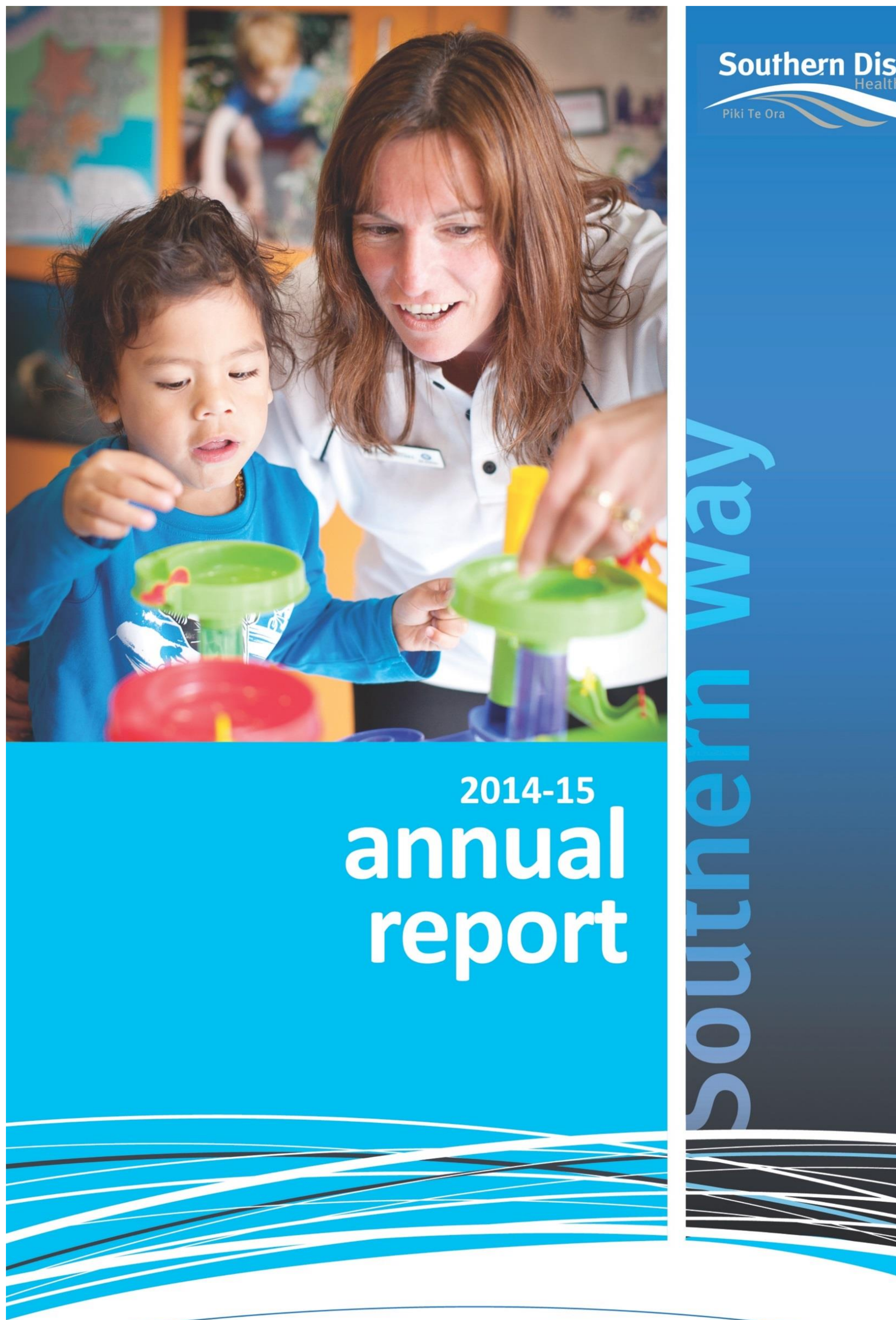

Southern District Health Board

Piki Te Ora

2014-15 annual report

Southern way

southerndhb.govt.nz

SOUTHERN DISTRICT HEALTH BOARD ANNUAL REPORT 2014/15

Produced in 2015

by the Southern District Health Board

PO Box 1921

Dunedin

www.southerndhb.govt.nz

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DIRECTORY

PREVIOUS BOARD MEMBERS 30 JUNE 2014 – 18 JUNE 2015

Joe Butterfield MNZM	*Chairman*
Tim Ward	*Deputy Chairman*
John Chambers	
Neville Cook	
Sandra Cook	
Kaye Crowther QSO	
Mary Gamble	
Tony Hill	
Tuari Potiki	
Branko Sijnja	
Richard Thomson	
Jan White	*Crown Monitor*

COMMISSIONER TEAM 18 JUNE – 30 JUNE

Kathy Grant	*Commissioner*
Graham Crombie	*Deputy Commissioner*
Richard Thomson	*Deputy Commissioner*

BOARD OFFICE

Wakari Hospital
369 Taieri Road
DUNEDIN 9010

POSTAL ADDRESSES

Private Bag 1921	P O Box 828
DUNEDIN 9054	INVERCARGILL 9840

CONTACT NUMBERS

	Telephone	*Facsimile*
Dunedin Hospital	03 474 0999	03 474 7025
Southland Hospital	03 214 5786	03 214 5742
Lakes District Hospital	03 441 0015	03 442 3305

CHIEF EXECUTIVE OFFICER

Carole Heatly

EXECUTIVE MANAGEMENT TEAM

Lexie O'Shea	*Executive Director Patient Services/ Deputy CEO*
Steve Addison	*Executive Director Communications*
Mike Hoshek	*Acting Executive Director Finance*
Peter Beirne	*Executive Director Infrastructure and Strategic Projects*
Sandra Boardman	*Executive Director Planning & Funding*
Richard Bunton	*Medical Director of Patient Services*
Donovan Clarke (previous) Pania Coote (Acting)	*Kaiwhakahaere Hauora Māori (Executive Director, Māori Health)*
Lynda McCutcheon	*Executive Director Allied Health, Scientific & Technical*
John Pine	*Executive Director Human Resources*
Jim Reid	*Primary Care Advisor*
Leanne Samuel	*Executive Director of Nursing & Midwifery*
David Tulloch	*Chief Medical Officer 1 July 2014 – 12 June 2015*
Richard Bunton	*Acting Chief Medical Officer 15 June 2015 - present*

EXTERNAL REPRESENTATIVES

Ian Macara	*Chief Executive Officer, WellSouth Primary Health Network*
Barry Taylor	*Dean, Dunedin School of Medicine*

AUDITOR

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

BANKERS

Westpac Business Banking
106 George Street
PO Box 5345
DUNEDIN 9058

COMMISSIONER AND CEO'S FOREWORD

The 2014/15 year has been a difficult time for Southern DHB as we have worked to grapple with a deteriorating financial position. There have however also been many positive achievements for the organisation.

While our finances continue to be a serious issue, our staff can be proud of the way in which they serve the community and the health and disability care that they provide.

We have improved our performance against health targets. We have consolidated gains in the *Shorter Stays in Emergency Departments* target, which is pleasing as this target is an indicator of the efficiency of the system as a whole. We have exceeded the target for providing elective surgery and we have also improved in other areas particularly in the *Better Help for Smokers to Quit* target. We are close to reaching our immunisation targets for under-eight-year-olds and recognise that we have work to do on our progress towards other targets.

We have also improved in our performance against quality indicators and by the end of the year led the country in the hand hygiene target.

Strategic Plan

A highlight for the year was the adoption of our strategic plan. During the year we were out in the community as we consulted on and then launched the plan.

This important document is a road map showing what our health services in Southern should look like over the next 10 years and how the health system is going to work collectively to get there. It is a plan for all Southern health and disability providers and the entire community. It aims to bring together family doctors, community health and disability providers, and hospital care so that we work together around community health disability needs.

It has six key outcomes:

1. Develop a coherent system of care

This means we will build care around individuals so that when you need health-care services they are provided in the right place and at the right time. We describe it as the patient journey, which is a way of talking about how we enter and move through the health system. We want to make this as easy as possible so that even though you may be seeing a number of health-care providers they will work together as one. We also talk about making it easier to navigate, which means that you will pass from one provider to the next more easily with better understanding of each provider's job.

2. Build the system on a foundation of primary/community care

This means your family doctor (general practice) and community health providers should be the main place in which you receive health care. Your family health providers know you best. They will assist you to manage any health issues you may have or to prevent health issues from occurring by giving you the best advice on eating to avoid diabetes, assistance to stop smoking or tests for possible heart problems.

3. Secure access to sustainable specialist services

This means that we will ensure that you can access specialist hospital services when you need to. We will look at which of our specialist hospital services could be affected by a shortage of doctors, surgeons or patients and look at ways that we can stop that from happening. This may include working with neighbouring district health boards to provide services together to ensure that you receive the best possible care. Some services need to be provided at a national centre such as Starship Children's Health for children, or specialist centres for back injuries or burns. Other services will be best provided in partnership with other District Health Boards and the majority of services provided locally within Southern.

4. Strengthen clinical leadership, engagement and quality improvement

Front line health staff know the system best and know how to make it work better. We will work with clinicians (doctors, surgeons, nurses, physiotherapists, dieticians etc) from family, community and hospital care so that they can work together to lead changes to our health and disability system that will make it better for you.

5. Enhance system capacity and capability

This means that we will develop plans which ensure that we have the right mix of clinical staff in community and hospital care to provide the best health and disability services from the best facilities. We will plan the development of our clinical workforce (doctors, surgeons, nurses, physiotherapists, dieticians etc) at the same time as planning our new and upgraded hospital buildings.

6. Live within our means

We need to reduce waste and duplication and ensure that we deliver the most appropriate services. We need to ensure that we spend our money wisely and where it has the most benefit for the community.

Buildings

Another highlight has been progress on a business case for urgent work on the Dunedin Hospital campus. This business case will see the much needed re-development of ICU, gastroenterology and audiology facilities at Dunedin Hospital.

Work also continued on planning for the re-build of the Dunedin Hospital Clinical Services Block and further re-development of the hospital, as well as a new training facility at Southland Hospital.

Finances and Board

In June the Southern District Health Board was replaced with a Commissioner, supported by three deputy commissioners.

The move was made as the Board had been unable to satisfactorily control the growth in the DHB's deficit and the projected deficit for the 2015/16 year.

The Commissioner is Dunedin lawyer and director Kathy Grant who is supported by deputy commissioners Graham Crombie, Richard Thomson and Dr Angela Pitchford.

The team will focus on developing a way forward for the DHB designed around new models of care which ensure patients get the right care, in the right place, at the right time and by the right people.

This is an important time for the DHB as we look at the way in which we do things and look for solutions that improve the delivery of sustainable health and disability services to the community.

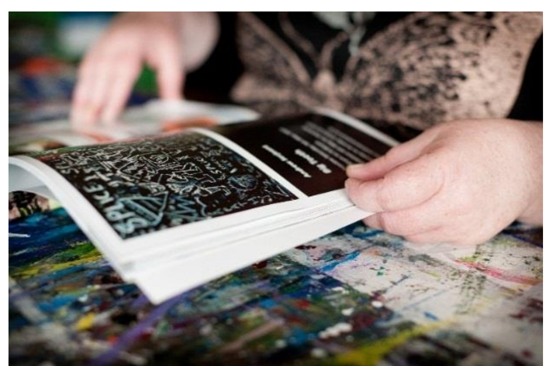
Kua tawhiti ke to haerenga mai, kia kore e haere tonu.

He tino ui rawa ou mahi, kia kore e mahi nui tonu.

We have come too far, not to go further.

We have done too much, not to do more.

Kathy Grant	**Carole Heatly**
Commisioner	**Chief Executive**
Southern DHB	**Southern DHB**



STATEMENT OF RESPONSIBILITY

FOR THE 12 MONTHS ENDED 30 JUNE 2015

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 on 30 June 2015 fairly reflect the financial position and operations of Southern DHB.

Kathy Grant	**Carole Heatly**
Commissioner	**Chief Executive**
29 October 2015	**29 October 2015**

Graham Crombie

Deputy Commissioner

29 October 2015

OVERVIEW OF SOUTHERN DHB

PURPOSE OF SOUTHERN DHB AND HOW WE FUNCTION

Southern DHB is responsible for the planning, funding and provision of publicly funded health care services. The statutory (New Zealand Public Health & Disability Act 2000 - NZPHD Act 2000) purpose of Southern DHB is to:

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

The Commissioner Team

The Board of the Southern District Health Board was removed by the Health Minister Jonathan Coleman on 18 June 2015.
Kathy Grant was appointed Commissioner and took up the role on 18 June 2015. Mrs Grant appointed Graham Crombie and Richard Thomson as deputies.

Dr Angela Pitchford was appointed as a third deputy on 22 July 2015.

Governance

The governance function is responsible for the development of policy and strategy. It is accountable for ensuring that the needs of the population are identified and services are prioritised accordingly. Policy matters pertaining to operational management of the DHB are designated to the Chief Executive Officer (CEO), through the Delegation of Authority Policy, who in turn is supported by an Executive Management Team (EMT).

Provider Services

The provider services of Southern DHB provides secondary, community, disability and mental health services to the Southern region and tertiary services to the Southern region and New Zealand.

Funder

The funder of the DHB has the following functions:

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

Partnership with Iwi

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

The NZPHD Act 2000 outlines the responsibilities Southern DHB has in honouring the principles of the Treaty of Waitangi. On 31 May 2011 a milestone in Southern DHB Iwi relations was achieved when Murihiku and Araiteuru Rūnaka and Southern DHB signed a collective Principles of Relationship (PoR) agreement. The PoR agreement sets out 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, namely:

- 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 will work together in good faith to address Māori health inequalities and improve the health and wellbeing of our Southern population. Some of the work undertaken is the Southern Māori Health Plan, this plan provides a one year subset of actions and targets related to Māori health. The Southern Strategic Health Plan – Piki te Ora and the District Annual Plan are drivers to address the prime causes of health inequality and improve Māori health outcomes.

Mauri ora ki a tātou katoa

WHO WE ARE: A SNAPSHOT OF THE SOUTHERN DISTRICT HEALTH BOARD

OUR POPULATION

Southern DHB is the most southern DHB in New Zealand with the largest geographical area to cover (62,356 square kilometres).

Our Southern District has a population of 308, 600 people. The majority, approximately 60%, live in the two main cities of Dunedin or Invercargill. The other approximately 40% live in rural areas dispersed across the eight Territorial Local Authorities (TLA).

We are a slightly older and predominantly European population when compared with the national average with 32,711 (11%) of Māori and Pacific people combined.

Our population is projected to increase only slightly over the next few years, with the main growth area being in the Queenstown-Lakes TLA.

Southern DHB ranks as the 6th least-deprived DHB in New Zealand (out of 20), with only 13% of the total population living in quintile 1 areas (least deprived).

HEALTH PROFILE

Overall health for our Southern DHB residents compares well with other New Zealanders. Life expectancy at birth was 81 years for the years 2010 to 2012, slightly less than the New Zealand average. Males lag females in life expectancy at birth by 3.9 years; Māori males lag by 7.4 years and female Māori 7.2 years.

The leading causes for avoidable mortality for our residents aged 0-74 years were ischaemic heart disease, suicide and self-inflicted injuries, lung cancer, and motor vehicle accidents.

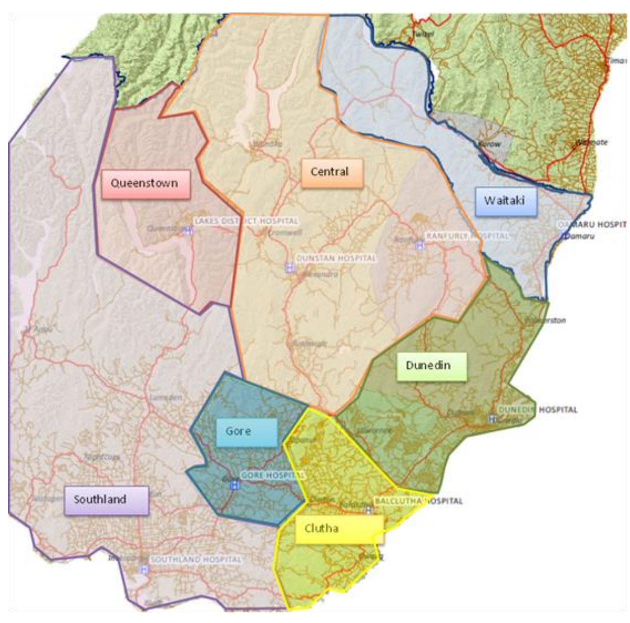
Based on work to analyse the health data for our population the key areas for the health of Southern DHB residents that we need to address include: tobacco smoking, obesity and nutrition, hazardous alcohol consumption, access and use of primary care, Māori and Pacific health, mental health service access, chronic disease management and high rates of aged residential care.

VISION

Better Health, Better Lives, Whānau Ora

MISSION

We work in partnership with people and communities to achieve their optimum health and well-being. We seek excellence through a culture of learning, inquiry, service and caring.



THE SOUTHERN WAY

The community and patients are at the centre of everything we do.

We are a single unified DHB which values and supports staff.

We are a high performing organisation with a focus on quality.

We provide clinically and financially sustainable services to the community we serve.

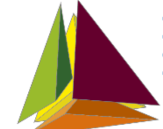
We work closely with all primary care to provide the right care in the right place at the right time and to improve the health of the community.

OUR FOURFOLD AIM

The Southern DHB focuses its planning and decisions on The Fourfold Aim. We believe that all four elements of the Fourfold Aim are of equal importance, and together they make up a single unified goal for the DHB.

We believe that no one aspect of the aim should be pursued at the expense of the others; that to achieve excellence, we need to be committed to achieving excellence in all four aspects of the aim.

Our Fourfold Aim



- Improve the health of our population
- Improve the care experience of our patients
- Improve the efficiency of our DHB
- Improve learning opportunities for current and future staff

HOW WE ALLOCATE OUR FUNDING

Southern DHB receives over $883 million per year from a variety of sources with the bulk of funding from Vote Health via the Ministry of Health. Expenditure is over a large variety of services; the largest area receiving DHB funding is hospital services at nearly $525 million per year.

Table 1: Southern DHB Revenue 2014/15

Income	2015 Actual $M
Ministry of Health	$ 826.68
Health Workforce NZ	$ 7.36
IDF and Other DHBs	$ 19.45
Other Income	$ 11.45
Accident Insurance	$ 9.88
Other Government	$ 5.65
Patient and Consumer Sourced	$ 3.44
Total Income	**$ 883.91**

Table 2: Southern DHB Expenditure 2014/15

Expenditure	2015 Actual $M
Hospital Services	$ 524.77
DHB Admin	$ 10.21
Community Pharmacy	$ 70.03
Laboratory Services	$ 18.38
PHO Organisations	$ 52.66
Other Personal, Public and Māori Health	$ 63.05
Mental Health	$ 20.02
Disability Support Services	$ 116.25
Services provided by other DHBs	$ 35.71
Total Expenditure	**$ 911.08**

Figure 1: Southern DHB Revenue 2014/15 (millions)

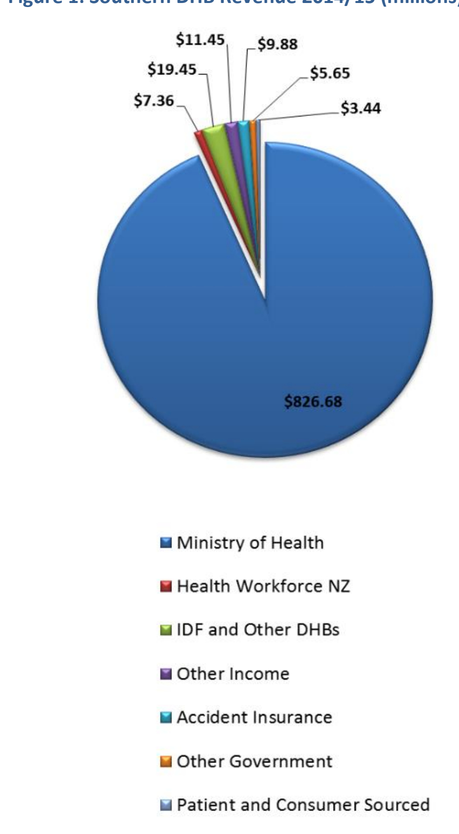
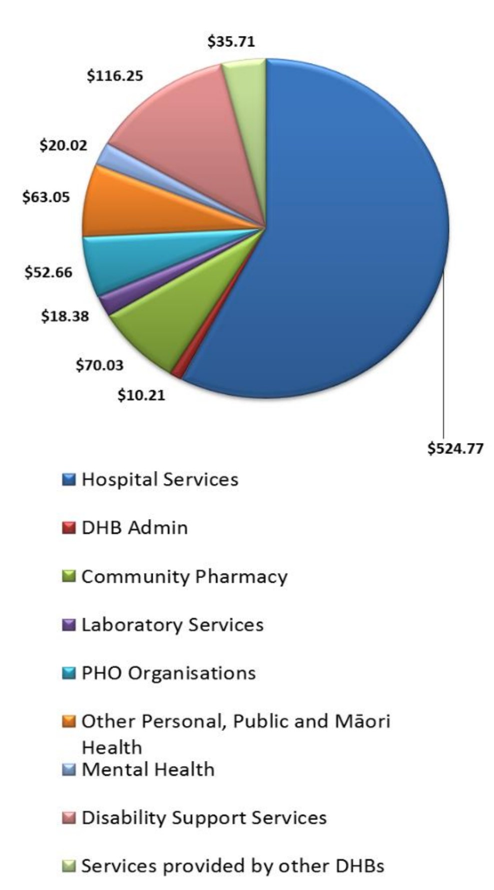


Figure 2: Southern DHB Expenditure 2014/15 (millions)



KEY FACTS AND FIGURES

Our Population

308,600 people live in the Southern DHB district which spans south of the Waitaki River to Stewart Island and includes eight Territorial Local Authorities – Dunedin, Central Otago, Waitaki, Queenstown Lakes, Clutha, Gore, Invercargill and Southland.

There are 28,060 Māori living in Southern, which is 9% of the population.

Overall our population growth is forecast to increase by 3% to 2031.

We are a large geographic region with 34,000 (11%) of our population living more than two hours away from a hospital.

Community Services

There were 3,277 babies born in our district during the 2014/2015 year.

Southern DHB vaccinated 19,516 children who are five years or under in 2014/15.

We have over 300 General Practitioners in the Southern district.

Our mental health, addictions and intellectual disability staff had direct contact with 2,287 families.

Southern DHB's home and community support services (HCSS) alliance with three HCSS providers supports approximately 4,050 older people to live in their own homes by supporting them to retain and use their everyday abilities.

Southern DHB supported the cost of aged residential care for approximately 3,880 people.

There are two hospices located in Dunedin and Invercargill, and they also provide outreach services across the district.

Hospital Services

We have nine hospitals with inpatient beds across our district. Three are owned and managed by the DHB; the other six are owned and run by rural communities.

Our hospitals provide 311 general beds, 132 mental health beds, 44 intensive care and high dependency beds, 66 rehabilitation beds and 63 maternity beds.

There were 10,062 acute surgical discharges from our hospitals.

Surgical services in our district performed 12,246 elective surgery procedures.

There were 26,587 discharges from our medical specialities.

2014/15 KEY HIGHLIGHTS AND ACHIEVEMENTS

2014/15	KEY HIGHLIGHTS AND ACHIEVEMENTS
1.	We launched a strategic plan for the Southern district following extensive stakeholder and community consultation. The strategic plan focuses on developing a more cohesive health system focusing on the needs of patients
2.	Alliance South was reframed to focus on improving the transition between primary and secondary care
3.	We achieved our target of saving 6,000 bed days. This means that more people had care in the community and at home
4.	We topped the country in Hand Hygiene results in our hospitals. More of our clinical staff undertook the correct hand hygiene procedures more often than in any other DHB
5.	We exceeded the Minister's Elective Surgery target meaning more people got the treatment they needed
6.	A new Oral Health Clinic was opened adjacent from Lakes District Hospital in Frankton, which will provide improved services to the community
7.	We launched the XCELR8 programme for leading transformational change in the health sector
8.	Health pathways were introduced as part of a programme to improve patient care and a more seamless health system.

DHB GOVERNANCE

BOARD MEMBER MEETING ATTENDANCE

Table 3: Southern DHB attendance at board and committee meetings: 30 June 2014 – 18 June 2015

Board Member		Board	Hospital Advisory	Audit & Risk	CPHAC/DSAC	Iwi Governance
		11 meetings	*6 meetings*	*10 meetings*	*8 meetings*	*7 meetings*
	Joe Butterfield Chairman	*9*	*5*	*10*	*-*	*-*
	Tim Ward Deputy Chair	*11*	*-*	*10*	*8*	*4*
	John Chambers	*11*	*6*	*-*	*-*	*-*
	Sandra Cook	*11*	*-*	*6*	*5*	*1*
	Neville Cook	*11*	*-*	*-*	*6*	*-*
	Kaye Crowther	*11*	*-*	*-*	*8*	*7*
	Mary Gamble	*10*	*4*	*-*	*-*	*-*
	Tony Hill	*11*	*6*	*10*	*-*	*2*
	Tuari Potiki	*10*	*6*	*10*	*-*	*6*
	Dr Branko Sijnja	*10*	*-*	*-*	*6*	*-*
	Richard Thomson	*11*	*6*	*-*	*-*	*-*

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 resource policy which encompasses the requirements for fair and proper treatment of employees in all areas of their employment. We value equal employment opportunities by identifying and eliminating barriers that may negate staff from being considered equitably for employment opportunities of their choice and the chance to perform to their fullest potential.

Southern DHB is committed to the highest level of integrity and ethical standards in everything we do. We are committed to the principles of natural justice and 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.

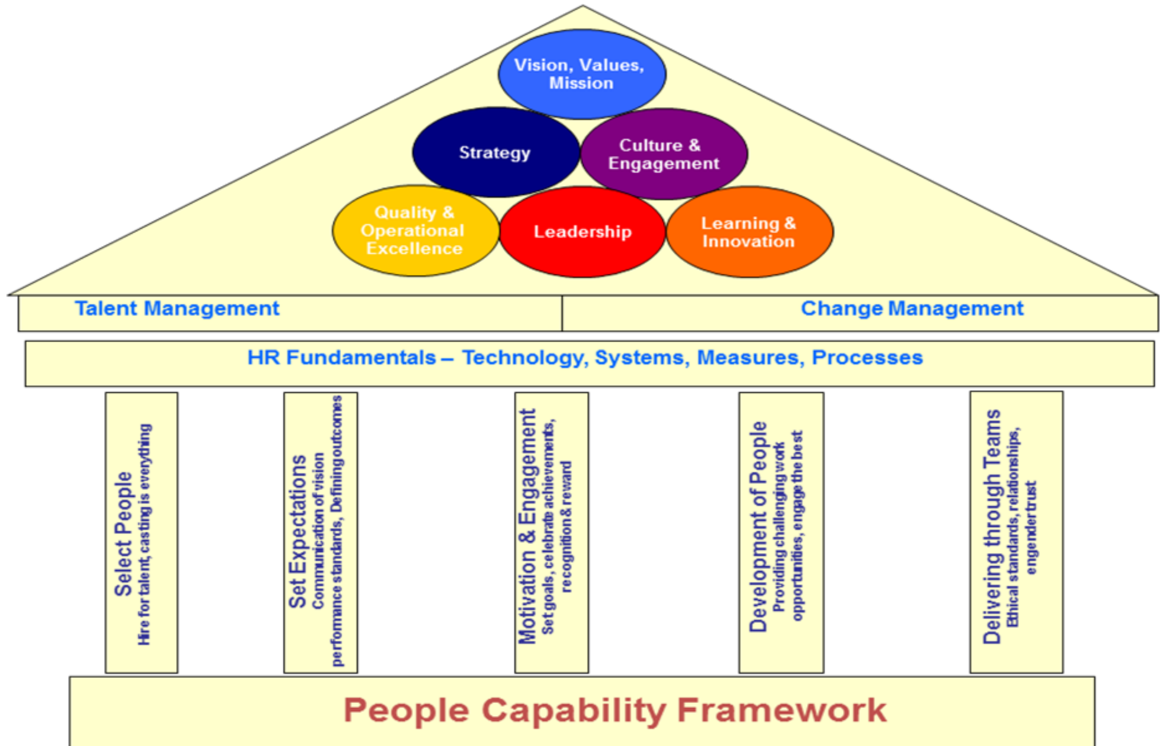
A suite of equal employment opportunity polices underpin the execution of activities that relate to the recruitment and management of employees for recruitment, pay and rewards, professional development and work conditions.

The People Capability Framework captures our organisational people-related practices. There are five pillars that support the Framework, these drive organisational practice and outcomes relating to the recruitment and management of employees.

1. Select the best – recruitment and selection practices.
2. Set expectations – performance management and appraisal practices.
3. Employee motivation and engagement – reward, recognition, engagement practices.
4. Developing our people – learning and development curriculum, career development practices.
5. Developing through teams – our ways of working together, district wide.

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 Management Advisory Group – Māori Health at the Board 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 Management Team.

Figure 3: Southern DHB People Capability Framework



A healthy and safe workplace for all employees, students, volunteers and contractors is supported by a dedicated Occupational Health Team and organisational policy.

An outline of practices, processes and programmes that support our Good Employer Obligations are listed below.

Figure 4: An outline of practices, processes and programmes that support our Good Employer Obligations

AREA	PRACTICES, PROCESSES AND PROGRAMMES THAT SUPPORT OUR GOOD EMPLOYER OBLIGATIONS
LEADERSHIP & ACCOUNTABILITY	Clinician-manager partnerships at the Executive and Senior levels. Southern Way Newsletter for staff. Multi-disciplinary involvement in decision making.
RECRUITMENT, SELECTION & INDUCTION	Southern DHB orientation for all new staff. Nurse Entry to Practice Programme for new graduate nurses. Management training modules provided for recruitment and interview skills.
EMPLOYEE DEVELOPMENT, PROMOTION & EXIT	Mentoring Programme for senior leaders and managers. Exit interviews and surveys conducted. Sabbaticals for Senior Medical Officers. Numerous staff development programmes in place. Annual performance review and individual development/objective setting.
FLEXIBILITY & WORK DESIGN	Childcare centre for staff's children on Dunedin site with flexible hours for rostered staff. Flexible rostering practices, subject to clinical requirements. Part-time and job-share positions in place.
REMUNERATION RECOGNITION & CONDITIONS	The majority of staff are on Multi-Employer Collective Agreements. Annual review of IEA remuneration. Job size determined utilising validated and reliable job evaluation methodology.
HARRASSMENT & BULLYING PREVENTION	Zero tolerance stance supported by policies and Code of Conduct and Integrity Policy. Trained Human Resources and Management staff to deal with bullying complaints.
SAFE & HEALTHY ENVIRONMENT	Health and Safety network, with staff representatives and committees throughout organisation. Hazard management process in place. ACC Partnership Programme. Employee Assistance Programme delivered by external contractor available for all staff. Free work-related Occupational Health assessments for staff. Work area safety checks and workstation assessments. Free outpatient physiotherapy assessment and treatment for employees.

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).

Outcomes and Impacts

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

The four strategic outcomes are:

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

Outcome Two: People stay well in their own homes and communities

Outcome Three: People with complex illness have improved health outcomes

Outcome Four: People experience optimal functional independence and quality of life.

The intervention logic diagram (see Figure 6) visually demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired longer-term outcomes and the delivery of the expectations and priorities of Government.

Output 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 care and are applicable to all DHBs (see Figure 5 - Scope of DHB operations – output classes against the continuum of care).

The output measures chosen cover the activities with the potential to make the greatest contribution to the well-being of our population in the shorter term, and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year - and therefore reflect a reasonable picture of activity across the whole of the Southern health system.

To ensure the quality of services provided, the DHB invests in programmes that are evidence-based or evidence-informed such as ABC Smoking Cessation[1] and InterRAI[2] – where research shows definite gains and positive

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[1] ABC Smoking Cessation is a simple and easy tool that all clinicians can use to guide their action. Ask about and document every person's smoking status. Give Brief advice to stop to every person who smokes. Strongly encourage every person who smokes to use Cessation support.

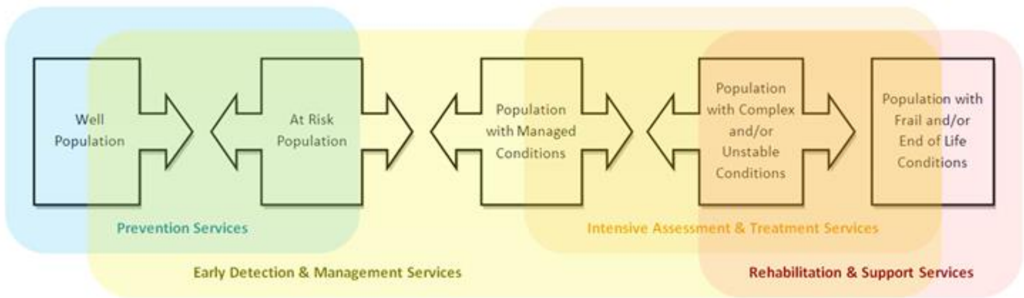
[2] InterRAI is a tool that provides a comprehensive clinical assessment of medical, rehabilitation and support needs and abilities such as mobility and self-care.

outcomes. This provides the DHB with greater assurance that these are 'the right services', allowing us to focus on monitoring implementation and whether the right people have access, at the right time and in the right place. In some cases the DHB will measure the number of people 'trained' in a particular programme or method, to give further assurance of quality provision and of the capacity of the system to deliver these services.

Appropriations

The 2014/15 Vote Health Estimates of Appropriations noted that performance information for selected Non-departmental Appropriations (Health Workforce Training and Development, National Child Health Services, National Contracted Services, National Disability Support Services, National Elective Services, National Emergency Services, National Health Information Systems, National Maternity Services, National Mental Health Services, National Personal Health Services, and Primary Health Care Strategy) would be reported in part through DHBs 2014/15 Annual Reports. The Ministry of Health has advised DHBs that the Minister of Health will report this information instead of DHBs. Readers wishing to view the overall budget and performance information for these selected Non-departmental Appropriations will be able to refer to the Minister of Health's 2014/15 Vote Health Non-Departmental Expenditure report. This report will be made available on the Ministry of Health's website.

Figure 5: Scope of DHB operations – output classes against the continuum of care



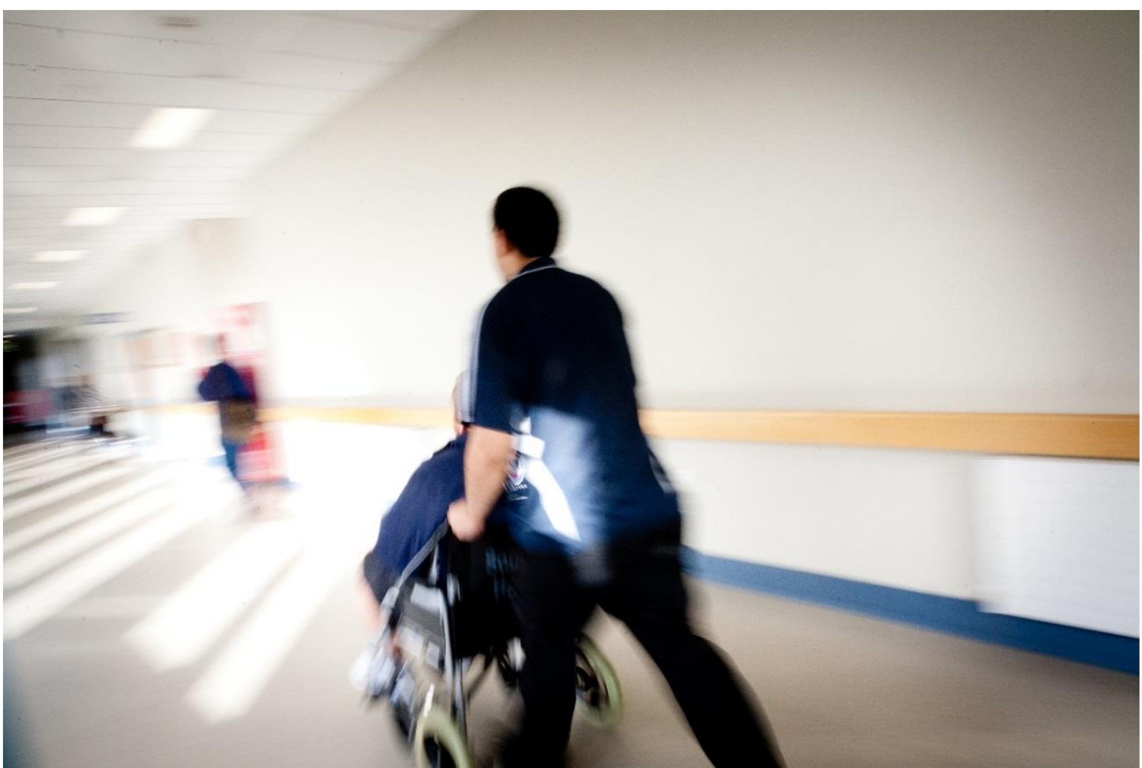


Figure 6: DHB Intervention Logic Diagram

South Island Intervention Logic Framework

HEALTH SECTOR OUTCOMES

Ministry of Health Sector Goals

All New Zealanders to live longer, healthier and more independent lives, while ensuring the health system is cost effective and supports a productive economy.

- New Zealanders are healthier and more independent
- Health services are delivered better, sooner and more conveniently
- The future sustainability of the health system is assured

REGIONAL HIGH LEVEL OUTCOMES

South Island Regional Vision

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

- **Population Health** Improved health & equity for all populations
- **Experience of Care** Improved quality, safety and experience of care
- **Sustainability** Best value for public health system resources

Southern DHB Vision

Better health, better lives, Whānau Ora.

DHB LONG TERM OUTCOMES	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	People experience optimal functional independence & quality of life
Measures of success	▪ *A reduction in smoking and in obesity rates*	▪ *A reduction in acute medical admission rates*	▪ *A reduction in acute readmission rates* ▪ *A reduction in mortality rates*	▪ *An increase in the proportion of older people living in their own homes*
DHB MEDIUM TERM IMPACTS *Measures of success*	▪ *More babies are breast-fed* ▪ *Fewer young people take up smoking*	▪ *People access urgent care when they need it* ▪ *Fewer people are admitted to hospital with 'avoidable' conditions* ▪ *Children have improved oral health*	▪ *People have shorter waits for treatment* ▪ *People have increased access to elective services* ▪ *People stay safe in hospital*	▪ *Fewer older people are admitted to hospital as a result of a fall*
OUTPUTS	Prevention services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services

INPUTS

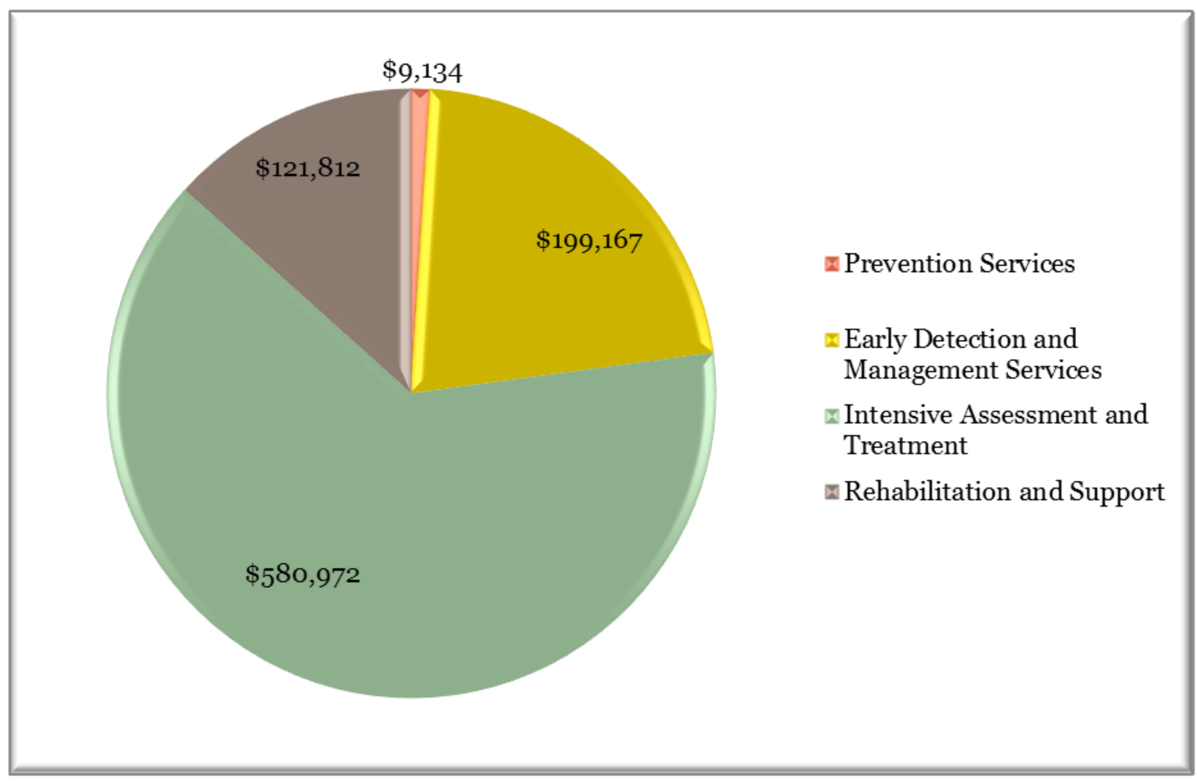
Workforce resources	Alliance networks & relationships	Financial resources	Quality systems & processes	Health information & systems	Assets & infrastructure

Cost of Service Statement

Table 4: Revenue and Expenditure by Output Class

	2015 Actual (000's)	2015 Budget (000's)
Income		
Prevention Services	9,134	9,813
Early Detection and Management Services	198,263	197,580
Intensive Assessment and Treatment	555,745	553,546
Rehabilitation and Support	120,762	118,587
Total income	**883,905**	**879,525**
Expenditure		
Prevention Services	9,134	9,813
Early Detection and Management Services	199,167	195,381
Intensive Assessment and Treatment	580,972	573,098
Rehabilitation and Support	121,812	116,032
Total expenditure	**911,085**	**894,324**
Share of profit/(loss) in associates	-	-
Surplus/(Deficit) for the year	**(27,180)**	**(14,800)**

Figure 7: Graph of Expenditure by Output Class



Improving Health Outcomes for Our Population

WHAT ARE WE TRYING TO ACHIEVE?

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

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

The South Island DHBs have collectively identified four strategic outcomes and a core set of associated indicators, which demonstrates the 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.

Outcome One: People are Healthier and Take Greater Responsibility for Their Own Health

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

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and well-being. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOME - A REDUCTION IN SMOKING RATES

OUTCOME MEASURE: THE PERCENTAGE OF THE POPULATION (15+) WHO SMOKE.		ACTUAL 2006/07	ACTUAL 2011/12	ACTUAL 2011-13	ACTUAL 2011-14[3]
	SOUTHERN DHB	-	21.8%	21.5%	19.8%
	SOUTH ISLAND	19.5%	17.9%	N/A	N/A
	NEW ZEALAND	19.9%	18.4%	18.0%	17.7%

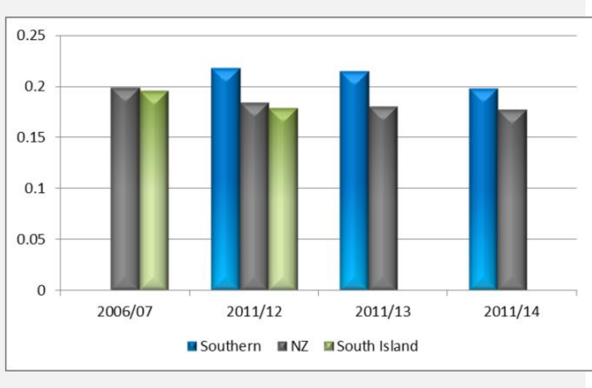
The New Zealand Health Survey data shows that smoking rates across New Zealand have declined by over 20% in the past 10 years. Specific data for Southern DHB does not exist for the same period so we are unable to show the actual rate of change over the same period.

The rate of smoking for Southern is slightly higher than New Zealand with a rate of 19.8%, or over 66,600 people in our community.

There are two approaches to reducing smoking.

> Prevent people starting smoking. This is one area where there has been some success. There has been a significant decrease in the number of year-10 children starting smoking (refer to page 20).

Figure 8: Percentage of the Population (age 15+) Who Smoke



[3] Data is collated from the period 2011 to 2014. The New Zealand Health Survey (NZHS) provides information about the health and well-being of New Zealanders. The NZHS became a continuous survey in 2011, enabling the publication of annual updates on the health of New Zealanders.

OUTCOME - A REDUCTION IN SMOKING RATES

Supporting people to quit. This is an area where we have not had the success as anticipated. Whilst 95% of people who are admitted to hospital are offered support to quit, the majority of people are seen in primary care. The evidence of embedding the smoking question routine indicates we can see a more pronounced reduction in smoking rates. Primary care has made significant progress in the past six months and it is anticipated to meet the 95% target in 2015/16. See Better Help for Smokers to Quit-Primary Care on page 36.

Data sourced from national NZ Health Survey.[4]

OUTCOME - A REDUCTION IN OBESITY RATES

OUTCOME MEASURE: THE PERCENTAGE OF THE POPULATION (15+) WHO ARE OBESE.		ACTUAL 2006/07	ACTUAL 2011/12	ACTUAL 2011-13	ACTUAL 2011-14[5]
	SOUTHERN DHB	N/A	29.8%	28.9%	29.4%
	SOUTH ISLAND	26.2%	26.5%	N/A	N/A
	NEW ZEALAND	26.5%	28.4%	29.9%	29.7%

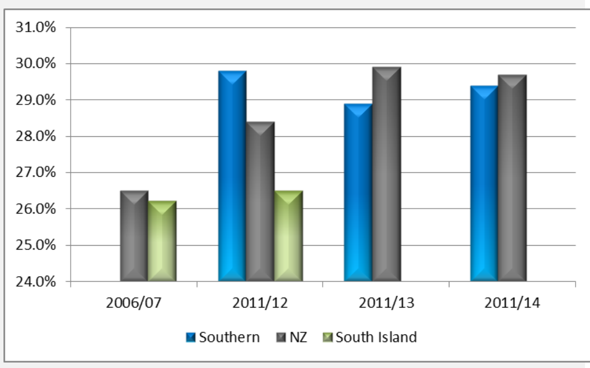
Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and well-being and to preventing and better managing long-term conditions and disability at all ages.

The percentage of the population (15+) who are obese in Southern is slightly lower than New Zealand with a rate of 29.4%, compared to 29.7% nationally.

Health promotion by the DHB, PHO, NGOs and government agencies is targeted at a population level to improve awareness and understanding of food, exercise and lifestyle choices.

Specific funded activities include Active Families and Green Prescriptions which people in need of lifestyle modifications are referred to for a specific activity programme. A new programme called Healthy Families is currently being piloted in Invercargill.

Figure 9: Percentage of the Population (age 15+) Who Are Obese



Data sourced from national NZ Health Survey.[4]

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

[5] Data is collated from the period 2011 to 2014. The New Zealand Health Survey (NZHS) provides information about the health and well-being of New Zealanders. The NZHS became a continuous survey in 2011, enabling the publication of annual updates on the health of New Zealanders.

IMPACT - MORE BABIES ARE BREASTFED

THE PERCENTAGE OF BABIES FULLY/EXCLUSIVELY BREASTFED AT SIX WEEKS.		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
	SDHB - TOTAL	67%	65%	70%	70%	≥70%
	SDHB - MĀORI	67%	56%	66%	65%	≥70%
	NEW ZEALAND	66%	65%	66%	74%	≥70%

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

Although breastfeeding is natural, it sometimes doesn't come naturally, so it's important that mothers have access to appropriate support and advice. Lead maternity carers (LMCs) encourage and assist all mothers when appropriate to try and establish breastfeeding.

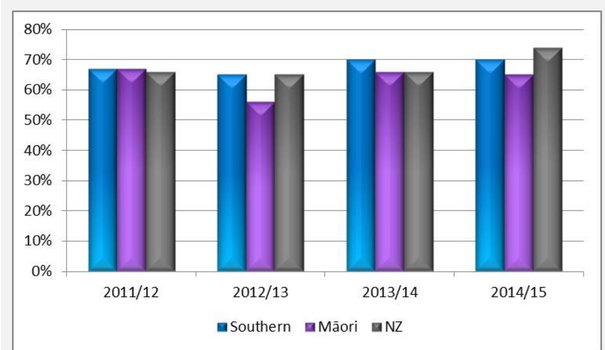
The percentage of babies that are breastfed at six weeks in Southern has maintained at the target level of 70%.

Southern DHB supports all maternity facilities in Southern to continue to attain Baby Friendly Hospital accreditation.

The Baby Friendly Hospital Initiative is a global campaign of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Maternity facilities attain accreditation by implementing policies and procedures to support the goal to increase breastfeeding initiation and duration rates by protecting, promoting and supporting breastfeeding.

WellSouth and Public Health South promotes and supports breastfeeding through peer supporters and the Breastfeeding Ultimate Refuel Place (BURP) smartphone application.

Figure 10: Percentage of babies fully/exclusively breastfed at 6 weeks



Data sourced from Plunket via the Ministry of Health.

IMPACT – FEWER YOUNG PEOPLE TAKE UP TOBACCO SMOKING

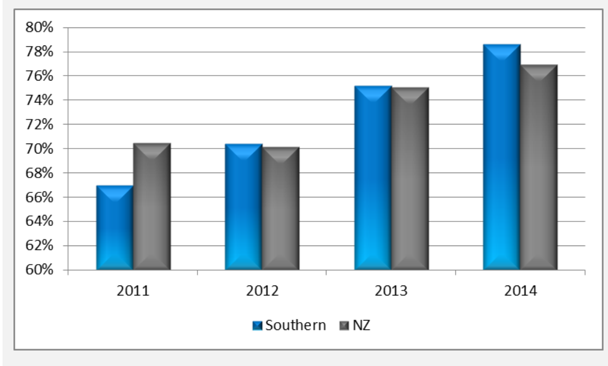
THE PERCENTAGE OF 'NEVER SMOKERS' AMONG YEAR-10 STUDENTS.		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
	SOUTHERN DHB	67%	70%	75%	79%	76%
	NEW ZEALAND	70%	70%	75%	77%	N/A

Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence is largely dependent on preventing young people from taking up smoking.

The increase in 'year-10 students who have never smoked' has been significant over the past five years. Southern DHB rates have now increased to higher than the national rate. Preventing people taking up smoking is a foundation for New Zealand to fulfil the goal of being smokefree by 2025 (Smokefree Aotearoa 2025).

There has been considerable investment in health promotion, both at national level and local level. A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and

Figure 11: Percentage of 'Never Smokers' Among Year-10 Students



IMPACT – FEWER YOUNG PEOPLE TAKE UP TOBACCO SMOKING

engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.	Data sourced from national Year-10 ASH Survey.[6]

Outcome Two: People Stay Well in their Own Homes and Communities

Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better managing their illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness.

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

OUTCOME - A REDUCTION IN ACUTE MEDICAL ADMISSIONS

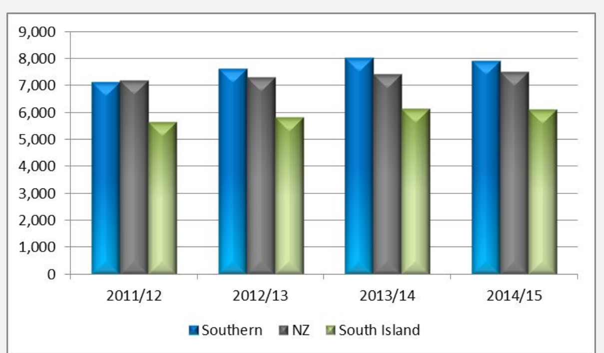
OUTCOME MEASURE: THE RATE OF ACUTE MEDICAL ADMISSIONS TO HOSPITAL (AGE-STANDARDISED, PER 100,000).		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15
	SOUTHERN DHB	7,137	7,634	8,030	7,923
	SOUTH ISLAND	5,657	5,827	6,155	6,116
	NEW ZEALAND	7,197	7,298	7,428	7,516

The rate of acute medical admissions to hospital has plateaued but remains higher than elsewhere. A large number of people admitted acutely will be through the emergency department (ED); the increase in numbers to ED correlates to the number of acute admissions.

This is increasing the demand on hospital services and costs to the health system. Reducing acute hospital admissions will have a positive effect on productivity in hospital and specialist services - enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.

Urgent care is one of the priorities for Alliance South. Work has already commenced on improving access to urgent care in the community. A rapid response service was introduced in July 2014 which provides quick access to additional resources in the community and provides an alternative option to ED.

Figure 12: The Age-Standardised Rate of Acute Medical Admissions to Hospital, Per 100,000 People



Data sourced from National Minimum Data Set.

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

IMPACT – PEOPLE ACCESS URGENT CARE WHEN THEY NEED IT

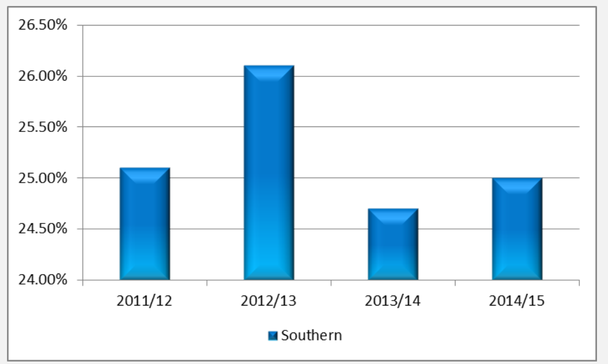
THE PERCENTAGE OF THE POPULATION PRESENTING AT ED.	ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
	25.1%	26.1%	24.7%	25.0%	<26.1%

Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, which is not necessarily in hospital Emergency Departments.

Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.

A reduction in the number of people presenting to the Emergency Department (ED) and an increase in the percentage of people presenting who are admitted are proxy measures of whether people are being more appropriately managed and supported elsewhere.

Figure 13: Percentage of the Population Presenting at ED



Data sourced from individual DHBs.[7]

IMPACT - FEWER PEOPLE ARE ADMITTED TO HOSPITAL WITH CONDITIONS CONSIDERED 'AVOIDABLE' OR 'PREVENTABLE'

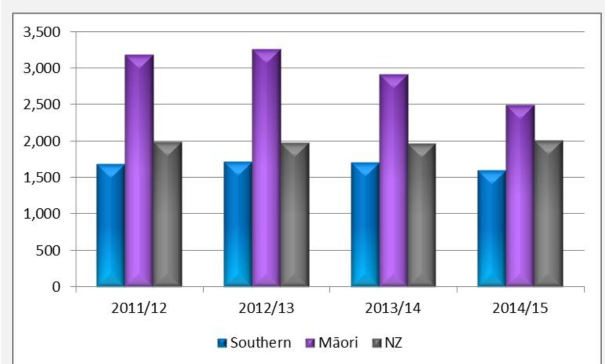
THE RATE OF AVOIDABLE HOSPITAL ADMISSIONS PER 100,000 POPULATION (<75).		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
	SDHB - TOTAL	1,691	1,718	1,711	1,605	<1,718
	SDHB - MĀORI	3,185	3,264	2,919	2,491	<2,747
	NZ - TOTAL	1,990	1,980	1,971	2,005	N/A

Ambulatory Sensitive Hospitalisations (ASH), commonly known as avoidable hospitalisations, has decreased well below national rates. The ASH rate for Māori has also decreased substantially and was well below the target for 2014/15. The gap is closing but the Māori ASH rate remains well above ASH rates for the total population.

Ambulatory sensitive admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.

These admissions provide an indication of the quality of early detection, intervention and disease management services. A reduction would indicate improvements in care and would also free up hospital resources for more complex and urgent cases.

Figure 14: The rate of Avoidable Hospital Admissions per 100,000 population 0-74 years



Data sourced from the Ministry of Health.

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

IMPACT – CHILDREN HAVE IMPROVED ORAL HEALTH

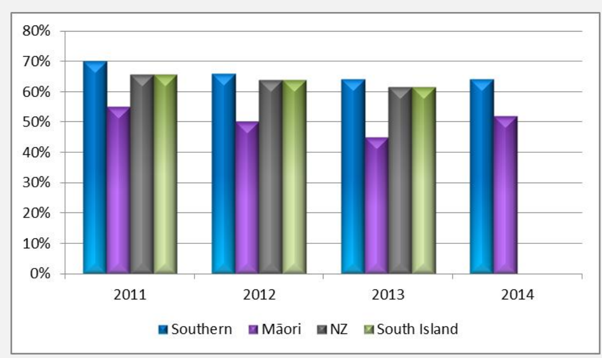
THE PERCENTAGE OF CHILDREN CARIES-FREE AT AGE 5 (NO HOLES OR FILLINGS).		ACTUAL 2011	ACTUAL 2012	ACTUAL 2013	ACTUAL 2014	TARGET 2014/15
	SDHB - TOTAL	70%	66%	64%	64%	≥70%
	SDHB - MĀORI	55%	50%	45%	52%	≥70%
	SOUTH ISLAND	66%	64%	61%	N/A	≥70%
	NEW ZEALAND	60%	59%	58%	N/A	≥70%

Oral health is an integral component of lifelong health and impacts a person's comfort in eating and ability to maintain good nutrition, self-esteem and quality of life.

The number of preschool children enrolled in the community oral health service has not increased at rates that would have been expected (see page 44). There has been a decrease in the number of Māori children enrolled and work is being done to address this in the coming year.

This is significant as evidence shows Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy measure of equity of access and the effectiveness of services in targeting those most at risk.

Figure 15: Percentage of Children Caries-Free At Age 5 (no holes or fillings)



Data sourced from Ministry of Health.

Outcome Three: People with Complex Illness Have Improved Health Outcomes

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or slowing the progression of illness, improving health outcomes by restoring functionality and improving the quality of life.

This goal also reflects the importance of the quality of treatment in that adverse events or ineffective treatment or support can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that negatively impact on the health of our population.

OUTCOME - A REDUCTION IN ACUTE READMISSION RATES

OUTCOME MEASURE: THE RATE OF ACUTE READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE.		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15
	SDHB - TOTAL	-	6.75%	7.35%	7.50%
	NZ - TOTAL	-	-	8.18%	7.90%
	SDHB - 75Y +	-	9.42%	9.76%	10.00%
	NZ - 75Y +	-	-	11.54%	10.70%

The Ministry of Health has not released final results due to data quality issues which are being investigated. There has been no indication when the data may be available.

Data sourced from Ministry of Health.

A new definition for acute readmission rates was introduced for 2013/14. There are no comparatives for 2011/12.

OUTCOME - A REDUCTION IN MORTALITY RATES

OUTCOME MEASURE: THE RATE OF ALL-CAUSE MORTALITY FOR PEOPLE AGED UNDER 65 (AGE STANDARDISED PER 100,000).		ACTUAL 2009	ACTUAL 2010	ACTUAL 2011	ACTUAL 2012 [8]
	SOUTHERN DHB	242	189	213	217
	SOUTH ISLAND	193	213	176	184
	NEW ZEALAND	298	282	273	265

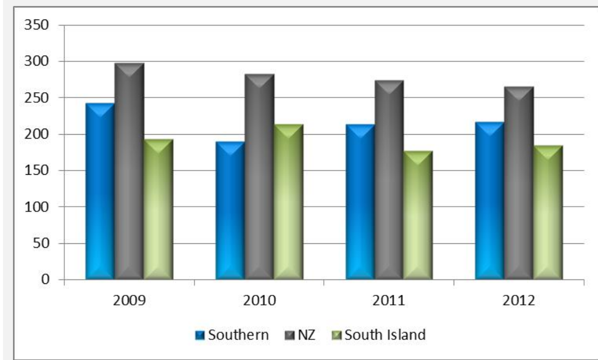
Mortality rates continue to trend down as people live longer.

Premature mortality is largely preventable with lifestyle change, early intervention and effective treatment. By detecting people at risk and improving the ongoing management of their condition, the more harmful impacts and complications of long-term conditions such as cardiovascular disease, diabetes and cancers can be reduced.

The increased number of people receiving 'more heart and diabetes checks' will identify more people at risk of CVD, and enable preventative measures to be put in place before an ischaemic event or a stroke.

CVD is significantly more prevalent amongst Māori and Pacific groups. Improved CVD outcomes are an opportunity to reduce inequalities and target improvements in the health of our more vulnerable populations.

Figure 16: Rate of all-cause mortality for people aged under 65 (age standardisation per 100,000)



Data sourced from MoH mortality collection.

[8] Mortality data containing information on the underlying causes of all deaths registered in New Zealand in 2012 was released in June 2015.

OUTCOME - A REDUCTION IN MORTALITY RATES

Advancement in the detection and treatment of cancers has significantly increased the survivability of cancer. The Faster Cancer Treatment (FCT) health target (see page 33) aims to reduce the waiting time to diagnosis and treatment for people with a high suspicion of cancer.

IMPACT –PEOPLE HAVE SHORTER WAIT TIMES FOR TREATMENT

THE PERCENTAGE OF PATIENTS PRESENTING IN ED WHO ARE ADMITTED, DISCHARGED OR TRANSFERRED WITHIN SIX HOURS.		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
	SOUTHERN DHB	89.9%	91.4%	90.5%	93.2%	95%
	NEW ZEALAND	94.0%	93.0%	93.9%	94.1%	95%

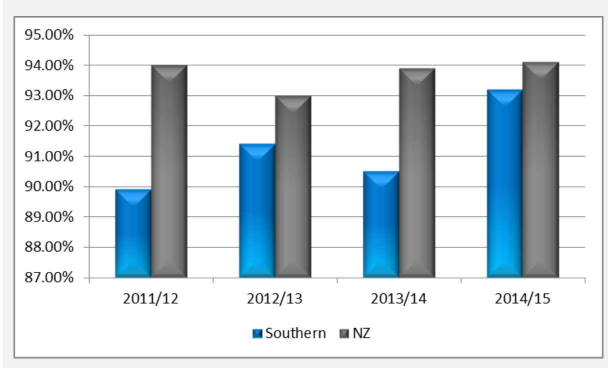
Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

Southern DHB has increased meeting ED waiting times to 93.2% for the past 12 months but continues not to meet the ED target.

Enhanced ED performance will improve outcomes by providing early intervention and treatment and improve public confidence and trust in health services.

Solutions to reducing ED wait times need to address the underlying causes of delay, and therefore span not only the hospital but the whole health system. In this sense, this indicator is indicative of how responsive the system is to the urgent care needs of the population.

Figure 17: Percentage of patients presenting at EDs admitted, discharged or transferred within 6 hours



Data sourced from individual DHBs.[9]

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

IMPACT – PEOPLE HAVE INCREASED ACCESS TO ELECTIVE SERVICES

ELECTIVE SERVICES PERFORMANCE INDICATOR (ESPI) MEASURE	ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
THE TIME PEOPLE WAIT FROM REFERRAL TO FIRST SPECIALIST ASSESSMENT (ESPI2)	99.9%	99.0%	99.2%	99.8%	100%
THE TIME PEOPLE WAIT FROM COMMITMENT TO TREAT UNTIL TREATMENT (ESPI5)	99.5%	99.4%	99.3%	99.5%	100%

Elective (non-urgent) services are an important part of the healthcare system; these services improve the patient's quality of life by reducing pain or discomfort and improving independence and well-being.

Timely access to services and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

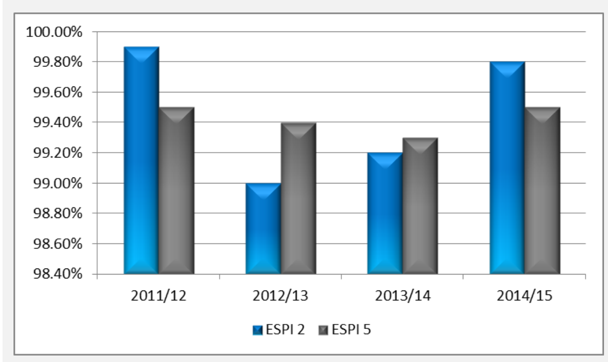
The Elective Services Patient Flow Indicators (ESPIs) are a series of six measures on meeting the required performance standard for elective surgery.

Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is indicative of how responsive the system is to the needs of the population.

Figure 18:

To December 2014: Percentage of people provided with an FSA within 5 months of referral (ESPI2) & percentage of people given a commitment to treatment and treated within 5 months of referral (ESPI5)[10]

From January 2015: Percentage of people provided with an FSA within 4 months of referral (ESPI2) & percentage of people given a commitment to treatment and treated within 4 months of referral (ESPI5)[10]



Data sourced from Ministry of Health.[10]

[10] The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. Historical data is against a six month target, while the target reduced to five months for 2013/14 and reduces to four months from January 2015.

IMPACT – PEOPLE STAY SAFE IN HOSPITAL

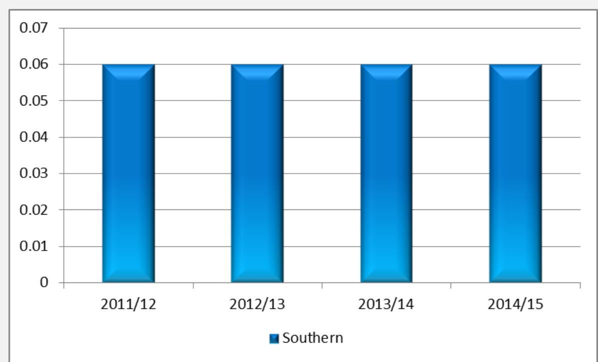
THE RATE OF SAC[11] LEVEL 1 AND 2 FALLS IN SOUTHERN DHB HOSPITALS.	ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
	0.06	0.06	0.06	0.06	0.05

Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.

The rate of falls is particularly important, as these patients are more likely to have a prolonged hospital stay, loss of confidence and independence and an increased risk of requiring institutional care.

In April 2014, Southern DHB established a multi-disciplinary and inter-sectorial Falls and Fracture Prevention Steering Group with a vision of over-65-year-olds being free of injury from falls and fractures. This steering group has led the formation of a community based fracture liaison service (FLS), which provides proactive interventions and care plans for people assessed to be at significant risk of a fracture as the result of a fall.

Figure 18: The rate of SAC1 and 2 falls in hospitals (all ages) per 1,000 inpatient bed days



Data sourced from individual DHBs.

[11] Severity Assessment Criteria (SAC) have been developed by the Health Quality and Safety Commission (HQSC) and are standardised tools to assist with the classification of incidents. SAC is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days.

Outcome Four: People Experience Optimal Functional Independence and Quality of Life

As well as providing early intervention and treatment, health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. With an ageing population, we will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease.

OUTCOME - AN INCREASE IN THE PROPORTION OF THE POPULATION OVER 75 YEARS LIVING IN THEIR OWN HOME

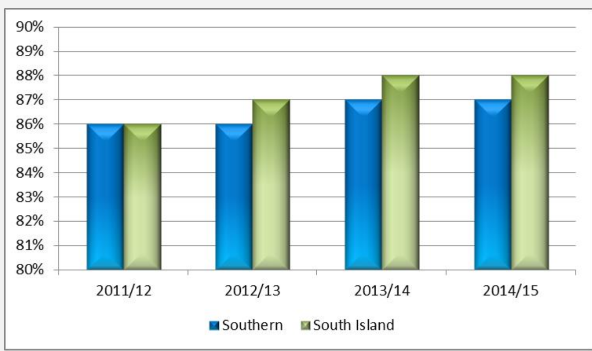
OUTCOME MEASURE: THE PERCENTAGE OF THE POPULATION (75+) LIVING IN THEIR OWN HOMES.		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15
	SOUTHERN DHB	86%	86%	87%	87%
	SOUTH ISLAND	86%	87%	88%	88%

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, evaluation of older people's services have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities. Southern has historically had a higher proportion of older people in ARC than the rest of New Zealand.

A greater number of older people with complex care requirements are now being cared for in their own homes through the new Home and Community Support Services (HCSS). This is seeing fewer people entering 'rest-home' level ARC. If ARC is required then people are more complex and usually require 'hospital' level residential care.

Living in ARC facilities can be associated with a more rapid functional decline than 'ageing in place'. An increase in the proportion of people supported in their own home can be used as a proxy measure of how well the systems are managing age-related long-term conditions and responding to the needs of our older population.

Figure 19: The percentage of the population (75+) living in their own homes



Data sourced from Client Claims Payments provided by the South Island Alliance Project Office (SIAPO).

IMPACT – FEWER PEOPLE ARE ADMITTED TO HOSPITAL AS A RESULT OF A FALL

THE PERCENTAGE OF THE POPULATION (75+) ADMITTED TO HOSPITAL AS A RESULT OF A FALL.		ACTUAL 2011/12	ACTUAL 2012/13	ACTUAL 2013/14	ACTUAL 2014/15	TARGET 2014/15
	SOUTHERN DHB	8.5%	8.6%	9.3%	8.8%	6.9%[12]
	SOUTH ISLAND	8.2%	8.1%	8.7%	8.7%	8.7%
	NEW ZEALAND	8.6%	8.7%	9.0%	8.9%	8.9%

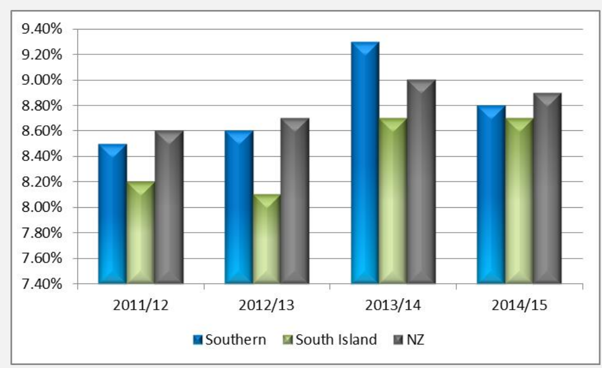
Reducing harm from falls is a key quality indicator from the Health Quality and Safety Commission (HQSC).

In April 2014, Southern DHB established a multi-disciplinary and inter-sectorial Falls and Fracture Prevention Steering Group with a vision of over-65-year-olds being free of injury from falls and fractures. This steering group has led the formation of a community based fracture liaison service (FLS), which provides proactive interventions and care plans for people assessed to be at significant risk of a fracture as the result of a fall.

A falls risk assessment and care planning are the processes fundamental to ensuring that individual patients receive the interventions and support which address their particular risks.

The DHB has increased the number of falls risk assessments to eligible people in the past year.

Figure 20: Percentage of the population (75+) admitted to hospital as a result of a fall



Data sourced from National Minimum Data Set.

[12] The 2014/15 target was set from an early query of the 2012/13 falls data from NMDS. A later query showed the 2012/13 result had increased to 8.6%, which is in line with previous results.

Health Targets

Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities. The impact they make can be measured to see how they are improving health for all New Zealanders. Three of the six health targets focus on patient access, and three targets focus on prevention. Health targets are reviewed annually to ensure they align with health priorities.

HT1 – Shorter Stays in Emergency Departments

HT2 – Improved Access to Elective Surgery

HT3 – Shorter Waits for Cancer Treatment (Q1) and Faster Cancer Treatment (Q2 - Q4)

HT4 – Increased Immunisation

HT5 - Better Help for Smokers to Quit (Hospital and Primary Care)

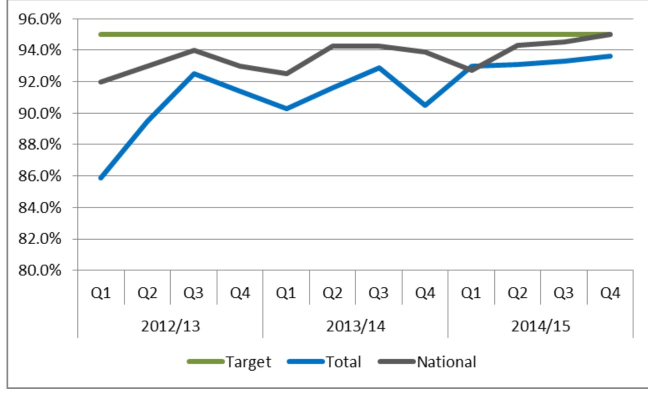
HT6 – More Heart and Diabetes Checks

SHORTER STAYS IN EMERGENCY DEPARTMENTS

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

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET	95%	95%	95%	95%
DHB	93%	93%	93%	94%
NEW ZEALAND	93%	94%	95%	95%

Figure 21: Health Target - Shorter Stays in Emergency Departments



Southern DHB has made steady and sustainable progress towards achieving ED target over the past 12 months.

What contributed to this result?

There are many variables that contribute to ED waiting times. The DHB continues to strive for an emergency and urgent care system involving primary care that is adaptable and responsive, irrespective of patient numbers, acuity or complexity.

The total number of presentations to Emergency Departments has increased in 2014/15 (see page 49).

The DHB has implemented initiatives to improve acute patient flow and the performance against this target has overall been increasing.

These initiatives include increased use of ED Observation Unit, trialling a short stay unit, and a nursing fast track service in ED.

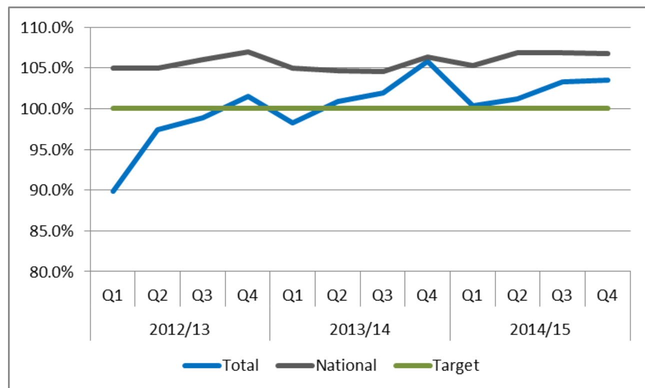
The DHB is working closely with the Primary Health Organisation (WellSouth Primary Health Network). The introduction of the 'free under 13' policy will see more children receive urgent care from general practice, and reduce the burden on ED.

IMPROVED ACCESS TO ELECTIVE SURGERY

The volume of elective surgery nationally will be increased by at least 4,000 discharges per year.

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET	100%	100%	100%	100%
DHB	100%	101%	104%	103%
NEW ZEALAND	105%	107%	107%	107%

Figure 22: The volume of elective surgery nationally will be increased by at least 4,000 discharges per year



Southern DHB has achieved the number of planned elective surgery procedures for all four quarters. A total of 11,039 elective procedures were completed which is 372 more than planned.

What contributed to this result?

The DHB continues to provide timely and improved patient access to elective services by implementing DHB-wide productivity and efficiency initiatives.

Production plans are developed, monitored, and where necessary modified, based on achieving (or working towards) performance requirements.

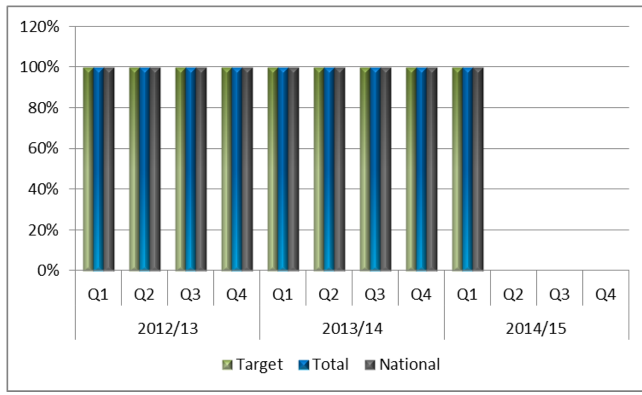
Productivity and efficiency initiatives include projects such as the Enhanced Day Surgery and Ambulatory Care (EDSAC) project and the Orthopaedic Pathway Programme (OPP).

SHORTER WAITS FOR CANCER TREATMENT

All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET	100%	100%	100%	100%
DHB	100%	100%	100%	100%
NEW ZEALAND	100%	100%	100%	100%

Figure 23: All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy



'Shorter waits for cancer treatment' was a Health Target for Quarter 1 before being removed as a Health Target. The measure is now reported as part of the DHB performance reporting.

It has been replaced by the 'Faster Cancer Treatment' measure – see below.

What contributed to this result?

The Southern Blood and Cancer Service continues to meet the target times for patients commencing radiotherapy or chemotherapy.

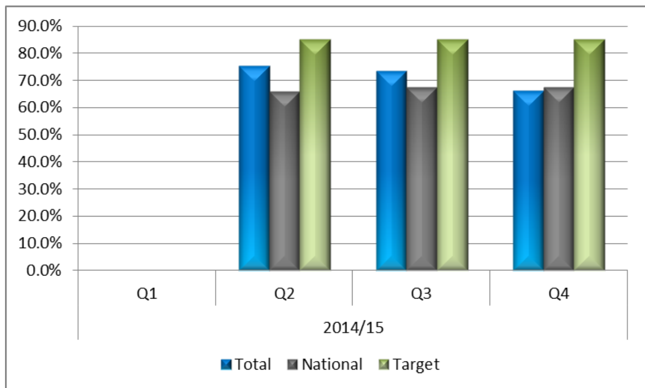
Southern DHB has consistently achieved the 100% target each quarter since the measure was changed to four weeks in January 2014.

FASTER CANCER TREATMENT

85 percent of patients 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 by July 2016, increasing to 90 per cent by June 2017.

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET		85%	85%	85%
DHB		75%	73%	66%
NEW ZEALAND		66%	67%	68%

Figure 24: Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer



The 'Faster Cancer Treatment' (FCT) measure was established as the Health Target from Quarter 2. It replaced the 'shorter wait for cancer treatment' measure – see above.

What contributed to this result?

The Faster Cancer Treatment measure was established in 2013/14. In the first year systems were developed to capture the necessary data and collect baseline data. Accurate coding and data capture is still being improved and has impacted on reported results.

The DHB has improved both the coding and data capture for Faster Cancer Treatment in 2014/15. Improved coding of patients to be counted in the denominator for this measure has seen the results reduce to 66% (based on data for January – June 2015). The number of patients receiving treatment has increased in 2014/15.

The DHB's FCT data system is a real benefit and is being modified to provide 'real time' information on the patient pathway. This will be very helpful in focusing efforts and identifying service improvement opportunities.

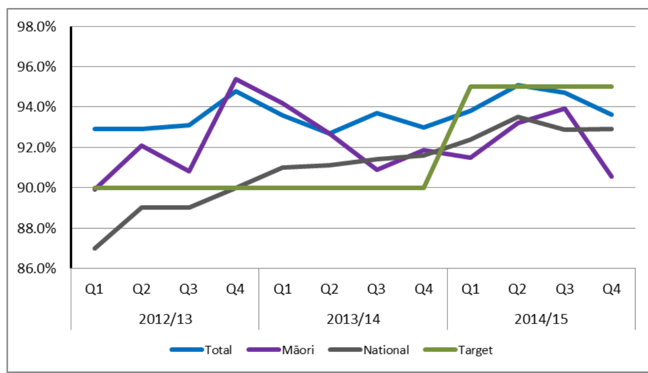
Improving the timeliness of the cancer pathway from decision-to-treat to first treatment is important and will help contribute to achievement of the 62-day FCT health target.

INCREASED IMMUNISATION

90% of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 per cent by December 2014.

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET	95%	95%	95%	95%
DHB	94%	95%	95%	94%
MĀORI	92%	93%	94%	91%
NEW ZEALAND	92%	94%	93%	93%

Figure 25: Percentage of children fully immunised at age 8 months



The DHB exceeded the 95% immunisation target in Q2 and this dropped to 93.6 % coverage by Q4.

What contributed to this result?

General practice delivers the majority of childhood immunisations.

The Immunisation Outreach Team is working to contact and immunise children not already immunised in general practice. Over 97% of children aged eight months were reached and offered vaccination.

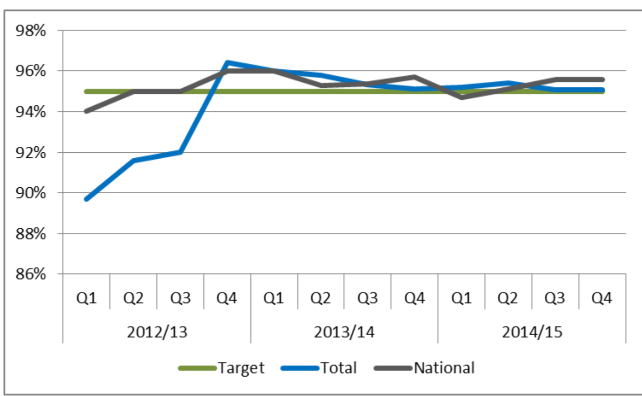
Additional work load from the 2015 Influenza Vaccination Programme has had an unintentional impact of a slight decrease in the number of children immunised, especially the 'hard to reach'. Strategies are in place to achieve and maintain their target.

BETTER HELP FOR SMOKERS TO QUIT - HOSPITAL

95% of hospitalised smokers are offered brief advice and support to quit smoking.

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET	95%	95%	95%	95%
DHB	95%	95%	95%	95%
MĀORI	93%	94%	96%	95%
NEW ZEALAND	95%	95%	96%	96%

Figure 26: Percentage of hospitalised smokers are offered brief advice and support to quit smoking



Southern DHB has maintained performance for all 4 quarters in achieving the 95% target 'hospitalised smokers are offered brief advice and support to quit smoking.'

What contributed to this result?

The DHB continues to achieve and maintain this target through strategies including; ABC[13] training to all staff during orientation. Awareness and education about smokefree support has increased within staff as well as community.

The target for Māori was achieved for Q3 and Q4.

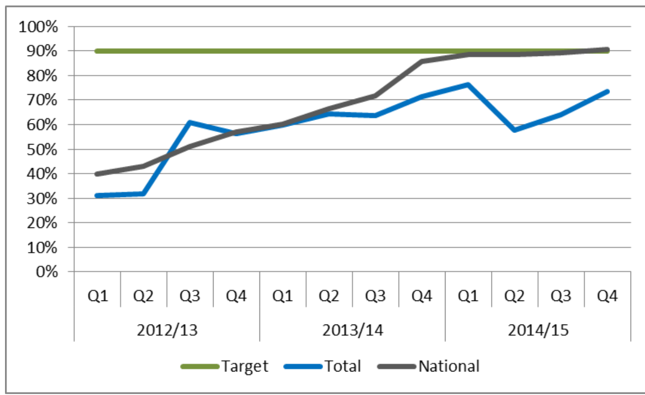
[13] ABC Smoking Cessation is a simple and easy tool that all clinicians can use to guide their action. **Ask** about and document every person's smoking status. Give **Brief** advice to stop to every person who smokes. Strongly encourage every person who smokes to use **Cessation** support.

BETTER HELP FOR SMOKERS TO QUIT – PRIMARY CARE

90% of smokers seen in primary care are offered brief advice and support to quit smoking.

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET	90%	90%	90%	90%
DHB	76%	58%	64%	74%
NEW ZEALAND	88%	89%	89%	90%

Figure 27: Percentage of smokers seen in primary care are offered brief advice and support to quit smoking



Primary care offering brief advice and support to quit smoking has increased 16% from Q2 to Q4.

There is a reported drop in performance in Q2. There are questions about the integrity of the data prior to Q1. WellSouth changed IT providers from 1 Jan 2015 and now uses DRINFO which is a well-tested, utilised and trusted IT product amongst PHOs.

What contributed to this result?

WellSouth Primary Health Network (PHN) and general practice are increasing their performance in this target area.

Data issues have now been largely resolved and all necessary systems to improve performance are in place.

A range of best practice initiatives have been implemented including training and providing up-to-date monthly data and feedback on practice performances.

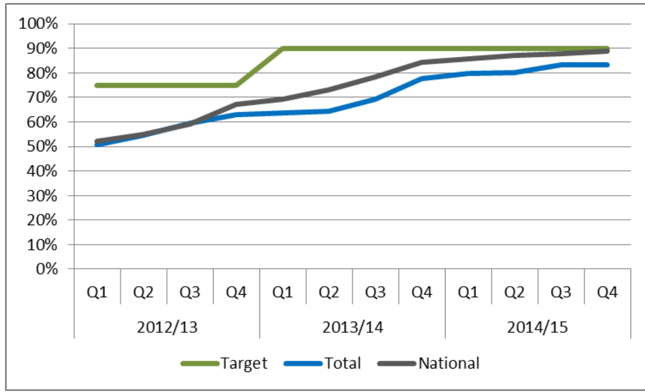
Access to Smokefree coordinators who are able to support practices with a range of resources and supporting tools is playing a positive role in improving the target performance in WellSouth PHN.

MORE HEART AND DIABETES CHECKS

90% of the eligible population have their cardiovascular risk assessed once every five years.

2014/15 RESULTS				
	Q1	Q2	Q3	Q4
TARGET	90%	90%	90%	90%
DHB	80%	80%	83%	83%
MĀORI	72%	72%	76%	76%
NEW ZEALAND	86%	87%	88%	89%

Figure 28: Percentage of the eligible population have their cardiovascular risk assessed once every five years



Progress on meeting the 90% target for CVD risk assessments has not met expectations.

What contributed to this result?

Achievement towards achieving the 90% target by June 2015 has been steady but not at the pace anticipated.

WellSouth PHN has increased both the investment and focused activity to achieve the target. WellSouth PHN provides the following products to practices to support the target; DRINFO, Patients Dashboard, texting services as well as funding the risk assessments.

This has been enabled by WellSouth using a new IT provider from 1 Jan 2015. Practices have greater real-time visibility on activity and progress down to patient level, and can plan and respond more effectively.

WellSouth PHN also provides staff to support practices in identifying and contacting eligible people.

Output Class Measures

Prevention services

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

Immunisation Services

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

Output Measures		Results 2012/13	Results 2013/14	Results 2014/15	Target 2014/15	Comments
Percentage of children fully immunised at age 8 months.	Total	95%	93%	**94%**	95%	1
	Māori	95%	92%	**91%**	95%	
Percentage of children fully immunised at age 2 years.	Total	95%	94%	**95%**	95%	2
	Māori	95%	95%	**93%**	95%	
Percentage of children (aged 8 months) 'reached' by immunisation services.	Total	98%	97%	**97%**	99%	3
Percentage of children (aged 2) 'reached' by immunisation services.	Total	98%	99%	**98%**	99%	3
Percentage of eligible young women (12-18 years) engaged (receiving first dose) in the HPV vaccination programme.	Total	68%	66%	**68%**	70%	4
	Māori	71%	74%	**72%**	70%	
Percentage of people aged over 65 having received a flu vaccination.	Total	69%	68%	**65%**	75%	5
	Māori	69%	71%	**61.4%**	75%	

Figure 29: Percentage of children fully immunised at age 8 months

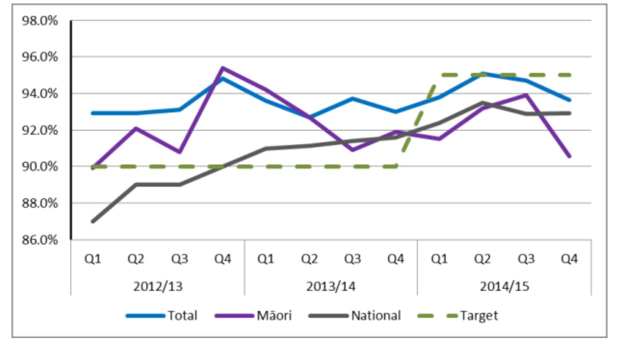
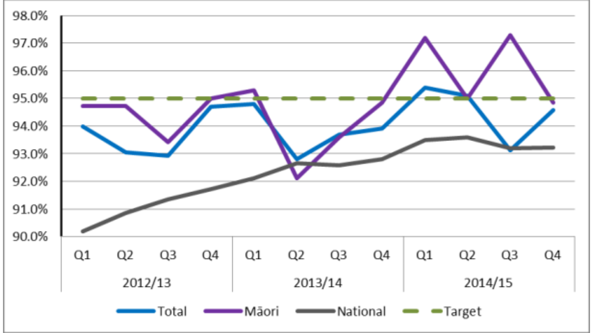


Figure 30: Percentage of children fully immunised at age 2 years



1. Refer to the Health Target 'Increased Immunisation' on page 34 - see Figure 29.

2. High rates of immunisation for two year olds continue to be maintained. The 95% target was achieved for Q4 for the total population; the rates for Māori were just below the target at 93% - see Figure 30.

3. A high number of children continue to be 'reached" which means they have been offered the vaccination by a suitable qualified health professional. There is a cohort of parents that continue to decline vaccinations for their children. At eight months, 2.7% have declined, and this increases to 3.9% at two years.

Immunisation Services	
4.	Data presented is for the 2014 calendar year. The vaccination for human papillomavirus (HPV) is three doses over a six-month period and is offered to girls at year 8 over the school year. WellSouth and Public Health South work in partnership to deliver the three-dose HPV vaccinations to year-8 girls. Immunisation against HPV prevents the spread of HPV in the population and reduces the risk of cervical cancers.
5.	People over the age of 65 are recommended to have a free influenza vaccination as they have a higher risk of complications from the flu virus as their immune systems are comparatively weaker. This improves well-being and reduces potentially avoidable hospitalisations.

Health Promotion and Education Services

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

Output Measures		Results			Target 2014/15	Comments
		2012/13	2013/14	2014/15		
Smokers receive advice and support to quit smoking in hospital.	Total	96%	95%	**95%**	95%	6
	Māori	96%	95%	**95%**		
Smokers receive advice and support to quit smoking in primary care.	Total	56%	71%	**74%**	90%	7
	Māori	59%	74%	**77%**		
Percentage of pregnant smokers being offered advice and support to help quit smoking.	Total	-	96%	**94%**	90%	
	Māori	-	100%	**90%**		
Infants fully and exclusively breastfeed at 6 weeks.	Total	65%	68%	**70%**	74%	8, 9
	Māori	56%	63%	**65%**		
Infants fully, exclusively or partially breastfeed at 6 months.	Total	-	-	**61%**	30%	9
	Māori	-	-	**51%**		

Figure 31: Smokers receive advice and support to quit

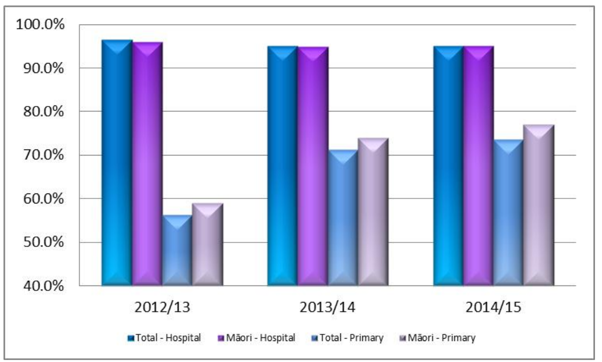
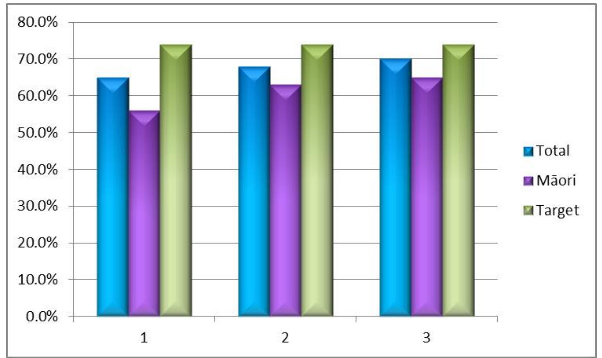


Figure 32: Infants fully and exclusively breastfeed at 6 weeks



6.	Refer to the Health Target 'Better Help for Smokers to Quit - Hospital' on page 35.
7.	Refer to the Health Target 'Better Help for Smokers to Quit – Primary Care' on page 36.
8.	Breast feeding rates continue to rise towards the aspirational targets set – see Figure 32. Breast feeding is promoted by lead maternity providers (LMCs), Plunket and Well Child Tamariki Ora (WCTO) providers, and general practice. The Ministry of Health currently collects data from Plunket and is working to gather the data from WCTO providers to show a more comprehensive picture.
9.	The definition for the breastfeeding measure at six months has been changed since the target was set. It now includes partially breastfed babies in addition to fully and exclusively. Therefore no comparable data is available for prior periods.

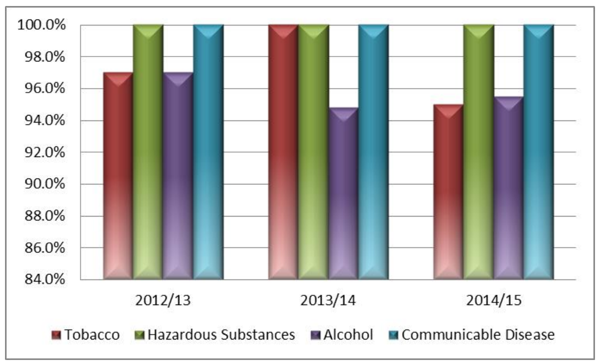
Statutory Regulation

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.

Output Measures	Results			Target	Comments
	2012/13	2013/14	2014/15	2014/15	
Tobacco retailers are compliant with current legislation.	97%	100%	**95%**	85%	10
Alcohol retailers are compliant with current legislation.	97%	95%	**96%**	95%	10
The proportion of communicable disease notifications investigated.	100%	100%	**100%**	100%	11
The proportion of hazardous substances inspections and audits completed.	100%	100%	**100%**	100%	12

Figure 33: Public Health Unit statutory activity



10. Public Health South continues to exceed the targets for retailers being compliant with both tobacco and alcohol legislation – see Figure 33.

Retailers selling tobacco and alcohol must comply with all legal requirements including selling to only people who meet the age restrictions. The Public Health Unit provides education and awareness to retailers about the legal restrictions and requirements. Compliance monitoring by the Public Health Unit demonstrates very good retailer awareness and compliance which has consistently exceeded the Ministry of Health requirements.

11. The Medical Officers of Health and the Public Health Unit fulfilled the statutory requirement to investigate all (100%) of communicable disease notifications within the required timeframe.

12. The Public Health Unit fulfilled the statutory requirement to complete all (100%) of hazardous substances inspections and audits within the required timeframe.

Population Based Screening

POPULATION BASED SCREENING

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

Output Measures		Results 2012/13	Results 2013/14	Results 2014/15	Target 2014/15	Comments
The proportion of the eligible population (50-69 years) receiving breast screen examinations.	Total	74%	81%	**78%**	70%	13
	Māori	61%	70%	**71%**		
Women are re-screened between 20 and 24 months from their previous breast screen examination.	Total	69%	37%	**31%**	75%	14
The proportion of the eligible population (25-69 years) receiving cervical cancer screens.	Total	79%	79%	**79%**	80%	15
	Māori	60%	62%	**59%**		
The percentage of eligible children receiving Before School Checks (B4SC).	Total	91%	99%	**100%**	90%	16
	Quintile 5	92%	97%	**100%**		

Figure 34: The proportion of the eligible population receiving breast screen examinations and cervical cancer screens

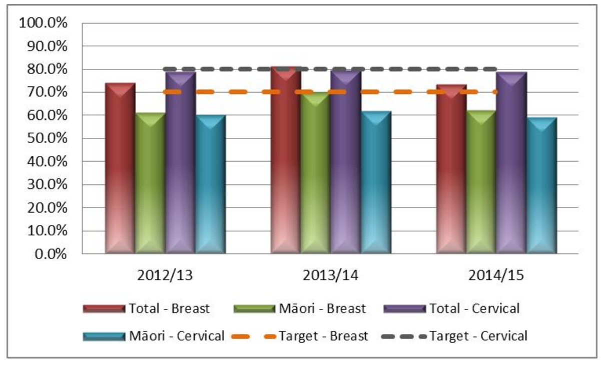
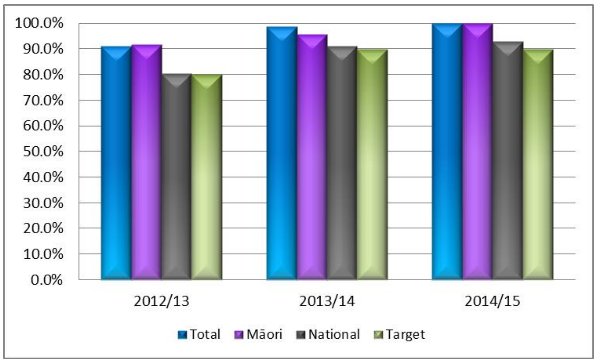


Figure 35: The percentage of eligible children receiving Before School Checks (B4SC)



13. Breast screening rates for both Māori and the total population continue to exceed the national target of 70%.

14. BreastScreen Otago Southland (part of BreastScreen Aotearoa) commenced the provision of breast screening services from August 2014. Data for the re-screen rate was not available at the time this report was prepared.

15. Cervical cancer screening rates have remained consistent over the past few years. The total eligible population rate is fractionally below the target; rates for Māori remain well below both the target and total population.

Cervical screening is one of the foundation measures for the Integrated Performance and Incentive Programme (IPIF). IPIF provides financial incentives for primary care to achieve the targets for both total eligible population and Māori.

16. 100% of eligible children received B4 School Check. The percentage of children receiving their B4 School Check continues to exceed the Ministry targets. The B4 School Check is a free health and development check for all four-year-olds, and is undertaken by DHB public health nurses.

Early detection and management

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

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

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

PRIMARY HEALTH CARE SERVICES

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

OUTPUT MEASURES		RESULTS 2012/13	RESULTS 2013/14	RESULTS 2014/15	TARGET 2014/15	COMMENTS
The percentage of the DHB population enrolled in a Primary Healthcare Organisation.	Total	93%	93%	**93.4%**	95%	17
	Māori	76%	83%	**85.8%**		
The number of skin lesions removed in primary care (by a GP with special interest – GPSI) without the need for a hospital appointment.		830	1269	**1133**	1200	18
Ambulatory Sensitive Hospital (ASH) admission rates for children aged 0-4 years are reduced.	Total	116%	117%	**108%**	108%	19
	Māori	208%	183%	**147%**		
Ambulatory Sensitive Hospital (ASH) admission rates for population aged 0-74 years are reduced.	Total	87%	87%	**80%**	95%	19
	Māori	165%	148%	**124%**		
The number of people receiving a brief intervention from the primary mental health service.		3,923	4,356	**4,384**	4,000	19

Figure 36: The percentage of the DHB population enrolled in a Primary Healthcare Organisation

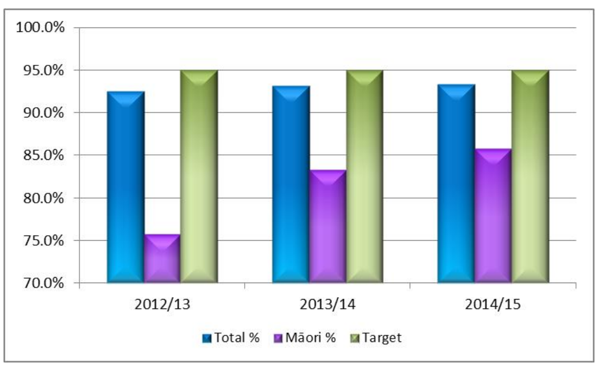
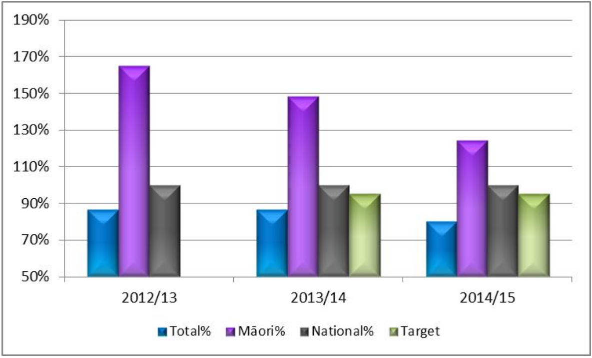


Figure 37: Ambulatory Sensitive Hospital (ASH) admission rates for the population aged 0-74 years are maintained



17. The number of people enrolled in the PHO continues to increase towards the 95% target with a notable increase in the number of people identifying as Māori.

	Primary Health Care Services
	The University of Otago Student Health Services are not part of WellSouth, and as a result, significant cohorts of the population who are engaged with primary care are not enrolled in a PHO.
18.	The number of skin lesions removed in primary care (by a GP with special interest – GPSI) continues to increase. Fewer procedures are now being done in the hospital, freeing up capacity for more complex procedures. Demand for removal of skin lesions continues to increase putting pressure on the GPSI service.
19.	The rates for Ambulatory Sensitive Hospital (ASH) admissions (avoidable hospitalisations) continue to decline which is a reflection of the initiatives put in place to improve the management of long-term conditions, and access to urgent primary care. The DHB and WellSouth have been working on improving access for children with more practices offering 'free under sixes' care for regular consultations and after hours.

Oral Health

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

Output Measures		Results			Target 2014/15	Comments
		2012/13	2013/14	2014/15		
The number of eligible preschool children enrolled in school and community oral health services.	Total	16,007	17,691	**15,486**	16,632	20
	Māori	1,952	2,420	**2,174**	3,147	
The percentage of eligible preschool children enrolled in school and community oral health services.	Total	84%	89%	**82%**	86%	20
	Māori	54%	78%	**61%**		
The number of eligible children from year 1 to year 8 enrolled in school and community oral health services.	Total	26,260	28,090	**27,971**	27,000	21
	Māori	2,994	4,300	**3,629**	5,108	
The percentage of eligible adolescents who access funded oral health services.		85%	83%	**82%**	85%	22
The percentage of children caries-free at five years of age.	Total	66%	64%	**64%**	70%	23
	Māori	51%	45%	**52%**		

Figure 38: Access for preschool children & adolescents oral health services

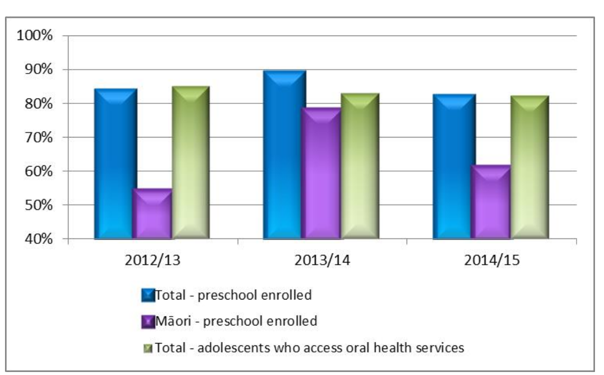
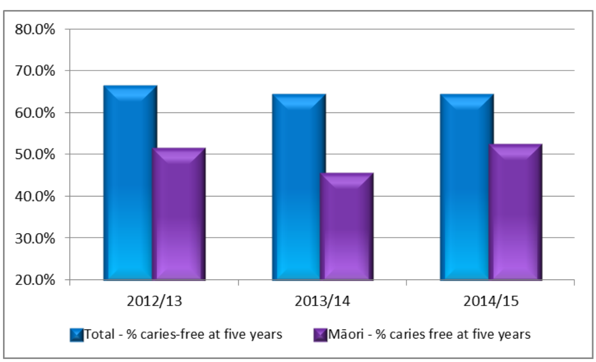


Figure 39: The percentage of children caries-free at five years of age



20. The number of preschool children enrolled in the community oral health service has decreased over the year. System and workforce issues have impacted on the number of new children being enrolled. There has also been a decrease in the number of Māori children enrolled and work is being done to address this over the coming year.

The Oral Health team are actively engaging with Well Child services to identify children. They are working with preschools and non-government organisations (NGO) to promote enrolment with child oral health services and deliver oral health information to parents with children aged 0-4 years.

The DHB is working with WellSouth to investigate the feasibility to have a more streamlined process for enrolling newborns into the PHO, general practice, Well Child Tamariki Ora, and oral health services.

21. The number of enrolled primary school children (year 1 to year 8) decreased slightly to 27,971 in line with the forecast population numbers in this age group. The percentage of Māori primary school children enrolled has decreased a little over the last year.

22. The majority of adolescents access funded oral health services through visiting a dentist in the community. Some adolescents visit the community oral health service if they are unable to access a dentist.

23. The oral health status of children at five years of age has remained constant, and below the national target of 70%. DMFT (decayed, missing, or filled teeth) rates for Māori children remain well below, but have shown an improvement from the previous year.

Long-term Conditions Management

Long-term Conditions Management

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

Output Measures		Results			Target	Comments
		2012/13	2013/14	2014/15	2014/15	
The proportion of the eligible population (45-79) having a CVD risk assessment in the last five years.	Total	63%	78%	**83%**	90%	24
	Māori	56%	64%	**76%**		
Percentage of patients with good or acceptable glycaemic control.	Total	78.6%	55.4%	**53.3%**	78.6%	25
	Māori	-	51.1%	**47.4%**		
Percentage of potentially eligible stroke patients thrombolysed.		-	6.7%	**6.0%**	6%	26
Percentage of high-risk patients receiving an angiogram within three days of admission.	Total	-	77.2%	**82.4%**	70%	27

Figure 40: The proportion of the eligible population (45-79) having a CVD risk assessment in the last five years

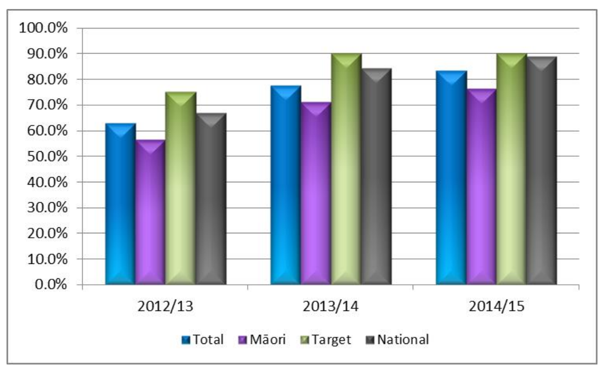
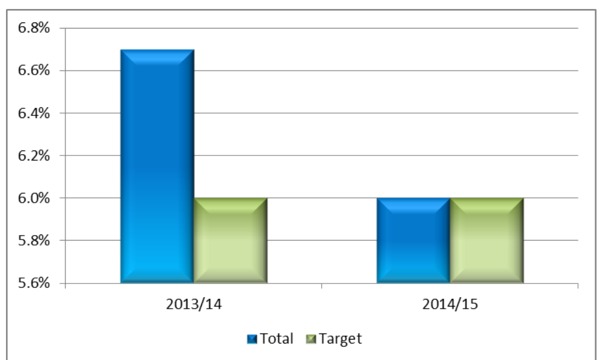


Figure 41: Percentage of potentially eligible stroke patients thrombolysed



24. Refer to the Health Target 'More Heart and Diabetes Checks' on page 37.

25. The definition for this measure was refined for 2013/14 and cannot be accurately compared with previous years. The target is therefore no longer directly comparable to the result.

The numerator is unchanged but the denominator has changed from the people tested to the enrolled population on the Virtual Diabetes Register (VDR). This is a more accurate reflection of the whole population and includes the patients who have not engaged with their GP.

The percentage of well managed diabetics is linked to the Diabetes Care Improvement Package (DCIP) undertaken by general practice.

26. Commencement of appropriate thrombolysis is time critical. Rapid triage and transport to hospital is crucial for people with suspected stroke. The rate of thrombolysis is an indication of responsiveness to people with suspected stroke.

Stroke thrombolysis is currently offered in Dunedin, Invercargill, Oamaru and Dunstan Hospital. Dunedin Hospital provides a backup service for areas where the local provider cannot offer the thrombolysis service 24/7. These services meet the national target.

27. Coronary angiograms are used in higher risk patients with suspected acute coronary syndrome (ACS) and help determine the best course of treatment. Some lower risk patients can be treated without an angiogram.

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. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. To improve performance, we will target improved primary care access to diagnostics to improve clinical referral processes and decision-making.

Output Measures		Results			Target 2014/15	Comments
		2012/13	2013/14	2014/15		
Percentage of accepted referrals for coronary angiography receiving procedure within 90 days.	Total	-	99%	**100%**	90%	28
Percentage of patients, ready for treatment, waiting less than four weeks for radiotherapy or chemotherapy.		100%	100%	**100%**	100%	29
Percentage of patients referred with a high suspicion of cancer waiting 62 days or less to receive their first treatment (or other management).		-	-	**66%**	85%	30
The percentage of accepted referrals for CT scans receiving procedure within 42 days.		63%	79%	**66%**	90%	31
The percentage of accepted referrals for MRI scans receiving procedure within 42 days.		52%	52%	**45%**	80%	31

Figure 42: Percentage of patients, ready for treatment, waiting less than four weeks for radiotherapy or chemotherapy

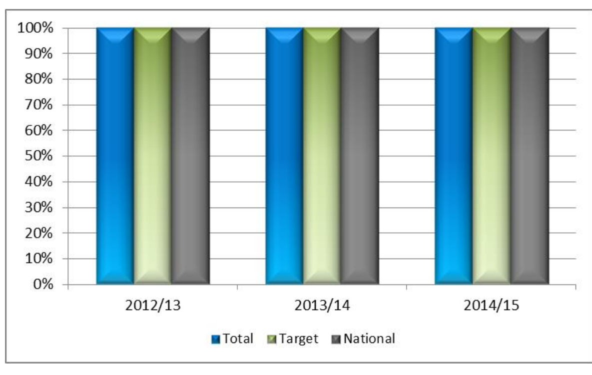
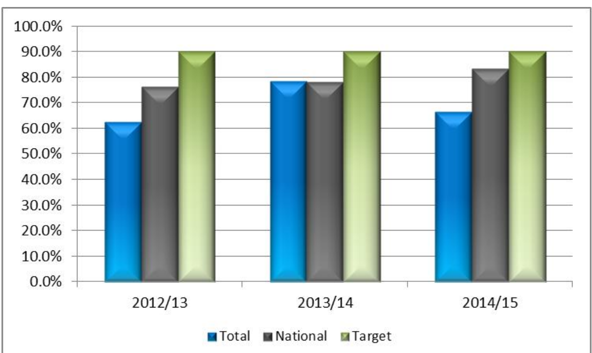


Figure 43: The percentage of accepted referrals for CT scans receiving procedure within 42 days



28.	All referrals for coronary angiography were completed within the 90 day target.
29.	Refer to the Health Target 'Shorter Waits for Cancer Treatment' on page 32. This measure ceased as the health target after quarter 1.
30.	Quarter 4 result. Refer to the Health Target 'Faster Cancer Treatment' on page 33. This measure was established as the health target from quarter 2.
31.	Referrals for CT and MRI continued to increase at a rate greater than capacity – see Figure 43. Work is being undertaken to increase efficiency and throughput.

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.

The 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. This includes elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or pre-admission assessments).

OUTPUT MEASURES	RESULTS			TARGET	COMMENTS
	2012/13	2013/14	2014/15	2014/15	
The number of medical and surgical First Specialist Appointments (FSA).	34,565	37,618	**38,443**	35,964	32
Theatre utilisation - proportion of resourced theatre minutes used to total resourced theatre minutes.	86%	85%	**81%**	88%	33
The number of elective surgical services discharges (incl. dental and cardiology).	11,750	12,390	**12,415**	11,816	34
The number of elective surgical services discharges (excl. dental and cardiology).	10,270	10,948	**11,039**	10,667	34
The number of elective surgical services caseweights (CWDs) delivered.	14,948	15,646	**15,331**	15,284	34
The proportion of people receiving elective or arranged surgery on the day of admission.	90%	90%	**92%**	95%	35
Average elective and arranged inpatient length of stay (days) is maintained.	3.79	3.03	**2.98**	3.14	36
Outpatient 'Did Not Attend' (DNA) rates are reduced.	8.2%	5.7%	**7.3%**	7.95%	37

ELECTIVE SERVICES – INPATIENT AND OUTPATIENT

Elective Services – Inpatient and Outpatient

Figure 44: Average elective and arranged inpatient length of stay (days) is maintained

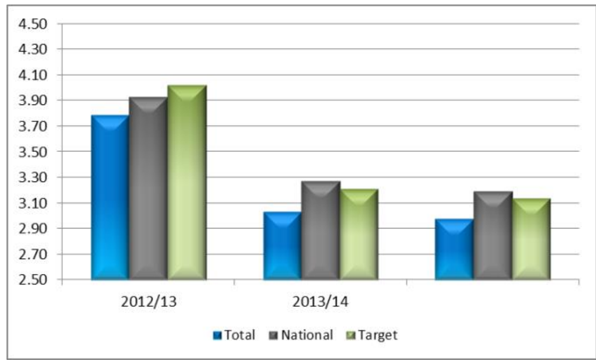
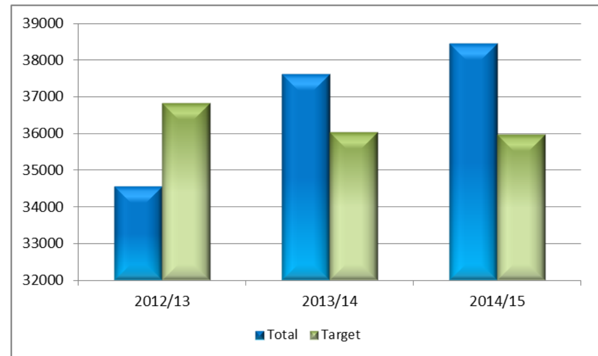


Figure 45: The number of medical and surgical First Specialist Appointments (FSA)



32. Referrals to hospital-based specialist services, and hence the number of First Specialist Appointments (FSA) continues to increase each year – see Figure 45. This is aligned to increased elective surgery and the ever increasing demand for hospital-based specialist services.

    In the future we will potentially see fewer hospital-based specialist appointments with the adoption of different ways of working. This could include more specialised services undertaken by a GP with special interest (GPSI), better access to diagnostics or specialist advice.

33. The reported 4% decrease in theatre efficiency is due to a number of drivers, and the way in which data is captured. For example, utilisation of the theatres in un-resourced theatre time or variation in theatre list running over their allocated resourced theatre time has an impact on the measure.

34. Surgical activity has increased in line with the increased number of elective surgical procedures the DHB is required to perform. The slight reduction in caseweights would indicate that the overall mix of procedures was marginally less complex.

35. The increase in the number of people receiving elective or arranged surgery on the day of admission is good for patient convenience and outcomes.

36. The average elective and arranged inpatient length of stay continues to be below both the target and performance of other DHBs - see Figure 44.

37. 'Did not attend' (DNA) rates are below the projected (target) number for 2014/15. Continuing to reduce DNA rates is an opportunity to make services better, with more patient-focused appointments, and improved scheduling for more timely services.

Acute Services

Acute Services

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

Output Measures		Results			Target 2014/15	Comments
		2012/13	2013/14	2014/15		
People are assessed, treated or discharged from the emergency department (ED) in under six hours.		91.4%	90.5%	**93.6**	95%	38
Number of people presenting at ED.		80,275	76,618	**77,811**	83,300	39
The acute readmission rate to hospital.	Total	6.75%	7.35%	**7.5%**	<7.5%	40
	75 years +	9.42%	9.76%	**10.00%**	<9.9%	

Acute Services					
The acute inpatient average length of stay in hospital (days).	4.00	3.76	**3.64**	3.88	41

Figure 46: Number of people presenting at ED

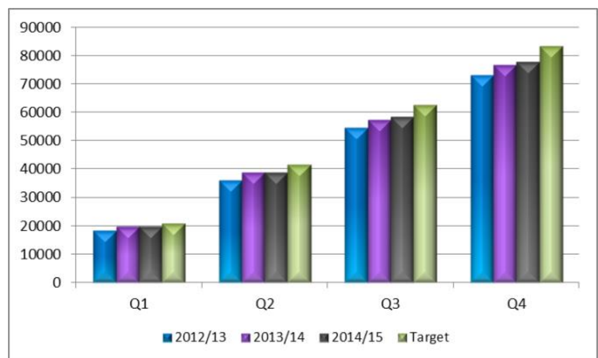
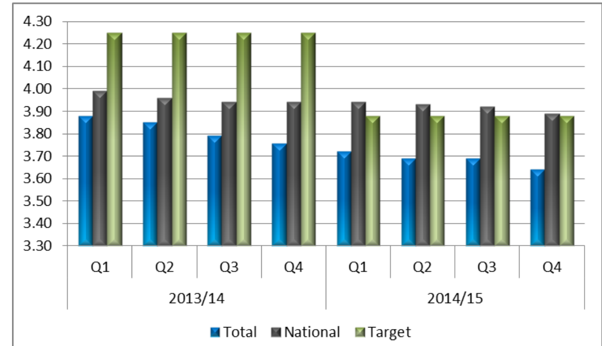


Figure 47: Acute inpatient average length of stay in hospital



38. Refer to the Health Target 'Shorter Stays in Emergency Departments' on page 30.

39. The total number of people attending the DHB hospital emergency departments (ED) has increased slightly in 2014/15. This is less than the target of 83,300 and demonstrates that some of the initiatives to control the number of people attending ED have had an impact.

Total numbers presenting to ED still present a challenge. The Urgent Care service level alliance is developing a model of care for the district that will inform future services to better manage the response to urgent care across the whole system from primary care to emergency care.

40. The acute readmission rate to hospital is one of a number of indicators that show system performance. Southern has consistently achieved one of the lowest acute readmission rates in New Zealand. There has been a slight increase for the 2014/15 period which is reflected in an increase in acute readmission in the 75+ age group.

41. The acute inpatient average length of stay has decreased from 2012/13 and is below target at 3.64 days.

SPECIALIST MENTAL HEALTH SERVICES

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.

OUTPUT MEASURES			RESULTS 2012/13	RESULTS 2013/14	RESULTS 2014/15	TARGET 2014/15	COMMENTS
Improving the health status of people (aged 0-19 years) with severe mental illness through improved access.		Total	3.49%	4.02%	**3.84%**	3.31%	42
		Māori	3.73%	4.10%	**3.76%**		
Improving the health status of people (aged 20-64 years) with severe mental illness through improved access.		Total	3.61%	4.04%	**3.68%**	3.63%	42
		Māori	7.26%	7.66%	**6.50%**	5.52%	
The percentage of children and young people who have a current relapse prevention plan.		Total			**37%**	95%	43
The percentage of people (age 0-19 years) referred for non-urgent Provider Arm mental health services are seen in a timely manner.	3 weeks	Total	75%	72%	**79%**	80%	44
		Māori					
	8 weeks	Total	95%	93%	**95%**	95%	44
		Māori					
The percentage of people (age 0-19 years) referred for non-urgent addiction services (Provider Arm and NGO[14]) are seen in a timely manner.	3 weeks	Total	-	74%	**81%**	80%	44
		Māori	-				
	8 weeks	Total	-	84%	**96%**	95%	44
		Māori	-				

Figure 48: The percentage of people (age 0-19 years) referred for non-urgent Provider Arm mental health services are seen in a timely manner

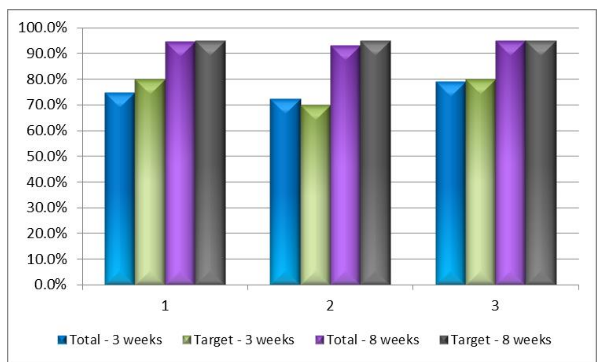
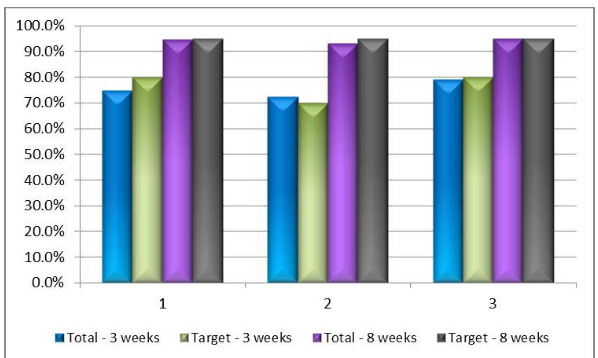


Figure 49: The percentage of people (age 0-19 years) referred for non-urgent addiction services (Provider Arm and NGO) are seen in a timely manner



42. Access to specialist mental health services has been maintained at or above the target levels.

43. New definition for this measure was put in place for the 2014/15 year. Specific work around Transition Planning commenced from July 2014 and there are no data comparisons to previous years as this is a new measure. Reported result is based on the quarter 4 results.

44. The percentage of people (age 0-19 years) seen by both DHB and NGO providers for both non-urgent mental health and addiction services shows continued improvement.

[14] Non-government organisation (NGO)

MATERNITY SERVICES

MATERNITY SERVICES

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

OUTPUT MEASURES		RESULTS			TARGET 2014/15	COMMENTS
		2012/13	2013/14	2014/15		
The number of births in the DHB region.	Total	3,503	3,384	**3,277**	<3,508	45
	Māori	515	542	**548**	>515	
New mothers have established breastfeeding on discharge from hospital.	Total	83%	82%	**81%**	85%	46, 48
Baby friendly hospital accreditation is maintained.		100%	100%	**100%**	100%	47, 48

Figure 50: The number of births in the DHB region

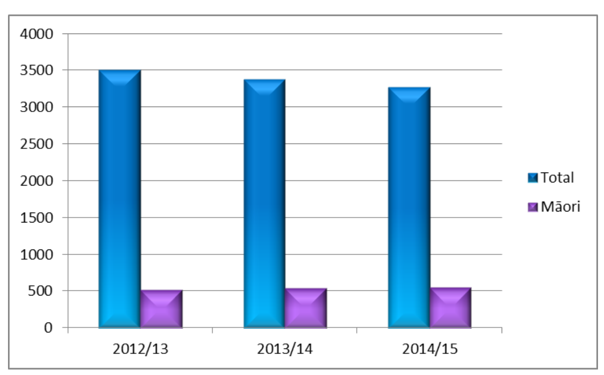
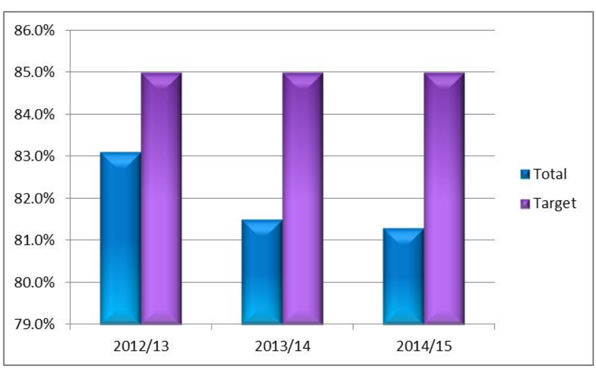


Figure 51: Established breastfeeding on discharge from hospital



45. Statistics New Zealand forecasted fewer total births for Southern for 2014/15, but an increased number of births for Māori. The total number of births has reduced slightly as forecast, and the number of births for Māori increased.

46. Breastfeeding from birth continues to be encouraged for mothers. Establishing breastfeeding in hospital or maternity facility increases the likelihood of babies being exclusively breastfed for the first six months.

47. All Maternity facilities in Southern continue to attain Baby Friendly Hospital accreditation.

    The Baby Friendly Hospital Initiative is a global campaign of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Maternity facilities attain accreditation by implementing policies and procedures to support the goal to increase breastfeeding initiation and duration rates by protecting, promoting and supporting breastfeeding.

48. The Maternity Quality Framework sets out the standards for the delivery of maternity services.

ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)

ASSESSMENT, TREATMENT AND REHABILITATION SERVICES

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

OUTPUT MEASURES	RESULTS			TARGET 2014/15	COMMENTS
	2012/13	2013/14	2014/15		
Average length of stay (days) for inpatient AT&R services (65 years and over).	18.7	18.2	**18.6**	18.5	49
Average length of stay (days) for inpatient AT&R services (under 65 years).	28.3	28.3	**25.4**	28.3	49
AT&R patients have improved functionality on discharge (65 years and over).	16.9	17.1	**17.4**	16.9	50, 52
AT&R patients have improved functionality on discharge (under 65 years).	24.2	24.2	**21.4**	24.2	51, 52

Figure 52: Average length of stay (days) for inpatient AT&R services 65 years and over & under 65 years

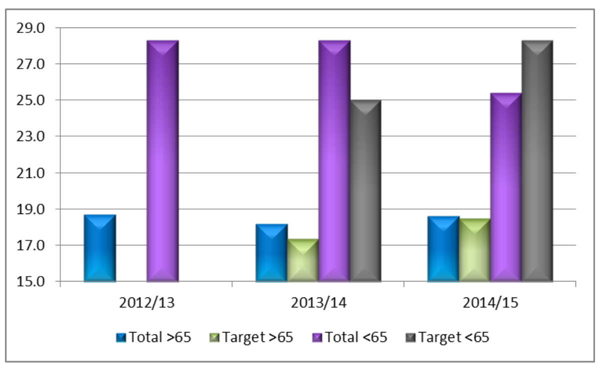
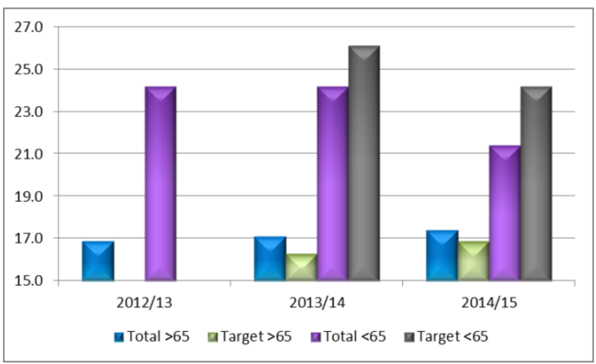


Figure 53: AT&R patients have improved functionality on discharge 65 years and over & under 65 years



49. There was an improvement in the average length of stay (ALOS) for inpatient AT&R services for patients under 65 years and the target was achieved. AT&R services for patients 65 years and over performed similar to previous years in terms of ALOS – see Figure 52.

50. The Functional Independence Measure (FIM™) scores for patients 65 years and over is similar to previous years. FIM™ scores provide a uniform system of measurement for disability based on the International Classification of Impairment, Disabilities and Handicaps; measures the level of a patient's disability and indicates how much assistance is required for the individual to carry out activities of daily living.

51. For patients under 65 years there was a decrease in the FIM™ scores. The small number of patients can influence the overall score and is not necessarily representative of the outcomes.

52. AT&R functionality is measured by the FIM™ instrument, which is a basic indicator of 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 of rehabilitation episodes – see Figure 53.

Rehabilitation and support

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

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

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

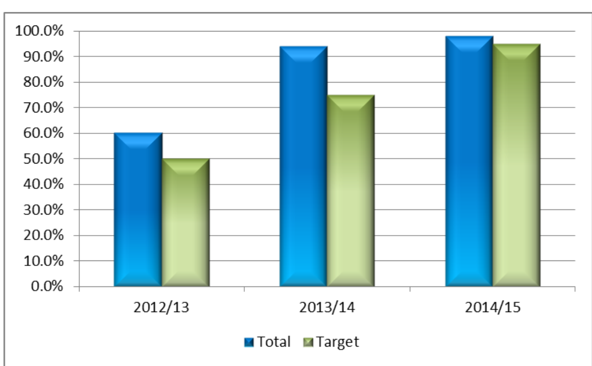
Needs Assessment and Services Coordination Services

NASC

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

Output Measures	Results			Target 2014/15	Comments
	2012/13	2013/14	2014/15		
Total number annual comprehensive clinical assessments (interRAI) provided for clients aged over 65 years	2,429	4069	**3,117**	4,000	53
Percentage of people 65 years and over receiving long-term HCSS who had had a comprehensive clinical assessment and an individual care plan.	60%	94%	**98%**	95%	54

Figure 54: Percentage of people 65 years and over receiving long-term HCSS who had had a comprehensive clinical assessment and an individual care plan



53. A regular clinical assessment of need using InterRAI is a cornerstone of the restorative based home and community support service (HCSS). InterRAI is a tool that provides a comprehensive clinical assessment of medical, rehabilitation and support needs and abilities such as mobility and self-care. InterRAI was introduced in 2012/13 and required all existing as well as new clients to be assessed. This has now been completed. Figure 54 shows the progress since the implementation of InterRAI.

Non-complex clients are assessed by the HCSS providers, and complex clients are assessed by the DHB and Rural Hospital Clinical Needs Assessors.

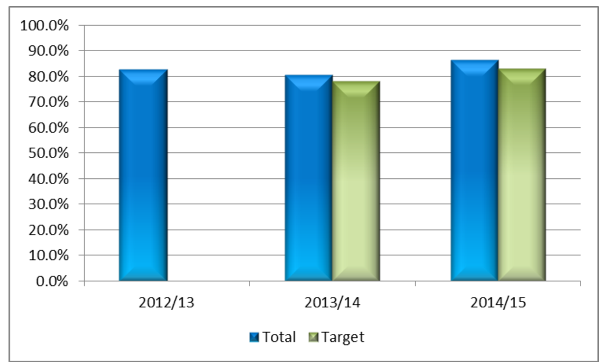
54. The process for clinical assessment of need is now well embedded and the national goal of 95% is being consistently attained – see Figure 54.

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.

Output Measures	Results			Target 2014/15	Comments
	2012/13	2013/14	2014/15		
The ratio of number of days of respite care allocated to number of days used.	82.8%	80.4%	**86.4%**	83%	55
The total number of eligible clients accessing Dementia Day Activity Programmes.	0	15	**27**	16	56

Figure 55: The ratio of number of days of respite care allocated to number of days used



55. Respite care is being allocated on an 'as required' basis. This allows for a more responsive respite care service and better management and utilisation of respite care beds.

56. The Dementia Day Activity Programme was introduced in 2013/14 and provides respite to the primary carer and therapeutic service to the client. A total of 27 individual clients received dementia day activity services in 2014/15 which exceeded the number expected to utilise the service.

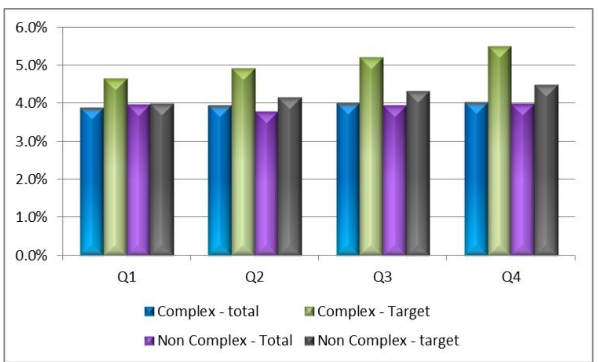
Home and Community Support Services

Home and Community Support Services

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

Output Measures	Results			Target	Comments
	2012/13	2013/14	2014/15	2014/15	
Number of eligible complex clients receiving home and community support services (HCSS) per head of population aged over 65 years.		4.4%	**4.0%**	5.5%	57
Number of eligible non-complex clients receiving HCSS per head of population aged over 65 years.		3.8%	**4.0%**	4.5%	58
Percentage of HCSS clients aged over 65 years with goals-based care plans.		90.9%	**99.7%**	60%	59
Percentage of HCSS support workers who have completed minimum training requirements.		46.3%	**78.4%**	80%	60
Percentage of health of older people (HOP) clients receiving HCSS who are complex.		44.6%	**49.5%**	55%	61

Figure 56: Number of eligible complex & non-complex clients receiving HCSS per head of population aged over 65 years



57. Home and Community Support Services are tailored (based on client goals) to meet the needs identified by the interRAI comprehensive clinical assessment. The restorative model of care has now been implemented. More clients (98%) have now been interRAI assessed. This has increased significantly since 2013/14.

58. Home and Community Support Services are tailored (based on client goals) to meet the needs identified by the interRAI comprehensive clinical assessment. The restorative model of care has now been implemented which aims to keep people in their own homes if possible.

59. Nearly all (99.7%) of clients have goals-based care plans. Goals-based care plans informed by interRAI assessments are an integral part of the restorative model of HCSS.

60. The number of support workers with formal qualifications has increased significantly over the past two years. 78.4% of support workers have completed training to level 2 or above. A more skilled workforce is a cornerstone of the new restorative-based home and community support service. A better trained workforce leads to better quality care.

61. The percentage of HCSS clients who are complex has increased since 2013/14 to 49.5%. This demonstrates that a larger number of older people are 'ageing in place' and living independently in their own homes. The service is benefiting those with the greatest need.

Palliative Care Services

PALLIATIVE CARE SERVICES

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

Output Measures	Results			Target 2014/15	Comments
	2012/13	2013/14	2014/15		
People in hospice services are assessed and being supported by the Liverpool Care Pathway.	73%	69%	**N/A**	90%	62
ARC hospital level facilities are trained to provide the Liverpool Care Pathway.	70%	68%	**N/A**	90%	62

62. The Liverpool Care Pathway is no longer being supported or measured.

The 'Last days of life' national working group has developed new guidelines that will be implemented in 2015/16. The new guidelines are client focussed and will support patients and their families/ whanau.

Rehabilitation Services

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.

Output Measures	Results			Target 2014/15	Comments
	2012/13	2013/14	2014/15		
People are referred to cardiac rehabilitation services after an acute event.	68%	N/A	**N/A**	70%	63
The number of people who are discharged from inpatient services, and who receive a community mental health contact in the seven days immediately following discharge.	61%	N/A	**84%**	73%	64

63. Confirmed cardiac rehabilitation service data is not available at the time the report was completed.

64. The Ministry of Health sources data from PRIMHD. PRIMHD (pronounced 'primed') is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers. Results have improved as providers improve the data capture and reporting.

Age Related Residential Care

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 being successfully supported to continue living in their own homes and is balanced against the level of home-based support.

Output Measures	Results			Target 2014/15	Comments
	2012/13	2013/14	2014/15		
Number of rest home bed days per capita of the population aged over 65 years.	8.29	7.89	**7.94**	8.00	65, 66
Percentage of residential care facilities using interRAI assessment tool.	0%	21%	**98%**	100%	66
Number of people in 'rest home' level aged residential care.	1,333	1,144	**1,151**	1,280	67
Number of people in 'hospital' level aged residential care.	927	1,012	**1,091**	960	68

Figure 57: Number of rest home bed days per capita of the population aged over 65 years

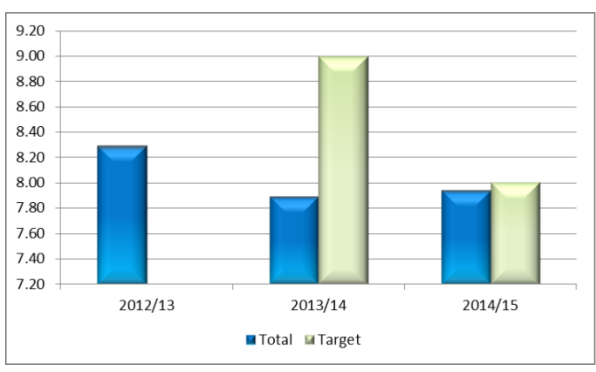
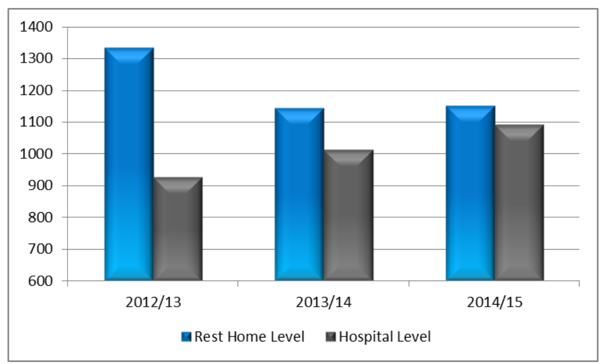


Figure 58: Number of people in 'rest home' and 'hospital' level aged residential care



65. Utilisation of Aged Residential Care (ARC) increased slightly in 2014/15. The main area of growth, in line with expectations and trends elsewhere, has been in 'hospital' level care which is for people with more complex health needs.

The South Island, including Southern, still has a greater utilisation (beds days per capita) of aged residential care than the rest of New Zealand. The introduction of interRAI (see 66) is anticipated over time to result in the ARC utilisation rate trending towards the rest of New Zealand.

66. InterRAI is the national standardised assessment tool for eligibility to aged residential care.

Currently, 98% of Aged Residential Care (ARC) facilities have completed the training and have been assessed as competent in interRAI. All ARC facilities are now using interRAI as their primary assessment tool.

67. The South Island, including Southern, still has a greater utilisation of aged residential care than the rest of New Zealand. The introduction of interRAI (see 66) is anticipated over time to result in the ARC utilisation rate trending towards the rest of New Zealand, i.e. more people with less complex needs cared for in their own homes and fewer people entering into 'rest home' level ARC facilities – see Figure 58.

68. Ageing in place has resulted in a greater number of older people accessing 'hospital' level care directly from home – see Figure 58. This is appropriate for people with more complex health needs and is in line with expectations and trends elsewhere.

STATEMENT OF FINANCIAL PERFORMANCE

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Actual $000
Patient revenue	2	872,773	869,344	862,496
Other revenue	3	9,192	8,361	9,583
Interest revenue		1,940	1,820	1,818
Total revenue		**883,905**	**879,525**	**873,897**
Personnel costs	5	343,849	339,395	336,753
Depreciation, amortisation and impairment expense	7,8	20,765	19,721	19,758
Outsourced services		34,246	33,831	19,051
Clinical supplies		74,127	82,583	74,260
Infrastructure and non-clinical expenses		44,120	33,864	41,230
Other district health boards		38,820	36,657	35,938
Payments to non-health board providers		337,284	329,944	346,697
Other expenses	4	3,526	3,705	3,699
Finance costs		4,544	4,537	4,517
Capital charge	6	9,804	10,087	9,816
Total expenses		**911,085**	**894,324**	**891,719**
Surplus/(deficit) for the year	14	**(27,180)**	**(14,800)**	**(17,822)**
Other Comprehensive revenue				
Items that will not be reclassified to surplus/ (deficit)				
Revaluation of land and buildings	14	-	-	10,056
Total other comprehensive revenue/ (expense)		-	-	10,056
Total Comprehensive revenue/ (expense)	23	**(27,180)**	**(14,800)**	**(7,766)**

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Actual $000
Equity at beginning of the year		**129,215**	**131,310**	**128,688**
Comprehensive revenue / (expense)				
Surplus/ (deficit) for the year		(27,180)	(14,800)	(17,822)
Other Comprehensive revenue / (expense)		-	-	10,056
Capital contributions from the Crown (Deficit Support and Project Equity Funding)		10,704	20,700	9,000
Other equity movements	14	(707)	(707)	(707)
Equity at end of the year		**112,032**	**136,503**	**129,215**

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION

As at 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Actual $000
Assets				
Property, plant and equipment	7	288,887	299,765	293,587
Intangible assets	8	14,361	10,182	13,346
Total non-current assets		**303,248**	**309,947**	**306,933**
Inventories held for distribution	9	4,677	4,746	4,792
Trade and other receivables	11	30,166	29,436	31,662
Cash and cash equivalents	12	3,658	10,685	12,441
Non-current assets held for sales	13	451	-	1,099
Total current assets		**38,952**	**44,867**	**49,994**
Total assets		**342,200**	**354,814**	**356,927**
Equity				
Crown equity	14	88,836	100,928	78,839
Property revaluation reserves	14	94,121	94,570	94,571
Accumulated surpluses/ (deficits)	14	(70,925)	(58,995)	(44,195)
Total equity		**112,032**	**136,503**	**129,215**
Liabilities				
Interest-bearing loans and borrowings	15	87,964	89,198	89,805
Employee benefits	16	15,564	15,094	15,212
Total non-current liabilities		**103,528**	**104,292**	**105,017**
Interest-bearing loans and borrowings	15	18,269	14,707	15,306
Trade and other payables	17	46,755	36,814	46,787
Employee benefits	16	61,616	62,498	60,602
Total current liabilities		**126,640**	**114,019**	**122,695**
Total liabilities		**230,168**	**218,311**	**227,712**
Total equity and liabilities		**342,200**	**354,814**	**356,927**

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS

For the year ended 30 June 2015

	Note	2015 Actual $000	2015 Budget $000	2014 Actual $000
Cash flows from operating activities				
Cash receipts from Ministry of Health and patients		885,292	878,893	863,535
Cash paid to suppliers		(531,863)	(526,600)	(513,251)
Cash paid to employees		(339,326)	(338,283)	(333,712)
Cash generated from operations		**14,103**	**14,011**	**16,572**
Interest received		1,940	1,820	1,818
Interest paid		(4,544)	(5,107)	(4,514)
Net taxes refunded/ (paid) (goods and services tax)		(840)	(3,014)	1,166
Capital charge paid		(9,805)	(10,486)	(14,547)
Net cash flows from operating activities	**12**	**854**	**(2,776)**	**495**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		651	-	67
Acquisition of property, plant and equipment		(14,000)	(19,922)	(19,974)
Net cash movement in investments		(883)	(883)	(1,746)
Net cash flows from investing activities		**(14,232)**	**(20,805)**	**(21,653)**
Cash flows from financing activities				
Proceeds from equity injection		5,845	19,993	8,292
Drawdown (repayment) of borrowings		(1,250)	1,833	(1,935)
Net cash flows from financing activities		**4,595**	**21,826**	**6,357**
Net increase / (decrease) in cash and cash equivalents		(8,783)	(1,756)	(14,801)
Cash and cash equivalents at beginning of year		12,441	12,441	27,242
Cash and cash equivalents at end of year	**12**	**3,658**	**10,685**	**12,441**

The accompanying notes form part of these financial statements

STATEMENT OF CONTINGENCIES AND COMMITMENTS

As at 30 June 2015

Contingent Liabilities	2015 Actual $000	2014 Actual $000
Legal proceedings against Southern DHB	-	-
Personal grievances	-	-
	-	**-**

Contingent Assets	2015 Actual $000	2014 Actual $000
Legal proceedings by Southern DHB	-	-
	-	-

The DHB is still in dispute with a provider regarding a claim relating to unspent savings. Any successful recovery would result in the funds returned being spent on health services, and as such no contingent assets or liabilities are recorded.

As at 30 June 2015

	2015 Actual $000	2014 Actual $000
Capital Commitments	**6,265**	**13,971**

	2015 Actual $000	2014 Actual $000
Non-cancellable commitments - operating lease commitments		
Not more than one year	1,298	2,042
One to two years	898	1,248
Two to three years	237	1,144
Three to four years	17	321
Four to five years	12	-
Over five years	73	-
	2,535	**4,755**

The accompanying notes form part of these financial statements

NOTES TO THE FINANCIAL STATEMENTS

1. STATEMENT OF ACCOUNTING POLICIES FOR THE YEAR ENDED 30 JUNE 2015

REPORTING ENTITY

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

Southern DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 2013, 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 2015 are for the Southern DHB only. They were approved by the Board on 7 October 2015. The owner, the Crown, does not have the power to amend the financial statements after issue.

BASIS OF PREPARATION

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).

These financial statements comply with Public Sector PBE accounting standards.

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

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new PBE accounting standards.

GOING CONCERN

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

Although the 2014/15 annual plan was not signed by the Minister, Southern DHB's Commissioner and Deputy Commissioners have received a letter of support from the Ministers of Health and Finance that the Government is committed to working with them over the medium term to maintain its financial viability. It also acknowledges that deficit support may be required and the Crown will provide such support where 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 annual plan has yet to receive approval from the Ministry of Health.

The Southern DHB has a number of initiatives underway that aim to reduce the ongoing deficit position of the DHB and the ongoing requirement of support from the Crown. These initiatives continue to be developed and refined as the Commissioners finalise their workplan for the 2015/16 financial year. The DHB is working with the Ministry to agree and finalise the plan for the 15/16 financial year end.

FUNCTIONAL AND PRESENTATION CURRENCY

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

MEASUREMENT BASE

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

The financial statements 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.

There are no standards, amendments, and interpretations issued that are not yet effective that have not been early adopted and which are relevant to the DHB.

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. SDHB has applied these standards in preparing the 30 June 2015 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. The results of which forms 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.

Major areas of estimate uncertainty that have a significant impact on the amounts recognised in the financial statements are;

- Fixed assets revaluations, note 7, and
- Employee entitlements, note 16.

Significant Accounting Policies

Revenue

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

MOH Revenue

The DHB is primarily funded through revenue received from the MoH. 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 Income

Interest income is recognised using the effective interest method.

Rental Income

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

Provision of Services

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

Donations and Bequests

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

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.

Leases

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.

Operating Leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of the asset.

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.

Foreign Currency Transactions

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

Cash and cash equivalents

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

Trade and other receivables

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

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

Investments

Bank deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest rate method, less any provisions for impairment. A bank deposit is impaired when there is objective evidence that the Southern DHB will not be able to collect amounts due according to the original terms of the deposit.

Inventories

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

Inventories Held for Distribution

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

Non-current assets held for sale

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

Any increases in fair value (less cost to sell) are recognised up to the level of any impairment losses previously recognised.

Impairment losses are recognised in the surplus and deficit.

Non-current assets held for sale are not depreciated or amortised while held for sale.

Property, Plant and Equipment

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

- land
- buildings
- plant and equipment
- motor vehicles.

Land is measured at fair value, buildings are measured at fair value less accumulated depreciation and impairment losses. All other assets are measured at cost less accumulated depreciation and impairment losses.

The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located and an appropriate proportion of direct overheads.

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 in other comprehensive revenue.

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

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the 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).

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.

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	15 to 80 years	1.25-6.67%
Plant and Equipment	3 to 15 years	6.67-33%
Motor Vehicles	5 years	20%

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

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

Intangible Assets

Intangible assets that are acquired by Southern DHB are stated at cost less accumulated amortisation (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.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Benefits Limited (HBL), now called New Zealand Health Partnerships, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

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%

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's 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 and deficit.

Trade and Other Payables

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

Borrowings

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.

Employee Benefits

Employee Entitlements

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:

- the likely future entitlements accruing to staff based on years of service; years to entitlement; and
- the likelihood that staff will reach the point of entitlement and contractual entitlement information; and
- 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.

Superannuation Schemes

Defined Contribution Plans

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

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when Southern DHB has 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, and a reliable estimate can be made of the amount of the obligation.

Restructuring

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

Onerous Contracts

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

ACC Partnership Programme

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

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

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

Income Tax

The 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.

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.

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.

Financial Instruments

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

Cost of Service Statements

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

Cost Allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

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

Comparative Data

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

The first time adoption of PBE IPSAS has not resulted in any material adjustments and as such no reconciliation has been provided.

2. REVENUE

	2015 Actual $000	2014 Actual $000
Health and disability services (MOH contracted revenue)	834,037	822,816
ACC contract revenue	9,883	10,261
Inter district patient inflows	19,448	19,139
Other revenue	9,405	10,280
	872,773	**862,496**

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

3. OTHER REVENUE

	2015 Actual $000	2014 Actual $000
Gain on sale of property, plant and equipment	121	67
Donations and bequests received	381	1,248
Rental revenue	1,900	1,802
Other revenue	6,790	6,466
	9,192	**9,583**

4. OTHER EXPENSES

	Note	2015 Actual $000	2014 Actual $000
Impairment of trade receivables (doubtful debts)		(108)	647
Bad debts written off		752	2
Loss on disposal of property, plant and equipment		110	340
Audit fees (for the audit of financial statements)		181	171
Fees paid to other auditors for assurance and related services including internal audit		69	82
Board member fees	21	357	345
Operating lease expenses		2,163	2,110
Koha		2	2
		3,526	**3,699**

5. PERSONNEL COSTS

	2015 Actual $000	2014 Actual $000
Wages and salaries	339,390	333,040
Increase/ (decrease) in employee benefit provisions	4,459	3,713
	343,849	**336,753**

6. CAPITAL CHARGE

Southern DHB pays capital charge to the Crown twice yearly. This is based on closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the period ended 30 June 2015 was 8 per cent. The amount charged during the period was $9.80 million (2014: $9.82 million).

7. PROPERTY, PLANT AND EQUIPMENT

Cost	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant and equipment $000	Vehicles $000	Work in progress $000	Total $000
Balance at 1 July 2013	25,158	233,870	147,155	1,484	5,392	**413,059**
Additions	-	-	-	-	17,301	**17,301**
Transfers from Work in Progress	-	10,247	9,650	20	(19,917)	**-**
Disposals	-	(2)	(10,650))	-	-	**(10,652)**
Transfers	(560)	(539)	(839)	839	-	**1,099)**
Revaluations & impairment	2,889	(20,722)	-	-	(1,956)	**(19,789)**
Balance at 30 June 2014	**27,487**	**222,854**	**145,316**	**2,343**	**820**	**398,820**
Balance at 1 July 2014	27,487	222,854	145,316	2,343	820	**398,820**
Additions	-	-	-	-	14,877	**14,877**
Transfers from Work in Progress	-	2,061	11,171	-	(13,232)	**-**
Disposals	-	-	(4,002)	(11)	-	**(4,013)**
Transfers	-	-	-	-	-	**-**
Revaluations & impairment	-	-	-	-	-	**-**
Balance at 30 June 2015	**27,487**	**224,915**	**152,485**	**2,332**	**2,465**	**409,684**
Depreciation and impairment losses						
Balance at 1 July 2013	-	22,716	104,192	391	-	**127,299**
Depreciation charge	-	8,146	10,121	220	-	**18,487**
Impairment losses	-	-	-	-	-	**-**
Reversal of impairment losses	-	-	-	-	-	**-**
Disposals	-	(2)	(10,265)	-	-	**(10,267)**
Transfers	-	-	(290)	290	-	**-**
Revaluations	-	(30,286)	-	-	-	**(30,286)**
Balance at 30 June 2014	**-**	**574**	**103,758**	**901**	**-**	**105,233**
Balance at 1 July 2014	-	574	103,758	901	-	**105,233**
Depreciation charge	-	7,847	10,501	271	-	**18,619**
Impairment losses	-	-	-	-	-	**-**
Reversal of impairment losses	-	-	-	-	-	**-**
Disposals	-	-	(3,044)	(11)	-	**(3,055)**
Transfers	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Balance at 30 June 2015	**-**	**8,421**	**111,215**	**1,161**	**-**	**120,797**
Carrying amounts						
At 1 July 2013	25,158	211,154	42,963	1,093	5,392	**285,760**
At 30 June 2014	**27,487**	**222,280**	**41,558**	**1,442**	**820**	**293,587**
At 1 July 2014	27,487	222,280	41,558	1,442	820	293,587
At 30 June 2015	**27,487**	**216,494**	**41,270**	**1,171**	**2,465**	**288,887**

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 is effective as at 30 June 2014 as there is no material changes in the fair value of these land and buildings from 30 April 2014 that will affect their carrying amount as at 30 June 2015

RESTRICTIONS

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

8. INTANGIBLE ASSETS

	FSPC	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
Balance at 1 July 2013	1,841	17,563	19,404
Additions	1,745	3,403	5,148
Disposals	-	-	-
Balance at 30 June 2014	**3,586**	**20,966**	**24,552**
Balance 1 July 2014	3,586	20,966	24,552
Additions	883	2,160	3,043
Disposals	-	-	-
Balance at 30 June 2015	**4,469**	**23,126**	**27,595**
Amortisation and impairment losses			-
Balance at 1 July 2013	-	9,935	9,935
Amortisation charge for the year	-	1,271	1,271
Impairment losses	-	-	-
Reversal of impairment losses	-	-	-
Disposals	-	-	-
Balance at 30 June 2014	**-**	**11,206**	**11,206**
Balance 1 July 2014	-	11,206	11,206
Amortisation charge for the year	-	1,842	1,842
Impairment losses	-	186	186
Reversal of impairment losses	-	-	-
Disposals	-	-	-
Balance at 30 June 2015	**-**	**13,234**	**13,234**
Carrying amounts			
At 1 July 2013	1,841	7,628	9,469
At 30 June 2014	**3,586**	**9,760**	**13,346**
At 1 July 2014	3,586	9,760	13,346
At 30 June 2015	**4,469**	**9,892**	**14,361**

IMPAIRMENT

There was one impairment loss recognised in the 2015 year. The assessment of the useful life of certain software resulted in its useful life being reduced. The value of the impairment was $186,377.

At 30 June 2015, the DHB had made payments totalling $4.469 million (2014: $3.586 million) to HBL in relation to the Finance, Procurement and Supply Chain (FPSC) programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid, from the surplus assets, an amount equal to the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

In 2014 the government agreed to a proposal from DHBs to move the implementation of the shared services programmes from HBL to a DHB owned vehicle. This was agreed to be completed by 30 June 2015. DHB FPSC rights in HBL are expected to transfer into the new DHB owned vehicle.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

A revised FPSC programme business case was approved by the DHB sector in May 2015 and all DHBs have committed to providing the balance of funding required to complete the programme. The programme will be implemented by a DHB owned vehicle, NZ Health Partnership, in which all DHBs have a shareholding of 5%. On this basis, the depreciated replacement cost of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired.

9. INVENTORIES HELD FOR DISTRIBUTION

	2015 Actual $000	2014 Actual $000
Pharmaceuticals	1,420	1,057
Surgical & Medical supplies	3,257	3,735
	4,677	**4,792**

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2015 was $4.677 million (2014 $4.792 million).

10. ASSOCIATED ENTITIES

a) General information

Name of entity	Principal activities	Interest held at 30 June 2015	Balance Date
South Island Shared Service Agency Limited	South Island Shared Service Agency Limited is a non-operating company	30%	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.

11. TRADE AND OTHER RECEIVABLES

	2015 Actual $000	2014 Actual $000
Receivables (gross)	32,543	34,148
Less: provision for impairment	(2,377)	(2,486)
Total receivables	**30,166**	**31,662**
Total receivables comprise:		
Receivables (non-exchange transactions)	12,656	7,312
Other accrued revenue (exchange transactions)	17,510	24,350
	30,166	**31,662**

Trade receivables are shown net of provision for doubtful debts amounting to $2.377 million arising from identified debts unlikely to be recovered (2014: $2.486 million).

12. CASH AND CASH EQUIVALENTS

	2015 Actual $000	2014 Actual $000
Bank balances	-	-
Cash and cash equivalents	16	15
Demand funds with Health Benefits Limited	3,642	12,426
Cash and cash equivalents in the statement of cash flows	**3,658**	**12,441**

WORKING CAPITAL FACILITY

At 30 June 2015, the Southern DHB held no bank overdraft facilities.

Southern DHB is a party to the 'DHB Treasury Services Agreement' between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to 'sweep' DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of a month's Provider Arm funding plus GST. For Southern DHB, that equates to $43.18m.

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

	2015 Actual $000	2014 Actual $000
Net surplus/(deficit) for the period	(27,180)	(17,822)
Add/(less) non-cash items:		
Depreciation and assets written off	20,765	19,758
Increase/ (decrease) in fair value of interest free loans	182	1,818
Increase/ (decrease) in provision for doubtful debts	(108)	647
Add/(less) items classified as investing or financing activity:		
Net loss/ (gain) on disposal of property, plant and equipment	(11)	273
Movements in working capital:		
(Increase)/ decrease in trade and other receivables	5,756	(9,283)
(Increase)/ decrease in inventories	115	25
Increase/ (decrease) in trade and other payables	(3,188)	1,623
Increase/ (decrease) in employee benefits	4,523	3,456
Net movement in working capital	**7,206**	**(4,179)**
Net cash inflow/ (outflow) from operating activities	**854**	**495**

13. NON-CURRENT ASSETS HELD FOR SALE

The Southern DHB owns land and buildings at High Street in Dunedin which has been classified as held for sale following the Board approval to sell the property, as it holds no future use to the DHB. The sale is expected to be completed within the next 12 months.

Non-current assets held for sale include:	2015 Actual $000	2014 Actual $000
Land	360	560
Buildings	91	539
Total non-current assets held for sale	**451**	**1,099**

14. CAPITAL AND RESERVES

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2013	70,546	84,515	(26,373)	128,688
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	9,000	-	-	9,000
Equity repayment to the Crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	10,056	-	10,056
Transfers from revaluation of land and buildings on impairment	-	-	-	-
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Deficit for the period	-	-	(17,822)	(17,822)
Balance at 30 June 2014	**78,839**	**94,571**	**(44,195)**	**129,215**
Balance at 1 July 2014	78,839	94,571	(44,195)	129,215
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	10,704	-	-	10,704
Equity repayment to the Crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	(450)	-	(450)
Transfers from revaluation of land and buildings on impairment	-	-	-	-
Transfers from revaluation of land and buildings on disposal	-	-	450	450
Deficit for the period	-	-	(27,180)	(27,180)
Balance at 30 June 2015	**88,836**	**94,121**	**(70,925)**	**112,032**

Equity is made up of	2015 Actual $000	2014 Actual $000
Equity	106,626	124,268
Restricted Equity *	5,406	4,947
Total Equity	**112,032**	**129,215**

* 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,

15. INTEREST-BEARING LOANS AND BORROWINGS

	2015 Actual $000	2014 Actual $000
Non-current		
Secured loans	83,930	88,116
Unsecured loans	388	134
Finance lease liabilities	3,646	1,555
	87,964	**89,805**
Current		
Current portion of secured loans	16,600	12,850
Current portion of finance lease liabilities	1,426	2,330
Current portion of unsecured loans	243	126
	18,269	**15,306**
	106,233	**105,111**

Secured loans

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

The details of terms and conditions are as follows:

Interest rate summary	2015 Actual	2014 Actual
Crown loans - fixed interest	2.94% to 6.42%	2.61% to 6.55%

Repayable as follows:	2015 Actual $000	2014 Actual $000
Within one year	16,600	12,976
One to two years	600	16,723
Two to three years	16,600	600
Three to four years	15,100	6,600
Four to five years	7,600	25,100
Later than five years	44,029	39,015
	100,529	**101,014**

Term loan facility limits	2015 Actual $000	2014 Actual $000
Crown loans	97,400	97,400
Term loan facility	-	-

SECURITY AND TERMS

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

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

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

16. EMPLOYEE BENEFITS

	2015 Actual $000	2014 Actual $000
Non-current liabilities		
Liability for long-service leave	3,203	3,030
Liability for sabbatical leave	1,473	1,320
Liability for retirement gratuities	10,888	10,862
	15,564	**15,212**
Current liabilities		
Liability for long-service leave	3,825	3,360
Liability for sabbatical leave	142	131
Liability for retirement gratuities	3,116	2,551
Liability for annual leave	34,827	33,641
Liability for sick leave	243	251
Liability for continuing medical education	6,105	6,075
Salary and wages accrual	13,358	14,593
	61,616	**60,602**

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 2.93% (2014: 3.7%) and an inflation factor of 1.63% (2014: 2.1%) were used.

17. PAYABLES & DEFERRED REVENUE

	2015 Actual $000	2014 Actual $000
Trade payables to non-related parties	6,352	7,141
GST payable	4,519	5,350
Revenue in advance relating to contracts with specific performance obligations	340	539
Capital charge due to the Crown	-	-
Other non-trade payables and accrued expenses	35,544	33,757
	46,755	**46,787**

	2015 Actual $000	2014 Actual $000
Total payables comprise:		
Exchange transactions	41,896	40,898
Non-exchange transactions	4,859	5,889
	46,755	**46,787**

18. OPERATING LEASES

Leases as lessee	2015 Actual $000	2014 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1,298	2,042
Between one and five years	1,164	2,713
More than five years	73	-
	2,535	**4,755**

During the year ended 30 June 2015, $2.163 million was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2014: $2.110 million).

19. FINANCIAL INSTRUMENTS

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

CREDIT RISK

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 11.8 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.

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

	2015		2014	
Trade receivables	Gross Receivable $000	Impairment $000	Gross Receivable $000	Impairment $000
Not past due	-	-	30	
Past due 0-30 days	2,535	(5)	5,844	(518)
Past due 31-120 days	1,012	(248)	1,768	(36)
Past due 121-360 days	888	(265)	691	(37)
Past due more than 1 year	1,918	(1,859)	2,101	(1,895)
Total	**6,353**	**(2,377)**	10,434	(2,486)

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

Trade receivables	2015 Actual $000	2014 Actual $000
Gross trade receivables	6,353	10,434
Individual impairment	(2,377)	(2,486)
Collective impairment	-	-
Net total trade receivables	**3,976**	**7,948**

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.

Movement in the provision for impairment of receivables is as follows:

Provision for impairment of receivables	2015 Actual $000	2014 Actual $000
Balance as at 1 July	(2,486)	(1,839)
Additional provisions made	(643)	(647)
Receivables written off	752	-
Balance as at 30 June	**(2,377)**	**(2,486)**

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

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.

2015	Balance sheet $000	Contractual cash flow $000	6 months or less $000	6-12 months $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured loans	100,529	100,529	300	16,300	600	39,300	44,029
Unsecured loans	631	631	122	137	233	140	-
Finance lease liabilities	5,073	5,072	711	715	1,187	1,407	1,052
Trade and other payables	46,755	46,755	46,755	-	-	-	-
Total	**152,988**	**152,987**	**47,888**	**17,152**	**2,020**	**40,847**	**45,081**
Inflow	-	-	-	-	-	-	-
Outflow	152,988	152,987	47,888	17,152	2,020	40,847	45,081

2014	Balance sheet $000	Contractual cash flow $000	6 months or less $000	6-12 months $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured loans	100,966	122,677	2,552	12,552	16,926	42,281	48,366
Unsecured loans	260	249	63	63	123	-	-
Finance lease liabilities	3,885	5,165	723	547	916	1,595	1,384
Trade and other payables	46,787	46,787	46,787	-	-	-	-
Total	**151,898**	**174,878**	**50,125**	**13,162**	**17,965**	**43,876**	**49,750**
Inflow	-	-	-	-	-	-	-
Outflow	151,898	174,878	50,125	13,162	17,965	43,876	49,750

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.

	2015						
	Effective interest rate (%)	**Total $000**	**6 months or less $000**	**6-12 months $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%	3,129	300	300	600	1,800	129
Crown loans *	4.74%	10,000	-	-	-	-	10,000
Crown loans *	2.94%	6,000	-	-	-	6,000	-
Crown loans *	4.75%	10,000	-	10,000	-	-	-
Crown loans *	5.75%	6,000	-	6,000	-	-	-
Crown loans *	6.42%	10,000	-	-	-	10,000	-
Crown loans *	3.37%	5,000	-	-	-	-	5,000
Crown loans *	3.44%	10,000	-	-	-	-	10,000
Crown loans *	4.34%	4,500	-	-	-	4,500	-
Crown loans *	4.40%	1,250	-	-	-	-	1,250
Crown loans *	4.40%	5,400	-	-	-	-	5,400
Crown loans *	5.06%	10,000	-	-	-	10,000	-
Crown loans *	5.22%	7,000	-	-	-	7,000	-
Crown loans *	3.40%	6,000	-	-	-	-	6,000
Crown loans *	3.40%	6,250	-	-	-	-	6,250
Finance lease liabilities*	5.80%-12.55%	5,072	711	715	1,187	1,407	1,052
Unsecured bank loans	0.00%	631	121	137	233	140	-

* These assets/ liabilities bear interest at fixed rates

	2014						
	Effective interest rate (%)	Total $000	6 months or less $000	6-12 months $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%	3,365	300	300	600	1,800	365
Crown loans *	4.74%	10,000	-	-	-	-	10,000
Crown loans *	2.61%	6,000	-	6,000	-	-	-
Crown loans *	6.55%	6,250	-	6,250	-	-	-
Crown loans *	2.94%	6,000	-	-	-	6,000	-
Crown loans *	4.75%	10,000	-	-	10,000	-	-
Crown loans *	5.75%	6,000	-	-	6,000	-	-
Crown loans *	6.42%	10,000	-	-	-	10,000	-
Crown loans *	3.37%	5,000	-	-	-	-	5,000
Crown loans *	3.44%	10,000	-	-	-	-	10,000
Crown loans *	4.34%	4,500	-	-	-	4,500	
Crown loans *	4.40%	1,250	-	-	-	-	1,250
Crown loans *	4.40%	5,400	-	-	-	-	5,400
Crown loans *	5.06%	10,000	-	-	-	10,000	-
Crown loans *	5.22%	7,000	-	-	-	-	7,000
Finance lease liabilities*	9.68%	3,884	503	458	897	890	1,136
Unsecured bank loans	0.00%	249	63	63	123	-	-

* These assets/ liabilities bear interest at fixed rates

FOREIGN CURRENCY RISK

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

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

CAPITAL MANAGEMENT

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

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

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

SENSITIVITY ANALYSIS

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

At 30 June 2015, it is estimated that a general change of one percentage point in interest rates would increase or decrease Southern DHB's operating result by approximately $1.025 million (2014: $1.026 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:

		Loans and receivables	Other amortised cost	Carrying amount Actual	Fair value Actual
		$000	$000	$000	$000
2015	**Note**				
Trade and other receivables	11	30,166	-	30,166	30,166
Cash and cash equivalents	12	3,658	-	3,658	3,658
Secured loans	15	-	100,529	100,529	100,529
Finance lease liabilities	15		5,073	5,073	5,073
Unsecured liabilities	15		631	631	631
Trade and other payables	17		46,755	46,755	46,755
2014					
Trade and other receivables	11	31,662		31,662	31,662
Cash and cash equivalents	12	12,441	-	12,441	12,441
Secured loans	15		100,966	100,966	100,966
Finance lease liabilities	15		3,885	3,885	3,885
Unsecured liabilities	15		260	260	260
Trade and other payables	17		46,787	46,787	46,787

ESTIMATION OF FAIR VALUES ANALYSIS

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

INTEREST-BEARING LOANS AND BORROWINGS

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

FINANCE LEASE LIABILITIES

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

TRADE AND OTHER RECEIVABLES/PAYABLES

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

INTEREST RATES USED FOR DETERMINING FAIR VALUE

The entity uses the government yield curve as of 30 June 2015 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2015 Actual %	2014 Actual %	
Finance leases	5.93%	5.90%	Reserve Bank of NZ retail interest rate
Loans and borrowings	2.94% to 6.42%	2.61% - 6.55%	Rates per confirmation and also discount rates for FV loans

20. 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.

21. BOARD MEMBERS REMUNERATION

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

	Board Members Fees	
	2015 Actual $000	2014 Actual $000
Joe Butterfield MNZM	56	54
Neville Cook	29	29
Sandra Cook	29	26
Kaye Crowther QSO	29	29
Mary Flannery	-	14
Malcolm Macpherson	-	14
Paul Menzies	-	18
Tahu Potiki	-	6
Branko Sijnja	27	27
Richard Thomson	27	27
Tim Ward	39	35
John Chambers	27	15
Mary Gamble	28	17
Tony Hill	35	18
Tuari Potiki	31	16
	357	**345**

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

The Board of Southern DHB was replaced on 17 June 2015 by the Minister of Health and replaced with a Commissioner and 3 deputy commissioners. As at balance date only 2 of the 3 deputies had been appointed.

Commissioners' remuneration accrued during the period was:

	Commissioners Fees	
	2015 Actual $000	**2014 Actual $000**
Kathy Grant	7	-
Graham Crombie	3	-
Richard Thomson	3	-
	13	**-**

KEY MANAGEMENT TEAM REMUNERATION

The key management remuneration is as follows:

	2015 Actual $000	**2014 Actual $000**
Board Members		
Remuneration	357	345
Full time equivalent members	1.2 FTE	1.2 FTE
Commissioners		
Remuneration	13	-
Full time equivalent members	0.1 FTE	-
Executive Management		
Remuneration	2,776	2,585
Full time equivalent members	10.7 FTE	10.4 FTE
Total Remuneration	**3,146**	**2,930**
Total full time equivalent	**12.0 FTE**	**11.6 FTE**

The full time equivalent (FTE) for Board members has been determined on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings.

EMPLOYEE REMUNERATION

The number of employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2015 were:

TOTAL REMUNERATION AND OTHER BENEFITS $000

	Number of Employees	
	2015	**2014**
100 - 110	112	95
110 - 120	60	42
120 - 130	43	46
130 - 140	34	34
140 - 150	23	34
150 - 160	29	26
160 - 170	12	23
170 - 180	22	12
180 - 190	15	17
190 - 200	18	16
200 - 210	15	15
210 - 220	11	13
220 - 230	16	9
230 - 240	19	16
240 - 250	11	7
250 - 260	11	18
260 - 270	15	18
270 - 280	14	13
280 - 290	18	9
290 - 300	8	7
300 - 310	9	7
310 - 320	4	12
320 - 330	7	4
330 - 340	4	4
340 - 350	6	7
350 - 360	3	2
360 - 370	5	3
370 - 380	1	3
380 - 390	2	2
390 - 400	1	1
400 - 410	4	2
410 - 420	-	-
420 - 430	-	-
430 - 440	1	-
440 - 450	2	-
450 – 460	-	-
460 – 470	1	-
470 – 480	-	1
480 – 490	1	1
490 – 500	1	-
500 – 510	1	2
510 – 520	-	-
520 – 530	2	-

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 over $10,000.

Of the 561 employees shown above, 413 were medical/dental employees (2014: 391 employees were medical/ dental). If the remuneration of part-time employees was grossed-up to a Full Time Equivalent (FTE) basis, the total number with FTE salaries of $100,000 or more would be 807, compared with the actual total number of 561 (2014: 780 and 521).

The Chief Executive's remuneration and other benefits, either paid or accrued are in the band 500-510.

22. 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 2015 has resulted in a deficit of $0.5 million for mental health services. Additionally Southern DHB has a brought forward overspend of $2.3 million; meaning that the carry forward overspend is $2.8 million.

23. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

The unfavourable variance in total comprehensive revenue and expenses against budget for the year ended 30 June 2015 was $12.380m.

At a high level the following contributed to the overall variance (unfavourable variances shown in brackets):

Areas where actual costs were less than budget or revenue greater than budget

- $4.4m of additional revenue, most of which has costs associated with it including increases in funding for Aged Residential Care, Sleepover Settlements, Health Research funding and a refund relating to capital charge payments on revalued assets;
- $1.3m of savings in allied health personnel costs, partly due to unfilled mental health positions;
- $0.8m of savings in medical personnel costs including outsourced costs due to vacant Senior Medical Officer positions.

Areas where actual costs were greater than budget or revenue less than budget

- ($0.6m) of additional hotel services, laundry and cleaning costs;
- ($0.6m) of additional costs on instruments and equipment;
- ($0.8m) of additional price adjusters and premium;
- ($0.8m) of additional costs relating to laboratory costs, specifically send-away tests and other non-contracted tests;
- ($1.1m) of additional home support costs;
- ($1.3m) of additional expenditure on information systems and telecommunications due to increased licensing costs necessary to ensure DHB compliance;
- ($2.1m) of additional costs on inter-district outflows (Southern-based people treated in other District Health Boards) due primarily to one high cost burns patient;
- ($2.3m) of additional outsourced costs excluding medical outsourced costs due to outsourced radiology and urology costs in lieu of vacant positions. Additional costs were also incurred relating to the Health Benefits Ltd (HBL) Food and Laundry business cases and the HBL finance procurement and supply chain;
- ($3.9m) of additional nursing personnel expenses due to higher FTE levels driven by the level of patient acuity experienced during the year combined with a higher than budgeted award settlement;
- ($4.4m) of additional residential care costs due to an increase in both the price paid per bed and the number of beds occupied compared to the assumptions used when setting the budget, (partially offset by additional revenue).

24. EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date.

On 1 July 2015, Health Benefits Limited's business and operations were transferred over to a newly formed entity, NZ Health Partnerships Limited.

All the assets and liabilities, including SDHBs interest in the FPSC rights, transfer over to the new entity with no adjustment.

Independent Auditor's Report

To the readers of Southern District Health Board's financial statements and performance information for the year ended 30 June 2015

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

We have audited:

- the financial statements of the Health Board on pages 58 to 86, that comprise the statement of financial position and the statement of contingencies and commitments as at 30 June 2015, 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 14 to 57.

Unmodified opinion on the financial statements

In our opinion

- the financial statements of the Health Board:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2015; and
    - its financial performance and cash flows for the year then ended; and
  - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Reporting Standards.

The Health Board is reliant on deficit support from the Crown

Without modifying our opinion on the financial statements, we considered the adequacy of the disclosures made in note 1 on page 62 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 deficit support, where necessary, to maintain viability. We consider these disclosures to be adequate.

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

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators) rely on information from third-party health providers, such as primary health organisations and South Link Health. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2014, which is reported as comparative information, was modified for the same reason.

In our opinion, except for the effect of the matters described above, the performance information of the Health Board on pages 14 to 57:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2015, including:
    - for each class of reportable outputs:
        - its standards of performance achieved as compared with forecasts included in the statement of performance expectations for the financial year;
        - its actual revenue and output expenses 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.
- complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 29 October 2015. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Commissioner;
- the appropriateness of the reported performance information within the Health Board's framework for reporting performance;
- the adequacy of the disclosures in the financial statements and the performance information; and
- the overall presentation of the financial statements and the performance information.

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

We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Commissioner

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

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

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.

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

Responsibilities of the Auditor

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

Independence

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

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

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