Southern District Health Board

Piki Te Ora

Annual Report 2015/16

Owning our Future

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Annual Report 2015/16

Owning our Future

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Commissioner's foreword

In many, highly publicised ways, the 2015/16 year was unlike any other at Southern DHB. It began soon after the Minister of Health appointed the Commissioner team to replace the health board, and with this came the mandate and responsibility to bring Southern DHB to a financially and clinically sustainable position.

We began this process by creating our Owning our Future one-page work plan, to ensure clarity around immediate priority areas during the Commissioner team's initial appointment from June 2015 until December 2016. These focus on our health delivery performance, quality and safety, finances, planning and processes, capital works and strengthening our 'whole of system' service provision.

In addition, the work plan identifies a number of 'building blocks' – areas of investment and focus that will need to be progressively implemented to achieve our key performance targets in the short term, and build the organisational resilience and responsiveness to adapt to the ever-changing health care environment in the longer term. These include areas such as quality initiatives, building a stronger internal culture, making sure our services work together more closely, improving communication, and developing our data and information capability.

The work plan contributes to Southern DHB's vision and four-fold aim, and sits alongside existing strategic plans, including the DHB Annual Plan, Southern Strategic Health Plan and Māori Health Plan and is intended to support their implementation.

Taken together, our overall direction is towards a seamless, integrated health care system for our district that places the patient at the centre of how we operate. This approach draws upon international evidence that by focusing on quality and safety, and an understanding of what patients truly place value on, health care costs less and delivers better outcomes.

Now, a year later, it is gratifying to be able to report on our progress towards these goals.

Our primary concern is contributing to the health outcomes of our population. Over the past year, we have improved our performance against the government's health targets. There has also been considerable progress in initiatives across the wider health system, from enabling more sustainable after-hours services in rural areas to investments in clinical pharmacy, aiming to reduce risks for those on multiple medications. Information on our health outcomes and impact measures are detailed in our Statement of Service Performance on pages 15 to 52.

We have demonstrated our commitment to focusing on patients' experiences (pages 53 to 55), and understanding their priorities was a core focus of our Southern Future Listening sessions. This has provided important guidance towards improving their experience.

Building a more resilient organisation has been a strong area of focus this year (see pages 57 to 64), and is necessary if the transformation of the DHB is to be sustainable in the long term.

We were pleased to end the year slightly ahead of the budget deficit we had agreed with the Minister of Health, giving us confidence that we can learn to live within our means while also improving health outcomes.

Significant progress has been made in reshaping executive portfolios and recruiting leadership capability. And our investment in our internal culture through the Southern Future programme and internal capability initiatives will continue to build an organisation that is collaborative, innovative and able to meet the ever changing demands of the health system.

There is a great deal of work yet to do.

And while 2015/16 may have had some very unusual characteristics, our greatest strengths are the things that have never wavered. These include the dedication of all our staff who every day make a difference to the patients and community we serve – whether directly on the front line of health care, or behind the scenes – and we appreciate the ongoing efforts of all the staff who have committed to this journey with us.

We acknowledge also the outstanding contributions of the district's Primary Health Organisation WellSouth and primary health network, our rural providers, NGO and community groups, our partners in education, and iwi.

We look forward to working together to continue our progress in the coming years.

Kathy Grant
Commissioner

Statement of Responsibility

For the 12 months ended 30 June 2016

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 2016 fairly reflect the financial position and operations of Southern DHB.

Chris Fleming
Interim Chief Executive Officer
28 October 2016

Kathy Grant
Commissioner
28 October 2016

2015/16 Key highlights

More **sustainable rural after hours services** enabled through collaboration among general practices and rural hospitals

During the **2015/16 year**, Southern DHB improved across all of the health targets

Improved financial position, finishing 2015/16 year slightly **ahead of budget**

A total of **13,324** elective procedures were completed – 886 more than planned

Immunisation rates **remain high**, with rates for Māori outperforming non-Māori in several measures

Another successful Southern Innovation Challenge, drawing entries from across Southern DHB

Largest ever consultation with staff and community undertaken with our Southern Future transformation programme, and generating over **3,000 items of feedback**

Progress towards upgrading facilities, including planning for redeveloping **audiology, gastroenterology** and **ICU/HDU** facilities, and preparing for Dunedin Hospital rebuild

The Southern District

Our Purpose

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 provider services of Southern DHB delivers secondary, community, disability and mental health services to the Southern district, and tertiary services to the Southern district and New Zealand.

The funder services of the DHB has the following functions:

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

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).

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. The Commissioner's term will continue until Southern DHB elections resume in late 2019.

Partnership with Iwi

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

The Treaty of Waitangi is an important founding document for New Zealand. As an agent of the Crown, the DHB is committed to fulfilling its role as a Treaty partner. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure). The DHB and Māori will have a shared role in implementing health strategies for Māori, and will relate to each other in good faith, with mutual respect, co-operation and trust.

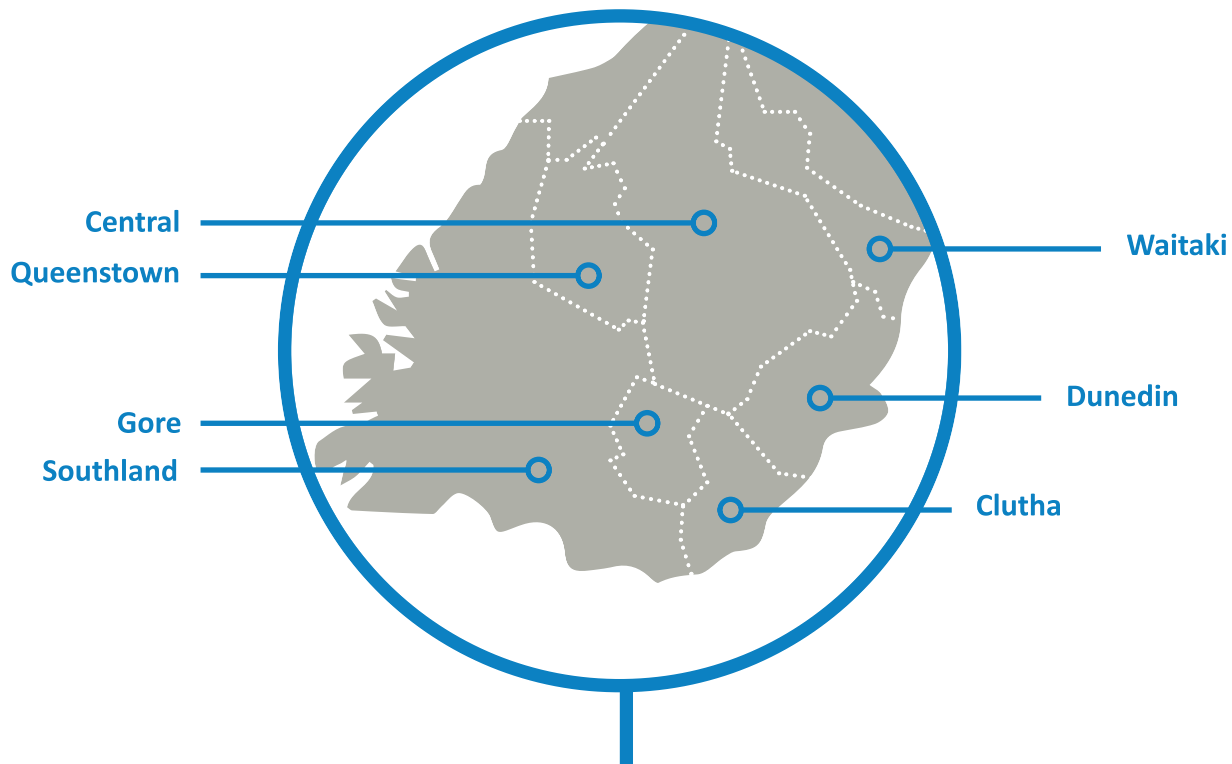
The NZPHD Act 2000 outlines the responsibilities Southern DHB has in honouring the principles of the Treaty of Waitangi. On 31 May 2011 a milestone in Southern DHB-Iwi relations was achieved when Murihiku and Araiteuru Rūnaka and Southern DHB signed a collective Principles of Relationship (PoR) agreement.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

Our Population



62,356km²

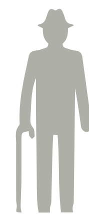
We are the DHB in New Zealand with the largest geographical area

The Southern district has a population of **315,940** residents, the majority living in Dunedin and Invercargill

Ethnically the Southern district is predominantly **European, at 83%.** 10% are Māori, 6% Asian and 2% Pacific

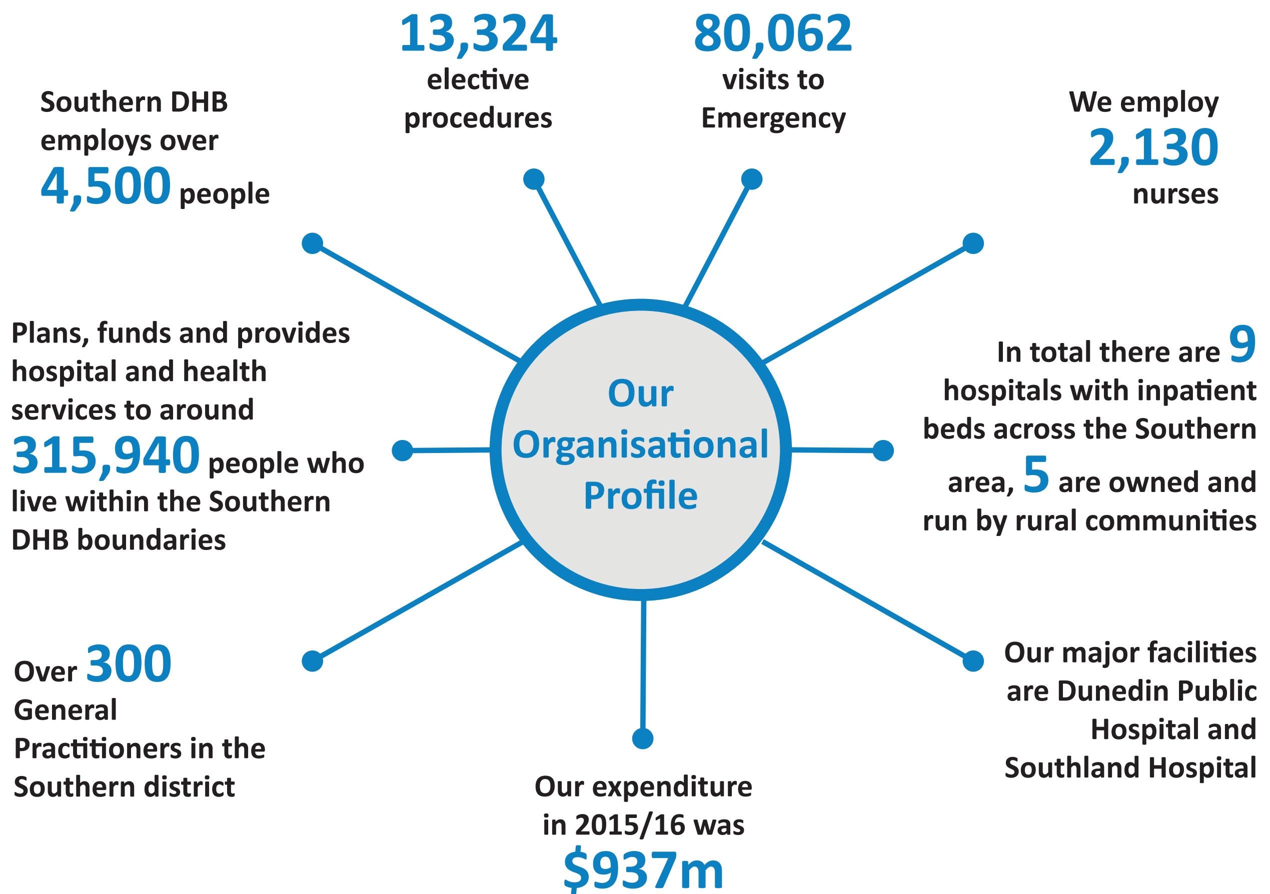
There were a total of **3,352** babies born in the Southern DHB last year with the majority of these occurring at Dunedin Public Hospital and Southland Hospital

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



Our population is slightly older when compared to the national average **51,930** people are aged 65 and over

Our Organisational Profile

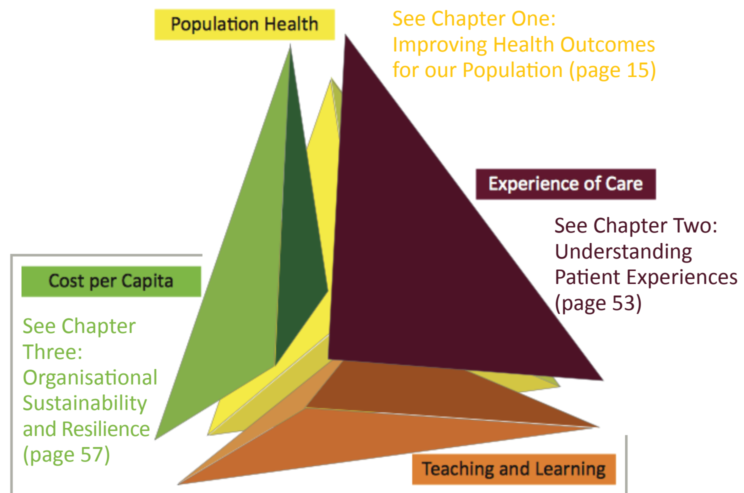


Our Performance Story

Southern DHB's journey to delivering the best possible health outcomes for the district, whilst achieving clinical and financial sustainability, is underpinned by our vision, purpose and strategic plans. In turn, further plans and frameworks have been developed to provide more focused lenses to guide immediate actions, or ensure the achievement of critical areas.

These supporting plans are integrated with each other, aligned with national and South Island regional priorities and built on a common foundation of our organisational values.

Our Four-Fold Aim is to achieve excellence as a DHB through balancing the components of health care delivery



Owning Our Future

Culture

An organisation united around its aims and the way it operates

Values: Known and Shared
Vision: Agreed, Aligned, Understood

Agreed expectations of how we work together

Our Principles

These principles are the measurement base we will test our performance against

Visibly lead the Southern DHB Plan

Patients are at the centre of everything we do

Actively build capacity and capability of our people

Ensure fair access to services across the whole district

Ensure Māori health and well-being is integral to planning and service delivery

Focus on the development of a District-wide network of care

Develop and enable clinical leadership

A commitment to continuous quality improvement and patient safety

Take a long term view of decision making

Be transparent in our decision making

Be visible and connected to our staff Be in the community

Build one source of truth

Invest to save

Key Performance Targets

These targets are the specific outcomes we envisage by December 2016

Finance

Agree and achieve 2015/16 budget
Agree 2016/17 budget
Financial performance demonstrating improvement

Capital

Urgent interim works commenced ($22.5m capital) and on plan
Visible signs of change to facilities
DHB partnering in the development of Dunedin Hospital and on plan
Hospital and on plan

Lift Performance

Achievement of all key Ministerial targets to national performance expectations with emphasis on supporting PHO involvement

District Wide Services

Stabilise and embed components of district network of care

Realign

Significant progress in developing models of care in Long-Term Conditions, Older People's Health and Urgent Care

Planning

By 30 September 2016 plan evolved for next 2-3 years

Building Blocks

These projects are critical in building the base to allow success in the organisation

Build Organisational Capability

Key appointments of CMO, CFO and Strategic Communications

Develop organisational capability and capacity

Facilitate clinical engagement district wide

Clinical leadership programme

Finance & Business Intelligence

Capability and capacity strengthened

Data and Information Capability

Improve use of data through accessibility, accuracy and capability

Quality Initiatives

Performance Improvement Framework in place building on

clinical involvement to reduce waste

Use agreed methodology to effect change

Service realignment projects to establish baselines

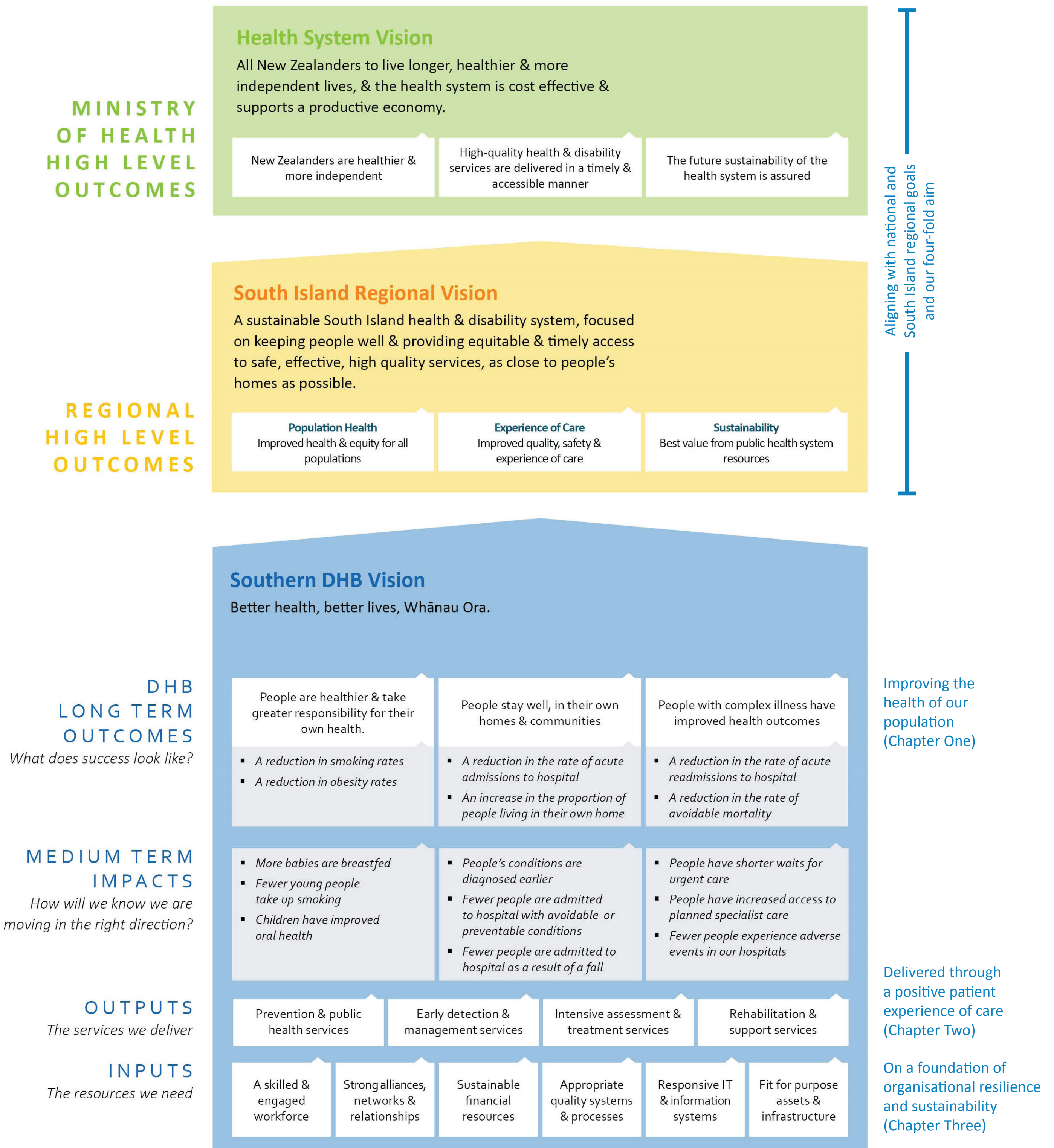
Systematic review of actual baseline performance data building one source of truth

Communication

Both internal and external communication strengthened to build reputation as well as to inform and engage

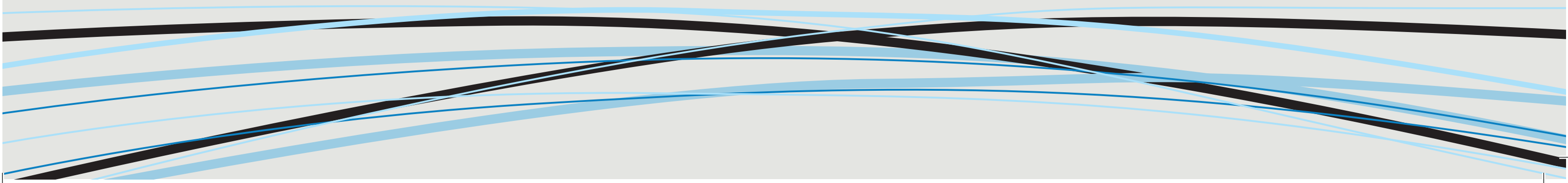
South Island Intervention Logic Framework

This annual report reports on our performance against the health goals articulated in our Annual Plan 2015/16 and the South Island Intervention Logic Framework.



IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

Statement of Service Performance



Statement of Service Performance

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

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

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

Improving Health Outcomes for Our Population

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

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

The three strategic outcomes outlined in the Annual Plan 2015/16 with associated outcome and impact measures are shown below.

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

Cost of Service Statement

	2015/16 Actual $000	2015/16 Budget $000
Income		
Prevention Services	9,386	10,160
Early Detection and Management Services	182,031	195,240
Intensive Assessment and Treatment	595,583	574,739
Rehabilitation and Support	116,677	116,914
Total Income	**903,676**	**897,053**
Expenditure		
Prevention Services	9,386	10,160
Early Detection and Management Services	187,321	203,208
Intensive Assessment and Treatment	617,690	593,472
Rehabilitation and Support	122,822	126,168
Total Expenditure	**937,218**	**933,008**
Share of profit/(loss) in associates	-	-
Surplus/(Deficit) for the year	**(33,543)**	**(35,955)**

Appropriations

Under the Public Finance Act, the DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by the DHB for the financial year 2015/16 is $791,730,000 which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 16 to 51.

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

Why is this important?

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.

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

- more babies being breastfed
- more children caries free
- fewer young people taking up smoking.

How did we perform?

We are seeing pleasing results in areas including breastfeeding, and reducing the uptake of smoking. Areas such as ensuring access to oral health services will require greater focus to ensure it is contributing to this important health outcome.

SUPPORTING STORY

SmokeFree Babies Programme

Southern DHB Smokefree team are offering women (under 28 weeks pregnant) who smoke and live in either Dunedin Gore/Mataura, Edendale and Bluff areas the chance to enrol in the Smokefree Babies Programme.

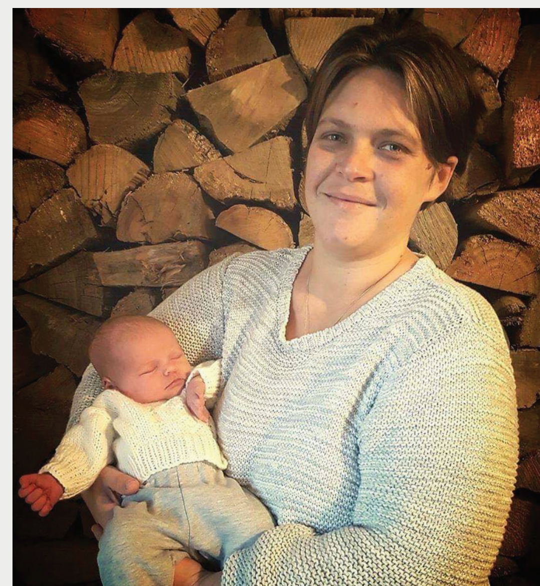
"The aim of the project is to increase smokefree pregnancies by using positive reinforcement to shape behaviour," said Southern DHB Smokefree Babies Programme Coordinator, Anita Clouston.

Drawing upon international evidence that incentives may be an effective strategy in getting pregnant women to quit smoking, those who enrol in the programme receive:

- free and confidential help to stop smoking
- weekly supportive catch ups at home
- grocery and Warehouse vouchers for themselves and their family to spend
- a beautiful mother and baby pamper pack when their baby arrives.

People who support the women are also encouraged to join the programme with free stop smoking support and vouchers available.

So far, the results have been promising. A total of 124 women from a variety of ethnicities have been referred into the programme, with high retention rates.



Olivia and daughter Tayla: Smokefree and doing great!

Outcome: Smoking Rates

Tobacco smoking kills an estimated 5,000 people in New Zealand every year. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke; and a risk factor for six of the eight leading causes of death worldwide.

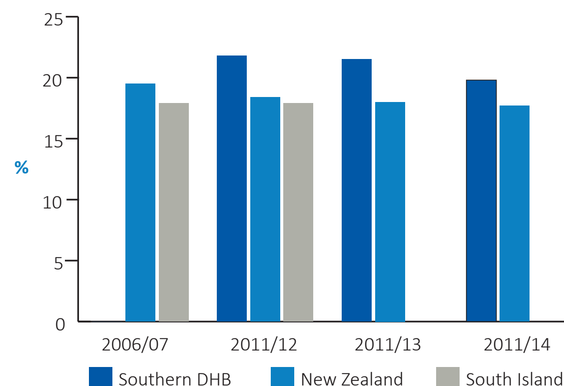
In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

One of the significant challenges the DHB faces is around reducing the number of smokers in our population.

Supporting our population to say "no" to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori. We are investing in programmes targeting our vulnerable populations particularly those who are pregnant and want to stop smoking. We have invested in smoking cessation services across the district to provide support to people who seek help to stop smoking.

Percentage of the population (15+) who smoke[2]

	2011/12	2011/13	2011/14	2011/15
Southern DHB	21.8%	21.5%	19.8%	N/A[1]
New Zealand	18.4%	18.0%	17.7%	N/A



Data sourced from national NZ Health Survey[2].

[1]The New Zealand Health Survey to 2015 has not been released yet (14 September 2016)
[2]The New Zealand Health Survey historically was undertaken every five years (2006/7 & 2011/12). It is now undertaken on a rolling basis and results are collated over a period of years and the column headings show the years that the data was collated.

Outcome: Obesity Rates

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

Improving healthy eating and physical activity behaviours is an ongoing challenge. It is estimated that by 2018 approximately 500 children will be classified each year as obese and will need to be referred through to health professionals. As a population there are similar rates of obesity in people aged over 15 years.

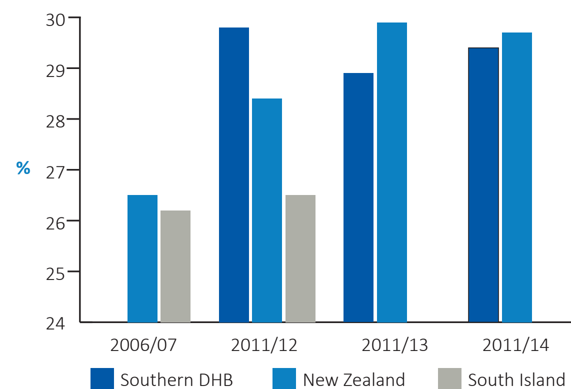
Obesity has significant implications for rates of cardiovascular and respiratory disease, diabetes and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

Southern DHB is participating in the national healthy food and drink project for DHBs to improve the food and beverages on offer in our institutions. It is anticipated that this will be used as a role model for other organisations.

Improving health behaviours of our population through good nutrition and physical activity is fundamental to improving health and well-being and preventing long term conditions. We encourage new parents to breastfeed their babies through all our maternity facilities. We are funding Green Prescription/ Healthy Families initiatives to enable families to make healthy choices.

Percentage of the population (15+) who are obese[2]

	2011/12	2011/13	2011/14	2011/15
Southern DHB	29.8%	28.9%	29.4%	N/A[3]
New Zealand	28.4%	29.9%	29.7%	N/A



Data sourced from national NZ Health Survey[2].

[3] The New Zealand Health Survey to 2015 has not been released yet (14 September 2016).

SUPPORTING STORY

Taking Action

When Keira Clarkson was referred to the DHB-funded Active Families programme by her GP, she and her Mum, Nanette, said they were looking for ways to increase their fitness levels, improve their diet and boost Keira's confidence.

Initially, Keira talked about physical activity as being "OK", but not something that she really enjoyed. She talked about activities that she liked to do and realised that there were quite a few of these that she could do. It was just a matter of prioritising time for these activities.

Through Active Families, Keira was super enthusiastic at the Zumba session and really challenged herself with the exercises and games at the Exercise Class. She came along to Sport Otago's Rainbow Run and had a wonderful time, and as running really wasn't Keira's favourite physical activity, the fun element was extremely important! She enjoyed the non-competitive nature of the run, being able to jog at her own pace. She loved the interaction of running through the colour stations, ending up looking a bit like a very happy, walking rainbow herself.

Then, Keira learned about the opportunity to take part in the Weet-Bix Kids TRYathlon, a non-competitive and inclusive event, which is why it is promoted through the Active Families programme. It would have to be the biggest physical challenge Keira had ever undertaken.

On the day of the TRYAthlon, Keira really did "try"! It wasn't easy for her, but she gave it her all. Keira's Weet-Bix medal and T-shirt are now framed and she takes great pride in her achievement.

Keira Clarkson celebrates completing the Weet-Bix Kids TRYathlon

SUPPORTING STORY

Returning to work while breastfeeding: Signe Stanbridge and baby Emma

Walking the Talk

Knowing that breastfeeding provides children with the best start in life, Southern DHB and WellSouth PHO are active supporters of breastfeeding not only in the community, but among its community of staff.

With breastfeeding peer counsellors, the Breast Room in Dunedin, breastfeeding friendly policies and the work of lactation consultants, maternity staff and health promoters, women are supported to breastfeed their babies for as long as they wish.

Southern DHB Clinical Nurse Specialist Signe Stanbridge works in the Dunedin Hospital Emergency Department, and through the support of the DHB has been able to continue breastfeeding her baby Emma since her return to work from maternity leave.

"Being able to continue to breastfeed Emma after returning to work is very important to me as I want to give Emma the best start in life I can," says Signe.

"Emma is cared for in the Dunedin Hospital Early Childhood Centre adjacent to the hospital and I've been able to pop out to feed her when she's needed it, which is fabulous.

"With this support I was able to return to work earlier than I had originally planned to take up a seconded position to Clinical Nurse Specialist which is great for both myself and Emma.

"I can't promote the convenience of being able to breastfeed enough - it's on tap, the right temperature, portable, I don't need to sterilise bottles and Emma gets all the nutrients she needs."

Medium Term Indicator: Breastfeeding

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

Breastfeeding is the unequalled way of providing ideal food for the healthy growth and development of infants and toddlers. This measure supports the sector to get ahead of the chronic disease burden. Breastfeeding sustains the link between mother and baby's immune systems established during pregnancy.

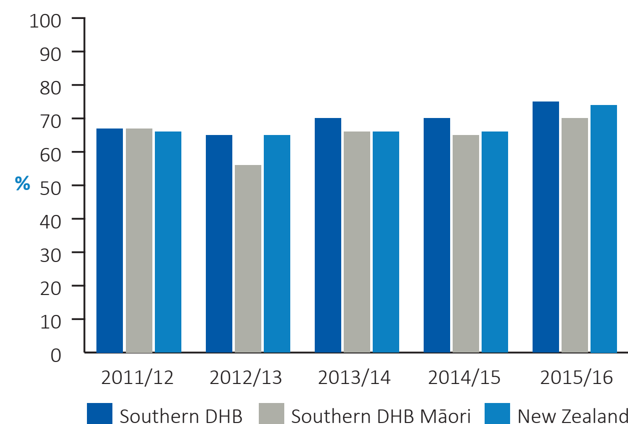
The DHB is reassured with the upward trend that breastfeeding has shown over the last few years. In particular it is very pleasing to see the percentage of Māori babies being breastfed at six weeks is also on target.

Our primary health organisation WellSouth Primary Health Network alongside our Public Health Unit promote and support breastfeeding through their Peer Supporters programme and the BURP smartphone application.

[4] Because provider data is currently not able to be combined, performance data from the largest provider (Plunket) is therefore presented. While this covers the majority of children, because local WellChild/Tamariki Ora providers specifically target Māori and Pacific mothers, results for these ethnicities are likely to be understated.

Percentage of babies fully/exclusively breastfed at 6 weeks

	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Southern DHB	70%	70%	>70%	75%
Southern DHB Māori	66%	65%	>70%	70%
New Zealand	66%	66%	>70%	74%



Data Source: Plunket via the Ministry of Health[4]

Medium Term Indicator: Oral Health

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

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

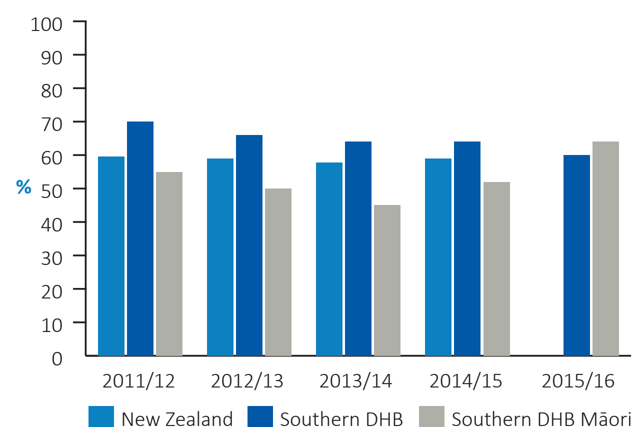
Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy indicator of equity of access and the effectiveness of services in targeting those most at risk.

The target for this measure has been set to maintain the total population rate while placing particular emphasis on improving the rates for Māori and Pacific children.

Results continue to show an increase in the number of Māori children who at five years old are caries free. However, the overall trend shows a slow decline in the percentage of five year olds who are caries free.

Percentage of 5 year olds who are caries free

	2013	2014	2015	
	Actual	Actual	Target	Actual
Southern DHB	64%	64%	>70%	60%
Southern DHB Māori	45%	52%	>70%	64%
New Zealand	58%	59%	>70%	N/A[5]



Data Source: Ministry of Health Oral Health Team

[5] The collated oral health data for all New Zealand DHBs will be available late 2016 and not in time for this Annual Report

Medium Term Indicator: Reduced Smoking

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

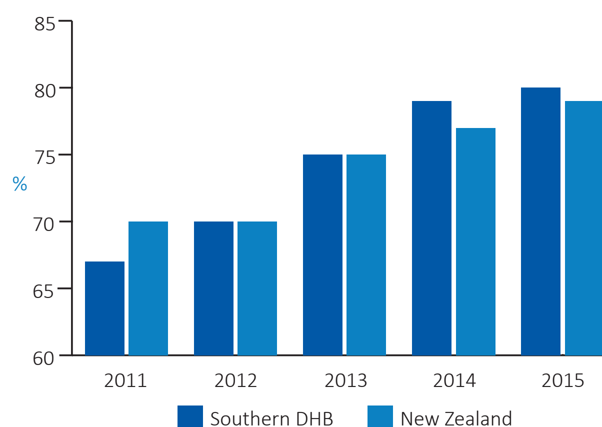
A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Southern DHB has shown particular success with increasing the percentage of youth who have never smoked and this can be linked back to good public health campaigns.

This measure is taken from the ASH survey completed annually with Year 10 students.

Percentage of Year 10 students who have 'never smoked'

	2013	2014	2015	
	Actual	Actual	Target	Actual
Southern DHB	75%	79%	77%	80%
New Zealand	75%	77%	77%	79%



Data Source: Plunket via the Ministry of Health

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

Why is this important?

We want our population to be supported to stay well in the community, as they will need fewer hospital-level or long-stay interventions. General practice can deliver services sooner and closer to home through early detection, diagnosis and treatment and deliver improved health outcomes.

Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes at a lower cost.

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

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

How did we perform?

Results from 2015/16 show many positive trends including more people living at home, earlier diagnosis of conditions enabled by hi-tech imaging, and continued reduction in avoidable hospital admissions. Further work is required in our efforts to prevent falls, and this will become a concentrated area of focus for Southern DHB for 2016/17.

Outcome: Acute Medical Admissions

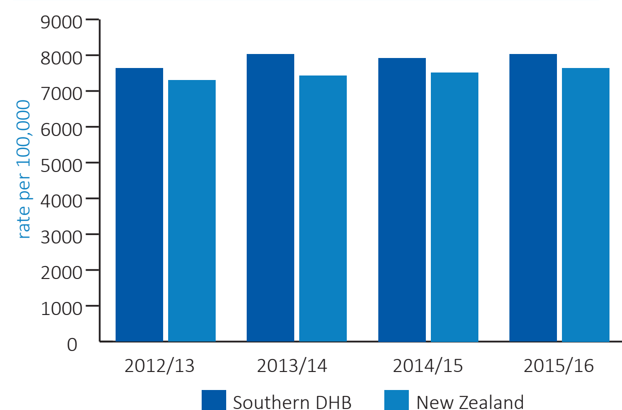
Lower acute admission rates can be used as a proxy indicator of improved conditions management. They can also be used to indicate the accessibility of timely and effective care and treatment in the community.

Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources that would otherwise be taken up by reacting to demand for urgent care.

The rate of acute medical admissions continues to be a challenge where Southern remains above the national rate. As part of Alliance South, the Urgent Care Network has been established with the aim of reducing Emergency Department attendances and hospital admissions.

The rate of acute medical admissions to hospital (age-standardised, per 100,000)[6]

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



Data sourced from National Minimum Data Set.

[6] This ASH measure differs from the measure in the Annual Plan 2015/16. Following a review of the ASH measures in 2015, the ASH definitions were altered and ASH 0-74 years is no longer collected. ASH 45-64 years is now considered the appropriate measure for adults and this has been used in the Annual Report.

Outcome: People Living at Home

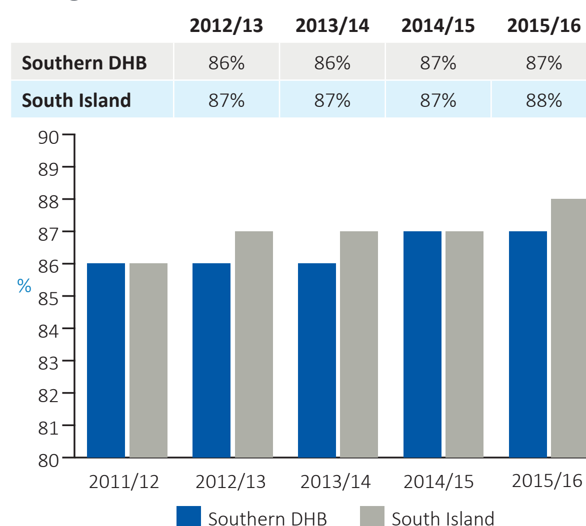
While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.

Living in ARC is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.

An increase in the proportion of older people supported in their own homes can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

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

	2012/13	2013/14	2014/15	2015/16
Southern DHB	86%	86%	87%	87%
South Island	87%	87%	87%	88%



Medium Term Indicator: Earlier Diagnosis

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

Timely access to diagnostics can be seen as a proxy indicator of system effectiveness where effective use of resources is needed to minimise wait times while meeting increasing demand.

Increased service demand and capacity constraints have contributed to not achieving the target for accepted referrals for CT and MRI scans. There is currently a radiology project underway that is looking at all radiology modalities across the Southern system. It is developing a range of pathways to manage appropriate demand for radiology, and seeking to better utilise the capacity around the district.

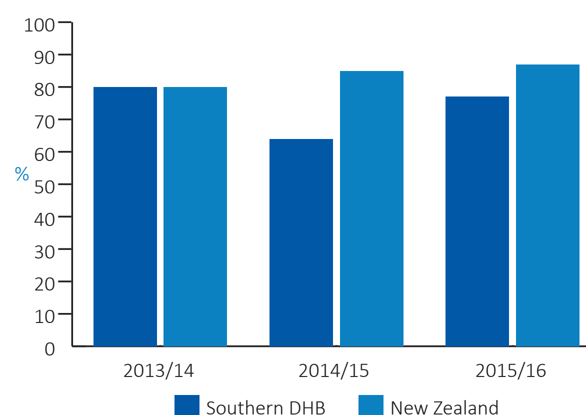
Percentage of people waiting no more than 6 weeks for their CT scan

	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Southern DHB	80%	64%	95%	77%
New Zealand	80%	85%	95%	87%

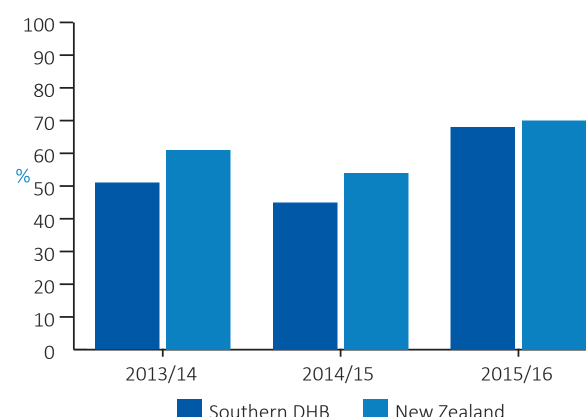
Percentage of people waiting no more than 6 weeks for their MRI scan

	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Southern DHB	51%	45%	85%	68%
New Zealand	61%	54%	85%	70%

Percentage of CT scans within 6 weeks



Percentage of MRI scans within 6 weeks



Data Source: Individual DHB Patient Management Systems

SUPPORTING STORY

Asthma Nurse Educator making a difference

Fourteen-year-old Darryn Poihakena-Jackson from Invercargill was suffering from such severe asthma that his mother Gina Malcolm found it hard to sleep at night in case he had an asthma attack, and she was worried about inviting visitors to the family home in case Darryn caught an infection.

All this has changed thanks to a treatment regime introduced by Dr Ian Shaw, Paediatrician at Southland Hospital, and the hard work and dedication of Asthma Educator, Annie Smith. In conjunction with Sports Southland, they have worked closely with Darryn and other teenagers to ensure they succeed in controlling their asthma.

Darryn has suffered from asthma since he was born and has been in and out of hospital since he was two. Mum Gina says that for the two years prior to starting the new treatment regime, Darryn was admitted to hospital on average every month due to his asthma, and despite trying everything nothing seemed to make it any better.

"I got to the point where I couldn't exercise and was always worried I'd have an asthma attack. We couldn't find any specific triggers so I never knew when one would happen," said Darryn.

The treatment regime has, according to Darryn and his mum, "changed his life". The hospital team started from scratch and removed all Darryn's medication, reintroducing maintenance and relieving therapy slowly, with Annie providing education and support.

"Annie has been just amazing," says Gina. "Not only has she provided fantastic education and support to Darryn, she has provided support and education to a group of boys also suffering from asthma. Annie has gone above and beyond her job, taking the boys to fitness sessions at Southland Stadium and being on hand in case they had an asthma attack."

Medium Term Indicator: Avoidable Hospital Admissions

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

Lower avoidable admission rates are seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

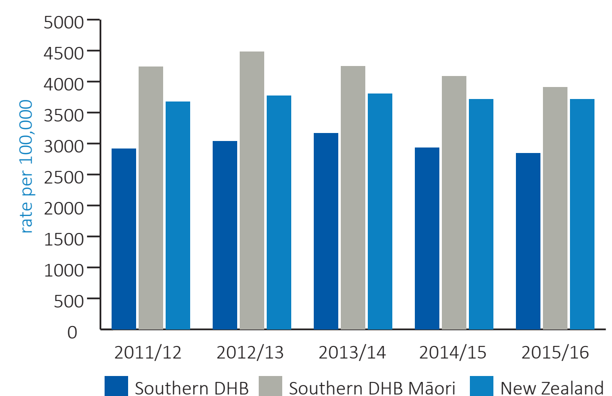
Lowering acute admissions can be used as an indicator to demonstrate how well long-term conditions (CVD, respiratory disease, diabetes and mental illness) are being managed in the community. It can be used to indicate the accessibility of timely and effective care and treatment in the community.

We continue to investigate those people who are frequent attenders at ED and work with the PHO to keep these people healthy in the community.

We fund a voucher scheme to enable people who might access ED to attend their primary care provider in the community.

Rate of avoidable hospital admissions for the population aged 45-64 years (rate per 100,000)

	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Southern DHB	3,169	2,937	N/A[7]	2,844
Southern DHB Māori	4,249	4,091	N/A[7]	3,912
New Zealand	3,805	3,716	N/A	3,717



Data Source: Ministry of Health Performance Reporting SI1[8]

[7] The ASH measure was reviewed in 2015 and the definitions were changed. The target set for 2015/16 is no longer comparable. Historical results have been reset utilising the updated definitions.

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

Medium Term Indicator: Falls Prevention

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

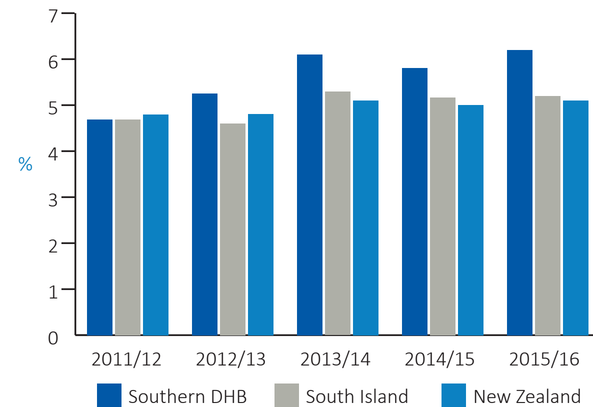
With an ageing population, a focus on reducing falls will help people to stay well and independent and reduce the demand on acute and aged residential care services. Solutions to reducing falls span both the health and social service sectors and include appropriate medications use, improved physical activity and nutrition, appropriate support and a reduction in personal and environmental hazards.

Lower falls rates can therefore be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided.

Reducing falls is a priority for Southern and an area for improving outcomes for older people. We have established a multi-sector Falls Governance Group which is currently overseeing the implementation of the Fracture Liaison Service in the community. We are also partnering with the Health Quality and Safety Commission (HQSC) and ACC on collaborative falls initiatives.

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

	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Southern DHB	6.10%	5.81%	-[9]	6.20%
South Island	5.29%	5.17%	-	5.20%
New Zealand	5.10%	5.00%	-	5.10%



Data Source: National Minimum Data Set

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

SUPPORTING STORY

Community Oral Health Clinic in Central

A new clinic in Queenstown is helping meet the needs of the ever-increasing number of teeth in this growing region.

Serving children aged from 0 to 12/13 years (Year 8 pupils) in Queenstown, Frankton and Arrowtown and other remote primary schools, the two-chair oral health clinic has been built in Douglas Street opposite the Lakes District Hospital and is being funded by the Ministry of Health based on the projected population figures for Wakatipu over the next 20 years.

“We’re really excited that we’ll be providing local children a modern community dental facility,” says Southern DHB Dental Public Health Specialist, Clinical Leader Oral Health Services, Dr Tim Mackay.

This project completes the Southern DHB’s part of a nationwide programme that overhauled the way dental services were provided to schoolchildren, with an emphasis on prevention, education and input from parents.

This is by far the largest investment in school-based oral health facilities in the Otago and Southland region since the Ministry of Education built the school dental clinics between the 1930s-1960s.

It will serve, in total, 3,000 pre-schoolers and primary schoolchildren in this area.

“These modern facilities will enable the clinicians who work in this new clinic to better diagnose oral health problems and make better treatment decisions. They will be able to provide a standard of care that reflects their dedication and professionalism,” says Dr Mackay.

Outcome 3.

People with Complex Illness Have Improved Health Outcomes

Why is this important?

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

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

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

How did we perform?

As our population lives longer with multiple conditions, we are seeing higher volumes of patients with complex medical needs. While this is a challenging area, our rates of acute readmission are stable and we are continuing to report reducing mortality.

Outcome: Acute Readmissions

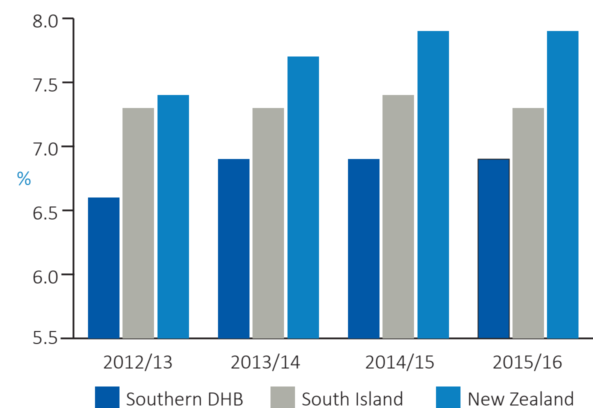
Unplanned hospital readmissions are largely (though not always) related to the care provided to the patient.

As well as reducing public confidence and driving unnecessary costs, patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

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

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

	2012/13	2013/14	2014/15	2015/16
Southern DHB	6.6%[10]	6.9%[10]	6.9%[10]	6.9%
South Island	7.3%[10]	7.3%[10]	7.4%[10]	7.3%
New Zealand	7.4%[10]	7.7%[10]	7.9%[10]	7.9%



Data Source: Ministry of Health Performance Data OS8

[10] The definition for acute hospital readmission rates has changed since the previous Annual Report. Results from previous years have been recalculated to reflect the updated definition to allow comparisons between years.

Outcome: Mortality Rates

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

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

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

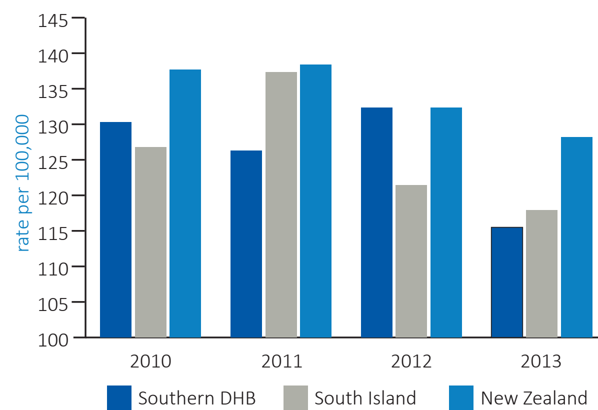
Rates of avoidable mortality are decreasing in all areas of New Zealand. Southern has shown significant decrease in avoidable mortality from 2010 to 2013. Southern mortality rates are significantly lower than the New Zealand mortality rates.

Avoidable mortality rates are reduced through timely and effective diagnosis and treatment for complex illnesses such as cancer and cardiovascular disease.

Note there is a delay in mortality data as the cause of death has to be established for all reported deaths. Data is currently only available to 2013.

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

	2010	2011	2012	2013
Southern DHB	130.3	126.3	132.3	115.5
South Island	126.8	137.3	121.4	117.9
New Zealand	137.7	138.4	132.3	128.2



Data sourced from MoH Mortality Collection.

SUPPORTING STORY

Faster Treatment for Southern Prostate Cancer Patients

Southern DHB patients with prostate cancer have been benefiting from the introduction of a radiation treatment which is given in a quicker, more efficient way and with the potential to cause fewer side-effects.

The DHB is offering Volumetric Arc Therapy (VMAT), the latest generation of external beam radiotherapy treatment.

"VMAT allows the clinical team to target the tumour more specifically and deliver radiotherapy to the exact area they need to in a shorter time, without damaging other areas," says Southern DHB Radiation Oncologist Dr Shaun Costello.

In standard radiation therapy sessions, radiation therapists must set up a target for a dose of radiation, apply it, then stop and move to the next location, several times. The radiation beam shape is fixed and it often has to be readjusted throughout the treatment. This takes time, meaning the possibility for movement and the potential for surrounding healthy cells of the patient to be put at risk.

With VMAT, one continuously-moving beam which changes its shape as it moves around the patient is aimed at the tumour for precision radiation treatment. This conforms to the shape of the tumour and at the same time minimises the amount of radiation to the normal surrounding tissues. The strength of the beam is continuously adjusted to ensure the right dose is given to the tumour as the machine travels around the patient.

"This treatment allows a more accurate use of the radiation beam and also allows tissues not affected by the cancer to have a lower dose of radiotherapy, resulting in reduced side-effects of the treatment.

"VMAT is a lot more comfortable for the patient and brings the treatment time down to just a few minutes," says Dr Costello, who adds that for some patients treatment has been reduced from seven to four weeks.

The treatment also reduces the common side-effects seen with traditional radiation therapy, including diarrhoea, bladder irritation and bleeding.

SUPPORTING STORY

Te Kākano Nurse-Led Clinics

Nurse-led clinics are dealing with the primary health care needs for dozens of people across the Southern District.

Te Kākano Nurse-Led Clinics have become an important focal point for care in Dunedin, Central Otago, East and North Otago, Bluff, South Invercargill, Gore and Mataura, with services led by Nadine Goldsmith in Southland and Lorna Scoon in Otago.

"We are focusing on people who may not access a GP for various reasons, and getting them to re-engage with primary health care," says Lorna.

"A lot of our work involves chronic disease management, such as diabetes and heart disease, but we also offer other services such as cervical smears and sexual health. We use the WellSouth voucher system to enable people to re-engage with their GP and work under WellSouth standing orders to treat uncomplicated illness."

Clinics are held fortnightly in some areas and monthly in others. There is a strong educational component with visiting educators from health organisations such as Heart Foundation and Diabetes New Zealand.

Patients are encouraged to share food and spend time with others which, for some, helps alleviate social isolation.

Close links with Whānau Ora services mean there is also other help available, for example with WINZ and housing applications.

Medium Term Indicator: Waits for Urgent Care

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

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

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

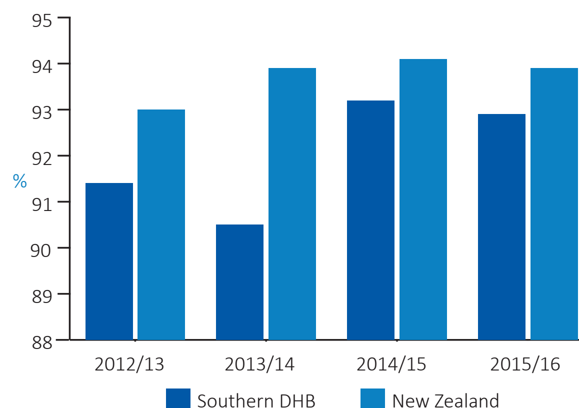
The number of people accessing Emergency Departments continues to rise. This in turn puts pressure on the ED to deliver timely care to its patients.

Meeting the ED health target is an ongoing challenge and requires a system-wide response. In addition to the ongoing improvements in ED and the hospitals, the Urgent Care Network has made a number of recommendations to the Alliance Leadership Team that will reduce the number of people presenting at ED:

- implementation of a Primary Options for Acute Care (POAC) programme
- a better integrated workforce development programme
- a review of after-hours care in Invercargill and Dunedin
- an ongoing urgent care public education programme across Southern District.

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

	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Southern DHB	90.5%	93.2%	95%	92.9%
New Zealand	93.9%	94.1%	95%	93.9%



Data Source: Individual DHB Patient Management Systems[11]

[11] This indicator is based on the national DHB Health Target 'Shorter Stays in ED' introduced in 2009 – in line with the health target reporting, the annual results presented are those from the final quarter of the year.

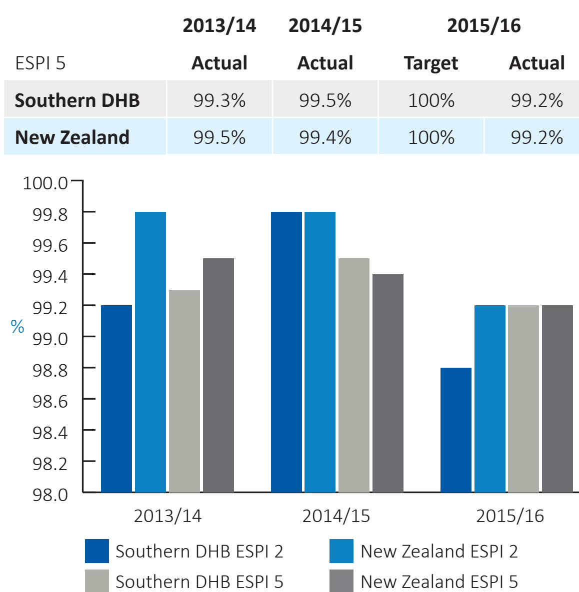
Medium Term Indicator: Access to Planned Care

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

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

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

	2013/14	2014/15	2015/16	
ESPI 2	Actual	Actual	Target	Actual
Southern DHB	99.2%	99.8%	100%	98.8%
New Zealand	99.8%	99.8%	100%	99.2%



	2013/14	2014/15	2015/16	
ESPI 5	Actual	Actual	Target	Actual
Southern DHB	99.3%	99.5%	100%	99.2%
New Zealand	99.5%	99.4%	100%	99.2%

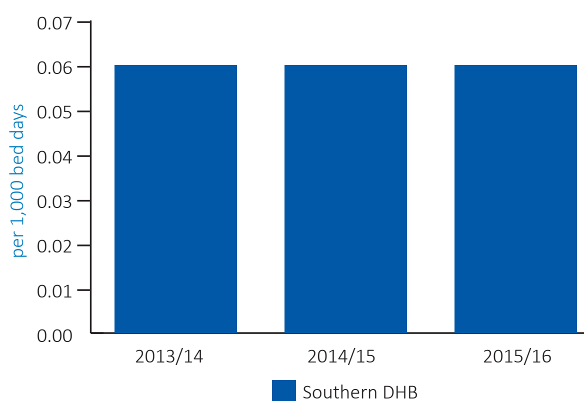
Data Source: Ministry of Health Quickplace Data Warehouse[12]

Medium Term Indicator: Adverse Events

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

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

	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Southern DHB	0.06	0.06	0.055	0.06



Data Source: Individual DHB Quality Systems[13]

[12] The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs are provided with individual performance reports from the Ministry of Health on a monthly basis.
[13] The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood.

National Health Targets

During the 2015/16 year Southern DHB saw improvements across all of the health targets. Some of these targets involve work being undertaken in primary care with our health partners.

Shorter stays in Emergency Departments

95 per cent of patients will be admitted, discharged or transferred from an Emergency Department (ED) within 6 hours.

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

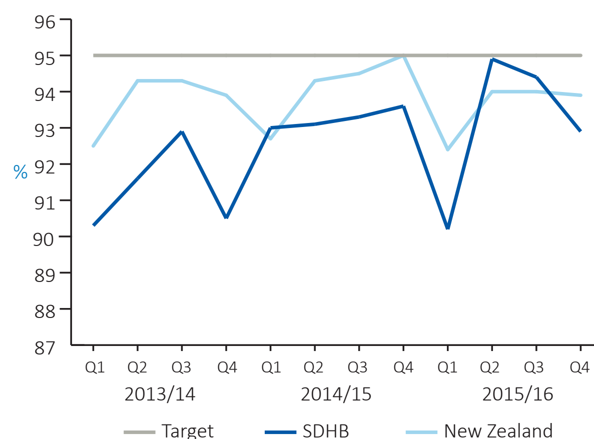
The number of people accessing Emergency Departments continues to rise. This in turn creates pressure for ensuring people receive timely care. Southern DHB achieved 95 per cent in the ED health target for the first time in Quarter Two but maintaining the target is an ongoing challenge.

Initiatives are in place to increase accessibility to urgent care in the community and to improve acute patient flow once in ED. The "free under 13 years" policy was rolled out and ensures more children are receiving access to general practice, including free urgent care.

The DHB implemented initiatives including: nurse-led early treatment zones; working with the PHO to examine the frequent attenders; implementation of Internal Medicine Winter Flex Unit; daily meeting in ED focusing on presentations, breaches and resolutions; and streamlining of patient administrative processes.

The Urgent Care Network has recently established three workstreams to continue the improvement of urgent and acute care services across the district.

Figure 2: Shorter stays in Emergency Departments



Improved Access to Elective Surgery

Nationally, DHBs will deliver an increase in the volume of elective surgery by an average of 4,000 per year. Southern will deliver at least 12,438 elective surgeries in 2015/16.

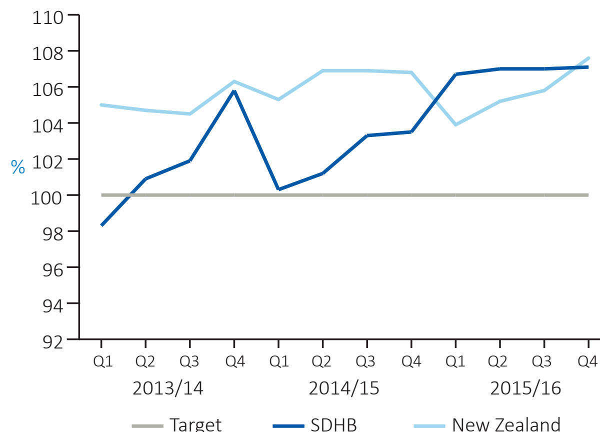
	Q1	Q2	Q3	Q4
Target	100%	100%	100%	100%
SDHB	107%	107%	107%	107%
NZ	104%	105%	106%	108%

Southern DHB has again achieved the number of planned elective surgery procedures for the 2015/16 period. A total of 13,324 elective procedures were completed which is 886 more than planned.

Southern DHB continues to provide timely and improved access to elective services.

Production plans are developed, monitored and where necessary modified, with the expectation of working towards the performance requirements.

Figure 3: Improved access to elective surgery



Faster Cancer Treatment

85 per cent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016.

	Q1	Q2	Q3	Q4
Target	85%	85%	85%	85%
SDHB	67%	77%	78%	77%
NZ	69%	75%	75%	74%

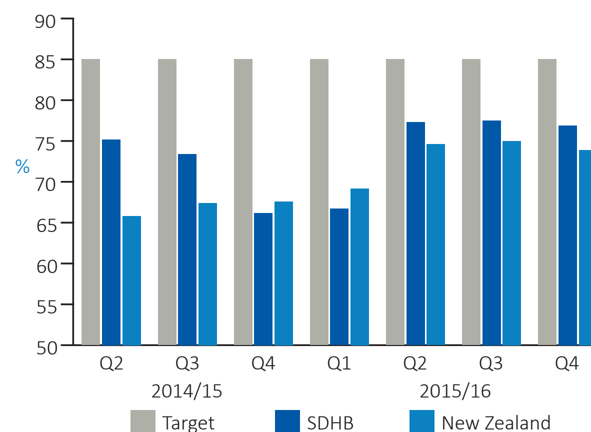
The Faster Cancer Treatment (FCT) measure was established as the Health Target in Quarter Two of 2014/15. It replaced the Shorter Wait for Cancer Treatment measure.

The DHB has shown some improvement from the previous year but like most DHBs we are still to reach the 85 percent target.

An FCT registered nurse is tasked with increasing clinical engagement, to further improve the ownership and quality of FCT data. The DHB's FCT data system has been modified to real-time information for the patient pathway. There is improved feedback to the multidisciplinary meetings on performance including the development of an FCT dashboard.

Accurate coding and data capture is still being improved and has impacted on data reporting. Systems within the DHB reporting system now have a mandatory field for suspicion of cancer, and there is a FCT flag on all departmental radiology referrals.

Figure 4: Faster cancer treatment



Increased Immunisation

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

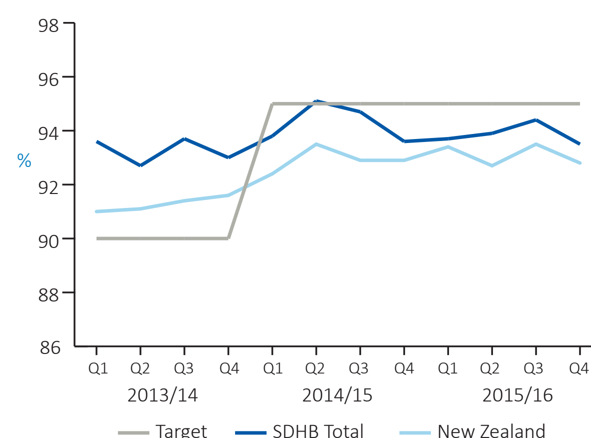
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
SDHB	94%	94%	94%	94%
NZ	93%	93%	94%	93%

The DHB maintained a 94 per cent immunisation coverage rate for all four quarters but did not reach the 95 per cent target.

Over 98 per cent of children aged eight months were reached and offered vaccination during the 2015/16 year. Opportunistic vaccination is offered to children at every contact with a health professional such as during visits with a Lead Maternity Carer, GP or practice nurse, when presenting at ED or Paediatric Outpatients, or at the B4 School Check.

The Southern Vaccine Preventable Disease Steering group is a multidisciplinary group which oversees immunisation coverage across the Southern district. Southern DHB remains one of the higher performing DHBs for this target.

Figure 5: Increased immunisation



Better Help for Smokers to Quit - Hospital

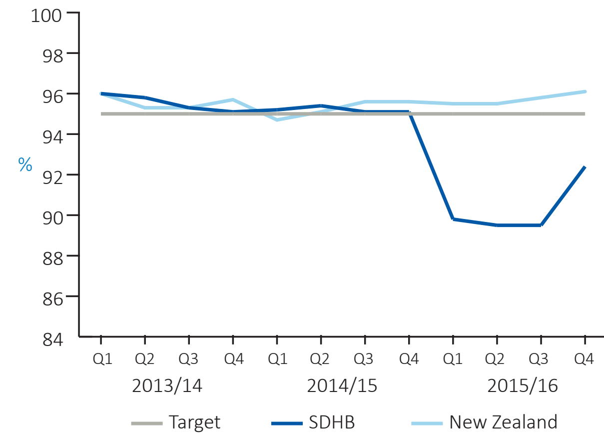
95 per cent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.

	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
SDHB	90%	90%	90%	92%
NZ	96%	96%	96%	96%

The DHB has not maintained the Health Target in the hospital setting, which highlights the challenge of embedding processes into routine business. In mid-2016 a mandatory field was included in the Emergency Department IT system recording smoking status. This will contribute to an improvement over the coming year.

The DHB continues to work towards achieving this target through strategies such as ABC training for all staff during orientation, raising awareness and education about smokefree support and continuing to support our Smokefree Champions within the DHB.

Figure 6: Better help for smokers to quit - Hospital



Better Help for Smokers to Quit - Primary

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

	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
SDHB	78%	87%	90%	88%
NZ	83%	85%	86%	86%

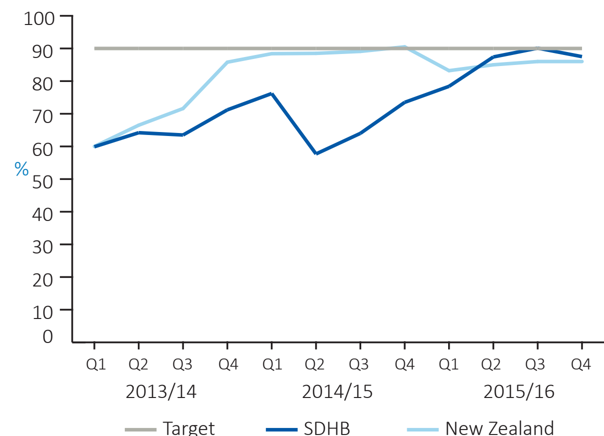
Primary care offering brief advice and support to quit smoking has increased significantly over the past year. The 90 per cent target was achieved for the first time in the third quarter.

WellSouth is now using a new IT provider which has improved data quality.

Other initiatives that have been implemented include training and providing up to date monthly data and feedback on practice performances.

Resources have been provided to practices to support them with tools to improve on target performance.

Figure 7: Better help for smokers to quit - Primary



Better Help for Smokers to Quit - Maternity

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

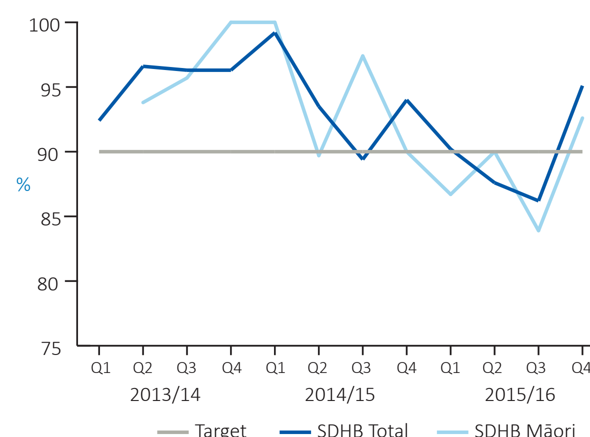
	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
SDHB	90%	88%	86%	95%
NZ	-	-	-	-

The maternity Better Help for Smokers to Quit target was achieved in two quarters in the last year.

There are some issues with the data accuracy. This is being continually worked on as part of our work with Lead Maternity Carers (LMC).

A number of initiatives have been focused around babies such as the Smokefree Babies project piloted in Dunedin and Mataura and the Pēpi–Pod programme which is aimed at providing a safe sleeping space for babies who have been exposed to tobacco smoke during pregnancy.

Figure 8: Better help for smokers to quit - Maternity



More Heart and Diabetes Checks

90 per cent of the eligible population will have had their cardiovascular risk assessed in the last five years.

	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
SDHB	85%	87%	88%	88%
NZ	90%	90%	90%	90%

There has been upward progression from last year to 88 per cent at the end of 2015/16, but Southern DHB is yet to reach the more heart and diabetes health check target.

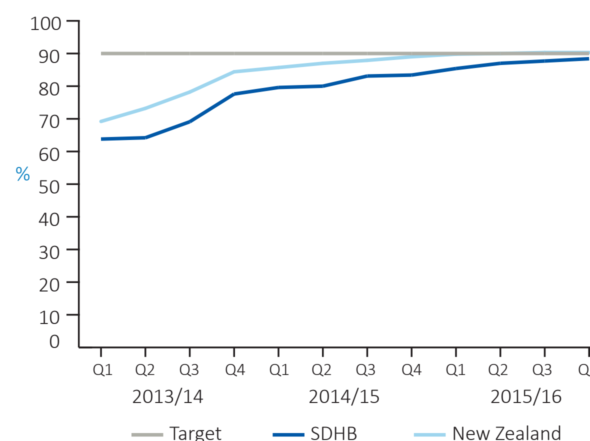
WellSouth has undertaken a number of initiatives including developing tables indicating practice performance. Information tools and reporting programmes are provided to practices, in particular Patient Dashboard, DRINFO and Appointment Scanner.

WellSouth has employed Outreach Nurses in Otago and Southland to follow up hard-to-reach patients on behalf of practices.

WellSouth has improved access to primary care through the voucher programme which is supporting high needs/vulnerable populations.

The use of a new IT provider has enabled greater real-time visibility to practices on activity and progress.

Figure 9: More heart and diabetes checks



Outputs – Short-Term Performance Measures

Output Class: Prevention

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

These services include education programmes and services to raise awareness of 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

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

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

How did we perform?

Southern DHB has consistently achieved high rates of immunisation cover for both Māori and non-Māori throughout 2015/16. It has closed the gap between Māori and non-Māori in the target for eight-month olds, and in other measures the results for Māori outperform those of non-Māori. Southern DHB has reached the 95 per cent target (for both those aged eight months and two years) for a single quarter, and now the focus is on maintaining the result at or above 95 per cent (see Figures 10 and 11).

Southern DHB is reaching 98 per cent of eligible babies by eight months of age and 99 per cent of eligible children by two years of age to ensure that immunisation has been offered.

Table 1: 2015/16 Performance Results for Immunisation Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Percentage of children fully immunised at 8 months (Health Target)	Total	93%	94%	95%	94%
	Māori	92%	91%	95%	94%
Percentage of children fully immunised at 2 years	Total	94%	95%	95%	95%
	Māori	95%	93%	95%	96%
Percentage of children fully immunised at 5 years	Total	N/A	N/A	95%	91%
	Māori	N/A	N/A	95%	92%
Percentage of children (aged 8 months) 'reached' by immunisation services	Total	97%	97%	99%	98%
Percentage of children (aged 2 years) 'reached' by immunisation services	Total	99%	98%	99%	99%
Percentage of eligible girls fully immunised with 3 doses of HPV Vaccine[14]	Total	-	-	65%	76%
	Māori	-	-	65%	81%
Percentage of people aged over 65 having received a flu vaccination	Total	68%	65%	75%	N/A[15]
	Māori	71%	61%	75%	N/A[15]

[14] The measure for the coverage of HPV vaccination changed in 2015/16 so prior years are not comparable.
[15] Data not available at the time of reporting.

The Southern Vaccine Preventable Disease Steering Group is a multidisciplinary group which oversees immunisation coverage across the Southern district.

There are a number of ways that vaccination rates are followed up and monitored:

- maternity providers/LMCs provide birth notifications to National Immunisation Register (NIR) to support immunisation coverage
- babies are entered onto the NIR and followed up to ensure a Practice of Enrolment
- NIR administrators contact GPs regarding babies not accepted for enrolment
- NIR and WellSouth do monthly audits of babies who are overdue for immunisation and parents are contacted to encourage attendance
- unvaccinated children presenting to ED and Paediatric Outpatients are opportunistically vaccinated
- at the B4 School Check, immunisation status of four-year-olds is checked, and a referral made if necessary
- The HPV online learning tools have been promoted to increase knowledge of the benefits of the HPV programme
- Southern DHB and WellSouth have worked with GPs to recall over 65s for seasonal influenza vaccinations.

Figure 10: Percentage of children fully immunised at age 8 months

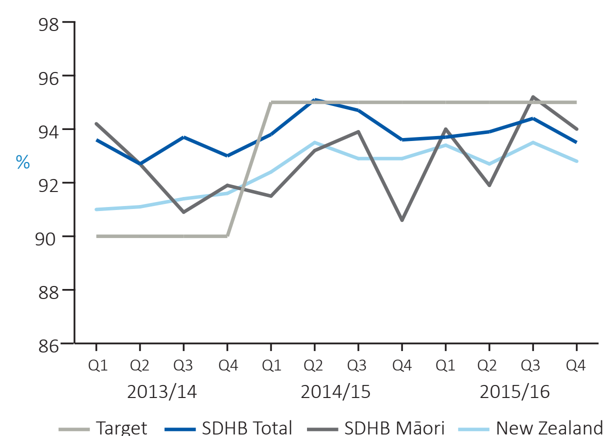
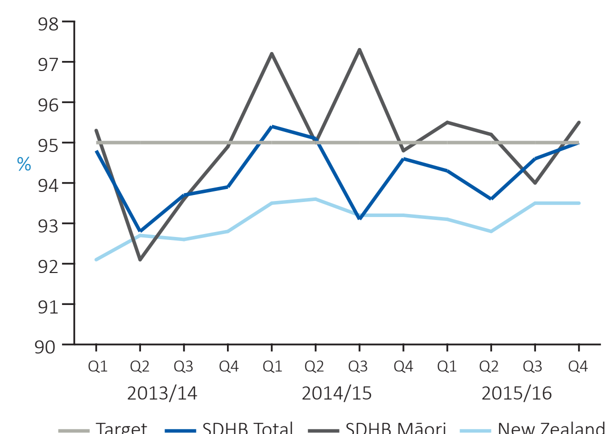


Figure 11: Percentage of children fully immunised at age 2 years



Health Promotion and Education Services

Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt. Brief advice works by triggering a quit attempt rather than by increasing the chances of success of a quit attempt. By encouraging and supporting more smokers to make quit attempts we expect there will be an increase in successful quit attempts, leading to a reduction in smoking rates and a reduction in the risk of the individuals contracting smoking-related diseases.

All health professionals at our hospitals and primary care are trained on how to routinely address nicotine dependence.

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. This measure supports the sector to get ahead of the chronic disease burden.

How did we perform?

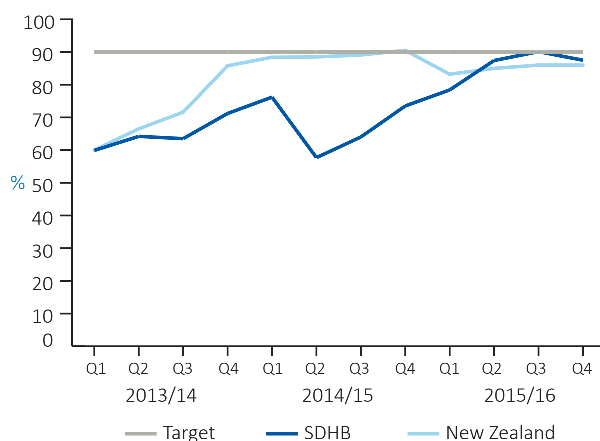
Southern DHB continues to show improvement against most smoking targets. The DHB has struggled to maintain the Health Target in the hospital setting which highlights issues with embedding processes into routine business. In mid-2016 a mandatory field was included in the Emergency Department IT system recording smoking status which will contribute to an improvement over the coming year.

Table 2: 2015/16 Performance Results for Health Promotion and Education Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Percentage of smokers receiving advice and support to quit smoking in hospital	Total	95%	95%	95%	92%
	Māori	95%	95%	95%	95%
Percentage of Primary Health organisation smokers who receive advice and support to quit smoking	Total	71%	74%	90%	88%
	Māori	74%	77%	90%	88%
Percentage of pregnant smokers being offered advice and support to help quit smoking	Total	96%	94%	90%	90%
	Māori	100%	90%	90%	88%
Percentage of pregnant women who are smokefree at 2 weeks postnatal	Total	-	-	95%	87%
	Māori	-	-	95%	70%
Infants exclusively or fully breastfed at 6 weeks	Total	68%	70%	75%	75%
	Māori	63%	65%	75%	70%
Infants exclusively or fully breastfed at 3 months	Total	-	-	60%	57%
	Māori	-	-	60%	47%
Infants receiving breast milk at 6 months	Total	-	61%	65%	65%
	Māori	-	51%	65%	57%

Figure 12 shows a significant increase in the health target Smokers Receive Advice and Support to Quit Smoking in Primary Care.

Figure 12: Smokers receive advice and support to quit smoking in primary care



Smoking cessation providers continue to play a pivotal role in supporting people to quit. In 2015/16 the Ministry of Health led a national tobacco re-alignment process and selected one regional stop smoking service provider Nga Kete Mataraunga Pounamu to deliver this service across the Southern district.

Southern DHB has been successful in piloting the Smokefree Babies project in two high smoking prevalence areas (South Dunedin and Mataura) with positive results.

The Pēpi-Pod programme is also aimed at vulnerable populations providing a safe sleeping space for babies who have been exposed to tobacco smoke during pregnancy.

In primary care an automated referral system is in place in general practice to enable patients to be referred to community stop smoking services. WellSouth have continued to resource general practice staff with support they need to enable achieving the community stop smoking target.

Breastfeeding rates are continuing to increase for both our Māori and Pakeha population, particularly at the six week measure. Southern reached the 75 per cent target in Quarter Four for the total rate.

The DHB has undertaken a large number of initiatives in 2015/16 which will have contributed to our overall increase in breastfeeding rates such as:

- working with our Māori and Pacific providers to encourage pregnant women to register with an LMC in their first trimester of pregnancy
- WellSouth and PHS continue to promote the Breastfeeding Ultimate Refuel Place (BURP) mobile phone application, which outlines places where women are able to breastfeed comfortably
- a single Pregnancy and Parenting service, established in early 2016, which has a focus on high needs populations and encouraging breastfeeding
- the Smokefree Babies project – Auahi Kore Mo Ka – and the Pēpi-Pod programme were promoted to share harm reduction messages with families and whanau and encouraged them to have positive behaviours around new babies.

Statutory Regulation

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

How did we perform?

The DHB has met three of the four statutory requirements which are core responsibilities for public health units. The Public Health Unit no longer undertakes hazardous inspections, and the way in which audits are processed and recorded has changed in 2015.

Table 3: 2015/16 Performance Results for Statutory Regulation

Measure	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
Percentage of tobacco retailers compliant with current legislation	100%	95%	85%	99%
Alcohol retailers are compliant with current legislation	95%	96%	95%	98%
Proportion of communicable disease notifications investigated	100%	100%	100%	100%
Proportion of hazardous inspections and audits completed	100%	100%	100%	N/A[16]

Population-Based Screening

Breast cancer is the most common cancer in New Zealand women and as women get older, the risk increases. Of those women who get breast cancer, three quarters are 50 years and over. For women aged 50-65, screening reduces the chance of dying from breast cancer by approximately 30 per cent (National Screening Unit, 2014). Breast screening is provided to reduce women's morbidity and mortality from breast cancer by identifying cancers at an early stage, allowing treatment to be applied.

Cervical screening is available for women aged 20-69 years. A cervical smear test looks for abnormal changes in cells on the surface of the cervix. Some cells with abnormal changes can develop into cancer if they are not treated. Treatment of abnormal cells is very effective at preventing cancer.

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

How did we perform?

Southern DHB has shown a positive progression across all population-based screening measures and has exceeded the target for all measures except for those relating to cervical screening for all women and breast screening for Māori women.

The DHB continues to achieve the breast screening rates at a population level. However, Māori and Pacific women have lower levels of coverage, with an extra 114 and 24 additional screens respectively needed to be undertaken to meet this target.

WellSouth PHO works closely with BreastScreen Aotearoa (BSA) to carry out a data matching process that identifies enrolled women who are not currently on the BSA database. This information is provided to General Practice to support the women to receive a mammogram.

Table 4: 2015/16 Performance Results for Population Based Screening

[16] Public Health South no longer undertakes hazardous substance inspections. The requirements for hazardous substance audits have also changed. Therefore the measure is no longer able to be reported as stated.

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Percentage of women (50-69 years) who have had a BSA mammogram breast screen examination in the past 2 years	Total	81%	73%	70%	74%
	Māori	70%	62%	70%	65%
Percentage of women (25-69 years) who have had a cervical screening event in the past 3 years	Total	79%	79%	80%	79%
	Māori	62%	59%	80%	61%
Percentage of eligible children receiving B4 School Checks	Total	99%	100%	90%	94%
	Quintile 5	97%	100%	90%	99%

Southern DHB has made some improvement this year ensuring eligible Māori women are up to date with their cervical screening. The DHB has strengthened linkages and relationships with local Māori communities over the last year. The introduction of a new IT system will allow screeners to identify and target population groups at a practice level who are due for their screening.

Southern DHB continues to exceed its target for B4 School Checks. Positive relationships exist between public health nursing service, NGOs (Māori and Pacific providers, Plunket, WCTO providers, WellSouth, GPs, Well Child Networks, and Family Works) and early education providers to encourage participation in the service.

Output Class: Early Detection and Management

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.

Oral Health

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

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

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

How did we perform?

Overall, Southern DHB has not met its targets that were set out in our Annual Plan for oral health.

Table 5: 2015/16 Performance Results for Oral Health

Measure		2013/14 Actual	2014/15 Actual	2015/16 Target	2015/16 Actual
Number of eligible preschool children enrolled in school and community oral health services	Total	17,691	15,486	18,000	15,075
	Māori	2,420	2,174	3,300	2,325
Percentage of eligible preschool children enrolled in school and community oral health services	Total	89%	82%	95%	80%
	Māori	78%	61%	95%	65%
Number of eligible children from Year 1 to Year 8 enrolled in school and community oral health services	Total	28,090	27,971	28,000	28,218
	Māori	4,300	3,629	5,108	3,892
Percentage of eligible adolescents who access funded oral health services	Total	83%	82%	85%	75%
Percentage of children caries-free at five years of age	Total	64%	64%	70%	60%
	Māori	45%	52%	70%	64%

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

The DHB is undertaking work to understand why enrolments are lower than the target set, with analysis to understand where the 'missing' adolescents and preschool children are living within the Southern catchment to determine if there are any particular localities that need to be targeted. Determining this will direct what action the DHB will need to take.

Another strand of activity will be the establishment of a reporting template to help identify facilities with high rates of patients not attending appointments (DNA 'did not attend' rates). Maintenance of up-to-date Year 1 to 8 lists using school information will assist in accurate correlation with oral health service data. This analysis will be completed routinely.

The percentage of all children caries-free at five years of age has decreased, although for Māori children this has increased. This in part could be attributed to the lower than expected pre-school enrolments in the oral health services which have been occurring over the last few years.

Long-term Conditions Management

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

Cardiovascular disease (CVD) is still the leading cause of death in New Zealand and many of these deaths are premature and preventable. Some risk factors for cardiovascular disease are unavoidable, such as age or family history.

Many risk factors are avoidable, through improving diet, stopping smoking, and exercising. Increasing the percentage of people having CVD Risk Assessments ensures those at risk are identified early and can therefore be managed appropriately.

How did we perform?

There has been upward progression from last year to 88 per cent at the end of 2015/16 but Southern DHB is yet to reach the more heart and diabetes health check target.

WellSouth has undertaken a number of initiatives such as providing tables indicating practice performance, information tools and reporting programmes to practices. These include Patient Dashboard, DRINFO and Appointment Scanner. WellSouth has improved access to primary care through the voucher programme which is supporting high needs/ vulnerable populations.

Table 6: 2015/16 Performance Results for Long-Term Conditions Management

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
The proportion of the eligible population (45-79) having a CVD risk assessment in the last five years (Health Target)	Total	78%	83%	90%	88%
	Māori	64%	76%	90%	82%
Percentage of eligible patients (15-74 years) with good or acceptable glycaemic control	Total	55%	53%	79%	53%
	Māori	51%	47%	79%	46%
Percentage of potentially eligible stroke patients thrombolysed	Total	7%	6%	6%	3%
Percentage of high-risk patients receiving an angiogram within three days of admission	Total	77%	82%	70%	79%
Percentage of patients presenting with Acute Coronary Syndrome (ACS) who undergo coronary angiography have completion of ANZAC Q1 data collection within 30 days	Total	-	95%	95%	99%
	Māori	-	95%	95%	100%

The Long-Term Conditions (LTC) Network is developing a model of care utilising risk stratification to implement standardised, consistent and targeted long term conditions management in General Practice. A proposed model is currently being consulted on with a view to implement in 2016/17. The next phase will be to determine packages of care for patients with different levels of complexity and appropriateness to conditions.

Stroke thrombolysis is currently offered in Dunedin, Southland, Oamaru and Dunstan Hospitals. Dunedin Hospital provides a backup service where providers cannot offer services 24/7.

The target of high-risk patients receiving an angiogram within three days of admission has been achieved.

Community Referred Testing and Diagnostics

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

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

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

How did we perform?

Southern DHB continued to meet its target around patients receiving radiotherapy or chemotherapy within four weeks. The Health Target for patients referred with a high suspicion of cancer waiting 62 days or less was not reached, although we continue to perform well relative to other DHBs in this Health Target. There is ongoing development to improve the systems and processes to better utilise capacity and better manage demand over the course of the next year.

The DHB has historically met the targets for coronary angiography but a significant increase in demand over the past six months has resulted in a drop in performance.

Table 7: 2015/16 Performance Results for Community Referred Testing and Diagnostics

Measure	2013/14 Actual	2014/15 Actual	2015/16 Target	2015/16 Actual
Percentage of accepted referrals for coronary angiography receiving procedure within 90 days	99%	100%	95%	92%
Percentage of patients, ready for treatment, waiting less than four weeks for radiotherapy or chemotherapy	100%	100%	100%	100%
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%	77%
The percentage of accepted referrals for CT scans receiving procedure within 42 days	79%	66%	95%	76%
The percentage of accepted referrals for MRI scans receiving procedure within 42 days	52%	45%	80%	55%

Increased service demand and capacity constraints have contributed to not achieving the target for accepted referrals for CT and MRI scans. There is currently a radiology project underway that is looking at all radiology modalities across the Southern system. It is developing a range of pathways to manage appropriate demand for radiology, and seeking to better utilise the capacity around the district.

Primary Health Care Services

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

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

How did we perform?

PHO enrolment has reached the 95 per cent target, however the Māori enrolled population was slightly below target. 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. Of more significance is the reduction in Māori ASH rates.

The DHB and WellSouth have been working on improving access for children with more practices offering ‘free under 13 years’ care for regular consultations and after hours.

Figure 13: Ambulatory Sensitive Hospital (ASH) admission rates for children aged 0-4 years

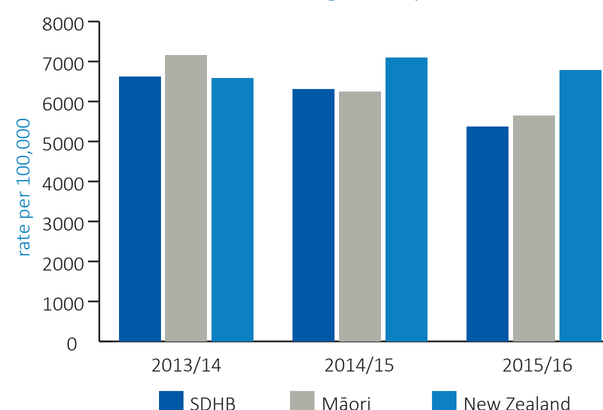


Table 8: 2015/16 Performance Results for Primary Health Care Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
The percentage of the DHB population enrolled in a Primary Healthcare Organisation	Total	93%	93%	95%	95%
	Māori	83%	86%	95%	93%
The number of skin lesions removed in primary care (by a GP with special interest – GPSI) without the need for a hospital appointment	Total	1,269	1,133	1,200	1,778
Ambulatory Sensitive Hospital (ASH) admission rates for children aged 0-4 years are reduced	Total	6,618	6,312	N/A	5,366
	Māori	7,163	6,246	N/A	5,651
Ambulatory Sensitive Hospital (ASH) admission rates for population aged 45-64 years are maintained[17]	Total	3,169	2,937	N/A	2,844
	Māori	4,249	4,091	N/A	3,912
The number of people receiving a brief intervention from the primary mental health service	Total	4,356	4,384	4,000	4,735

Demand for the GPSI based skin lesion service continues to outstrip supply. The programme is currently under review to understand how it can be delivered in a sustainable way over coming years. One of the principles behind the programme is to avoid unnecessary referral to secondary services such as Plastic Surgery and ENT thus relieving avoidable pressure on secondary services.

Output Class: Intensive Assessment and Management

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

Southern DHB provides a range of intensive treatment and complex specialist services to its population. The DHB also funds some intensive assessment and treatment services for its population that are provided by other DHBs, private hospitals or private providers. A proportion of these services are driven by demand which the DHB must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Elective Services – Inpatient and Outpatient

These are services for people who do not need immediate hospital treatment and are ‘booked’ or ‘arranged’ services.

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

How did we perform?

Southern DHB continues to perform strongly with delivery of elective services. The number of referrals to hospital based specialist services continues to increase. Actual delivery of First Specialist Appointment (FSA) was 7.9 per cent higher than target.

Elective surgical discharges achieved target. Some specialties performed better than others but on aggregate the Southern population benefited. The slight increase in caseweights would indicate that the overall mix of procedures was more complex.

Good use of resources and quality are demonstrated by:

- good theatre utilisation at 87 per cent against a target of 88 per cent, which compares favourably with other DHBs
- an inpatient average length of stay (LoS) of 1.54 days. The national average was 1.61 days.

[17] The definition for ASH was changed in late 2015. It is now measured as a rate per 100,000 and not as a percentage. A target was not set while the review of the ASH definitions were underway.

Table 9: 2015/16 Performance Results for Elective Services - Inpatient and Outpatient

Measure	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
The number of medical and surgical First Specialist Appointments (FSA)	37,618	38,443	35,818	38,662
Theatre utilisation - proportion of resourced theatre minutes used to total resourced theatre minutes	85%	81%	88%	87%
Number of elective surgical services discharges (incl. dental and cardiology)	12,390	12,415	12,000	13,064
Number of elective surgical services discharges (excl. dental and cardiology) – Health Target	10,948	11,039	12,438	13,324
The number of elective surgical services caseweights (CWDs) delivered	15,646	15,331	15,641	15,419
Average elective inpatient length of stay (days) is maintained[18]	-	-	1.55	1.54
Outpatient 'Did Not Attend' rates are reduced	5.7%	7.3%	8%	7.5%

Did not attend (DNA) rates for Outpatients were 7.5 per cent, achieving the target of less than 8 per cent. Services are diligent in following up with patients to advise and remind them of their appointments including the use of text-based reminders. Where services are aware of cancellations every opportunity is used to reallocate the appointment slot to another patient.

Acute Services

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

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

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

How did we perform?

The number of people accessing Emergency Departments continues to rise. This in turn puts pressure on our delivery of timely care.

Table 10: 2015/16 Performance Results for Acute Services

Measure	2013/14	2014/15	2015/16	
	Actual	Actual	Target	Actual
People are assessed, treated or discharged from the emergency department (ED) in under six hours	91%	94%	95%	93%
Number of people presenting at ED	76,618	77,811	<83,300	80,062
The acute inpatient average length of stay in hospital (days)[19]	-	-	<2.36	2.3

18 The definition for measuring average elective inpatient length of stay changed in 2015/16 and prior year's results are not comparable.
19 The definition for measuring average acute inpatient length of stay changed in 2015/16 and prior year's results are not comparable.

Meeting the ED health target is an ongoing challenge and requires a system-wide response. In addition to the ongoing work in ED and the hospitals, the Urgent Care Network has made a number of recommendations to the Alliance Leadership Team that will reduce the number of people presenting at ED:

- implementation of a Primary Options for Acute Care (POAC) programme
- a better integrated workforce development programme
- a review of after-hours care in Invercargill and Dunedin
- ongoing urgent care public education programme across Southern district.

The DHB performed well on the acute inpatient average length of stay (LOS) which was 2.30 days, below the target of 2.36 and also below the national average of 2.55 days.

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. The DHB monitors volumes in this area to determine access and responsiveness of services.

How did we perform?

The number of births in the district continues to be relatively constant with minor variation from year to year.

There are ten birthing facilities across the Southern district. The Maternity Quality Framework sets out the standards for the delivery of maternity services.

Table 11: 2015/16 Performance Results for Maternity Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
The number of births in the DHB region	Total	3,384	3,277	<3,384	3,352
	Māori	542	548	>542	544
New mothers have established breastfeeding on discharge from hospital	Total	82%	81%	85%	84%
	Māori	N/A	N/A	85%	N/A[20]
Baby friendly hospital accreditation is maintained	Total	100%	100%	100%	100%

New mothers are encouraged and supported to be breastfeeding prior to leaving birthing facilities and Southern has demonstrated improved breastfeeding rates through such initiatives as the Peer Breastfeeding Support Service in Otago and Southland. Well Child Tamariki Ora nurses and LMCs have Mama Aroha cards to support breastfeeding education for new mothers.

A Baby Friendly Hospital co-ordinator is employed to ensure accreditation standards are met across the district and the DHB has achieved this target again.

Assessment, Treatment and Rehabilitation Services (AT&R)

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

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

How did we perform?

The rehabilitation Length of Stay is decreasing while the health gains, as measured by the Functional Independence Measure (FIM) score, are increasing. The Assessment, Treatment and Rehabilitation Service is transitioning from a service based on patient's age to a service based on patient's needs, with services not restricted to the patient's stay on the AT&R ward.

[20] The data is not available at the time of this report.

Table 12: 2015/16 Performance Results for Assessment, Treatment and Rehabilitation Services (AT&R)

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Average LoS for inpatient AT&R services	<65 years	28.3	25.4	<28.3	26.0
	>65 years	18.2	18.6	<18.5	16.7
AT&R patients have improved functionality (FIM score) on discharge	<65 years	24.2	21.4	>24.2	25.7
	>65 years	17.1	17.4	>16.9	17.6

Specialist Mental Health Services

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

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

How did we perform?

Southern DHB has well established district-wide specialist mental health services delivered in both rural and urban settings which is contributing to achieving access rates above target. This year has seen the establishment of specialist services delivered on site at Dunedin-based general practices and mental health NGOs.

Table 13: Specialist Mental Health Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Improving the health status of people (aged 0-19 years) with severe mental illness through improved access	Total	4.0%	3.84%	3.75%	4.56%
	Māori	4.10%	3.76%	3.75%	4.59%
Improving the health status of people (aged 20-64 years) with severe mental illness through improved access	Total	4.04%	3.68%	3.75%	4.12%
	Māori	7.66%	6.50%	5.52%	7.55%
The percentage of children and young people who have a transition (discharge) plan[21]	Total	-	37%	95%	67%
The percentage of people (aged 0-19 years) referred for non-urgent Provider Arm mental health services are seen in a timely manner	<3 weeks	72%	79%	80%	79%
	<8 weeks	93%	95%	95%	96%
The percentage of people (aged 0-19 years) referred for non-urgent addiction services (Provider Arm and NGO) are seen in a timely manner	<3 weeks	74%	81%	80%	79%
	<8 weeks	84%	96%	95%	97%

[21] Description of the measure has been amended to reflect the updated definition.

Notable achievements over the year include:

- dedicated Māori mental health services based in both Otago and Southland contribute to high access rates for Māori
- good improvement in the number of children and youth with a transition (discharge) plan. This significant progress needs to be maintained as we work towards meeting the target
- meeting the timely access target of 80 per cent of young people seen within eight weeks of referral, and reaching 79 per cent for those seen within three weeks
- implementing electronic systems changes to enable accurate recording and monitoring of performance.

Output Class: Rehabilitation and Support

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

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentation and the need for more complex intervention. These services also support the flow of patients and improved recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and/or maximise their quality of life.

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

Southern has introduced a 'restorative' approach to home support, including individual packages of care that better meet people's needs. This may include complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital we monitor the effectiveness of these services, and that we use the InterRAI (International Residential Assessment Instrument) tool to ensure people receive equitable access to clinically appropriate support services that best meet their needs.

Needs Assessment & Services Co-ordination Services

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

How did we perform?

The volume of people requiring needs assessment continues to increase to 4,393 in the 2015/16 year. Over 99 per cent of people receiving funded home and community support services (HCSS) have received a comprehensive clinical assessment and individual care plan – see Figure 14.

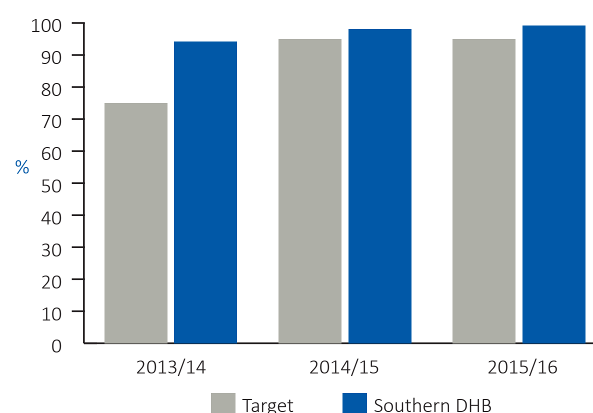
Table 14: 2015/16 Performance Results for Needs Assessment & Service Coordination Service (NASC)

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Total number annual Comprehensive Clinical Assessments (interRAI) provided for clients aged over 65 years	Total	4,069	3,117	>4,000	4,393
Percentage of people 65 years and over receiving long-term HCSS who have a comprehensive clinical assessment and an individual plan	Total	94%	98%	95%	99%

Non-complex clients are assessed by the Home and Community Support Services (HCSS) Alliance providers, and complex clients are assessed by the DHB and Rural Hospital Clinical Needs Assessors.

HCSS Alliance providers are using interRAI to assess clients to determine their needs. Clients work with health professionals to develop their individualised care plans.

Figure 14: Percentage of people 65 years and over receiving long-term HCSS who have a comprehensive clinical assessment and individual plan



Home and Community Support Services

These services are to support people to continue living in their own homes and to restore functional independence. An increase in the number of people being supported is indicative of increased capacity in the system.

How did we perform?

The HCSS Alliance has continued to work to implement the Restorative Model of Care, using the interRAI Comprehensive Clinical Assessment to determine clients' needs, work with clients to determine their goals and put Service Plans in place that address these. The DHB is satisfied that almost all of our HCSS clients have goals-based care plans based on their interRAI Comprehensive Clinical Assessment.

A similar percentage of non-complex clients are receiving HCSS services, with more complex clients being supported to live in their own homes.

Table 15: 2015/16 Performance Results for Home and Community Support Services

Measure		2013/14 Actual	2014/15 Actual	2015/16 Target	2015/16 Actual
Number of eligible people aged over 65 years supported by HCSS	Total	-	-	4,000	4,191
Number of eligible non-complex clients receiving HCSS per head of population aged over 65 years	Total	3.8%	4%	3.75%	4%
Percentage of HCSS clients aged over 65 years with goals-based care plans	Total	90.9%	99.7%	60%	97%
Percentage of HCSS support workers who have completed minimum training requirements	Total	46%	78%	80%	70%
Percentage of Health of Older People (HOP) clients receiving HCSS who are complex	Total	44.6%	49.5%	55%	50.9%

A well-trained workforce is critical to quality services for our older people. We continue to measure the percentage of the HCSS workforce who have completed minimum training requirements and expect these numbers to increase next year. The HCSS Alliance Service Development Group (SDG) is monitoring the issue around minimum training requirement for staff, and providers have committed to making improvements.

The HCSS Alliance SDG meets regularly to monitor activity, concerns, and improve quality.

More people are receiving services to enable them to live in their own homes by supporting them to retain and use their everyday abilities.

Respite and Day Services

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

How did we perform?

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

Table 16: Respite and Day Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Ratio of number of days of respite care allocated to number of days used	Total	80%	86%	83%	86%
The total number of eligible clients accessing Dementia Day Activity Programmes	Total	15	27	16	49
Number of eligible clients accessing Day Activity Programme[22]	Total	-	-	170	238

Day activity and dementia day activity usage is increasing, providing more support to assist ageing in place.

There is good utilisation of allocated respite in aged residential care. Respite is used to give the primary caregiver a break from looking after an older person at home. Respite can take many forms including Carer Support, respite in a residential aged care facility and community day activity programmes. Southern DHB reviewed how we use Respite during the 2016 year and will consider changes as a result of that review.

Rehabilitation Services

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

How did we perform?

Rehabilitation services is an area of development and we are still working towards meeting the targets.

The Fracture Liaison Service was established in early 2016 with the appointment of two co-ordinators employed by WellSouth. They have set up a framework, training processes and documentation to roll this programme out into primary care.

Table 17: 2015/16 Performance Results for Rehabilitation Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
People are referred to cardiac rehabilitation services after an acute event	Total	N/A	N/A	70%	N/A[23]
Number of people who are discharged from inpatient services, and who receive a community mental health contact in the 7 days immediately following discharge	Total	-	84%	73%	74%
Number of people referred to the Fracture Liaison Service[24]	Total	-	-	50	16
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathways		-	-	80%	89%[25]

[22] This is a new measure introduced in 2015.
[23] The data for cardiac rehabilitation is no longer collected in a way that supports the measure.
[24] The Fracture Liaison Service was established in early 2016.
[25] The percentage of patients admitted to a stroke unit is measured quarterly. This is the result from Quarter four (April-June).

Southern DHB has one organised Stroke Unit, at Dunedin Hospital. Stroke patients admitted at other hospitals are not admitted to an organised Stroke Unit. At the Southland Hospital site we have a general medicine ward, and all stroke patients are admitted to a designated section of the ward and they use a stroke pathway. Dunstan and Oamaru Hospitals meet the criteria established through the South Island Stroke Group for a hospital of their size.

Age-Related Residential Care

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

How did we perform?

Aged Care Facilities made a significant commitment to training and implementation of the interRAI LTCF (long term care facility) Comprehensive Clinical Assessment tool, with all facilities using it as their primary assessment and reassessment tool. This information is informing care plans and giving facilities the opportunity to use the data to identify opportunities to improve care.

While Rest Home level occupancy has decreased, despite an increase in the number of older people living in Southern DHB, overall numbers in the other levels of care have increased. This is due to a number of older people accessing secure dementia, hospital or psychogeriatric levels of residential care directly from the community, thereby reducing their overall time in residential care. This is directly related to the increased numbers of older people with complex needs receiving Home and Community Support Services in the community.

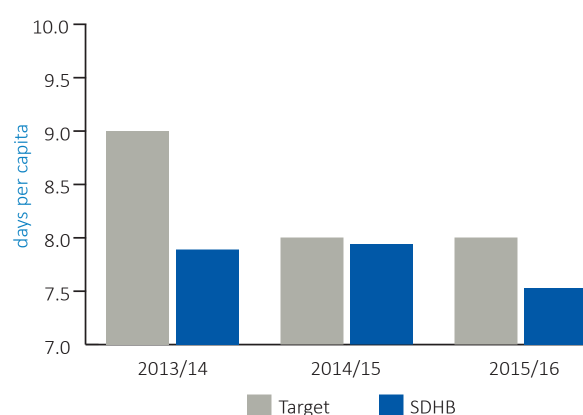
Regular forums between the DHB and Aged Care Facilities have supported the implementation of interRAI LTCF.

Table 18: 2015/16 Performance Results for Age-Related Residential Care

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	7.89	7.94	7.5	7.53
Percentage of residential care facilities using interRAI assessment tool	Total	21%	98%	100%	100%
Number of people in DHB subsidised aged residential care	Rest home	1,144	1,151	<1,150	1,135
	Dementia	-	-	<350	361
	Hospital	1,012	1,091	<975	1,108
	Psychogeriatric	-	-	<85	98

There is a greater focus on supporting and keeping people in their own homes. While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, Southern rates continue to decline in line with expectations – see Figure 15: Number of Rest Home Bed Days per capita of the population aged over 65 years. Living in ARC has been associated with a more rapid functional decline than ‘ageing in place’ and is a more expensive option. Resources could be better spent providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

Figure 15: Number of Rest Home Bed Days per capita of the population aged over 65 years



Palliative Care Services

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

How did we perform?

Te Ara Whakapiri - Principles and Guidance for the Last Days of Life was published on the Ministry's website in December 2015, replacing the Liverpool Care Pathway.

Te Ara Whakapiri was developed by the Palliative Care Council (PCC) and the responsibility for the guidance document transferred to the MoH in August 2015 when the PCC was disestablished. The document provides a recommended approach to caring for people in the last days of life across all settings in New Zealand. Implementation of *Te Ara Whakapiri* will occur during the 2016/17 year.

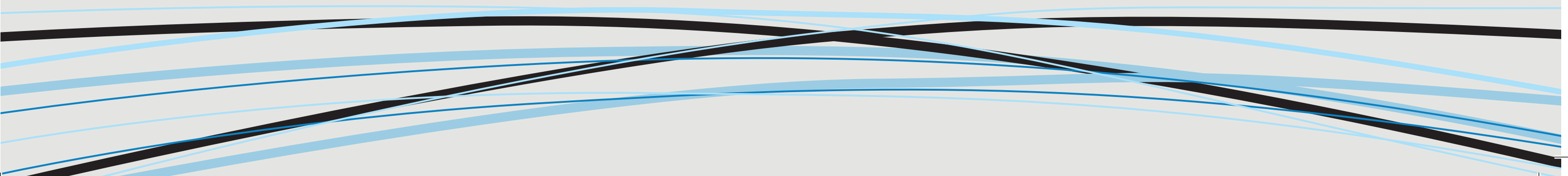
Assisting that implementation will be the new innovative service provided by Otago Community Hospice and Southland Hospice, with specialist palliative care nurses providing guidance, support, advice, education, and working alongside staff in Aged Care Facilities, to deliver quality end of life care.

Table 19: 2015/16 Performance Results for Palliative Care Services

Measure		2013/14	2014/15	2015/16	
		Actual	Actual	Target	Actual
People in hospice services are assessed and being supported by the Liverpool Care Pathway	Total	69%	N/A	90%	N/A[26]
Percentage of staff in ARC hospital level facilities are trained to provide the Liverpool Care Pathway	Total	68%	N/A	90%	N/A[26]

[26] Liverpool Care Pathway has been replaced by Te Ara Whakapiri - Principles and Guidance for the Last Days of Life. Data for the Liverpool Care Pathway is no longer collected.

UNDERSTANDING PATIENT EXPERIENCES



What were our aims?

- To gain a foundational understanding of our patients' experiences
- To identify the priorities that will make the greatest difference to our patients.

How did we perform?

- Our patient experience reports appear consistent with other DHBs
- Opportunities for improvement were identified, through a comprehensive patient engagement initiative.

Where to next?

- We will develop and implement organisation-wide initiatives, focusing on the specific priorities we heard from our patients, aimed at more consistently providing our best care.

Southern Future listening session outcomes

To better understand our patients' priorities, and how to improve their experience of care, we asked them. As part of our Southern Future programme, we held 'In Your Shoes' listening sessions with patients from across the district, in Dunedin, Invercargill, Queenstown, Wanaka, Alexandra and Oamaru. These included specific sessions for Māori, and for youth. In total 636 patients shared their perspectives through listening sessions or completing an online survey.

The outcomes have informed a programme of initiatives that will be undertaken over the next year.

Our patients asked us

1. To listen, communicate more and work in partnership

Patients want all of us to listen more, inform them better, improve our communication skills and develop an attitude of involvement partnership that puts patients and whānau at the centre of their own care.

2. To be more consistently kind, helpful and positive

Many patients report that the kind, friendly, helpful, positive attitude shown by our staff makes a big difference to their care. But not all patients say this, and some report the opposite. We will develop shared organisational values that set clear expectations, and support staff with the skills and resources to provide a consistently kind, helpful and positive experience.

3. To protect our patients' dignity at all times

We have heard too many stories about patients' dignity being compromised, for example being sent home in night attire. We must develop safeguards, attitudes and working practices to ensure that we never put patients' dignity or humanity at risk.

4. To value our patients', whānau and community's time

Our patients are asked to travel too often, appointments are not always co-ordinated, and we don't consider enough the impact on their lives. When planning care, we need to value more highly our patients' time, the impact on family, and the impact on local businesses when their staff are off work. We are part of a community, and it's only by considering the resources of the whole community that we can gauge the value we deliver. We will work with our front-line staff, and our patients, to re-model our services for our rural population, e.g. always offering appointments on one day; clinicians travelling to patients; tele-health; and a single health record.

5. To create a calmer, more compassionate experience

Especially to find ways to further reduce people's pain, anxiety and noise at night in our hospitals.

6. To continue working to improve the food we provide

Our commitment is to provide food that is high quality, nutritious and contributes to recovery. Many patients have told us that our food was not good enough, while others have told us they enjoyed the food. We will communicate openly and regularly about the steps we are taking to improve our patients' experiences of the food they receive in our care.

7. To keep listening to patients and whānau

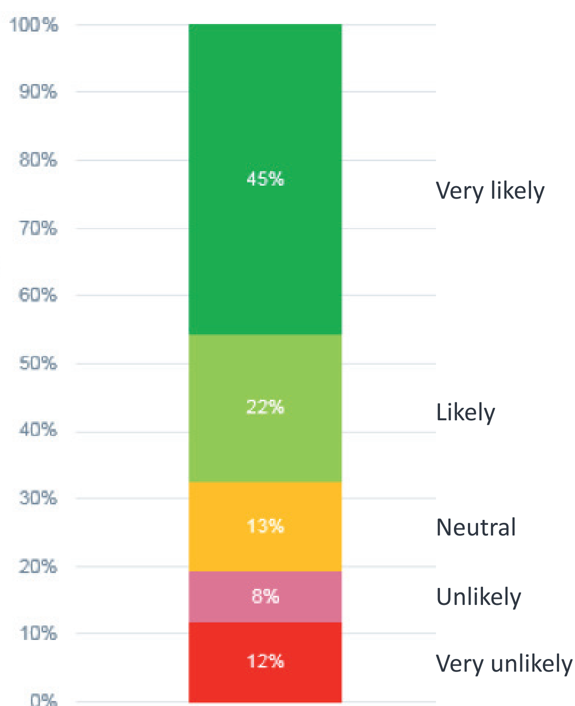
The 'In Your Shoes' sessions have given us a very helpful insight into what makes the most difference for patients and whānau, when we offer good care, and where we are letting them down. We plan to run more sessions and surveys to keep listening and keep improving.

Patient experience

The Southern Future programme also included gaining benchmark data relating to patient experiences, indicating that 80 per cent of patients are neutral or positive about their experiences with us. This aligns with the results from our patient experience quarterly surveys with dimensions of care receiving average overall scores of between 8.0 and 8.8 out of 10 in the last year. While these results are, overall, similar to

other DHBs, there remain opportunities for improving patients' experience by ensuring greater consistency in delivering our best care.

Patients were asked: How likely are you to recommend our service to someone if they needed similar care or treatment?

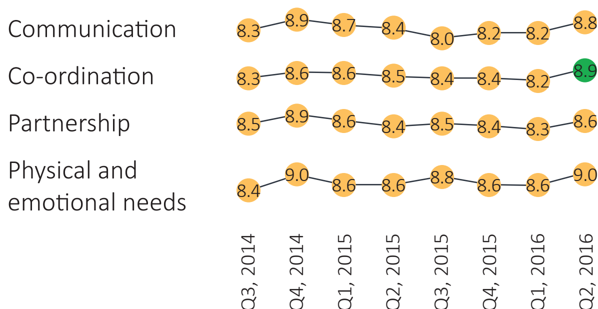


Net promoter score, Southern Future patient survey, n 412

Adult inpatient experience survey

Compared with national average

Score out of 10 by domain



Higher than other DHBs
Lower than other DHBs
About the same as other DHBs

Patient Experience Survey results to end of Q2 2016, Health Quality and Safety Commission New Zealand

Further information about quality measures and initiatives will be published in our 2016 Quality Account.

SUPPORTING STORY

Nurses release more time to care

Nurses at Southern DHB are working to enhance patients' experiences in hospital, by finding ways to spend more time with them.

The DHB is implementing, 'Releasing Time to Care,' a programme originally developed for Britain's NHS to enable nurses to streamline ward processes, freeing them to spend more time with patients.

Southern DHB initially rolled out the programme in Dunedin Hospital on the 4th, 7th and 8th floors, the Rotary Children's Ward and the Emergency Department, together with the Medical Ward at Southland Hospital.

Southern DHB Nursing Director, Medical Directorate, Sally O'Connor says, "The programme encourages staff to look at what, how and why they do things and to come up with different ways to make the ward processes more efficient and effective, giving staff more time with the patients they look after.

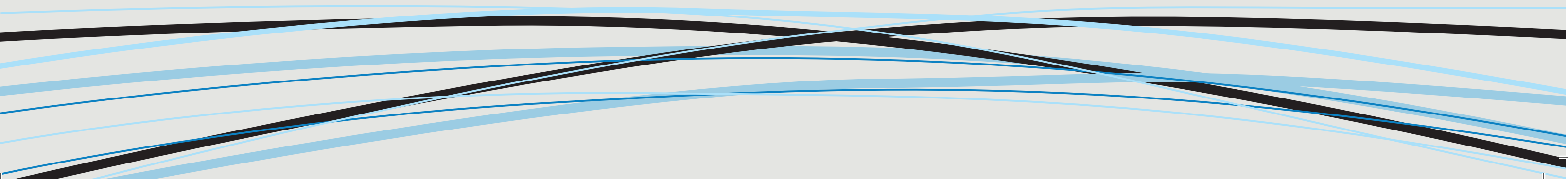
"Simple changes such as organising the way equipment is stored has made a real difference, saving time taken to access equipment and ultimately releasing more time for our nurses to care for their patients."

Southern DHB Acting Charge Nurse Manager Ward 4C Linda Smillie has nothing but positive comments about the programme. "It has allowed us to take the initiative to look at ways to enable us to work smarter which enables us to spend more time with our patients," she says.

Wards taking part in the programme are now using the 'My Careplan' which is a visual display of relevant patient information. They are also using an electronic whiteboard system which shows patient status at a glance, enabling staff to be up to date with the needs of every patient.

Many areas have also introduced display boards (known as 'huddle boards') to communicate ward-based initiatives and changes, and of updating patient status to the team. Short daily meetings are held at the boards so that wards can implement improvement changes and celebrate their success.

ORGANISATIONAL RESILIENCE AND SUSTAINABILITY



What were our aims?

To implement building blocks described in 'Owning our Future', including:

- Building organisational capability
- Strengthening finance and information data and capability
- Implementing quality initiatives
- Improving internal and external communication

Progress building development programme to improve our physical environment.

How did we perform?

- Financial performance strengthening
- Key leadership appointments made
- Southern Future programme implemented to establish organisational values and build culture
- Urgent interim building works underway
- Integrated primary-secondary IT system advanced
- Investments and alignment with primary and community care.

Where to next?

- Continue progressing Southern Future initiatives
- Identify further opportunities for whole of system changes in health care delivery that are more patient-centred and efficient.

Building our resilience as an organisation has been a core principle of our Owning our Future plan.

Significant attention has centred on improving our financial performance, and learning to live within our means. We were pleased to end the year slightly ahead of our agreed budget, a result achieved while also improving our performance against the Minister's health targets. This has helped build confidence that we can pursue a programme of system-wide efficiencies in how health services are delivered, leading to both better outcomes and reduced costs.

This financial result also included unbudgeted costs, including addressing the discovery of asbestos in Dunedin Hospital's Clinical Services Building.

However, an improved financial position will not be sustainable in the long term unless it is accompanied by investments to build resilience of organisation, in our people, buildings and infrastructure, and taking a whole-of-system approach to finding better and more efficient ways of delivering the health care our community needs.

Organisational Capability

Leadership

Investing in leadership is a fundamental aspect of Southern DHB's development and transformation programme. We have made key executive appointments of Chief Medical Officer, Chief Finance Officer, Director of Strategic Communications, and Executive Director of Organisational Development and Performance. These new appointments provide the opportunity to build organisational capability and provide leadership and impetus for the strategic directions of the DHB.

Promoting the qualities required to drive transformational change is by no means reserved for senior members of Southern DHB. Recognising that courageous leadership occurs at all levels of the organisation, programmes including Skills for Change, Xcelr8, and Southern Innovation Challenge encourage staff from throughout the organisation to identify and pursue initiatives that will make a difference for the district.

Strengthening our culture

At the heart of a high-performing organisation is a strong internal culture. International evidence shows that focusing on the patient experience through prioritising quality, safety and removing waste from the system will improve clinical engagement and reduce costs. This requires an internal culture that supports innovation and collaboration. Developing our internal culture is therefore a critical element of building the foundation from which we can deliver better outcomes for our patients and communities.

This is essential to enabling the collaboration and innovation that will enable us to deliver more for patients within our resources, and foster a positive patient experience.

Southern Future – It's up to Us was introduced as a system-wide transformation project to build a stronger internal culture at Southern DHB.

In total, over 2,500 items of feedback were received from staff who attended 'In Our Shoes' listening sessions with staff, leaders and providers, and completed online surveys.

Through this process, a set of values was adopted to guide our behaviours and decision-making, and focus areas to help improve our staff experience were defined.

The seven priority areas are:

1. Find more time for people to focus on patients
2. Eradicate rudeness and bullying
3. Build a culture of appreciation
4. Grow teams across locations, roles and services
5. Liberate innovation
6. Develop great leaders
7. Create a learning culture, where people feel safe to speak up.

Being a good employer: Good Employer Obligations Report

Southern DHB is committed to meeting its statutory, legal and ethical obligations to be a good employer. We consider our human resources to be our most valuable asset.

Underpinning our organisational vision and Good Employer Obligations, Southern DHB facilitates a human resources policy 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, value all employees and treat them with respect. These expectations and principles are set out in the Code of Conduct and Integrity Policy for all employees and those who are involved in the operation of Southern DHB.

A suite of equal employment opportunity policies underpins recruitment, pay and rewards, professional development and work conditions for employees.

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

Our Values

Kind Manaakitanga

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

Open Pono

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

Positive Whaiwhakaaro

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

Community Whanaungatanga

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

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

EEO

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

Leadership, accountability and culture

Monthly, multidisciplinary decision forums are held at an executive and senior level involving representatives across allied health, nursing, medical and management. This provides a mechanism for improving organisational decision-making and joint ownership of outcomes that are designed to specifically improve service delivery and clinical outcomes at a strategic level.

Recruitment, selection and induction

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

Employee development, promotion and exit

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

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

Flexibility and work design

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

Extended hours are available at our childcare centre for staff members' children on the Dunedin Hospital site, and an additional childcare facility is being opened at Wakari Hospital in November 2016.

On-site gym and squash courts are accessible to all staff at low entry cost, and discounted membership is available at private gyms in Invercargill and Queenstown, and at a swimming pool in Invercargill.

Remuneration, recognition and conditions

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

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

Harassment and bullying prevention programme

We are currently engaging with unions to review our current harassment and bullying policy to ensure it encourages and supports behaviours in line with the new organisational values. Its focus will be to seek to address issues effectively and quickly at the lowest possible level. It will be supported by the 'Speak Up' campaign, aimed at creating a culture where it is safe to highlight concerns, and through investing in training managers and HR professionals in both bullying prevention, management and investigation.

Safe and healthy environment

Health and safety is an important priority for Southern DHB. A new Health and Safety Manager has recently been appointed to lead further development of our Health, Safety and Well-being Policy and underlying policies and processes. The Health, Safety and Well-being strategy and an improvement plan are in place with regular performance reporting to General Managers and the Commissioner team (monthly). Current practices include:

- more than 160 elected Health and Safety representatives in place across Southern DHB's operation
- critical risks are identified and risk reviews are underway to identify the efficacy of current controls and potential improvements
- safety1st is established as South Island-wide incident and near miss reporting mechanism
- tertiary accreditation and an active ACC partnership programme is in place
- a 24/7 employee assistance programme is available to all staff for both personal counselling and critical incident debriefing.

Employee demographics*

The Southern DHB currently employs 4,526 employees across Otago, Southland and Central Otago. Twenty one per cent of our employee base is male; 79 per cent are female. While there is approximately a 50/50 split between male and female junior medical staff, at a senior medical level female representation is approximately one third of the workforce. The nursing profession comprises 12 per cent male employees, whilst midwifery remains 100 per cent female. Service support staff, such as drivers, trades, security staff, are predominantly male (91.5 per cent).

Of the 4,214 employees who detailed their ethnicity, 207 (4.91 per cent) identify as Māori or Pacific. Non-New Zealand European/Pakeha employees represent 24.1 per cent of our employee population, which includes a total of 39 different ethnicities.

Southern DHB is committed to ensuring equal employment opportunities and is continuing to look at ways to improve diversity across all levels of the organisation.

*Data current as at 18 August 2016

Employees with disabilities

Previously, the Southern DHB has not recorded details of staff with disabilities.

To address this area, in March 2016 the 'Employee Contact Details Form' was revised and now includes a question of whether the new employee identifies as having a disability. Consequently the organisation will be able to report on the number of staff hired who have disabilities and this information will aid in ensuring Southern DHB is an equal opportunity employer.

Occupational Group	Gender	Total	Māori	Pacific	Asian*	Other**	Not stated
Nursing (Registered nurses, Enrolled, HCA)	M	265	13	0	4	230	18
	F	1865	72	9	10	1655	119
Corporate and other (Mgt and Admin)	M	142	5	1	2	126	8
	F	667	26	1	9	573	58
Allied and Scientific	M	141	11	2	4	111	13
	F	697	25	0	6	629	37
Care and Support	M	54	1	2	0	50	1
	F	5	1	0	0	4	0
Senior Medical (SMO)	M	201	2	2	7	174	16
	F	102	1	0	2	90	9
Junior Medical (HO, SHO, Registrar)	M	143	4	0	24	102	13
	F	147	6	0	21	110	10
Midwifery	M	0	0	0	0	0	0
	F	92	4	0	0	80	8
Totals		**4521**	**171**	**17**	**89**	**3934**	**310**

* Includes Chinese and Chinese Malaysian
** Other is a group amalgamation of all ethnicities that do not fall into the groups Māori, Pacific or Asian

Age	Male	Female	Percentage of employees who identified as Māori/Pacific
0-19	0.10%	0.14%	
20-29	2.83%	12.47%	14.01%
30-39	20.79%	20.48%	23.67%
40-49	22.47%	22.14%	25.60%
50-59	26.23%	28.33%	25.60%
60-69	15.46%	15.80%	10.14%
70-79	1.46%	0.64%	0.97%
80+	0.10%		
Total	**21.14%**	**78.86%**	**4.91%**
Total Employees 4526			

Our physical environment

The need to improve our physical facilities has long been acknowledged, and the discovery of asbestos in our clinical services building in October 2015 added to the urgency of this. This year, considerable progress has been made.

Dunedin Hospital Redevelopment

In 2015, the Southern Partnership Group was appointed by the Minister of Health to oversee the planning and execution of redevelopment. Based on other similar projects, a timeframe of seven to ten years has been estimated for this project. The planning process follows Treasury's Better Business Cases model, as is standard for investments of this kind. This year the Strategic Services Plan and Strategic Assessment documents were produced. The next step, the Indicative Business Case, is due in mid 2017, and business case writers and architectural health planners have been confirmed for this work. Southern DHB plays an active and leading role in this process and clinical engagement will be a continued focus. This stage includes developing first a long list, followed by a short list, and then identifying a preferred option for the redevelopment. This becomes the focus of the Detailed Business Case, which is due in mid 2018.

Urgent interim works

In September 2015, the Ministers of Health and Finance approved business cases for three projects: redeveloping our audiology and gastroenterology facilities, and a programme of deferred maintenance tasks. In June 2016, the business case was also approved for a reconfigured and modernised ICU/HDU critical care unit.

By the end of the financial year, the design stages were complete for audiology and well advanced for gastroenterology. Enabling activities, including decanting and relocating services during the redevelopments, were also well underway. We look forward to making use of our improved facilities within the next year, providing a more comfortable interim environment for both staff and patients as the larger-scale hospital development project continues.

Southland education centre

A new education centre at Southland Hospital has been under development this year. Located above the old Southland Hospital dining room, the centre is designed to support a range of collaborative, inter-professional opportunities, and will include simulation suites, lecture spaces, video-conference facilities and consultation rooms, and a dedicated skills lab for training a range of practical skills such as intravenous therapy. The centre will also be available for other health organisations and community groups that may wish to make use of these facilities.

Improving our systems

HealthOne/Health Connect South

Having shared access to accurate data is an essential step towards a seamless and integrated health care system. Southern DHB's Information Services are planned on a regional basis through the South Island Alliance and the Information Services Service Level Alliance (IS SLA).

In the past year, this plan saw Southern DHB make significant progress towards implementing Health Connect South, which went live on 26 July, and support primary care to implement a complementary system, Health One.

The system, which has already been successfully implemented in Canterbury, West Coast and South Canterbury districts, extracts important information from general practice, pharmacy, community nursing and hospital records. This is then available in a single record, so that clinicians caring for a patient can see a more complete picture. Once the regional rollout is complete, the same shared information system will be accessible across the whole South Island, leading to safer, faster and better informed care for all South Islanders.

The integration of Health Connect South and HealthOne also saves both patient and clinicians' time by removing the need for repeat laboratory or radiology tests, and ensures patients need only provide each piece of information once.

Whole-of-system alignment

A district-wide service goes beyond the Provider Arm hospitals, and requires co-operation and relationships between all providers of services including our NGO sector, primary and secondary care and rural hospitals to support all of our communities.

Alliance South

Alliance South's focus on the health of the population as a whole allows for broad innovation in the design and delivery of services. Work on particular areas of health care is undertaken by networks and work streams, which have been established for specific priority areas identified by the Leadership Team. Three areas of particular focus identified in 'Owning Our Future' are Long-Term Conditions, Health of Older People and Urgent Care. These networks are working collaboratively to develop new models of care that target at-risk population groups, tailor services to enhance management in the community setting and reduce the need for ED visits and/or hospital admissions.

Investments in Primary Health

Providing a more patient-centred system that focuses on care closer to home and preventing health events from worsening led to investments in more clinical pharmacists, and greater access to telehealth this year.

WellSouth Primary Health Network was contracted to employ additional clinical pharmacists to work with general practices to assist high-risk patients to self-manage their long-term conditions. Evidence has shown that clinical pharmacists can reduce medicine-related harm and reduce inappropriate medicines use, especially for patients over 65 years of age who use four or more medications. The contract value is $1.7 million for the three years 2016-19.

Meanwhile, a $496k investment in telehealth across the district will provide more accessible consultations for patients in rural communities. Telehealth involves the use of IT and video technology to enable hospital specialists in city offices to consult with patients and general practice staff in remote localities via a confidential, secure video link. The convenience has the potential to save patients many hours of travel that in the past would have required travelling round-trips from their rural homes. WellSouth has already successfully held clinics from its Dunedin office with the Lawrence Medical Centre.

SUPPORTING STORY

Online Fire Training Wins Innovation Challenge

Fire training has become a lot easier for Southern DHB staff thanks to an innovative online learning platform.

Kylie Machin from Southern DHB's Building and Property team was recognised in the 2015 Southern Innovation Challenge, receiving $3,000 to initiate efficient, time-saving online fire training for all staff.

"I never thought we offered the most effective training and knew the current format made it difficult to reach all clinical areas," says Kylie.

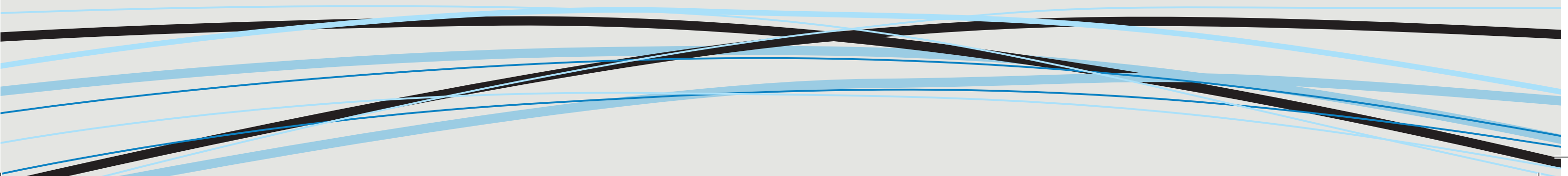
"A new staff member, who had worked at Waikato DHB, was part of a group there which changed its fire training to an e-learning platform. She explained how this worked across the organisation with the exception of practical training for high-risk areas."

With support from the Innovation team, Kylie was able to obtain a copy of this presentation and knew it would be perfect for the Southern DHB.

"Recognition of the concept in the Southern Innovation Awards was affirmation of the practicality of the idea. Once the Southern DHB new online fire training is fully implemented I know we will reach a wider audience, which is a great because it helps us meet our duty of care for staff, patients and visitors."

The Southern Innovation Challenge has run since 2012, and in 2015 drew 12 entries from across Southern DHB.

FINANCIAL STATEMENTS



Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2016

	Note	2016 Actual $000	2016 Budget $000	2015 Actual $000
Patient revenue	2	893,391	887,225	872,773
Other revenue	2	9,110	7,928	9,192
Interest revenue		1,175	1,900	1,940
Total revenue		**903,676**	**897,053**	**883,905**
Personnel costs	3	354,009	354,925	343,849
Depreciation, amortisation and impairment expense	11,12	20,986	21,351	20,765
Outsourced services		36,509	35,376	34,246
Clinical supplies		77,040	76,664	73,206
Infrastructure and non-clinical expenses		49,261	43,426	44,107
Other district health boards		40,006	39,762	38,820
Payments to non-health board providers		341,819	344,197	337,284
Other expenses	6	4,535	3,134	4,103
Finance costs	5	4,584	5,056	4,901
Capital charge	4	8,470	9,117	9,804
Total expenses		**937,219**	**933,008**	**911,085**
Surplus/(deficit) for the year	18	**(33,543)**	**(35,955)**	**(27,180)**
Other comprehensive revenue				
Items that will not be reclassified to surplus/(deficit)				
Revaluation of land and buildings	18			
Total other comprehensive revenue/(expense)		-	-	-
Total comprehensive revenue/(expense)		**(33,543)**	**(35,955)**	**(27,180)**

Statement of Changes in Equity

For the year ended 30 June 2016

	Note	2016 Actual $000	2016 Budget $000	2015 Actual $000
Balance at 1 July		**112,032**	**112,032**	**129,215**
Comprehensive revenue/(expense)				
Surplus/(deficit) for the year		(33,543)	(35,955)	(27,180)
Other comprehensive revenue/(expense)				
Capital contributions from the Crown (deficit support and project equity funding)		7,000	46,654	10,704
Other equity movements	18	(828)	(707)	(707)
Balance at 30 June		**84,661**	**122,024**	**112,032**

Statement of Financial Position

As at 30 June 2016

	Note	2016 Actual $000	2016 Budget $000	2015 Actual $000
Non-current assets				
Property, plant and equipment	11	286,847	299,940	288,887
Intangible assets	12	13,989	14,393	14,361
Total non-current assets		**300,836**	**314,333**	**303,248**
Current assets				
Inventories	9	5,065	4,676	4,677
Receivables	8	34,364	31,239	30,166
Cash and cash equivalents	7	8	16	3,658
Non-current assets held for sale	10	-	-	451
Total current assets		**39,437**	**35,931**	**38,952**
Total assets		**340,273**	**350,264**	**342,200**
Equity				
Contributed capital	18	95,107	134,783	88,836
Property revaluation reserves	18	94,022	94,121	94,121
Accumulated surplus/(deficit)	18	(104,468)	(106,880)	(70,925)
Total equity		**84,661**	**122,024**	**112,032**
Liabilities				
Non-current liabilities				
Borrowings	14	84,156	87,167	87,964
Employee entitlements	15	19,374	15,564	15,564
Total non-current liabilities		**103,530**	**102,731**	**103,528**
Current liabilities				
Cash and cash equivalents	7	9,858	832	-
Borrowings	14	20,205	17,425	18,269
Payables	13	56,452	40,206	46,555
Employee entitlements	15	63,754	67,046	61,616
Provisions	16	1,813	-	200
Total current liabilities		**152,082**	**125,509**	**126,640**
Total liabilities		**255,612**	**228,240**	**230,168**
Total equity and liabilities		**340,273**	**350,264**	**342,200**

Statement of Cash Flows

For the year ended 30 June 2016

	2016 Actual $000	2016 Budget $000	2015 Actual $000
Cash flows from operating activities			
Cash receipts from Ministry of Health and patients	896,291	894,209	885,292
Payments to suppliers	(544,024)	(543,335)	(531,863)
Payments to employees	(347,525)	(354,438)	(339,326)
Interest received	1,175	1,900	1,940
Interest paid	(4,290)	(5,058)	(4,544)
Net taxes refunded/(paid) (goods and services tax)	3,458	(1,361)	(840)
Payment to capital charge	(8,470)	(8,796)	(9,805)
Net cash flow from operating activities	**(3,385)**	**(16,879)**	**854**
Cash flows from investing activities			
Proceeds from sale of property, plant and equipment	482	451	651
Purchase of property, plant and equipment	(18,728)	(31,754)	(14,000)
Acquisition of investments	-	-	(883)
Net cash flow from investing activities	**(18,246)**	**(31,303)**	**(14,232)**
Cash flows from financing activities			
Proceeds from equity injection	10,324	45,947	5,845
Drawdown/(repayment) of borrowings	(2,201)	(2,240)	(1,250)
Net cash flow from financing activities	**8,123**	**43,707**	**4,595**
Net increase/(decrease) in cash and cash equivalents	**(13,508)**	**(4,475)**	**(8,783)**
Cash and cash equivalents at beginning of year	3,658	3,658	12,441
Cash and cash equivalents at the end of the year	**(9,850)**	**(817)**	**3,658**

Statement of Cash Flows
For the year ended 30 June 2016 (continued)

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

	2016 Actual $000	2015 Actual $000
Net surplus/(deficit) for the period	**(33,543)**	**(27,180)**
Add/(less) non-cash items:		
Depreciation and assets written off	20,986	20,765
Increase/(decrease) in fair value	342	182
Increase/(decrease) in provision for doubtful debts	14	(108)
Total non-cash items	**21,342**	**20,839**
Add/(less) items classified as investing or financing activity:		
Net loss/(gains) on disposal of property, plant and equipment	109	(11)
Total items classified as investing or financing activites	**109**	**(11)**
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(8,363)	5,756
(Increase)/decrease in inventories	(388)	115
Increase/(decrease) in trade and other payables	10,974	(3,188)
Increase/(decrease) in employee benefits	6,484	4,523
Net movements in working capital	**8,707**	**7,206**
Net cash inflow/(outflow) from operating activities	**(3,385)**	**854**

Statement of Contingencies
As at 30 June 2016

Contingent Liabilities	Note	2016 Actual $000	2015 Actual $000
Legal proceedings against Southern DHB		-	-
Personal grievances		-	-
Facilities - clearing asbestos	17	-	-
		-	**-**

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

Statement of Commitments

As at 30 June 2016

	2016 Actual $000	2015 Actual $000
Capital commitments		
Buildings	1,843	2,932
Clinical equipment	1,704	1,638
Computer equipment	1,238	1,568
Non-clinical equipment	116	127
Total capital commitments	**4,901**	**6,265**
Non-cancellable operating leases		
Less than one year	433	728
One to two years	83	411
Two to three years	23	77
Three to four years	18	17
Four to five years	12	12
Over five years	150	73
Total non-cancellable operating leases	**719**	**1,318**

Notes to the Financial Statements

1. Statement of accounting policies for the year ended 30 June 2016

REPORTING ENTITY

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

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

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

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

The financial statements presented for the year ended 30 June 2016 are for the Southern DHB only. They were approved by the Commissioner on 27 September 2016. The owner, the Crown, does not have the power to amend the financial statements after issue.

BASIS OF PREPARATION

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

Going concern

Southern DHB's Commissioner received a letter of support from the Ministers of Health and Finance that the Government is committed to working with 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 2016/17 annual plan has yet to receive approval from the Ministry of Health.

Statement of compliance

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

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

These financial statements comply with Public Sector PBE accounting standards.

Presentation currency and rounding

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

Measurement base

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

The financial statements have been prepared on a historical cost basis except:

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

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

In 2015, the External Reporting Board issued Disclosure Initiative (Amendments to PBE IPSAS 1), 2015 Omnibus Amendments to PBE Standards, and Amendments to PBE Standards and Authoritative Notice as a Consequence of XRB A1 and Other Amendments. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. Southern DHB will apply these amendments in preparing its 30 June 2017 financial statements. Southern DHB expects there will be no effect in applying these amendments.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

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

Foreign currency transactions

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

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is not recoverable as an input tax, it is recognised as part of the related asset or expense.

Income tax

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

Budget figures

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

Cost allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

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

Critical accounting estimates and assumptions

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

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

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

- fixed assets revaluations, note 11
- employee entitlements, note 15.

Custodial/trust and bequest funds

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

Comparative data

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

2. REVENUE

ACCOUNTING POLICY

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

MoH revenue

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

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

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

ACC contract revenue

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

Revenue from other DHBs

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

Interest 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.

Breakdown of Crown revenue

	2016 Actual $000	2015 Actual $000
Health and disability services (MoH contracted revenue)	852,602	834,037
ACC contract revenue	10,126	9,883
Inter-district patient inflows	21,159	19,448
Other revenue	9,504	9,405
Total funding from the Crown	**893,391**	**872,773**

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

Breakdown of other revenue

	2016 Actual $000	2015 Actual $000
Gain on sale of property, plant and equipment	482	121
Donations and bequests received	293	381
Rental revenue	3,207	1,900
Other revenue	5,128	6,790
Total other revenue	**9,110**	**9,192**

3. PERSONNEL COSTS

ACCOUNTING POLICY

Superannuation schemes

Defined Contribution Plans

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

Breakdown of personnel costs

	2016 Actual $000	2015 Actual $000
Salaries and wages	341,220	332,344
Defined contribution plans employer contributions	7,517	7,046
Increase/(decrease) in employee entitlements	5,272	4,459
Total personnel costs	**354,009**	**343,849**

EMPLOYEE REMUNERATION

There were 603 employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2016.

Total Remuneration and Other Benefits $000	Number of Employees	
	2016	2015
100 - 110	119	112
110 - 120	74	60
120 - 130	44	43
130 - 140	34	34
140 - 150	29	23
150 - 160	39	29
160 - 170	18	12
170 - 180	17	22
180 - 190	15	15
190 - 200	19	18
200 - 210	20	15
210 - 220	10	11
220 - 230	10	16
230 - 240	12	19
240 - 250	17	11
250 - 260	10	11
260 - 270	11	15
270 - 280	12	14
280 - 290	13	18
290 - 300	9	8
300 - 310	13	9
310 - 320	12	4
320 - 330	7	7
330 - 340	6	4
340 - 350	4	6
350 - 360	3	3
360 - 370	5	5
370 - 380	4	1
380 - 390	3	2
390 - 400	3	1
400 - 410	2	4
410 - 420	2	-
420 - 430	3	-
430 - 440	-	1
440 - 450	1	2
450 - 460	-	-
460 - 470	-	1
470 - 480	1	-
480 - 490	1	1
490 - 500	-	1
500 - 510	1	1
510 - 520	-	-
520 - 530	-	2
	603	**561**

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 603 employees in this category, 423 were medical/dental employees (2015: 413 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 863, compared with the actual total number of 603 (2015: 807 and 561).

The Chief Executive's remuneration and other benefits, either paid or accrued, is in the band 480-490.

EMPLOYEE TERMINATION PAYMENTS

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

The total payments were $642,637 (2015: 13 employees totalling $123,063).

2016 $000	2015 $000
160	30
122	24
120	22
97	13
65	8
16	6
12	5
10	4
9	3
6	2
6	4
5	1
4	1
3	
3	
2	
2	
1	
643	**123**

BOARD MEMBERS REMUNERATION

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

	2016 Actual $000	2015 Actual $000
Joe Butterfield MNZM	-	56
Neville Cook	-	29
Sandra Cook	-	29
Kaye Crowther QSO	-	29
Branko Sijnja	-	27
Richard Thomson	-	27
Tim Ward	-	39
John Chambers	-	27
Mary Gamble	-	28
Anthony Hill	-	35
Tuari Potiki	-	31
Total Board Member remuneration	**-**	**357**

The remuneration paid in 2015 relates solely to Board members' role on the Board and various statutory committees.

COMMISSIONER TEAM REMUNERATION

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

	2016 Actual $000	2015 Actual $000
Kathy Grant	165	7
Graham Crombie	102	3
Richard Thomson	58	3
Angela Pitchford	32	-
Total Commissioner team remuneration	**357**	**13**

There were payments made to the Chairperson of the Finance, Audit and Risk Committee, appointed by the Commissioner during the financial year. Payments totalled $21,550.

No Board members received compensation or other benefits in relation to cessation.

4. CAPITAL CHARGE

ACCOUNTING POLICY

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

FURTHER INFORMATION ON THE CAPITAL CHARGE

Southern DHB pays capital charge to the Crown twice yearly. This is based on closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the year ended 30 June 2016 was 8 per cent. The amount charged during the period was $8.47 million (2015: $9.80 million).

5. FINANCE COSTS

ACCOUNTING POLICY

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

Breakdown of finance costs

	2016 Actual $000	2015 Actual $000
Interest on secured loans	4,290	4,544
Interest on finance leases	294	357
Total finance costs	**4,584**	**4,901**

6. OTHER EXPENSES

ACCOUNTING POLICY

Operating Leases

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

Breakdown of other expenses

	Note	2016 Actual $000	2015 Actual $000
Impairment/recovery of trade receivables (doubtful debts)		14	(108)
Bad debts written off		705	752
Loss on disposal of property, plant and equipment		592	110
Audit fees (for the audit of financial statements)		189	181
Fees paid to other auditors for assurance and related services including internal audit		200	69
Board member fees	3	-	357
Commissioners fees	3	357	13
Operating lease expenses		2,476	2,727
Koha		2	2
Total other expenses		**4,535**	**4,103**

The operating lease payments are made up of vehicle leases (53 per cent), premises rental (31 per cent), the balance being clinical equipment and computer equipment rental (16 per cent).

During the year ended 30 June 2016, $2.476 million was recognised as an expense in the Statement of Comprehensive Revenue and Expense in respect of operating leases (2015: $2.727 million).

Operating leases as lessee

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

	2016 Actual $000	2015 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	433	728
Between one and five years	136	517
More than five years	150	73
Total non-cancellable operating leases	**719**	**1,318**

A significant portion of the non-cancellable operating lease expense relates to the lease of two premises for the Public Health and Mental Health services. These leases expire on 30 June 2017, with one having a three year right of renewal to 30 June 2020 and the other a one year right of renewal to 30 June 2018. The balance of the non-cancellable operating lease expense consists of less significant premises leases and fleet car leases.

7. CASH AND CASH EQUIVALENTS

ACCOUNTING POLICY

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

Breakdown of cash and cash equivalents and further information

	2016 Actual $000	2015 Actual $000
Bank balances	-	-
Cash at bank and on hand	(47)	16
Demand funds with New Zealand Health Partnerships Limited	(9,803)	3,642
Cash and cash equivalents in the Statement of Cash Flows	**(9,850)**	**3,658**

WORKING CAPITAL FACILITY

At 30 June 2016, the Southern DHB held no bank overdraft facilities.

Southern DHB is a party to the 'DHB Treasury Services Agreement' between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to 'sweep' DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of a month's Provider Arm funding plus GST. For Southern DHB, that equates to $45.75m.

8. TRADE AND OTHER RECEIVABLES

ACCOUNTING POLICY

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

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

Breakdown of receivables and further information

	2016 Actual $000	2015 Actual $000
Receivables (gross)	36,755	32,543
Less: provision for uncollectability	(2,391)	(2,377)
Total receivables	**34,364**	**30,166**
Total receivables comprise:		
Receivables (non-exchange transactions)	21,462	12,656
Other accrued income (exchange transactions)	12,902	17,510
	34,364	**30,166**

Trade receivables are shown net of provision for doubtful debts amounting to $2.391 million arising from identified debts unlikely to be recovered (2015: $2.377 million).

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

Trade receivables

	2016		2015	
	Gross Receivable $000	Impairment $000	Gross Receivable $000	Impairment $000
Not past due	314	-	-	-
Past due 0-30 days	4,197	-	2,535	(5)
Past due 31-120 days	1,510	(634)	1,012	(248)
Past due 121-360 days	1,078	(220)	888	(265)
Past due more than 1 year	1,592	(1,537)	1,918	(1,859)
Total	**8,691**	**(2,391)**	**6,353**	**(2,377)**

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

Trade receivables

	2016 Actual $000	2015 Actual $000
Gross trade receivables	8,691	6,353
Individual impairment	(2,391)	(2,377)
Collective impairment	-	-
Net total trade receivables	**6,300**	**3,976**

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

9. INVENTORIES HELD FOR DISTRIBUTION

ACCOUNTING POLICY

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

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

Breakdown of inventories

	2016 Actual $000	2015 Actual $000
Pharmaceuticals	2,698	1,420
Surgical & medical supplies	2,367	3,257
Total inventories	**5,065**	**4,677**

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2016 was $5.065 million (2015 $4.677 million).

10. NON-CURRENT ASSETS HELD FOR SALE

ACCOUNTING POLICY

A non-current asset is classified as held for sale if its carrying amount will be recovered principally through sale rather than through continuing use. The asset is measured at the lower of its carrying amount and fair value less cost to sell.

Write-downs of the asset are recognised in the surplus and deficit. Any increases in fair value (less cost to sell) are recognised in the surplus or deficit up to the level of any impairment losses that have previously been recognised.

A non-current asset held for sale is not depreciated or amortised while classified as held for sale.

Breakdown of non-current assets held for sale and further information

Southern DHB owns no land and buildings in the current year which have been classified as held for sale. The prior year amount relates to land and buildings in High St that held no future use to the DHB and were approved by the Board for sale. This sale has been completed.

Non-current assets held for sale include:	2016 Actual $000	2015 Actual $000
Land	-	360
Buildings	-	91
Total non-current assets held for sale	**-**	**451**

11. PROPERTY, PLANT AND EQUIPMENT

ACCOUNTING POLICY

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

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

The DHB increased its capitalisation limit for fixed assets from $500 to $2,000 in the 2015/16 year.

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

Revaluations

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

Additions

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

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

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

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus (deficit) is calculated as the difference between the net sales price and the carrying amount of the asset.

Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to accumulated surpluses (deficits).

Subsequent costs

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

Depreciation

Depreciation is provided on a straight-line basis on all fixed assets other than land, at rates which will write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Buildings	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.

Impairment

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

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

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

revaluation reserve, the balance is recognised in the surplus or deficit.

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

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

Breakdown of property, plant and equipment and further information

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant and equipment	Vehicles	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 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)	-
Revaluation increase	-	-	-	-	-	-
Disposals	-	-	(4,002)	(11)	-	(4,013)
Transfers	-	-	-	-	-	-
Balance at 30 June 2015	**27,487**	**224,915**	**152,485**	**2,332**	**2,465**	**409,684**
Balance at 1 July 2015	27,487	224,915	152,485	2,332	2,465	409,684
Additions					17,603	17,603
Transfers from Work in Progress	-	3,339	8,992	-	(12,331)	-
Revaluation increase	-	-	-	-	-	-
Disposals	-	(12)	(3,049)	-	-	(3,061)
Transfers	-	-	-	-	-	-
Balance at 30 June 2016	**27,487**	**228,242**	**158,428**	**2,332**	**7,737**	**424,226**
Depreciation and impairment losses						
Balance at 1 July 2014	-	574	103,758	901	-	105,233
Depreciation charge for the year	-	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**
Balance at 1 July 2015	-	8,421	111,215	1,161	-	120,797
Depreciation charge for the year	-	7,949	10,862	271	-	19,082
Impairment losses	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-
Disposals	-	(5)	(2,495)	-	-	(2,500)
Transfers	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Balance at 30 June 2016	**-**	**16,365**	**119,582**	**1,432**	**-**	**137,379**
Carrying amounts						
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**
At 1 July 2015	27,487	216,494	41,270	1,171	2,465	288,887
At 30 June 2016	**27,487**	**211,877**	**38,846**	**900**	**7,737**	**286,847**

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 change in the fair value of these land and buildings from 30 April 2014 that will affect their carrying amount as at 30 June 2016.

Restriction

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

12. INTANGIBLE ASSETS

ACCOUNTING POLICY

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

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

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

New Zealand Health Partnerships Limited (NZHPL) has issued Class B shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain Shared Service. The following rights are attached to these shares:

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

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

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

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

NZ Health Partnerships Ltd was formerly Health Benefits Ltd. As from 1 July 2015, the operations of Health Benefits Limited transferred under the Health Sector (Transfers) Act 1993 to a new company called NZ Health Partnerships Ltd.

Amortisation

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

Amortisation starts when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The estimated useful lives are as follows:

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

Breakdown of intangible assets

	FSPC	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
Balance at 1 July 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**
Balance 1 July 2015	4,469	23,126	27,595
Additions	-	1,532	1,532
Disposals	-	-	-
Balance at 30 June 2016	**4,469**	**24,658**	**29,127**
Amortisation and impairment losses			-
Balance at 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**
Balance 1 July 2015	-	13,234	13,234
Amortisation charge for the year	-	1,904	1,904
Impairment losses		-	-
Reversal of impairment losses	-		-
Disposals	-	-	-
Balance at 30 June 2016	**-**	**15,138**	**15,138**
Carrying amounts			
At 1 July 2014	3,586	9,760	13,346
At 30 June 2015	**4,469**	**9,892**	**14,361**
At 1 July 2015	4,469	9,892	14,361
At 30 June 2016	**4,469**	**9,520**	**13,989**

The above balance includes $3.9 million of work in progress, the major contributing items being:

- $1.7 million relating to the Health Connect South project being a single clinical portal for the South Island
- $0.8 million relating to the E-Prescribing system that ensures safe medication management for patients via electronic prescribing
- $0.6 million relating to the South Island Patient Management System.

IMPAIRMENT

There were no impairment losses recognised in the 2016 year.

13. PAYABLES & DEFERRED REVENUE

ACCOUNTING POLICY

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

Breakdown of payables and deferred revenue

	2016 Actual $000	2015 Actual $000
Trade payables to non-related parties	8,681	6,352
GST payable	7,972	4,519
Revenue in advance relating to contracts with specific performance obligations	1,752	340
Capital charge due to the Crown	-	-
Other non-trade payables and accrued expenses	38,047	35,344
Total payables and deferred revenue	**56,452**	**46,555**

	2016 Actual $000	2015 Actual $000
Total payables comprise:		
Exchange transactions	46,728	41,696
Non-exchange transactions	9,724	4,859
	56,452	**46,555**

14. INTEREST-BEARING LOANS AND BORROWINGS

ACCOUNTING POLICY

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

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

FINANCE LEASES

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

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

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

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

Breakdown of interest bearing loans and borrowings

	2016 Actual $000	2015 Actual $000
Non-current		
Secured loans	81,400	83,930
Unsecured loans	277	388
Finance lease liabilities	2,479	3,646
Total non-current portion	**84,156**	**87,964**
Current		
Current portion of secured loans	18,847	16,600
Current portion of unsecured loans	141	243
Current portion of finance lease liabilities	1,217	1,426
Total current portion	**20,205**	**18,269**
Total borrowings	**104,361**	**106,233**

Secured loans

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

SECURITY AND TERMS

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

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

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

Breakdown of Crown loans

	2016 Actual $000	2015 Actual $000
Interest rate summary		
Crown loans - fixed interest	2.21% to 6.42%	2.94% to 6.42%
Repayable as follows:		
Within one year	18,847	16,600
One to two years	16,000	600
Two to three years	14,500	16,600
Three to four years	7,000	15,100
Four to five years	21,650	7,600
Later than five years	22,250	44,030
	100,247	**100,530**
Term loan facility limits		
Crown loans	97,400	97,400
Term loan facility	-	-

Breakdown of finance leases

	2016 Actual $000	2015 Actual $000
Within one year	1,217	1,426
One to two years	649	1,187
Two to three years	509	639
Three to four years	269	499
Four to five years	93	269
Later than five years	959	1,052
	3,696	**5,072**

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

15. EMPLOYEE ENTITLEMENTS

ACCOUNTING POLICY

Short-term employee entitlements

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

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

Long-term entitlements

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

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

Presentation of employee entitlements

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

Breakdown of employee entitlements

	2016 Actual $000	2015 Actual $000
Non-current portion		
Long-service leave	4,126	3,203
Sabbatical leave	1,757	1,473
Retirement gratuities	13,491	10,888
Total non-current portion	**19,374**	**15,564**
Current portion		
Long-service leave	3,672	3,825
Sabbatical leave	180	142
Retirement gratuities	3,294	3,116
Annual leave	38,561	34,827
Sick leave	237	243
Continuing medical education	6,200	6,105
Salary and wages accrual	11,610	13,358
Total current portion	**63,754**	**61,616**
Total employee entitlements	**83,128**	**77,180**

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 2.12 per cent (2015: 2.93 per cent) and an inflation factor of 3.17 per cent (2015: 1.63 per cent) were used.

16. PROVISIONS

ACCOUNTING POLICY

General

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

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

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

Restructuring

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

Facilities

A provision for facilities compliance has been recognised to bring identified at-risk areas up to the level of compliance required by the Health and Safety at Work (Asbestos) Regulations 2016.

Breakdown of provisions

	2016 Actual $000	2015 Actual $000
Current portion		
Restructuring	571	200
Facility compliance	1,242	-
Total current portion	**1,813**	**200**
Non-current portion		
Restructuring	-	-
Facility compliance	-	-
Total non-current portion	**-**	**-**
Total Provisions	**1,813**	**200**

Restructuring provision

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

Facilities

The DHB has identified locations that require clearing of asbestos. While these areas are being monitored currently to ensure there is no risk to staff or patients, it has been deemed necessary to clear the asbestos to ensure ongoing safety of staff and patients. Surveys have been completed on the areas to assess the level of clean-up required. The provision represents the estimated cost to clean the identified areas of asbestos based on costs incurred for similar areas cleaned within the DHB.

Movements in each class of provision are as follows:

	Restructuring $000	Facilities $000	Total
Balance at 1 July 2014			
Additional provisions made	200	-	200
Amounts used	-	-	-
Unused amounts reversed	-	-	-
Balance at 30 June / 1 July 2015	**200**	**-**	**200**
Additional provisions made	389	1,242	1,631
Amounts used	(18)	-	(18)
Unused amounts reversed	-	-	-
Balance at 30 June 2016	**571**	**1,242**	**1,813**

17. CONTINGENCIES

ACCOUNTING POLICY

Contingent Liabilities

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

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

The DHB has identified areas where asbestos is present and is working through a planned approach of clearing any area that it sees as an issue. At balance date, there are a number of maintenance areas (plant rooms) that the DHB is committed to clearing of asbestos in the 2016/17 year, however there is no reliable estimate of the cost involved.

There were no other contingent liabilities at year end.

18. EQUITY

ACCOUNTING POLICY

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

- contributed capital
- property revaluation reserves
- retained earnings.

Property revaluation reserve

These reserves relate to the revaluation of property, plant and equipment to fair value.

Capital management

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

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

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

Breakdown of equity

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 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
Other movements	-	-	-	-
Deficit for the period	-	-	(27,180)	(27,180)
Balance at 30 June 2015	**88,836**	**94,121**	**(70,925)**	**112,032**
Balance at 1 July 2015	88,836	94,121	(70,925)	112,032
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	7,000	-	-	7,000
Equity repayment to the Crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	(99)	-	(99)
Transfers from revaluation of land and buildings on impairment	-	-	-	-
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Other movements	(22)	-	-	(22)
Deficit for the period	-	-	(33,543)	(33,543)
Balance at 30 June 2016	**95,107**	**94,022**	**(104,468)**	**84,661**

Equity is made up of:

	2016 Actual $000	2015 Actual $000
Equity	79,329	106,626
Restricted equity*	5,332	5,406
Total equity	**84,661**	**112,032**

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

19. ASSOCIATED ENTITIES

Name of entity	Principal activities	Interest held at 30 June 2016	Balance date
South Island Shared Service Agency Limited	South Island Shared Service Agency Limited is a non-operating company	30%	30 June
New Zealand Health Partnerships Limited (NZHPL)	NZ Health Partnerships is led, supported and owned by the country's 20 District Health Boards (DHBs). It builds shared services for the benefit of the Health Sector.	5%	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.

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.

Key management team remuneration

The key management remuneration is as follows:

	2016 Actual $000	2015 Actual $000
Board Members		
Remuneration	-	357
Full time equivalent members	-	1.2 FTE
Commissioner Team		
Remuneration	357	13
Full time equivalent members	1.2 FTE	0.1 FTE
Total Board members and Commissioners team remuneration	**357**	**370**
Total Board members and Commissioners team full time equivalent	**1.2 FTE**	**1.3 FTE**
Executive Management		
Remuneration	2,983	2,585
Termination payments	377	-
Full time equivalent members	10.2 FTE	9.7 FTE
Total Executive management remuneration	**3,360**	**2,585**
Total Executive management full time equivalent	**10.2 FTE**	**9.7 FTE**
Total remuneration	**3,717**	**2,955**
Total full time equivalent	**11.4 FTE**	**11.0 FTE**

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

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

21. FINANCIAL INSTRUMENTS

ACCOUNTING POLICY

Southern DHB is party to financial instruments as part of its normal operations. Financial instruments are contracts which give rise to assets and liabilities or equity instruments in another 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 Expense. Except for those items covered by a separate accounting policy, all financial instruments are shown at their estimated fair value.

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

CREDIT RISK

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 29.5 per cent of total receivables). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

LIQUIDITY RISK

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

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

	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
2016							
Secured loans	100,247	121,287	21,263	2,296	20,051	51,777	25,900
Unsecured loans	418	432	83	58	116	175	-
Finance lease liabilities	3,696	4,567	842	573	807	1,469	876
Trade and other payables	56,452	56,452	56,452	-	-	-	-
Total	**160,813**	**182,738**	**78,640**	**2,927**	**20,974**	**53,421**	**26,776**
Inflow	-	-	-	-	-	-	-
Outflow	160,813	182,738	78,640	2,927	20,974	53,421	26,776
2015							
Secured loans	100,530	128,539	2,894	18,826	5,442	50,252	51,125
Unsecured loans	631	648	108	108	141	291	-
Finance lease liabilities	5,072	6,192	868	847	1,375	2,059	1,043
Trade and other payables	46,555	46,555	46,555	-	-	-	-
Total	**152,788**	**181,934**	**50,425**	**19,781**	**6,958**	**52,602**	**52,168**
Inflow	-	-	-	-	-	-	-
Outflow	152,788	181,934	50,425	19,781	6,958	52,602	52,168

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.

2016

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and cash equivalents	2.50%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office	0.00%	2,847	2,847				
Crown loans *	4.74%	10,000					10,000
Crown loans *	2.94%	6,000			6,000		
Crown loans *	6.42%	10,000			10,000		
Crown loans *	3.37%	5,000				5,000	
Crown loans *	3.44%	10,000				10,000	
Crown loans *	4.34%	4,500				4,500	
Crown loans *	4.40%	1,250				1,250	
Crown loans *	4.40%	5,400				5,400	
Crown loans *	5.06%	10,000				10,000	
Crown loans *	5.22%	7,000				7,000	
Crown loans *	3.40%	6,000					6,000
Crown loans *	3.40%	6,250					6,250
Crown loans *	2.21%	10,000	10,000				
Crown loans *	2.21%	6,000	6,000				
Finance lease liabilities*	5.80% - 18.34%	3,696	732	485	648	872	959
Unsecured bank loans	0.00%	418	83	58	219	58	

* These assets/liabilities bear interest at fixed rates.

2015

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and cash equivalents	2.50%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office *	0.00%	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%	632	122	137	233	140	-

* These assets/liabilities bear interest at fixed rates

FOREIGN CURRENCY RISK

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

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

SENSITIVITY ANALYSIS

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

At 30 June 2016, 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 $1.011 million (2014: $1.025 million).

CLASSIFICATION AND FAIR VALUES

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

ESTIMATION OF FAIR VALUES ANALYSIS

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

	Note	Loans and receivables $000	Other amortised costs $000	Carrying amount Actual $000	Fair value Actual $000
2016					
Trade and other receivables	8	34,364	-	34,364	34,364
Cash and cash equivalents	7	(9,850)	-	(9,850)	(9,850)
Secured loans	14		100,247	100,247	100,247
Finance lease liabilities	14		3,696	3,696	3,696
Unsecured liabilities	14		418	418	418
Trade and other payables	13		56,452	56,452	56,452
2015					
Trade and other receivables	8	30,166	-	30,166	30,166
Cash and cash equivalents	7	3,658	-	3,658	3,658
Secured loans	14		100,530	100,530	100,530
Finance lease liabilities	14		5,072	5,072	5,072
Unsecured liabilities	14		631	631	631
Trade and other payables	13		46,555	46,555	46,555

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 2016 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

- Finance leases: Reserve Bank of New Zealand retail interest rate
- Loans and borrowings: Rates per confirmation and also discount rates for fair value loans.

	2016 Actual %	2015 Actual %
Finance leases	5.06%	5.93%
Loans and borrowings	2.21% - 6.42%	2.94% - 6.42%

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 2016 has resulted in a deficit of $2.2 million for Mental Health services. Additionally Southern DHB has a brought-forward overspend of $2.8 million; meaning that the carry-forward overspend is $5.0 million.

23. EVENTS AFTER BALANCE DATE

The DHB received funding approval from the Minister of Health in July 2016 for the $11 million refurbishment of the Intensive Care Unit at Dunedin Hospital. This project is estimated to be completed by February 2018.

There were no other significant events after the balance date.

24. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

Explanations for major variances from Southern DHB's budgeted figures are as follows:

Statement of Comprehensive Revenue and Expense

The favourable variance in total comprehensive revenue and expenses against budget for the year ended 30 June 2016 was $2.4 million.

Revenue

Government and Crown revenue was $5.6 million higher than budgeted, largely due to $3.4 million of new contracts from the Ministry of Health. The most significant of these were to deliver additional elective surgical volumes and an increase in funding for children under 13 years. The increase in funding for children under 13 years old is aimed at improving access to health care for primary and intermediate school children, ensuring they can get the care they need when they need it and avoid possible complications and visits to hospital Emergency Departments.

Inter-district flow revenue also increased over budget by $1.2 million (Southern DHB treating patients domiciled in other District Health Boards).

Personnel costs and outsourcing

Personnel costs were favourable to budget by $0.9 million.

Infrastructure and non-clinical supplies

Other costs were $5.1 million over budget. This was mainly due to unexpected costs to remove asbestos from buildings of $2.9 million and additional food outsourcing costs of $2.1 million (partly offset by reduced personnel costs as above).

Payments to non-health board providers

Payments to non-health board providers were $2.4 million under budget due to a reduction in expenditure in residential care hospitals. This was due to lower numbers of occupants than expected.

Statement of Cash Flows

Payments to employees were $6.9 million less than budgeted due to:

- the outsourcing of food services
- vacant positions, primarily in medical staff, some of this offset by increased outsourcing costs.

Purchase of property, plant and equipment was $13.0 million less than budget due to a slower than expected uptake on capital plan purchases.

These and other smaller variances were offset by deficit funding being $35.6 million less than budget, contributing to the closing cash balance being $9.0 million less than budget.

Audit New Zealand
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of
Southern District Health Board's financial statements and performance information for the year ended 30 June 2016

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

Opinion on the financial statements and the performance information

We have audited:

- the financial statements of the Health Board on pages 65 to 95, that comprise the statement of financial position and the statement of contingencies and commitments as at 30 June 2016, 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 15 to 51 In our opinion:
- the financial statements of the Health Board:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2016; 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 Standards.

The Health Board is reliant on financial support from the Crown

Without modifying our opinion on the financial statements, we draw your attention to the disclosures made in note 1 on page 71 that outline that the Commissioner, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of support received from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, 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 2015, 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 15 to 51:

- Presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2016, 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 as compared with the forecasts included in the statement of performance expectations for the financial year;
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- Complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 28 October 2016. 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 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.

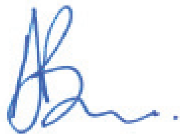
Responsibilities of the Auditor

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