allied Health and nursing staff reporting operationally to the relevant management position and professionally to the Chief Nursing and Midwifery Officer or Chief Allied Health, Scientific and Technical Officer respectively
- Providing greater clarity of accountability at Tier 3 level.

OUR STORY

Handover system earns international praise

A solution to improve weekend handover between medical teams at Dunedin Hospital has been featured at an international conference in London.

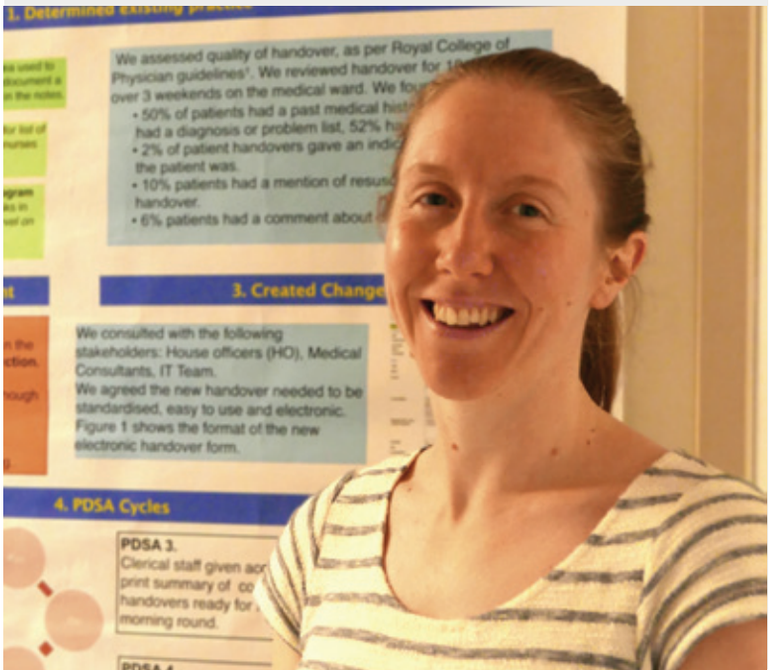
In April, Dr Yvonne MacFarlane, representing colleagues Drs Lucia Magee and Luke Foster and IT specialists Sapna Boyce and Lance Elder, presented a poster at the BMJ International Forum for Quality and Safety in Healthcare.

This followed the team earning a top prize in the Clinicians Challenge in November 2016 for the same handover solution.

The handover system streamlines transfer of patient care between clinicians. The single, electronic document, summarises all patient information, helping clinicians plan and prioritise their day.

“The tool has been rolled out across all wards at Dunedin Hospital, and is now being used as a day handover tool in Obs and Gynae, Paediatrics and the ISIS rehabilitation ward,” says Dr MacFarlane.

“It has also been incorporated into the formal IT orientation for all new doctors and an online help sheet is available.”



Giving staff the skills for change

Sometimes a small change can make a big difference.

The ongoing success of the 'Skills for Change' programme has given Southern DHB staff the tools to make changes to improve their own services.

Between July 2016 and June 2017, 50 project teams including 219 staff completed the programme, covering a wide range of topics from improving eye checks for NICU patients to the referral process for Māori support in Mental Health wards.

System Improvement Advisor and Programme Facilitator, Allan Cumming is delighted with the ongoing success of the programme. "We want staff to expand their knowledge and skills on quality improvement. This programme has the dual purpose of training teams in the use of improvement tools which they can apply to their own service."

Clinical

- Introducing Advance Directives in Mental Health
- Improving eye checks for NICU patients
- Transitioning 15-18 year old patients from paediatrics to adult services and primary care
- Best practice for cognition assessment in older in-patients

Administrative

- Use of laptops in community mental health services
- Use of electronic records in the wards
- Referral process for Māori support in Mental Health wards
- Non-attendance reduction in a number of different departments

Logistics

- Transfer of patients from Queen Mary to a rural maternity facility
- Management of patient alerts
- Theatre start delays due to patient transport
- Use of storage space
- Improving the patient and public entrance to a mental health ward
- Managing high workload in a large primary care practice.

Being a good employer: Good Employer Obligations Report

Southern DHB is committed to meeting its statutory, legal and ethical obligations to be a good employer. We consider our human resources to be our most valuable asset. Underpinning our organisational vision and Good Employer Obligations, Southern DHB facilitates a human resources policy that encompasses the requirements for fair and proper treatment of employees in all areas of their employment. We value equal employment opportunities, and work to identify and eliminate any barriers to staff being considered equitably for employment opportunities of their choice and the chance to perform to their fullest potential.

Southern DHB aims to uphold the highest level of integrity and ethical standards in everything we do.

We are committed to the principles of natural justice, value all employees and treat them with respect.

These expectations and principles are set out in the Code of Conduct and Integrity Policy for all employees and those who are involved in the operation of Southern DHB.

A suite of equal employment opportunity policies underpins recruitment, pay and rewards, professional development and work conditions for employees. Southern DHB recognises the Treaty of Waitangi as New Zealand's founding document which sets out the relationship between Iwi and the Crown. The Treaty is fundamental to the development, health and well-being of Māori, therefore each and every employee is expected to give effect to the principles of the Treaty and a number of policies support this commitment. Our obligation to the Treaty is supported by the Iwi Governance Committee and the Management Advisory Group – Māori Health at the governance and sub-committee levels. Māori health is reinforced by the Māori Health Directorate which is led by the Executive Director of Māori Health who sits on the Executive Leadership Team.

Our values

These commitments are supported by the focus on our internal culture through the Southern Future programme of work. The following systems and initiatives are also in place to ensure we uphold our obligations to our staff to be a good employer, and develop Southern DHB as a desirable place to work.

EEO

An EEO Policy was implemented in November 2015, with a review due in 2017. This includes a programme for annual reporting.

Leadership, accountability and culture

Investing in leadership has been a significant priority for Southern DHB over the past year (see update page 66), with the aim of strengthening our emphasis on strategic priorities, organisational culture, quality and decision-making. The ongoing investment in the Southern Future programme of work reflects the importance placed on leadership development and building our culture. The newly created position of Executive Director of Quality and Clinical Governance Solutions aims to ensure further leadership in strengthening patient-centred decision-making processes. Southern DHB takes its accountability to the community seriously, and has been developing stronger processes for understanding community needs and reporting back to them on our performance. These include the establishment of a Community Health Council, public forums, community consultation processes and inviting members of the public to ask questions directly to the Commissioner team at the public sessions of their meetings. Further initiatives are outlined in the previous section of this report, Improving Patient Experiences and Quality of Care (page 56).

Recruitment, selection and induction

Southern DHB is party to the ACE (Advanced Choice of Employment) programme operated by all DHBs to ensure fairness and transparency of recruitment for new graduate medical and nursing staff. Training is available to all leaders on best practice recruitment and selection practices as part of the DHB's wider Learning and Development Strategic Framework.

Employee development, promotion and exit

Performance and development processes are in place for a multitude of professional groups. Processes are currently being reviewed to ensure strategic alignment across Southern DHB and ensure that all employees have annual performance and development discussions. Leadership is developed through initiatives such as the Xcelr8 programme and our newly developed leadership framework.

We actively monitor the reasons for employee exit (capturing both internal transfers and external moves), enabling risk areas to be identified and proactively managed.

Flexibility and work design

Enhanced opportunities for job share, part-time and flexible working are enabled where service demands allow, supported by the introduction of a robust Flexible Working Guideline. Positions open to jobshare and part-time options are actively monitored and assessed for workability.

Extended hours are available at our childcare centre for staff members' children on the Dunedin Hospital site, and at Wakari Hospital. On-site gym and squash courts are accessible to all staff at low entry cost, and discounted membership is available at private gyms in Invercargill and Queenstown, and at a swimming pool in Invercargill.

Remuneration, recognition and conditions

A market-based model of job evaluation is in place for all non-clinical support roles to ensure market competitiveness is maintained and Southern DHB is able to attract and retain experienced employees.

A long-service recognition programme was introduced for employees in 2016 whose continuous service to Southern DHB is greater than 10 years.

Harassment and bullying prevention programme

We have recently reviewed our harassment and bullying policy to promote and support behaviour that reflects our organisational values. Its focus is on addressing issues effectively and quickly at the lowest possible level. It is supported by the 'Speak Up' Campaign (see page 64), aimed at creating a culture where it is safe to highlight concerns, and through investing in training managers and HR professionals in both bullying prevention, management and investigation.

Safe and healthy environment

Health and safety is an important priority for Southern DHB. A dedicated Health and Safety team are proactively ensuring compliance with the current Health, Safety and Welfare Policy and underlying policies and processes. The Health, Safety and Well-being strategy, improvement plan and Health and Safety Management System (HSMS) are in place with regular performance reporting to general managers, the executive leadership team and the commissioner team.

Current practices include:

- more than 160 elected health and safety representatives in place across Southern DHB's operation
- critical risks are identified and risk reviews are underway to identify the efficacy of current controls and potential improvements
- Safety1st is established as South Island-wide incident and near-miss reporting mechanism
- tertiary accreditation and an active ACC partnership programme is in place
- a 24/7 employee assistance programme is available to all staff for both personal counselling and critical incident debriefing.

Employee demographics*

The Southern DHB currently employs 4,633 employees across Otago, Southland and Central Otago. 21% of our employee base is male; 79 per cent are female. There is a 50/50 split between male and female junior medical staff, and at a senior medical level female representation is 34% of the workforce.

The nursing profession comprises 13 % male employees, whilst midwifery remains 100 per cent female. Service support staff, such as drivers, trades, security staff, are predominantly male (92%).

Of the 4,341 employees who detailed their ethnicity, 190 (4.38%) identify as Māori or Pacific.

New Zealand European/Pakeha employees represent 89.6% of our employee population, which includes a total of 44 different ethnicities. Southern DHB is committed to ensuring equal employment opportunities and is continuing to look at ways to improve diversity across all levels of the organisation.

*Data current as at 18 July 2017

Employees with disabilities

Previously, Southern DHB has not recorded details of staff with disabilities. To address this area, in 2016 the Employee Contact Details Form was revised and now asks new employees if they identify as having a disability. As this data set develops we will gain more information to aid in ensuring Southern DHB is an equal opportunity employer.

Age of employees	Male	Female	% of employees identified as Maori/Pacific
0-19	0.10%	0.25%	0.53%
20-29	15.09%	13.90%	13.16%
30-39	22.13%	20.25%	22.63%
40-49	21.53%	22.20%	25.79%
50-59	24.04%	26.88%	25.26%
60-69	15.49%	15.83%	12.11%
70-79	1.51%	0.69%	0.53%
80+	0.10%		
Grand Total	**21.45%**	**78.55%**	**4.10%**
Total Employees			**4633**

Occupational Group	Sex	Grand Total	Maori	Pacific	Asian	Other	Not Stated
Allied & Scientific	F	733	28	0	7	663	35
	M	152	11	1	4	122	14
Corporate & other	F	676	23	2	11	588	52
	M	146	8	1	1	128	8
Midwifery	F	96	4	0	0	84	8
	M	0	0	0	0	0	0
Nursing	F	1866	74	8	11	1663	110
	M	282	11	0	1	252	18
RMO	F	158	5	0	15	130	8
	M	158	3	1	21	119	14
SMO	F	106	1	0	1	95	9
	M	204	4	2	9	174	15
Support	F	4	1	0	0	3	0
	M	52	0	2	0	49	1
Grand Total		**4633**	**173**	**17**	**81**	**4070**	**292**

Our physical environment

Important developments have been made over the past year to enhance our physical facilities and environment. Progress on a hospital rebuild for Dunedin stepped up, while elsewhere in Southern there was much to celebrate with the opening of the new education centre at Southland Hospital and developing Lakes District Hospital in Queenstown as an emergency, diagnosis and transfer centre.

Planning for Dunedin Hospital rebuild

Work to progress the redevelopment of Dunedin Hospital gained pace. In September Dr David Perez was appointed to lead the Clinical Leadership Group. This group of medical, nursing and allied health staff will provide advice and recommendations to the Southern DHB and the Southern Partnership Group (SPG) which is overseeing the redevelopment. By the end of June 2017, the CLG had produced six discussion papers on future scenarios and models of care. The Project Management Office based at Dunedin Hospital was further strengthened and staff and public forums were held to update people about the project. The first stage of consultation with user groups representing all staff began.

In September, the Ministers of Health and Finance approved the Strategic Assessment for the redevelopment. This enabled work to begin on the Indicative Business Case (IBC), the first of the business case documents required under Treasury's Better Business Cases framework. The authors of this document developed a long list before narrowing it down to a preferred option for the redevelopment. The IBC was submitted in June to the SPG who were then to review and send it to Cabinet for approval. The next step is a Detailed Business Case which is due in mid-2018.

Southland Education Centre

Busy health staff at Southland Hospital can now upskill in a purpose-built education centre. The centre, which includes simulation suites to replicate operating theatres and emergency department resuscitation bays, will be used by nursing, medical and allied health staff, as well as students in these professions. As well as concentrating all training into one location, the centre immerses participants in a realistic environment to make the learning experience more powerful. The centre includes a dedicated skills lab, two simulation suites, a consultation room for simulated patient consultations and lecture spaces and meeting rooms.

Audiology

A larger, family-friendly Audiology Unit opened at Wakari Hospital in June 2017. The new unit is more spacious than its predecessor at Dunedin Hospital and has three soundproof testing booths, new equipment and an additional clinical space. The size boost means up to three clinics can be run at the same time, which has streamlined appointments. Patients have been pleased with the amount of parking available.

The new waiting room has a small play area for its many young patients and donations from Friends of the Children in Hospital and Fresh Choice Roslyn mean there are plenty of toys. The project team worked closely with the Hearing Association, Deaf Aotearoa and the Otago Association for Deaf Children. A small audiology unit has been retained on the second floor of Dunedin Hospital for in-hospital patients.

Pictured left to right: Audiology Clinical Lead, Robyn McNeur, Audiology Project Leader and Executive Director for Allied Health Lynda McCutcheon and Commissioner Kathy Grant

Dunedin Hospital's interim works programme

The key projects in this programme – the new combined ICU/HDU unit on the 5th floor and the 8th floor gastroenterology facility - moved through the design, tender and consent phases and the sites were handed over to construction contractors in June.

There was a considerable amount of preparatory work to clear the 5th floor in readiness for the construction work, such as relocating the operational areas including Ward 5B, Ward 5HDU, 5 Day unit, eye day unit, anaesthetic procedure room and eight offices.

The construction was launched in spectacular fashion. A staff-led initiative led to a 'golden sledgehammer' being used to start demolition in a ceremony on the 5th floor where the new ICU unit will be housed.

The new ICU and HDU facilities will have 22 bed spaces, enabling patients to transition between different levels of care without moving their physical location. The new gastroenterology facility on the eighth floor will have two endoscopy rooms, and dedicated admission, recovery and sterilising areas.

Asbestos

The management of asbestos in our facilities continues to challenge us, as we have sought to undertake maintenance work safely while minimising disruption to clinical areas. Over the last 12 months teams have carried out 90 asbestos management surveys of varying sizes. These surveys included all plant rooms across the region, Wakari Chapel, ward block service risers, and lecture theatres and areas for redevelopment such as ICU and gastroenterology. Spot surveys have also been carried out for maintenance requirements. Environmental cleans of the lecture theatres and associated plant rooms were completed. Challenges have included the discovery of asbestos in our clinical records area, requiring a management process to be established. The ongoing requirements for addressing asbestos has led to seeking an external review of our processes, to explore any opportunities for improvement. This will be considered alongside the maintenance plan to see us through until the new hospital is built.

Lakes District Hospital

A two-pronged approach to future-proofing Lakes District Hospital was announced in August 2016, followed by planning and design work, and the engagement of Queenstown project management firm RCP to oversee the development. The first stage will focus on the immediate needs of the hospital while work progresses on a wider vision for the district's needs. Bringing the hospital up to contemporary standard will allow time to address the longer term challenges posed by the area's rapid growth in a measured way.

The initial work focuses on reconfiguring the emergency department, developing diagnostics capacity (including exploring options for a CT scanner and ultrasound services), developing a whānau room and improving clinical and administrative areas.

Stage two of the process will draw on district-wide work already underway with a focus on primary care, community services, and the strengths and support provided by Dunstan, Southland and Dunedin Hospitals.

District-wide services

Alliance South

The Alliance South partnership between Southern DHB and WellSouth Primary Health Network has been working to improve the implementation of health-care across the district through a joined-up approach to delivering services.

Four workshops were held in August and September 2016 with the aim of reducing duplication in the areas of standardisation of care, creating a system that is responsive when people are acutely unwell, supporting people with complex needs and redesigning our services. The workshop outcomes formed the basis of Alliance South's priority areas of focus for 2016/2017.

The Alliance's nine networks – Rural Heath, Community & Hospital Pharmaceuticals, Long-term Conditions, Health of Older People, Urgent Care, Mental Health & Addictions, Child & Youth, as well as the Central Lakes and District Locality Networks – all progressed programmes that will help bring care closer to home, improve planning and communications amongst providers and address future demand on the system.

Stepped care action plan for mental health and addictions

An important step forward in delivering mental health and addictions care in the South was achieved with the completion of the Stepped Care Action Plan in December 2016. A key aspect of delivering Hāpai te Tūmanako Raise HOPE Strategic Mental Health & Addiction Plan, the action plan was developed by the Alliance South Mental Health and Addiction Network with extensive sector-wide consultation. The stepped care model provides a framework for how mental health and addiction services are planned, funded, delivered and evaluated in the future, based on an approach of intervening in the least intrusive way from self-care and across primary, community and specialist services, while enabling users to step between these contexts of care as seamlessly as possible.

The Action Plan outlines the key priorities and programme of work required to implement the Stepped Care Model for Mental Health and Addiction Services in the Southern district over the next four years. It takes a whole of sector, systems and population approach proven to improve outcomes for consumers, families and whānau. Implementation will be led by the Alliance South Mental Health & Addiction Network.

Telehealth

Based on geographical size, Southern DHB is the largest health board in the country – which makes investing in telehealth an important element of delivering care to its farthest reaches. Telehealth enables clinicians and patients to connect via video link from locations including other hospitals, a GP's office or health clinic, or even the patient's home.

A programme director and telehealth coordinator have been appointed to support services which include telehealth clinics and consultations as part of patient care and support. The DHB is also working closely with WellSouth to encourage uptake of telehealth among general practices in the district and has adopted the industry standard Vidyo platform, a high-definition videoconferencing solution to improve services.

Telehealth clinics have now been utilised in obstetrics, paediatric diabetes, geriatrics, neonatal intensive care, wound care, neurology, mental health, anaesthetics and more. The Lakes District Hospital, Oamaru Hospital, Dunstan Hospital, as well as GP practices in Dunedin and Wanaka, participate in telehealth clinics, linking with secondary care clinicians in Dunedin and Invercargill and sometimes outside the DHB with Canterbury and elsewhere.

Future opportunities for telehealth in the district may include linking with interpreter services, hospices, prisons and connecting with larger hospitals and expertise further afield.

Southern HealthPathways

In order to standardise and streamline patient care, Southern HealthPathways is being promoted as a referral information and condition-management website for clinicians working in the Southern district.

It provides guidelines specific to health-care services in this district, so that general practitioners and hospital-based specialists have consistent, up-to-date information for managing and referring patients.

There are already more than 400 localised HealthPathways – information specific to the Southern district, with more localised information being added regularly.

Southern DHB has enhanced and promoted the service this year, partnering with the WellSouth Primary Health Network to raise awareness and usage of HealthPathways across primary care and making the HealthPathways icon available on all Southern DHB desktop computers to improve access to the resource.

By promoting the use of Southern HealthPathways throughout the medical community, Southern DHB is aiming to ensure more consistent care for patients in the Southern district, in which they receive the right care, by the right provider, in the right location and in the right time frame.

OUR STORY

Central Lakes mental health services reaching out with telehealth

Using innovative ways to improve access to specialist care means less travel and improved access to specialist mental health services for patients based in the Central Lakes area.

The team run fortnightly telemedicine clinics from Queenstown, Wanaka or Clyde with a psychiatrist sitting in either Dunedin or Invercargill. This allows for a greater number of appointments to be available to the rural community with the benefits of reduced travel time for patients, their families and the consultant.

"Supporting communities to improve their mental health is important work, and the use of regular clinics held digitally has improved access to specialist care," says Southern DHB Clinical Team Manager Central Lakes Community Mental Health Team, Jo Harry.

"We are always looking at ways to further improve access to specialist mental health services for our patients and to expand these clinics," says Ms Harry. "We have flexibility for psychiatrists to see 'one off' patients on telemedicine at any other time outside of these planned clinics. And we're hoping we can soon expand the service even further so patients can access telehealth from the comfort of their own home."

Central Lakes Community Mental Health Team having a meeting across two sites via video conference

Radiology

CT, MRI, ultrasound, X-Rays, SPECT-CT scans – whatever the modality, radiology is a vital tool helping clinicians in various areas of health care to better diagnose and treat patients' conditions.

Demand for imaging continues to rise and Southern DHB is working to meet the increase in referrals with the help of new scanning equipment and innovative approaches to providing services.

In November, a new GE Optima 1.5 Tesla MRI machine was installed at Dunedin Hospital, while a digital Philips DR X-ray machine replaced an older unit in the ED in mid-2017. The new units are more comfortable for patients being scanned, are more efficient and produce better quality images.

Southern DHB also launched a pilot project providing general practitioners in the Southern district with direct access to high-tech imaging for CT for -KUB and US –DVT. The aim of the project is to improve access to two common studies, promote consistent and equitable access across the district and make optimal use of available resources.

Waitaki District Health Services

The need to provide sustainable, patient-centric health services in North Otago has led Southern DHB and Waitaki District Health Services (WDHS) to undertake a review of the model of care for this community.

A series of workshops by a review team was held in June 2016 to draw out ideas for change and gather community and staff feedback.

Recommendations in the report, published in November, include establishing a community clinical care hub as a local single point of entry, improving post-hospital discharge, providing services closer to home, better coordinating urgent care, improving communications, enhancing the workforce and establishing measures of success.

The implementation of the recommendations will be led by WDHS with continued support from Southern DHB.

Primary maternity services review

A wide-ranging report with strong community input will guide the future shape of primary birthing facilities in Otago and Southland. Launched in August 2016, the Primary Maternity Project aimed to work with communities to understand their needs and design a district-wide service that is clinically and financially sustainable. A series of meetings were held and 40 written submissions were received. The resulting report released in June recommended a continuing commitment to primary maternity services and maintaining a strong network of birthing units.

Other findings and recommendations included promoting and encouraging women to choose primary birthing services and ensuring more consistency in the operation and funding of primary birthing facilities across the district.

Southern DHB funds seven primary maternity facilities in rural locations – Oamaru, Alexandra, Balclutha, Gore, Winton, Lumsden and Queenstown - at a cost of $2.8m per annum. About 12% of Southern births are in primary maternity facilities compared to a national primary birthing rate of 8%.

Achieving financial sustainability

Following years of deficits, achieving financial sustainability is an important aspect of Southern DHB's journey. It puts us in a position of being able to make investments in services, better maintain our facilities and take greater control of our future. We were pleased that our financial results saw us achieve our budgeted deficit, and remain on a path towards a break-even position in 2019/20. It was also pleasing to have achieved this while still able to make the investments in improving patient care and our organisational resilience and sustainability contained in this report.

FINANCIAL STATEMENTS

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2017

	Note	2017 Actual $000	2017 Budget $000	2016 Actual $000
Patient revenue	2	923,973	923,338	893,391
Other revenue	2	10,007	6,991	9,110
Interest revenue		295	720	1,175
Total revenue		**934,275**	**931,049**	**903,676**
Personnel costs	3	361,973	360,405	354,009
Depreciation, amortisation and impairment expense	10,11	21,396	21,273	20,986
Outsourced services		42,785	37,943	36,509
Clinical supplies		80,247	77,313	77,040
Infrastructure and non-clinical expenses		45,269	42,649	49,261
Other district health boards		41,404	38,968	40,006
Payments to non-health board providers		351,120	359,138	341,819
Other expenses	6	4,241	3,573	4,535
Finance costs	5	2,668	4,287	4,584
Capital charge	4	5,042	7,500	8,470
Total expenses		**956,145**	**953,049**	**937,219**
Surplus/(deficit) for the year	17	**(21,870)**	**(22,000)**	**(33,543)**
Other comprehensive revenue				
Items that will not be reclassified to surplus/(deficit)				
Revaluation of land and buildings	17	(20,090)	-	-
Total other comprehensive revenue/(expense)		(20,090)	-	-
Total comprehensive revenue/(expense)		**(41,960)**	**(22,000)**	**(33,543)**

Statement of Changes in Equity
For the year ended 30 June 2017

	Note	2017 Actual $000	2017 Budget $000	2016 Actual $000
Balance at 1 July		**84,661**	**84,124**	**112,032**
Comprehensive revenue/(expense)				
Surplus/(deficit) for the year		(21,870)	(22,000)	(33,543)
Other comprehensive revenue/(expense)		(20,090)	-	-
Contributed capital – owner transaction		97,400	-	-
Capital contributions from the Crown (deficit support and project equity funding)		20,000	53,153	7,000
Other equity movements	17	(707)	(707)	(828)
Balance at 30 June		**159,394**	**114,570**	**84,661**

Statement of Financial Position
As at 30 June 2017

	Note	2017 Actual $000	2017 Budget $000	2016 Actual $000
Non-current assets				
Property, plant and equipment	10	269,870	319,918	286,847
Intangible assets	11	12,631	5,215	13,989
Total non-current assets		**282,501**	**325,133**	**300,836**
Current assets				
Inventories	9	4,922	4,668	5,065
Receivables	8	42,332	32,905	34,364
Cash and cash equivalents	7	8	8	8
Total current assets		**47,262**	**37,581**	**39,437**
Total assets		**329,763**	**362,714**	**340,273**
Equity				
Contributed capital	17	211,800	147,016	95,107
Property revaluation reserves	17	73,932	94,022	94,022
Accumulated surplus/(deficit)	17	(126,338)	(126,468)	(104,468)
Total equity		**159,394**	**114,570**	**84,661**
Liabilities				
Non-current liabilities				
Borrowings	13	3,643	92,933	84,156
Employee entitlements	14	18,149	18,936	19,374
Total non-current liabilities		**21,792**	**111,869**	**103,530**
Current liabilities				
Cash and cash equivalents	7	22,848	2,894	9,858
Borrowings	13	1,388	17,269	20,205
Payables	12	54,188	53,083	56,452
Employee entitlements	14	68,153	63,029	63,754
Provisions	15	2,000	-	1,813
Total current liabilities		**148,577**	**136,275**	**152,082**
Total liabilities		**170,369**	**248,144**	**255,612**
Total equity and liabilities		**329,763**	**362,714**	**340,273**

Statement of Cash Flows
For the year ended 30 June 2017

	2017 Actual $000	2017 Budget $000	2016 Actual $000
Cash flows from operating activities			
Cash receipts from Ministry of Health and patients	931,178	931,598	896,291
Payments to suppliers	(570,018)	(559,829)	(544,024)
Payments to employees	(358,281)	(362,299)	(347,525)
Interest received	295	720	1,175
Interest paid	(2,957)	(4,286)	(4,290)
Net taxes refunded/(paid) (goods and services tax)	(2,562)	(4,156)	3,458
Capital charge paid	(5,042)	(7,500)	(8,470)
Net cash flow from operating activities	**(7,387)**	**(5,752)**	**(3,385)**
Cash flows from investing activities			
Proceeds from sale of property, plant and equipment	483	-	482
Purchase of property, plant and equipment	(23,544)	(36,970)	(18,728)
Net cash flow from investing activities	**(23,061)**	**(36,970)**	**(18,246)**
Cash flows from financing activities			
Proceeds from equity injection	19,293	52,446	10,324
Drawdown/(repayment) of borrowings	(1,834)	(2,759)	(2,201)
Net cash flow from financing activities	**17,459**	**49,687**	**8,123**
Net increase/(decrease) in cash and cash equivalents	**(12,989)**	**6,965**	**(13,508)**
Cash and cash equivalents at beginning of year	(9,850)	(9,850)	3,658
Cash and cash equivalents at the end of the year	**(22,839)**	**(2,885)**	**(9,850)**

Statement of Cash Flows
For the year ended 30 June 2017 (continued)

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

	2017 Actual $000	2016 Actual $000
Net surplus/(deficit) for the period	**(21,870)**	**(33,543)**
Add/(less) non-cash items:		
Depreciation and assets written off	21,396	20,986
Increase/(decrease) in fair value	28	342
Increase/(decrease) in provision for doubtful debts	943	14
Non-cash transactions	184	-
Total non-cash items	**22,551**	**21,342**
Add/(less) items classified as investing or financing activity:		
Net loss/(gains) on disposal of property, plant and equipment	(391)	109
Total items classified as investing or financing activites	**(391)**	**109**
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(8,911)	(8,363)
(Increase)/decrease in inventories	143	(388)
Increase/(decrease) in trade and other payables	(3,695)	10,974
Increase/(decrease) in employee benefits	4,786	6,484
Net movements in working capital	**(7,677)**	**8,707**
Net cash inflow/(outflow) from operating activities	**(7,387)**	**(3,385)**

The one-off non-cash transaction for Capital contributions from the Crown of $97.40m has no effect on the Statement of Cashflows.

Statement of Contingencies
As at 30 June 2017

Contingent Liabilities	Note	2017 Actual $000	2016 Actual $000
Legal proceedings against Southern DHB		-	-
Personal grievances		-	-
Facilities - clearing asbestos	16	-	-
		-	**-**

Contingent Assets	Note	2016 Actual $000	2015 Actual $000
Legal proceedings by Southern DHB		-	-
		-	**-**

Statement of Commitments

As at 30 June 2017

	2017 Actual $000	2016 Actual $000
Capital commitments		
Buildings	11,818	1,843
Clinical equipment	1,123	1,704
Computer equipment	222	1,238
Non-clinical equipment	7	116
Total capital commitments	**13,170**	**4,901**
Non-cancellable operating leases		
Less than one year	1,303	433
One to two years	1,107	83
Two to three years	672	23
Three to four years	224	18
Four to five years	116	12
Over five years	138	150
Total non-cancellable operating leases	**3,560**	**719**

Notes to the Financial Statements

1. Statement of accounting policies for the year ended 30 June 2017

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 Public Finance Act 1989 and the Crown Entities Act 2004.

Southern DHB designated itself as a Public Benefit Entity (PBE) for financial reporting purposes.

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

The financial statements presented for the year ended 30 June 2017 are for the Southern DHB only. They were approved by the Commissioner on 25 October 2017. The owner, the Crown, does not have the power to amend the financial statements after issue.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Going concern

Southern DHB's Commissioner received a letter of support from the Ministers of Health and Finance that the Government is committed to working with the DHB over the medium term to maintain its financial viability. It acknowledges that equity support may be required and the Crown will provide such support should it be necessary to maintain viability. The letter of support is considered critical to the going concern assumption underlying the preparation of the financial statements, as the 2017/18 annual plan has yet to receive approval from the Ministry of Health.

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

These financial statements comply with Public Sector PBE accounting standards.

Presentation currency and rounding

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 have been prepared on a historical cost basis except:

- where modified by the revaluation of land and buildings
- non-current assets that are held for sale are stated at the lower of carrying amount and fair value less cost to sell
- inventories are stated at the lower of cost and net realisable value.

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

In 2017, the External Reporting Board issued amendments to PBE IPSAS 39, Employee benefits. This amendment is effective for annual financial statements beginning on or after 1 January 2019.

Southern DHB expects there will be no effect in applying these amendments.

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

Changes were made to PBE IPSAS 21 Impairment of Non-Cash-Generating assets.

Previously there was some uncertainty about the requirements relating to the recognition of an impairment loss when an item of revalued property, plant and equipment was damaged or no longer available for use. The issue was whether the entire class of assets needed to be revalued when an impairment loss on damaged/unusable property, plant and equipment was recognised.

This standard removes the uncertainty by including revalued property, plant and equipment and revalued intangible assets in the scope of the impairment standards.

SDHB is an early adopter of this policy, impairing those buildings that have quantifiable asbestos issues impacting their usability.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below.

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

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 not recoverable as an input tax, it is recognised as part of the related asset or expense.

Income tax

Southern DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

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.

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.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with International Public Sector Accounting Standards (IPSAS) requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue 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. These results form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

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

The major areas of estimate uncertainty that have a significant impact on the amounts recognised in the financial statements are:

- asbestos impairment, note 10
- fixed assets revaluations, note 11
- employee entitlements, note 14.

Custodial/trust and bequest funds

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

Comparative data

Comparatives have been reclassified as appropriate to ensure consistency of presentation with the current year.

2. REVENUE

ACCOUNTING POLICY

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

MoH revenue

Southern DHB is primarily funded through revenue received from the MoH. This funding is restricted in its use for the purpose of the DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

Revenue from the MoH is recognised as revenue at the point of entitlement if there are conditions attached in the funding.

The fair value of revenue from the MoH has been determined to be equivalent to the amounts due in the funding arrangements.

ACC contract revenue

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

Revenue from other DHBs

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

Interest revenue

Interest income is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Donations and bequests

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

Revenue from grants

Revenue from grants includes grants given by other charitable organisations, government organisations or their affiliates. Revenue from grants is recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset.

Grants are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as revenue received in advance and recognised as revenue when conditions of the grant are satisfied.

Research revenue

Research costs are recognised in the Statement of Comprehensive Revenue and Expense as incurred. Revenue received in respect of research projects is recognised in the Statement of Comprehensive Revenue and Expense in the same period as the related expenditure.

Where requirements for research revenue have not yet been met, funds are recorded as revenue in advance. The DHB receives revenue from organisations for scientific research projects. Under PBE IPSAS 9 funds are recognised as revenue when the conditions of the contracts have been met. A liability reflects funds that are subject to conditions that, if unfulfilled, are repayable until the condition is fulfilled.

Breakdown of Crown revenue

	2017 Actual $000	2016 Actual $000
Health and disability services (MoH contracted revenue)	884,692	852,602
ACC contract revenue	9,363	10,126
Inter-district patient inflows	21,442	21,159
Other revenue	8,476	9,504
Total funding from the Crown	**923,973**	**893,391**

Revenue for health and disability services includes revenue received from the Crown and other sources.

Breakdown of other revenue

	2017 Actual $000	2016 Actual $000
Gain on sale of property, plant and equipment	447	482
Donations and bequests received	422	293
Rental revenue	3,187	3,207
Other revenue	5,951	5,128
Total other revenue	**10,007**	**9,110**

3. PERSONNEL COSTS

ACCOUNTING POLICY

Superannuation schemes

Defined Contribution Plans

Obligations for contributions to defined contribution plans are recognised as an expense in the Statement of Comprehensive Revenue and Expense as incurred.

Breakdown of personnel costs

	2017 Actual $000	2016 Actual $000
Salaries and wages	349,218	341,220
Defined contribution plans employer contributions	8,100	7,517
Increase/(decrease) in employee entitlements	4,655	5,272
Total personnel costs	**361,973**	**354,009**

EMPLOYEE REMUNERATION

There were 656 employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2017.

Total Remuneration and Other Benefits $000	Number of Employees	
	2017	2016
100 - 110	148	119
110 - 120	80	74
120 - 130	52	44
130 - 140	26	34
140 - 150	37	29
150 - 160	33	39
160 - 170	16	18
170 - 180	19	17
180 - 190	18	15
190 - 200	20	19
200 - 210	12	20
210 - 220	14	10
220 - 230	14	10
230 - 240	12	12
240 - 250	18	17
250 - 260	23	10
260 - 270	13	11
270 - 280	10	12
280 - 290	11	13
290 - 300	7	9
300 - 310	10	13
310 - 320	10	12
320 - 330	8	7
330 - 340	6	6
340 - 350	6	4
350 - 360	6	3
360 - 370	3	5
370 - 380	4	4
380 - 390	4	3
390 - 400	5	3
400 - 410	-	2
410 - 420	1	2
420 - 430	3	3
430 - 440	2	-
440 - 450	2	1
450 - 460	-	-
460 - 470	-	-
470 - 480	-	1
480 - 490	-	1
490 - 500	-	-
500 - 510	-	1
510 - 520	-	-
520 - 530	2	-
530 - 540	-	-
540 - 550	-	-
550 - 560	1	-
	656	**603**

Each year, as required by the Crown Entities Act, our annual report shows numbers of employees receiving total remuneration over $100,000 per year, in bands of $10,000.

Of the 656 employees in this category, 438 were medical/dental employees (2016: 423 employees were medical/dental).

Due to the resignation of the Chief Executive in 2016-17, this role has been filled by two people (the latter outsourced from Nelson Marlborough DHB prior to his successful appointment). The Chief Executive's remuneration and all other benefits either paid or accrued therefore falls into two bands, one 300-310, the other 170-180. In addition, Nelson Marlborough DHB was paid $233,729 for the outsourced contract CEO services.

EMPLOYEE TERMINATION PAYMENTS

Fifteen employees received remuneration in respect of termination or personal grievance relating to their employment with Southern DHB.

The total payments were $697,961 (2016: 18 employees totalling $642,637).

2017 $000	2016 $000
408	160
178	122
20	120
17	97
15	65
13	16
12	12
9	10
7	9
5	6
5	6
4	5
2	4
2	3
1	3
0	2
	2
	1
698	**643**

BOARD MEMBERS REMUNERATION

There was no remuneration paid to Board members during the period, due to their replacement on 17 June 2015 by a Commissioner and three Deputy Commissioners.

COMMISSIONER TEAM REMUNERATION

The total value of remuneration paid or payable to the Commissioner and Deputy Commissioners during the year was:

	2017 Actual $000	2016 Actual $000
Kathy Grant	164	165
Graham Crombie	90	102
Richard Thomson	54	58
Angela Pitchford	-	32
Total Commissioner team remuneration	**308**	**357**

There were payments made to the independent Chairperson of the Finance, Audit and Risk Committee, appointed by the Commissioner since September 2015. Payments totalled $25,400.

The total value of remuneration paid or payable to Committee members (excluding Commissioner team) during the year was:

	2017 Actual $000	2016 Actual $000
Hospital Advisory Committee		
Suzanne Marie Crengle	1	-
Total remuneration	1	-
Community and Public Health Advisory Committee/Disability Support Advisory Committee		
Donna Christine Matahaere-Atariki	-	-
Total remuneration	-	-
Iwi Governance Committee		
Odele Stehlin	2	3
Taare Hikurangi Bradshaw	1	2
Donna Christine Matahaere-Atariki	1	1
Ann Margaret Johnstone	1	1
Justine Carmel Camp	1	-
Nola Vivienne Tipa	-	1
Sumaria Beaton	-	-
Total remuneration	**6**	**8**

Remuneration to Committee members of less than $500 is rounded down to a dash.

4. CAPITAL CHARGE

ACCOUNTING POLICY

The capital charge is expensed in the financial year to which the charge relates.

FURTHER INFORMATION ON THE CAPITAL CHARGE

Southern DHB pays capital charge to the Crown twice yearly. This is based on closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the period 1 July to 31 December 2016 was 7 per cent and for the period 1 January to 30 June 2017 was 6 per cent. The amount charged during the period was $5.04 million (2016: 8 per cent, $8.47 million).

The conversion of $97.4 million of debt to equity in February 2017 did not have an impact on the capital charge paid as the payments were based on the closing equity balances as at 30 June 2016 and 31 December 2016. The impact of this change will be seen in the 2017-18 year offset by lower interest costs.

5. FINANCE COSTS

ACCOUNTING POLICY

Borrowing costs are expensed in the financial year in which they are incurred.

Breakdown of finance costs

	2017 Actual $000	2016 Actual $000
Interest on secured loans	2,471	4,290
Interest on finance leases	197	294
Total finance costs	**2,668**	**4,584**

6. OTHER EXPENSES

ACCOUNTING POLICY

Breakdown of other expenses

	Note	2017 Actual $000	2016 Actual $000
Impairment of trade receivables		943	14
Bad debts written off		310	705
Loss on disposal of property, plant and equipment		56	592
Audit fees (for the audit of financial statements)		197	189
Fees paid to other auditors for assurance and related services including internal audit		95	200
Commissioners fees	3	308	357
Operating lease expenses		2,330	2,476
Koha		2	2
Total other expenses		**4,241**	**4,535**

Operating Leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of the asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

The operating lease payments are made up of vehicle leases (52 per cent), premises rental (33 per cent), with the balance being clinical equipment and computer equipment rental (15 per cent).

Operating leases as lessee

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

	2017 Actual $000	2016 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1,303	433
Between one and five years	2,119	136
More than five years	138	150
Total non-cancellable operating leases	**3,560**	**719**

The majority of the non-cancellable operating lease expense relates to 264 fleet car leases. These leases have terms of three to five years, the last ones expiring May 2022.

The balance of the non-cancellable operating lease expense consists of non-significant premises leases.

7. CASH AND CASH EQUIVALENTS

ACCOUNTING POLICY

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.

Breakdown of cash and cash equivalents and further information

	2017 Actual $000	2016 Actual $000
Cash at bank and on hand	(133)	(47)
Demand funds with New Zealand Health Partnerships Limited	(22,706)	(9,803)
Cash and cash equivalents in the Statement of Cash Flows	**(22,839)**	**(9,850)**

WORKING CAPITAL FACILITY

At 30 June 2017, the Southern DHB held no bank overdraft facilities.

Southern DHB is a party to the 'DHB Treasury Services Agreement' between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to 'sweep' DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of a month's Provider Arm funding plus GST. For Southern DHB, that equates to $46.24m.

8. TRADE AND OTHER RECEIVABLES

ACCOUNTING POLICY

Trade and other receivables are recorded at face value less any provisions for uncollectability and impairment.

A receivable is considered uncollectable when there is evidence that the DHB will not be able to collect the amount due. The amount that is uncollectable is the difference between the amount due and the present value of the amounts expected to be collected.

Breakdown of receivables and further information

	2017 Actual $000	2016 Actual $000
Receivables (gross)	45,666	36,755
Less: provision for uncollectability	(3,334)	(2,391)
Total receivables	**42,332**	**34,364**
Total receivables comprise:		
Receivables (non-exchange transactions)	22,479	21,462
Other accrued income (exchange transactions)	19,853	12,902
	42,332	**34,364**

Trade receivables are shown net of provision for doubtful debts and impairment amounting to $3.33 million arising from identified debts unlikely to be recovered (2016: $2.39 million).

The ageing profile of trade receivables at year end is detailed below:

Trade receivables

	2017		2016	
	Gross Receivable $000	Impairment $000	Gross Receivable $000	Impairment $000
Not past due	767	207	314	-
Past due 0-30 days	7,434	470	4,197	-
Past due 31-120 days	1,668	351	1,510	(634)
Past due 121-360 days	535	258	1,078	(220)
Past due more than 1 year	2,039	2,048	1,592	(1,537)
Total	**12,443**	**3,334**	**8,691**	**(2,391)**

Note: Trade receivables of $12.44 million are included in Receivables (gross) figure, $45.66 million (page 88).

Movements in the provision for uncollectability of trade receivables are as follows:

Trade receivables

	2017 Actual $000	2016 Actual $000
Gross trade receivables	12,443	8,691
Individual impairment	(3,334)	(2,391)
Collective impairment	-	-
Net total trade receivables	**9,109**	**6,300**

The provision for uncollectability of receivables is calculated by looking at the individual receivable balances and estimating the likelihood of recovery.

9. INVENTORIES HELD FOR DISTRIBUTION

ACCOUNTING POLICY

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 are stated at the lower of cost and current replacement cost.

Breakdown of inventories

	2017 Actual $000	2016 Actual $000
Pharmaceuticals	2,392	2,698
Surgical & medical supplies	2,530	2,367
Total inventories	**4,922**	**5,065**

10. PROPERTY, PLANT AND EQUIPMENT

ACCOUNTING POLICY

Property, plant and equipment consists of the following asset classes, which are measured as follows:

- land at fair value
- buildings at fair value less accumulated depreciation and impairment losses
- plant and equipment at cost less accumulated depreciation and impairment losses
- motor vehicles at cost less accumulated depreciation and impairment losses.

The DHB capitalises all fixed assets or groups of fixed assets costing greater than or equal to $2,000.

The cost of self-constructed assets includes the cost of materials, direct labour and 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.

Revaluations

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 other comprehensive revenue. 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.

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.

Additions

The cost of an item of property, plant and equipment is recognised as an asset 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 can be reliably measured.

Work in progress is recognised at cost less impairment, and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at fair value as at the date of acquisition.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus (deficit) 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 accumulated surpluses (deficits).

Subsequent costs

Costs incurred subsequent to initial acquisitions are capitalised only when it is probable that the service potential associated with the item will flow to the Southern DHB and the cost of the item can be reliably measured. All other costs are recognised in the surplus and deficit as an expense as incurred.

Depreciation

Depreciation is provided on a straight-line basis on all fixed assets other than 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	1 to 79 years	1.25-6.67%
Plant and Equipment	3 to 40 years	6.67-33%
Motor Vehicles	5 to 12 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.

Impairment

Property, plant and equipment and intangible assets that have a finite useful life are reviewed for indicators of impairment at each balance date and whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. If any such indications exist, the recoverable amount of the asset is estimated. The recoverable amount is the higher of an asset's fair value less cost to sell and value in use. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service unit approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information.

If an asset's carrying amount exceeds its recoverable amount, the assets are impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expenses to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that result is a debit in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus and deficit.

The reversal of an impairment loss on a revalued asset is credited to other comprehensive revenue and expenses and increases the asset revaluation reserve for that class of assets. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

Breakdown of property, plant and equipment and further information

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant and equipment	Vehicles	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 2015	27,487	224,915	152,485	2,332	2,465	409,684
Additions	-	-	-	-	17,603	17,603
Transfers from work in progress	-	3,339	8,992	-	(12,331)	-
Revaluation increase	-	-	-	-	-	-
Disposals	-	(12)	(3,049)	-	-	(3,061)
Balance at 30 June 2016	**27,487**	**228,242**	**158,428**	**2,332**	**7,737**	**424,226**
Balance at 1 July 2016	27,487	228,242	158,428	2,332	7,737	424,226
Additions	-	-	-	-	22,862	22,862
Transfers from work in progress	-	12,577	12,322	20	(24,919)	-
Revaluation increase	-	(20,090)	-	-	-	(20,090)
Disposals	-	(89)	(13,680)	(42)	-	(13,811)
Balance at 30 June 2017	**27,487**	**220,640**	**157,070**	**2,310**	**5,680**	**413,187**
Depreciation and impairment losses						
Balance at 1 July 2015	-	8,421	111,215	1,161	-	120,797
Depreciation charge for the year	-	7,949	10,862	271	-	19,082
Disposals	-	(5)	(2,495)	-	-	(2,500)
Revaluations	-	-	-	-	-	-
Balance at 30 June 2016	**-**	**16,365**	**119,582**	**1,432**	**-**	**137,379**
Balance at 1 July 2016	-	16,365	119,582	1,432	-	137,379
Depreciation charge for the year	-	8,364	11,040	275	-	19,679
Disposals	-	(89)	(13,621)	(31)		(13,741)
Revaluations	-	-	-	-	-	-
Balance at 30 June 2017	**-**	**24,640**	**117,001**	**1,676**	**-**	**143,317**
Carrying amounts						
At 1 July 2015	27,487	216,494	41,270	1,171	2,465	288,887
At 30 June 2016	**27,487**	**211,877**	**38,846**	**900**	**7,737**	**286,847**
At 1 July 2016	27,487	211,877	38,846	900	7,737	286,847
At 30 June 2017	**27,487**	**196,000**	**40,069**	**634**	**5,680**	**269,870**

Revaluation

Current Crown accounting policies require all Crown entities to revalue land and buildings in accordance with PBE IPSAS 17, 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 Southern District Health Boards was carried out as at 30 April 2014 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 revaluation that was effective 30 June 2014 has been reduced by $20.1 million due to the impairment of land and buildings. This has reduced the carrying amount as at 30 June 2017.

Restriction

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

IMPAIRMENT

Southern DHB impaired land and buildings by the value of $20.1 million at year end due to the impact on fair values due to asbestos contamination identified throughout the DHB.

This contamination has been located across a number of buildings.

The value of the impairment has been assessed as the loss of service potential due to the presence of asbestos in the buildings.

11. INTANGIBLE ASSETS

ACCOUNTING POLICY

Intangible assets that are acquired by Southern DHB are stated at cost less accumulated amortisation (assets with finite useful lives) and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overhead costs.

The Finance, Procurement and Supply Chain (FPSC) rights represent the DHB's right to access, under a service level agreement, shared FPSC services provided using assets funded by the DHBs.

NZ Health Partnerships Limited (NZHPL) was established on 1 July 2015 taking on the assets and liabilities of Health Benefits Limited (HBL). HBL was an agency set up by the Ministry of Health to provide shared services for District Health Boards. The investment was made to fund the establishment of a shared service arrangement to support the delivery of Finance, Procurement and Supply Chain services. NZHPL is owned by the 20 district health boards with each of the district health boards owning five (5) 'A' Class shares. The A class shares have been issued for a nil consideration. All district health boards also own 'B' Class shares in NZHPL reflecting the level of investment in the FPSC Programme. The SDHB holding of B class shares is 4,469,000 shares of the total B class shares issued of 68,333,000.

The following rights are attached to these shares.

- Class B shares confer no voting rights.
- Class B shareholders shall have the right to access the Finance, Procurement and Supply Chain Shared Services.
- Class B shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by NZHPL from the Finance, Procurement and Supply Chain Shared Service.
- Holders of Class B shares have the same rights as Class A shares to receive notices, reports and accounts of the company and to attend general meetings of the company.
- On liquidation or dissolution of the company, each Class B shareholder shall be entitled to be paid from surplus assets of the company an amount equal to the holder's proportional share of the liquidation value of the assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A shares.
- On liquidation or dissolution of the company, each unpaid Class B share confers no right to a share in the distribution of the surplus assets.

The rights attached to Class B shares include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and, therefore, the benefits conferred through this access. The service level agreement will contain five provisions specific to the recognition of the investment within the financial statements of DHBs. The five provisions are:

- the service level agreement is renewable indefinitely at the option of the DHBs
- the DHBs intend to renew the agreement indefinitely

- there is satisfactory evidence that any necessary conditions for renewal will be satisfied
- the cost of renewal is not significant compared to the economic benefits of renewal
- the fund established through the on-charging of depreciation by NZHPL will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

The application of these five provisions means the investment, upon capitalisation on the implementation of the FPSC programme, will result in the asset being recognised as an indefinite life intangible asset.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life.

Amortisation starts when the asset is available for use and ceases at the date that the asset is derecognised.

The amortisation charge for each financial year is recognised in the surplus or deficit.

The estimated useful lives are as follows:

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

Breakdown of intangible assets

	FSPC	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
Balance at 1 July 2015	4,469	23,126	27,595
Additions	-	1,532	1,532
Disposals	-	-	-
Balance at 30 June 2016	**4,469**	**24,658**	**29,127**
Balance 1 July 2016	4,469	24,658	29,127
Additions	-	358	358
Disposals	-	(464)	(464)
Balance at 30 June 2017	**4,469**	**24,553**	**29,022**
Amortisation and impairment losses			-
Balance at 1 July 2015	-	13,234	13,234
Amortisation charge for the year	-	1,904	1,904
Disposals	-	-	-
Balance at 30 June 2016	**-**	**15,138**	**15,138**
Balance 1 July 2016	-	15,138	15,138
Amortisation charge for the year	-	1,717	1,717
Disposals	-	(464)	(464)
Balance at 30 June 2017	**-**	**16,391**	**16,391**
Carrying amounts			
At 1 July 2015	4,469	9,892	14,361
At 30 June 2016	**4,469**	**9,520**	**13,989**
At 1 July 2016	4,469	9,520	13,989
At 30 June 2017	**4,469**	**8,162**	**12,631**

The above balance includes $1.6 million of work in progress, the major contributing items being:

- $0.9 million relating to the E-Prescribing system that ensures safe medication management for patients via electronic prescribing.
- $0.7 million relating to the South Island Patient Management System.

12. PAYABLES & DEFERRED REVENUE

ACCOUNTING POLICY

Trade and other payables are generally settled within 30 days and are recorded at face value.

Breakdown of payables & deferred revenue

	2017 Actual $000	2016 Actual $000
Trade payables to non-related parties	11,014	8,681
GST payable	5,415	7,972
Revenue in advance relating to contracts with specific performance obligations	4,051	1,752
Other non-trade payables and accrued expenses	33,708	38,047
Total payables and deferred revenue	**54,188**	**56,452**

	2017 Actual $000	2016 Actual $000
Total payables comprise:		
Exchange transactions	44,722	46,728
Non-exchange transactions	9,466	9,724
	54,188	**56,452**

13. INTEREST-BEARING LOANS & BORROWINGS

ACCOUNTING POLICY

Interest-bearing and interest-free borrowings are recognised initially at fair value less transaction costs. After initial recognition, borrowings are stated at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

FINANCE LEASES

A finance lease is a lease that transfers to the lessees substantially all risks and rewards incidental to ownership of the asset, whether or not title is eventually transferred.

At the start of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum 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.

The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Breakdown of interest bearing loans & borrowings

	2017 Actual $000	2016 Actual $000
Non-current		
Secured loans	1,670	81,400
Unsecured loans	166	277
Finance lease liabilities	1,807	2,479
Total non-current portion	**3,643**	**84,156**
Current		
Current portion of secured loans	600	18,847
Current portion of unsecured loans	116	141
Current portion of finance lease liabilities	672	1,217
Total current portion	**1,388**	**20,205**
Total borrowings	**5,031**	**104,361**

Secured loans

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

Crown Loans

The interest bearing Crown Loans of $97.4 million previously provided by the Ministry of Health was converted into Crown equity effective from 15 February 2017. This is in accordance with the Government's change in policy on the capital financing of District Health Boards whereby, all DHB sector Crown debt was converted to Crown equity and DHBs no longer have access to Crown debt financing for funding capital investment. Instead, the Crown's contribution to DHB capital investment will now be solely funded via Crown equity injections.

SECURITY AND TERMS

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

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

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

Breakdown of Crown loans

	2017 Actual $000	2016 Actual $000
Interest rate summary		
Crown loans - fixed interest	-	2.21% to 6.42%
Repayable as follows:		
Within one year	716	18,988
One to two years	666	16,000
Two to three years	611	14,500
Three to four years	559	7,000
Four to five years	-	21,650
Later than five years	-	22,250
	2,552	**100,388**
Term loan facility limits		
Crown loans	-	97,400
Term loan facility	-	-

Breakdown of finance leases

	2017 Actual $000	2016 Actual $000
Within one year	672	1,217
One to two years	486	649
Two to three years	269	509
Three to four years	93	269
Four to five years	103	93
Later than five years	856	959
	2,479	**3,696**

Finance leases have been entered into for various items of clinical equipment and computer equipment.

14. EMPLOYEE ENTITLEMENTS

ACCOUNTING POLICY

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, sick leave, sabbatical leave, long-service leave and retirement gratuities.

Southern DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long-service leave and retirement gratuities, have been calculated on an actuarial basis by AON New Zealand Ltd using accepted accounting principles. The calculations are based on:

- likely future entitlements accruing to staff based on years of service and years to entitlement
- the likelihood that staff will reach the point of entitlement and contractual entitlement information
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, continuing medical education leave, annual leave and vested long-service and sabbatical leave are classified as a current liability. Non-vested long-service leave, sabbatical leave, retirement gratuities, sick leave and continuing medical education leave expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Breakdown of employee entitlements

	2017 Actual $000	2016 Actual $000
Non-current portion		
Long-service leave	4,016	4,126
Sabbatical leave	1,680	1,757
Retirement gratuities	12,453	13,491
Total non-current portion	**18,149**	**19,374**
Current portion		
Long-service leave	3,616	3,672
Sabbatical leave	179	180
Retirement gratuities	3,398	3,294
Annual leave	40,636	38,561
Sick leave	343	237
Continuing medical education	6,389	6,200
Salary and wages accrual	13,592	11,610
Total current portion	**68,153**	**63,754**
Total employee entitlements	**86,302**	**83,128**

The private and public sector have experienced widespread issues relating to the Holidays Acts and employment agreements. This is particularly for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long-term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting and analytics, people and processes. Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of this annual report. Once the issues have been resolved the actual liability may be different.

Actuarial valuation of sabbatical leave, long-service leave and retirement gratuities

The present value of sabbatical leave, long-service leave, and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows.

The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A discount rate of 1.97 per cent (2016: 2.12 per cent) and an inflation factor of 3.37 per cent (2016: 3.17 per cent) were used.

15. PROVISIONS

ACCOUNTING POLICY

General

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event
- it is probable that an outflow of future economic benefits will be required to settle the obligation
- a reliable estimate can be made of the amount of the obligation.

Provisions are 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 may include a risk margin that represents the inherent uncertainty of the present value of the expected future payments.

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.

Facilities

A provision for facilities compliance was recognised in 2016 to bring identified at-risk areas up to the level of compliance required by the Health and Safety at Work (Asbestos) Regulations 2016. Subsequent to this, there has been an amendment to IPSAS 21 relating to the impairment of non cash generating assets and the DHB has been an early adopter of this, resulting in the reversal of the provision and the impairment of the cost of remediating these assets against the revaluation reserve reflecting the loss of service potential.

Breakdown of provisions

	2017 Actual $000	2016 Actual $000
Current portion		
Restructuring	2,000	571
Facility compliance	-	1,242
Total current portion	**2,000**	**1,813**
Non-current portion		
Restructuring	-	-
Facility compliance	-	-
Total non-current portion	**-**	**-**
Total Provisions	**2,000**	**1,813**

Restructuring provision

Costs associated with the ongoing restructuring of management positions have been included as a provision. The provision represents the estimated cost for severance payments arising from the restructure.

Movements in each class of provision are as follows:

	Restructuring $000	Facilities $000	Total
Balance at 1 July 2015	200	-	200
Additional provisions made	389	1,242	1,631
Amounts used	(18)	-	(18)
Unused amounts reversed	-	-	-
Balance at 30 June / 1 July 2016	**571**	**1,242**	**1,813**
Additional provisions made	2,000		2,000
Amounts used	(571)	(1,242)	(1,813)
Unused amounts reversed	-	-	-
Balance at 30 June 2017	**2,000**	**-**	**2,000**

16. CONTINGENCIES

ACCOUNTING POLICY

Contingent Liabilities

A contingent liability is a possible or present obligation arising from past events that cannot be recognised in the financial statements because:

- the amount of the obligation cannot be reliably measured
- it is not definite the obligation will be confirmed due to the uncertainty of future events
- it is not certain that the entity will need to incur costs to settle the obligation.

The DHB has identified areas where asbestos is present and is working through a planned approach of clearing any area that it sees as an issue. This process involves an independent survey of the contaminated area to determine both the extent of the asbestos contamination and the approach used to remedy any potential risk, ranging from encapsulating the asbestos to contain it to removing it completely from the site.

Asbestos may be found in buildings where the DHB has not provided for its impacts or costs of removal.

There were no other contingent liabilities at year end.

17. EQUITY

ACCOUNTING POLICY

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- contributed capital
- property revaluation reserves
- accumulated surplus/(deficit).

Property revaluation reserve

These reserves relate to the revaluation of property, plant and equipment to fair value. There has been a $20.1 million decrease in the reserve this year due to the impairment of land and buildings that have had asbestos identified and assessed.

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.

Breakdown of equity

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2015	88,836	94,121	(70,925)	112,032
Capital contributions from the Crown (deficit support and project equity funding)	7,000	-	-	7,000
Equity repayment to the Crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	(99)	-	(99)
Transfers from revaluation of land and buildings on impairment	-	-	-	-
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Other movements	(22)	-	-	(22)
Deficit for the period	-	-	(33,543)	(33,543)
Balance at 30 June 2016	**95,107**	**94,022**	**(104,468)**	**84,661**
Balance at 1 July 2016	95,107	94,022	(104,468)	84,661
Capital contributions from the Crown (deficit support and project equity funding)	20,000	-	-	20,000
Contributed capital - owner transaction	97,400	-	-	97,400
Equity repayment to the Crown	(707)			(707)
Movement in revaluation of land and buildings	-	-	-	-
Transfers from revaluation of land and buildings on impairment	-	(20,090)		(20,090)
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Other movements	-	-	-	-
Deficit for the period	-	-	(21,870)	(21,870)
Balance at 30 June 2017	**211,800**	**73,932**	**(126,338)**	**159,394**

Equity is made up of:

	2017 Actual $000	2016 Actual $000
Equity	154,202	79,329
Restricted equity*	5,192	5,332
Total equity	**159,394**	**84,661**

* Restricted equity refers to funds held that can only be used for specific purposes. The majority of this equity at Southern DHB relates to research funding. The restricted equity funds sit within the retained earnings balance.

18. ASSOCIATED ENTITIES

Name of entity	Principal activities	Balance date
South Island Shared Service Agency Limited	South Island Shared Service Agency Limited is a non-operating company	30 June
New Zealand Health Partnerships Limited (NZHPL)	NZ Health Partnerships is led, supported and owned by the country's 20 District Health Boards (DHBs). It builds shared services for the benefit of the Health Sector.	30 June

In 2013, SISSAL ceased operating and is held as a non-operating company. Because of this there is no share of profits/loss or assets and liabilities.

The functions of SISSAL are being conducted by South Island DHB's under an agency arrangement.

19. RELATED PARTIES

TRANSACTIONS WITH RELATED PARTIES

Southern DHB is a wholly owned entity of the Crown in terms of the Crown Entities Act 2004.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management team remuneration

The key management remuneration is as follows:

	2017 Actual $000	2016 Actual $000
Commissioner Team		
Remuneration	308	357
Full time equivalent members	1.1 FTE	1.2 FTE
Total Commissioner team remuneration	**308**	**357**
Total Commissioner team full time equivalent	**1.1 FTE**	**1.2 FTE**
Executive Management		
Remuneration	3,197	2,983
Termination payments	178	377
Full time equivalent members	10.7 FTE	10.2 FTE
Total Executive Management remuneration	**3,375**	**3,360**
Total Executive Management full time equivalent	**10.7 FTE**	**10.2 FTE**
Total remuneration	**3,683**	**3,717**
Total full time equivalent	**11.8 FTE**	**11.4 FTE**

The full time equivalent (FTE) for Board members, Commissioner and Deputies has been determined on the basis of days invoiced.

An analysis of Board member/Commissioner team remuneration is provided in Note 3.

20. FINANCIAL INSTRUMENTS

ACCOUNTING POLICY

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 entity. These financial instruments include bank accounts, short-term deposits, 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 surplus or deficit. Except for those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

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 Southern DHB to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

Southern DHB places its cash and short-term deposits with high-quality financial institutions and 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 44.3 per cent of total receivables). 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.

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

LIQUIDITY RISK

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

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

	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
2017							
Secured loans	2,270	2,404	300	300	600	1,204	-
Unsecured loans	282	290	58	58	116	58	-
Finance lease liabilities	2,479	3,152	479	328	615	687	1,043
Payables and deferred revenue	54,188	54,188	54,188	-	-	-	-
Total	**59,212**	**60,034**	**55,025**	**686**	**1,331**	**1,949**	**1,043**
Inflow	-	-	-	-	-	-	-
Outflow	59,219	60,034	55,025	686	1,331	1,949	1,043
2016							
Secured loans	100,247	121,287	21,263	2,296	20,051	51,777	25,900
Unsecured loans	418	432	83	58	116	175	-
Finance lease liabilities	3,696	4,567	842	573	807	1,469	876
Payables and deferred revenue	56,452	56,452	56,452	-	-	-	-
Total	**160,813**	**182,738**	**78,640**	**2,927**	**20,974**	**53,421**	**26,776**
Inflow	-	-	-	-	-	-	-
Outflow	160,813	182,738	78,640	2,927	20,974	53,421	26,776

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.

EFFECTIVE INTEREST RATES AND REPRICING ANALYSIS

In respect of revenue-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.

2017

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and cash equivalents	-	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office *	-	2,270	300	300	555	1,115	-
Finance lease liabilities*	5.80% - 18.34%	2,479	406	266	486	465	856
Unsecured bank loans	-	282	58	58	111	55	-

* These assets/liabilities bear interest at fixed rates

Conversion of existing Crown loans to Crown equity

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity.

On the 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

The impact on the statements of account for the DHB is as follows:

	Note	2017 Actual $000	2016 Actual $000
Opening Balance – Crown Loans	13	100,247	100,247
Increase Crown Loans			-
Repayment of Crown Loans		(577)	-
Conversion of loans to equity		(97,400)	-
Closing Balance – Crown Loans		**2,270**	**100,247**
Opening Balance – Contributed Capital	17	-	-
Capital contribution from/(repayment to) the Crown		-	-
Conversion of Crown loans to Crown equity		97,400	-
Closing Balance – Contributed Capital		**97,400**	**-**

2016

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and cash equivalents	2.50%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office	0.00%	2,847	2,847				
Crown loans *	4.74%	10,000					10,000
Crown loans *	2.94%	6,000			6,000		
Crown loans *	6.42%	10,000			10,000		
Crown loans *	3.37%	5,000				5,000	
Crown loans *	3.44%	10,000				10,000	
Crown loans *	4.34%	4,500				4,500	
Crown loans *	4.40%	1,250				1,250	
Crown loans *	4.40%	5,400				5,400	
Crown loans *	5.06%	10,000				10,000	
Crown loans *	5.22%	7,000				7,000	
Crown loans *	3.40%	6,000					6,000
Crown loans *	3.40%	6,250					6,250
Crown loans *	2.21%	10,000	10,000				
Crown loans *	2.21%	6,000	6,000				
Finance lease liabilities*	5.80% - 18.34%	3,696	732	485	648	872	959
Unsecured bank loans	0.00%	418	83	58	219	58	

* 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 and purchases that are denominated in a currency other than NZD. The currencies giving rise to this risk are primarily United States and Australian dollars.

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 2017, 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 $0.03 million (2016: $1.01 million).

CLASSIFICATION AND FAIR VALUES

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

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.

	Note	Loans and receivables $000	Other amortised costs $000	Carrying amount Actual $000	Fair value Actual $000
2017					
Trade and other receivables	8	42,332	-	42,332	42,332
Cash and cash equivalents	7	(22,840)	-	(22,840)	(22,840)
Secured loans	13	-	2,270	2,270	2,270
Finance lease liabilities	13	-	-	2,479	2,479
Unsecured liabilities	13	-	282	282	282
Trade and other payables	12	-	54,182	54,182	54,182
2016					
Trade and other receivables	8	34,364	-	34,364	34,364
Cash and cash equivalents	7	(9,850)	-	(9,850)	(9,850)
Secured loans	13	-	100,247	100,247	100,247
Finance lease liabilities	13	-	3,696	3,696	3,696
Unsecured liabilities	13	-	418	418	418
Trade and other payables	12	-	56,452	56,452	56,452

FAIR VALUE HIERARCHY

The only financial instruments measured at fair value in the statement of financial position are finance leases. The fair value of finance leases as represented by their carrying amount in the statement of financial position, is determined using a valuation technique that uses observable market inputs (level 2).

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 recorded at approximate fair value.

21. MENTAL HEALTH RING-FENCE

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

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

The year ended 30 June 2017 has resulted in a deficit of $0.9 million for Mental Health services. Additionally Southern DHB has a brought-forward overspend of $5.0 million; meaning that the carry-forward overspend is $5.9 million.

22. EVENTS AFTER BALANCE DATE

In August 2017 Ministers approved the Indicative Business Case (IBC) of the rebuild of Dunedin hospital at a cost of between $1.2 billion and $1.4 billion. The project is the result of a number of buildings on the hospital campus nearing the end of their life, including the Clinical Services Building built in 1960.

The Government approved the IBC which narrows down the options to two preferred ones; a new Dunedin Hospital to be built on a new city site yet to be selected or on Southern District Health Board land at Wakari. The build is estimated to be completed in seven to 10 years.

It may be that under a new build scenario certain existing assets have a useful life that is less than currently anticipated, however it is not possible to quantify the impact of this until there is more certainty around the plan once the election is over.

Approval was given to an upgrade proposal for Lakes

District Hospital Redevelopment up to an estimated $6.5 million.

There were no other significant events after the balance date.

23. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

Explanations for major variances from Southern DHB's budgeted figures are as follows:

Statement of Comprehensive Revenue and Expense

The unfavourable variance in total comprehensive revenue and expenses against budget for the year ended 30 June 2017 was $19.96 million.

Revenue

Government and Crown revenue was $0.6 million under budget, largely due to:

- $1.0 million less elective surgery revenue being received due to volumes being less than budgeted
- $1.2 million less revenue received for capital charge funding reflecting the decrease in the capital charge rate to 6 per cent
- $1.6 million less revenue to fund interest payments due to lower payments as a result of the debt to equity conversion.

These were partially offset by $2.1 million of additional funding for in-between travel, which is the travel for home and community support workers between clients. The DHB also received $1.1 million of additional funding for the health checks and ongoing needs of the Syrian refugees who have settled in Dunedin.

Personnel costs and outsourcing

Personnel costs were unfavourable to budget by $1.6 million. This was due to a provision of $2 million to cover the impact of the management restructure that was in progress at year end, and medical costs being $0.9 million over budget driven by;

- additional costs to cover the Registrars when on strike
- additional costs paid to junior doctors when reviews of their rosters showed them to be working above requirements.

These were partially offset by favourable variances resulting from the independent actuarial valuation of Retiring Gratuities, Long Service Leave and Sabbaticals.

Outsourced Services (includes outsourced personnel)

Outsourced services were $4.8 million over budget. This was due to;

- the outsourcing of both medical personnel and clinical services (Radiology) to cover vacant medical positions
- the additional outsourcing of elective procedures to try and maintain ESPI (Elective Service Performance Indicator) compliance and increase elective delivery

Clinical Supplies

Clinical supplies were $2.9 million over budget. This was due to;

- the increasing use of high cost pharmaceutical products within the hospital environment,
- additional high cost cardiac implant costs and an increased demand for pacemakers.
- research costs which were offset by revenue.

Infrastructure and non-clinical supplies

Other costs were $2.6 million over budget. This was due to additional Information Technology costs of $1.2 million to set up Infrastructure as a Service (IaaS), with the balance being additional costs associated with doubtful debts and patient food.

Payments to non-health board providers

Payments to non-health board providers were $8.0 million under budget. However the Commissioner's change initiative fund budget sits here, and this was partially used to meet change costs in other categories. There were also community pharmaceutical savings of $1.7 million, offsetting most of the pharmaceutical overspend in the hospitals, and lower demand for palliative care than expected.

Finance Costs

These costs were $1.6 million under budget due to lower interest payments being made with the conversion of the DHB's debt to equity.

Capital Charge

The favourable variance of $2.5 million in capital charge was directly attributable to a reduction in the rate charged from 8 per cent to 6 per cent.

Statement of Cash Flows

Payments to suppliers were $10.1 million more than budget due to:

- additional Inter-District Flow payments being the treatment of SDHB domiciled patients at other DHBs
- additional payments for in-between travel costs for carer support workers offset by additional revenue received
- outsourcing costs to increase elective delivery and maintain ESPI compliance.

Purchase of property, plant and equipment was $13.4 million less than budget due to a slower than expected uptake on capital plan purchases due in some instances to delays caused by the identification of asbestos in areas where work was to be carried out.

These and other smaller variances were offset by deficit funding being $20.0 million less than budget, and the drawdown on the interim capital works being $13 million less than budget contributing to the closing cash balance being $19.9 million less than budget.

Information on Ministerial Directions

The following Ministerial Directions have been received by Southern DHB.

WHOLE OF GOVERNMENT APPROACH

The Direction to support a whole of government approach was issued in April 2014 under s.107 of the Crown Entities Act. The three Directions relating to this cover Procurement, ICT and Property.

Southern DHB applies the Government Rules of Sourcing for procurement.

Southern DHB works closely with the Government Chief Information Officer to ensure compliance with directions in relationship to ICT.

Southern DHB is exempt from the direction regarding Property functional leadership.

REQUIREMENT TO IMPLEMENT NEW ZEALAND BUSINESS NUMBER

The Direction requires Southern DHB to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018. This Direction was issued in May 2016 under s.107 of the Crown Entities Act.

Southern DHB intends to replace its key finance and supply chain business system within the timeframe of the Direction, and the replacement system has taken the NZBN requirements, as provided to date, into account.

Work is also ongoing to identify other impacts and to establish the changes that need to be implemented as a result of this Direction.

AUTHENTICATION SERVICES

The Direction on the use of authentication services was issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 Direction.

Southern DHB works closely with the Government Chief Information Officer to ensure that our technology environment is compliant with the expected standards and applicable Directions as provided; this includes authentication services.

ELIGIBILITY DIRECTION

The 2011 Eligibility Direction was issued under s.32 of the NZ Public Health and Disability Act 2000.

Southern DHB strictly and consistently assesses patient eligibility against the Public Health and Disability Act 2000 to ensure that all eligible consumers are recognised as such.

Independent auditor's report

To the readers of Southern District Health Board's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of Southern District Health Board (the Health Board). The Auditor-General has appointed me, John Mackey, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 76 to 106, that comprise the statement of financial position, statement of contingencies and statement of commitments as at 30 June 2017, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and

- the performance information of the Health Board on pages 13 to 17, 19 to 20, 22 to 27, and 29 to 53.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Health Board on pages 75 to 106:

- present fairly, in all material respects:
    - its financial position as at 30 June 2017; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards.

Qualified opinion on the performance information because of limited controls on information from the third-party health providers in the prior year

In respect of the comparative information only, some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), relied on information from third party health providers, such as primary health organisations and South Link Health. The Health Board's control over much of this information in prior years was limited, and there were no practicable audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third party health providers meant that our work on the affected performance information contained in the statement of service performance for the comparative years was limited, and our audit opinion on the statement of service performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year. However, the limitation cannot be resolved for the prior years, which means that the Health Board's performance information reported in the statement of service performance for the 30 June 2017 year, may not be directly comparable to the prior years.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 13 to 17, 19 to 20, 22 to 27, and 29 to 53:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2017, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we highlight the Health Board is reliant on financial support from the Crown, we outline the responsibilities of the Commissioner and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw your attention to the disclosures made in note 1 on page 81 that outline that the Commissioner, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of support received from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Commissioner for the financial statements and the performance information

The Commissioner is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Commissioner is responsible for such internal control as she determines is necessary to enable her to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Commissioner is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Commissioner is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

The Commissioner's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit 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.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioner.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Commissioner and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Commissioner regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Commissioner is responsible for the other information. The other information comprises the information included on pages 1 to 12, 18, 21 and 54 to 74 but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

John Mackey
Audit New Zealand
On behalf of the Auditor-General
Dunedin, New Zealand