Southern District Health Board

Southern way

2013-14

annual report

southerndhb.govt.nz

Southern District Health Board Annual Report 2013/14

Produced in 2014

By the Southern District Health Board

PO Box 1921

Dunedin

www.southerndhb.govt.nz

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DIRECTORY

BOARD MEMBERS

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

Previous Board Members – Term Ended Dec 2013

Mary Flannery	
Paul Menzies	
Malcolm Macpherson	
Tahu Potiki	
Stuart McLauchlan	*Crown Monitor*

BOARD OFFICE

Wakari Hospital
369 Taieri Road
DUNEDIN 9010

POSTAL ADDRESSES

Private Bag 1921	P O Box 828
DUNEDIN 9054	INVERCARGILL 9840

CONTACT NUMBERS

	Telephone	*Facsimile*
Dunedin Hospital	03 474 0999	03 218 1949
Southland Hospital	034747640	03 214 5742
Lakes District Hospital	03 441 0015	03 442 3305

CHIEF EXECUTIVE OFFICER

Carole Heatly

EXECUTIVE MANAGEMENT TEAM

Lexie O'Shea	Executive Director Patient Services/ Deputy CEO
Steve Addison	Executive Director Communications
Peter Beirne	Executive Director Finance
Sandra Boardman	Executive Director Planning & Funding
Richard Bunton	Medical Director of Patient Services
Donovan Clarke	Kaiwhakahaere Hauora Māori (Executive Director, Māori Health)
Lynda McCutcheon	Executive Director Allied Health, Scientific & Technical
John Pine	Executive Director Human Resources
Jim Reid	Primary Care Advisor
Leanne Samuel	Executive Director of Nursing & Midwifery
David Tulloch	Chief Medical Officer

External Representatives

Ian Macara	Chief Executive Officer, Southern Primary Health Organisation
Barry Taylor	Dean, Dunedin School of Medicine

Previous Incumbent

Sharon Kletchko	Executive Director Strategy, Integration & Funding

AUDITOR

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

BANKERS

Westpac Business Banking
106 George Street
PO Box 5345
DUNEDIN 9058

CHAIRMAN AND CEO'S FORWARD

Southern DHB is the southernmost publicly funded health service in the world, covering the largest land area out of all the 20 New Zealand DHBs. Our relative remoteness has engendered a pioneering spirit – the Southern Way - which means we are dynamic in delivering health and disability services across our region. In approving this Annual Report each Board member wishes to thank each and every staff member on behalf of our population for their commitment and what they have achieved over the past year to provide valuable health and disability services to our community.

The 2013/14 period is characterised with some outstanding achievements, such as the above average results for the Ministry of Health targets for elective surgery waiting times, faster cancer treatment, and our hospital services providing people help to quit smoking. We have exceeded targets for Quality and Safety in hand hygiene and Central Line Associated Bacteraemia (CLAB) in the Dunedin Intensive Care Unit and have reduced peri-operative harm. We are also proud to present our community with the new and improved facilities, such as the Children's and Neonatal Intensive Care Ward at Dunedin Hospital, the new inpatient Mental Health Unit at Wakari,the Ronald McDonald Family Room for families at Southland Hospital, and a new radiation treatment machine.

The year has seen a change in the Board with the previous Board term ending in December 2013. We are thankful to have some Board members continuing on into the next term - Richard Thomson, Dr Branko Sijnja, Kaye Crowther, Neville Cook, Tim Ward and Sandra Cook. We are also fortunate to be joined by new members Dr John Chambers, Mary Gamble, Tony Hill and Tuari Potiki.

We wish to express gratitude to those Board members whose term ended in December. Their contribution has been substantial offering valuable business and health acumen over a number of Southern DHB Board terms, or that of its predecessors Southland or Otago DHBs; they are Dr Malcolm McPherson, Paul Menzies, and Tahu Potiki. Also a special thanks to Mary Flannery who served one term with us and made a considerable contribution.

The tenure for the new Board is not without its challenges, particularly in relation to our financial situation. We committed to a deficit reduction programme over three years in 2012; however the end-of-year result for 2013/14 was a disappointing deficit of $17.8m. We also have a number of strategic challenges, such as our ageing hospital facilities in Dunedin, supply and demand challenges such as our emergency department attendances rising faster than our population growth, an ageing population, and the rising prevalence of chronic disease.

Work to address these strategic challenges has been commenced: the Health Profile, which has subsequently been completed, and the Strategic Health Services Plan.

The Health Profile is a pivotal piece of the puzzle which provides a high level snapshot of the current population, our health status and overall patient flows. The Health Profile tells us that our health as a population compares well with the rest of New Zealand, however there is room for improvement in a number of key health areas, such as tobacco smoking, obesity and nutrition, and hazardous alcohol consumption. These, and other, key areas will be addressed in the Strategic Health Services Plan which will define our priorities and direction for the next decade. It focuses on a whole of system approach to DHB-provided services and those we fund for delivery by other providers, and will help us focus our resources to improve access and outcomes for the whole population.

Collaboration is vital to our sustainability. It is essential that we work collaboratively with our South Island DHB neighbours to improve the care we provide and be more efficient in the way we provide those services across the region. We are therefore appreciative of our South Island counterparts for the combined vision and drive to establish the South Island Alliance and the subsequent work that has progressed in 2013/14 under this Alliance. Work is well underway in a number of areas, such as the

cancer workstream, health of the older people, child health, mental health, support and information services and quality and safety.

Southern DHB in leading the South Island Alliance Information Systems workstream with the regional roll-out of Electronic Prescribing and Administration. This will be fully utilised by Southern DHB hospitals by the end of this year and will be implemented across other South Island DHBs. This will help in minimising prescribing errors and improve patient safety in our hospitals.

Locally we are seeking collaboration and greater integration across the health sector. The formation of an alliance with initially the Southern Primary Health Organisation was an important step. This alliance has quickly evolved into Alliance South and incorporates a wider community view. The Alliance is working towards a 'whole of system' approach and seamless integration across community and hospital services. Work which has commenced under the Alliance umbrella includes community and hospital pharmaceuticals, rural health and acute demand. All seek better health outcomes for our community.

We have accomplished a great deal and we are on a course to a new more sustainable future. However our health system is a very complex environment. We have had many challenges over the 2013/14 year, particularly with regard to the financial situation. There is no doubt that we need to live within our means whilst optimising our system capacity and capability.

On a final note we would like to sincerely thank the Board and staff for all their efforts, and all the associated individuals, businesses and organisations for their services over the past year. We therefore commend this Annual Report to the Minister of Health.

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

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

We have come too far, not to go further.

We have done too much, not to do more.

Joe Butterfield	**Carole Heatly**
Chairman	**Chief Executive**
Southern DHB	**Southern DHB**

STATEMENT OF RESPONSIBILITY

FOR THE TWELVE MONTHS ENDED 30 JUNE 2014

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

The Board and management of Southern DHB accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting. In the opinion of the Board and management of Southern DHB, the financial statements for the year ended on 30 June 2014, fairly reflect the financial position and operations of Southern DHB.

Joe Butterfield	**Tim Ward**	**Carole Heatly**	**Peter Beirne**
Chairman	**Deputy Chairman**	**Chief Executive**	**Executive Director Finance**
2 October 2014	**2 October 2014**	**2 October 2014**	**2 October 2014**

OVERVIEW OF SOUTHERN DHB

PURPOSE OF SOUTHERN DHB AND HOW WE FUNCTION

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

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

The Board

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

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

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

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

- Audit and Risk (A&R) Committee
- Iwi Governance Committee
- Appointments and Remuneration Advisory Committee

Southern DHB consists of three distinct functions, each charged with specific purposes and accountability – Governance, Provider Services and Funding.

Governance

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

Provider Services

The Provider Services of Southern DHB provide secondary, community, disability, and mental health services to the Southern region and tertiary services to the Southern region and New Zealand.

Funder

The Funder of the DHB has the following functions:

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

Partnership with Iwi – TuhonokiteIwi

Tenakoutou e karangatira o tenamarae o tenamarae,
mauriamaiouketemataurака, he
whangaikiteiwi, naumaiwhakataumai, tenatatoukatoa.

The NZPHD Act 2000 outlines the responsibilities Southern DHB has in honouring the principles of the Treaty of Waitangi. The DHB acknowledges the special relationship between Iwi and the Crown and as a Crown agent is committed to fulfilling its obligations under the Treaty of Waitangi. Some of the ways Southern DHB fulfils its obligations to the Treaty are outlined in the Māori Health Strategy – He Korowai Oranga and the Māori Health Action Plan – Whakatātaka. These documents provide a high level national perspective that assist to deliver to the Southern DHB Māori Health Plan 2013/14, focused on improving the health status of Māori in the district.

Maurioraki a tatoukatoa

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

OUR POPULATION

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

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

We are a slightly older and predominantly European population when compared with the national average with 28,060 (11%) of Māori and Pacific people combined.

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

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

HEALTH PROFILE

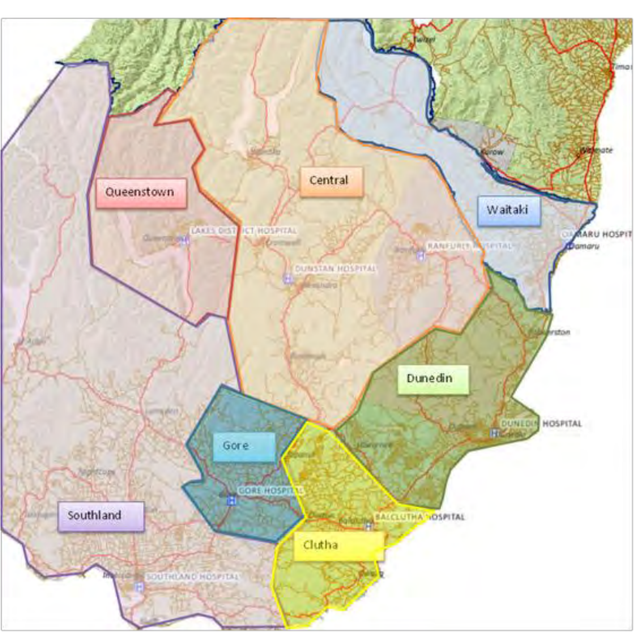
Overall health for our Southern DHB residents compares well with other New Zealanders. Life expectancy at birth was 81 years for the years 2010 to 2012, slightly less than the New Zealand average. Males lag females in life expectancy at birth by 3.9 years; Māori males lag by 7.4 years and female Māori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

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

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

Our Fourfold Aim

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



VISION

Better Health, Better Lives, Whānau Ora

MISSION

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

THE SOUTHERN WAY

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

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

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

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

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

OUR FOURFOLD AIM

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

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

HOW WE ALLOCATE OUR FUNDING

Southern DHB receives over $873 million per year from a variety of sources with the bulk of funding from Vote Health via the Ministry of Health. Expenditure is over a large variety of services; the largest area receiving DHB funding is hospital services at nearly $500 million per year.

Table 1: Southern DHB Income 2013/14

Income	2014 Actual
Ministry of Health	$ 815.73
Health workforce NZ	$ 7.08
IDF and Other DHB's	$ 19.14
Other Income	$ 11.67
Accident Insurance	$ 10.26
Other Government	$ 5.89
Patient and Consumer Sourced	$ 4.11
Total Income	**$ 873.90**

Table 2: Southern DHB Expenditure 2013/14

Expenditure	2014 Actual
Hospital Services	$ 499.55
DHB Admin	$ 9.53
Community Pharmacy	$ 75.02
Laboratory Services	$ 32.58
PHO Organisations	$ 51.61
Other Personal, Public and Maori Health	$ 59.65
Mental Health	$ 19.83
Disability Support Services	$ 111.10
Services provided by other DHBs	$ 32.85
Total Expenditure	**$ 891.72**

Figure 1: Southern DHB Income 2013/14

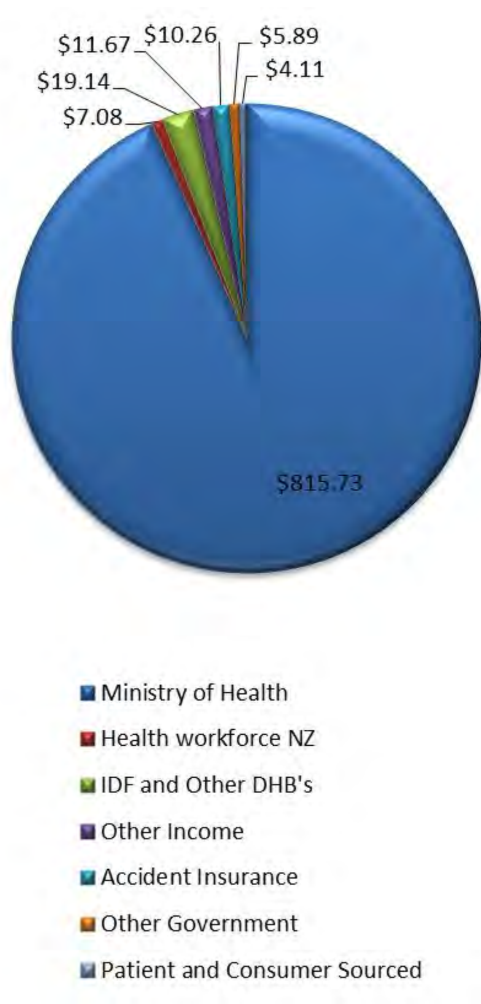
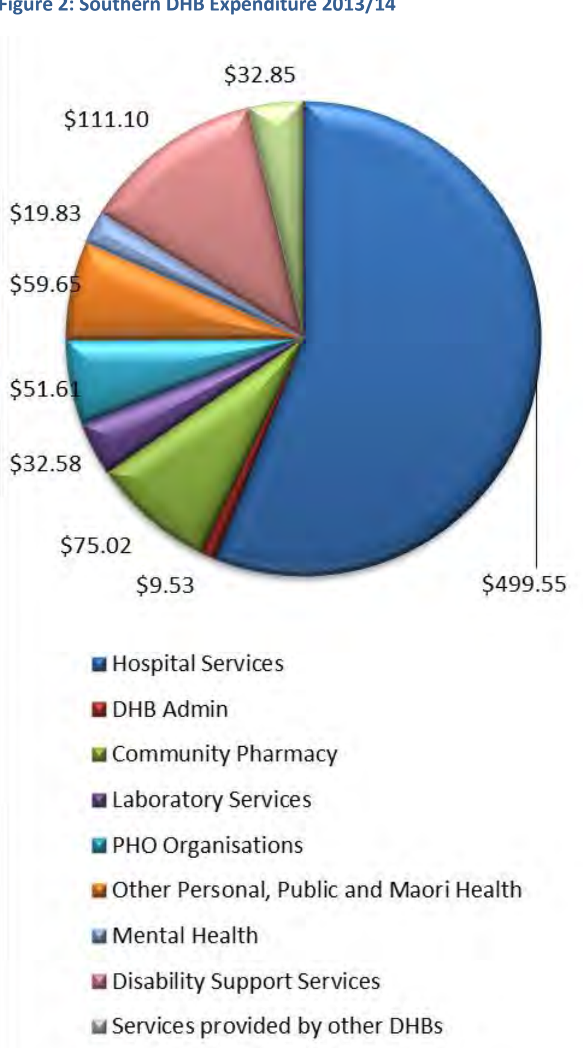


Figure 2: Southern DHB Expenditure 2013/14



KEY FACTS AND FIGURES

Our Population

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

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

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

We are a large geographic region with 34,000 (11%) of our population living more than 2 hours away from a hospital.

Community Services

There were 3384 babies born in our district.

Southern DHB vaccinated 20,071 children who are 5 years or under in 2013/14.

We have over 300 General Practitioners in the Southern district.

Our Mental Health, Addictions and Intellectual Disability staff had direct contact with 2159 families.

Southern DHB's home and community support services (HCSS) Alliance with three HCSS Providers supports approximately 4,000 older people to live in their own homes by supporting them to retain and use their everyday abilities.

Southern DHB supported the cost of aged residential care for approximately 3640 people.

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

Hospital Services

We have 9 hospitals with inpatient beds across our district. Three are owned and managed by the DHB; the other 6 are owned and run by rural communities.

Our hospitals provide 334 general beds, 97 mental health beds, 52 intensive care and high dependency beds, 70 rehabilitation beds and 63 maternity beds. We have 13 operating theatres, and 2 day surgery theatres.

There were 10,781 acute surgical discharges from our hospitals.

Surgical services in our district performed 10,948 elective surgery procedures.

There were 26,585 discharges from our medical specialities.

2013/14 KEY HIGHLIGHTS AND ACHIEVEMENTS

2013/14	Achieved 4 National Health Targets		
	• Improved access to elective surgery • Shorter waits for cancer treatment		• Increased Immunisation • Better help for smokers to quit (hospital)
2013 July	New community-based service for Dialysis patients initiated. Professor David Perez receives Queen's Honour, an Officer of the Order of New Zealand, for services to Oncology in Otago-Southland. Emergency Department project launched to target hazardous drinking – Ease Up. Better integration of care with advent of Alliance between Southern DHB and the Southern Primary Health Organisation.	**2014** January	New Executive Director Planning and Funding, Sandra Boardman, commences in role. Extra Ministry funding allocated for exemplar services to focus on the needs of young people with co-existing mental health and alcohol and drug issues.
August	$2 million energy savings for Dunedin Hospital half-way through energy performance contract. E-Prescribing Programme rolled out to the operating theatre and surgical areas. New linear accelerator (Linac) machine installed for radiation treatment at Dunedin Hospital.	February	Ronald McDonald Family Room opens for families at Southland Hospital. Work on the Southern Strategic Health Services Plan commences. Child and Youth Steering Group established.
September	Clutha Mental Health Services progress "One-Stop Shop" model.	March	Prime Minister Hon. John Key opens the Children's and Neonatal Intensive Care Ward at Dunedin Hospital. Walking in another's shoes programme, a training programme to help caregivers better understand dementia, commences.
October	Work commenced on the District's Health Profile, a summary of key health data that reflects the current state of the health of people living in the Southern DHB area.	April	New Traumatic Brian Injury Service commences.
November	B4 School Checks programme, a health assessment for four-year-old children, exceeds nationally-set target.	May	CEO Carole Heatly leads the South Island Neurosurgery Regional Governance Group. South Island DHBs working to address climate change and environmental sustainability.
December	Countdown Kids Hospital Appeal reaps $207,447 for children's wards. New DHB Board members commence in roles. First patients welcomed in the redeveloped Children's Health Inpatient Service at Dunedin Hospital.	June	Southern DHB receives funding for a new dental clinic in Queenstown.

DHB GOVERNANCE

BOARD MEMBER MEETING ATTENDANCE

DHB Board elections were held during the 2013/14 year which resulted in changes to the Board in December 20913. Table 3 shows the board member attendance on the previous Board to 6 December 2013. Table 4 shows the board member attendance on the new Board from 6 December 2013 to 30 June 2014.

Table 3: Southern DHB attendance at board and committee meetings: 1 July 2013 – 6 December 2013 (previous Board)

Board Member	Board	Hospital Advisory	Audit & Risk	CPHAC/DSAC	Iwi Governance
	5 meetings	*5 meetings*	*3 meetings*	*2 meetings*	*2 meetings*
Joe Butterfield *Chairman*	*4*	*-*	*3*	*-*	*-*
Tim Ward	*5*	*5*	*3*	*-*	*-*
Sandra Cook	*5*	*-*	*-*	*2*	*1*
Neville Cook	*4*	*3*	*-*	*2*	*-*
Kaye Crowther	*5*	*-*	*-*	*2*	*2*
Mary Flannery	*5*	*-*	*3*	*2*	*-*
Dr Malcolm Macpherson	*4*	*4*	*-*	*2*	*-*
Paul Menzies *Deputy Chair*	*4*	*4*	*1*	*-*	*1*
Tahu Potiki Note: Tahu Potiki resigned effective from 1 October 2013	*2*	*1*	*-*	*-*	*1*
Dr Branko Sijnja	*5*	*5*	*-*	*-*	*-*
Richard Thomson	*5*	*5*	*-*	*-*	*-*

Table 4: Southern DHB attendance at board and committee meetings: 6 December 2013 - 30 June 2014 (new Board)

Board Member	Board	Hospital Advisory	Audit & Risk	CPHAC/DSAC	Iwi Governance
	6 meetings	*3 meetings*	*2 meetings*	*3 meetings*	*3 meetings*
Joe Butterfield *Chairman*	*6*	*3*	*2*	-	-
Tim Ward *Deputy Chair*	*6*	-	*2*	*3*	*3*
John Chambers	*6*	*3*	-	-	-
Sandra Cook	*6*	-	-	*3*	*3*
Neville Cook	*5*	-	-	*2*	-
Kaye Crowther	*6*	-	-	*3*	*3*
Mary Gamble	*6*	*3*	-	-	-
Tony Hill	*6*	*3*	*2*	-	*3*
Tuari Potiki	*5*	*3*	*1*	-	*3*
Dr Branko Sijnja	*6*	-	-	*3*	-
Richard Thomson	*6*	*2*	-	-	-

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

Southern DHB is committed to the highest level of integrity and ethical standards in everything we do. We are committed to the principles of natural justice and value all employees and treat them with respect. These expectations and principles are set out in the Code of Conduct and Integrity Policy for all employees and those who are involved in the operation of Southern DHB.

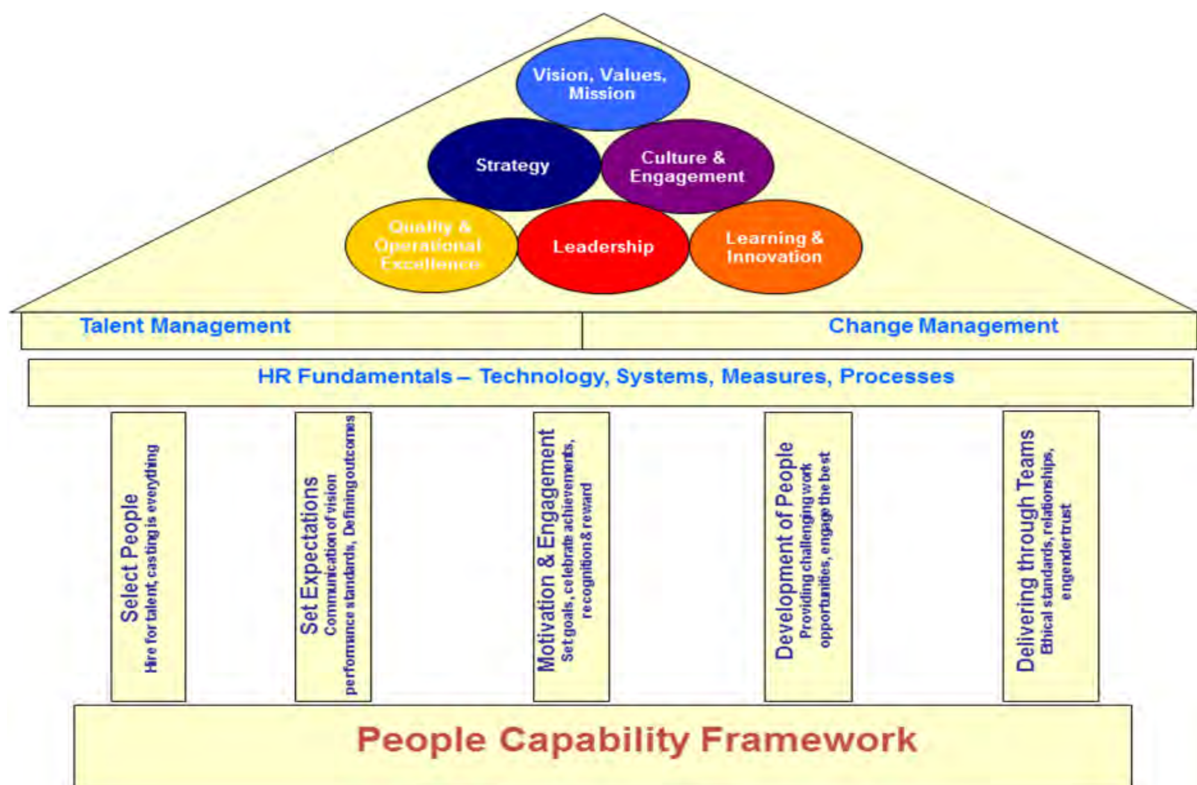
A suite of Equal Employment Opportunity polices underpin the execution of activities that relate to the recruitment and management of employees for recruitment, pay and rewards, professional development and work conditions.

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

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

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

Figure 3: Southern DHB People Capability Framework



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

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

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

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

STATEMENT OF SERVICE PERFORMANCE

MEASUREMENT OF PERFORMANCE

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

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

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

OUTCOMES AND IMPACTS

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

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

OUTCOME 1: PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH

A reduction in smoking rates.
A reduction in obesity rates.

OUTCOME 2: PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES

A reduction in the rate of acute medical admission.
A reduction in premature ischemic heart disease rates.

OUTCOME 3: PEOPLE WITH COMPLEX ILLNESS HAVE IMPROVED HEALTH OUTCOMES

A reduction in the rate of acute readmissions.
A reduction in premature cancer mortality rates.

OUTCOME 4: PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE

An increase in the proportion of people over 65 supported in their own homes.
A reduction in the rate of acute readmissions for people over 75.

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

OUTPUT MEASURES

In order to present a representative picture of performance, outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum care and are applicable to all DHBs (see Figure 5).

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

To ensure the quality of services provided, the DHB invests in programmes that are evidence-based or evidence-informed such as ABC Smoking Cessation and InterRAI – where research shows definite gains and positive outcomes. This provides the DHB with greater assurance that these are 'the right services', allowing us to focus on monitoring implementation and whether the right people have access, at the right time and in the right place. In some cases the DHB will measure the number of people 'trained' in a particular programme or method, to give further assurance of quality provision and of the capacity of the system to deliver these services.

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

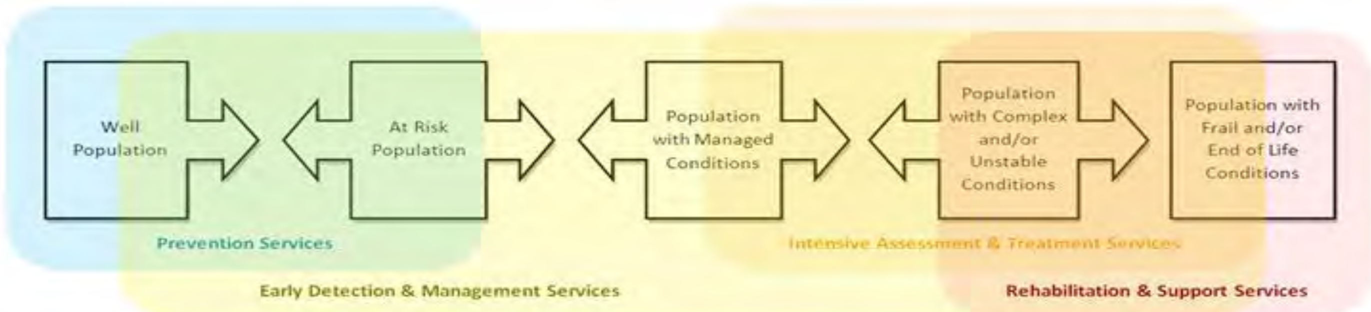


Figure 6: DHB Intervention Logic Diagram

MINISTRY OF HEALTH SECTOR GOAL

All New Zealanders live longer, healthier and more independent lives.

SECTOR OUTCOME	SECTOR OUTCOME	SECTOR OUTCOME	SECTOR OUTCOME
Good health & independence are protected & promoted.	A more unified & improved health & disability system.	People receive better health & disability services.	Health & disability services are trusted and used with confidence.

SOUTH ISLAND REGIONAL VISION

A clinically and fiscally sustainable South Island health system, where people are well and services are provided as close to people's homes as possible.

REGIONAL OUTCOME (5-10 YRS)	REGIONAL OUTCOME (5-10 YRS)	REGIONAL OUTCOME (5-10 YRS)	REGIONAL OUTCOME (5-10 YRS)
People are healthier and take greater responsibility for their own health.	People stay well in their own homes and communities.	People with complex illness have improved health outcomes.	People experience optimal functional independence and quality of life.
▪ A reduction in smoking rates. ▪ A reduction in obesity rates.	▪ A reduction in the rate of acute medical admission. ▪ A reduction in premature ischemic heart disease rates.	▪ A reduction in the rate of acute readmissions. ▪ A reduction in premature cancer mortality rates.	▪ An increase in the proportion of people 65+ supported in their own homes. ▪ A reduction in the rate of acute readmissions for people 75+.

SOUTHERN DHB'S MISSION

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

IMPACT (3-5 YRS)	IMPACT (3-5 YRS)	IMPACT (3-5 YRS)	IMPACT (3-5 YRS)
People are healthier and take greater responsibility for their own health.	People stay well in their own homes and communities.	People with complex illness have improved health outcomes.	People experience optimal functional independence and quality of life.
▪ Babies are breastfed. ▪ Fewer young people take up smoking.	▪ Children have good oral health. ▪ People access urgent care when they need it. ▪ Fewer people are admitted to hospital with 'avoidable' or 'preventable' conditions.	▪ People have shorter waits for emergency treatment. ▪ People have increased access to elective services. ▪ People stay safe in hospital.	▪ Fewer older people are admitted to hospital as a result of a fall.

LOCAL OUTPUTS	LOCAL OUTPUTS	LOCAL OUTPUTS	LOCAL OUTPUTS
Prevention services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services

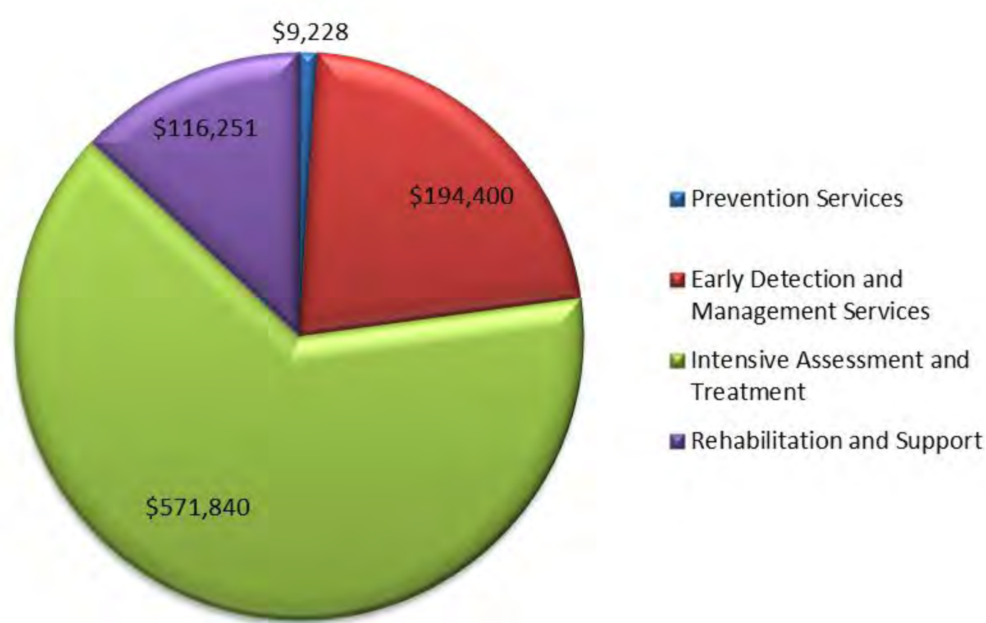
INPUTS	INPUTS	INPUTS	INPUTS	INPUTS	INPUTS
Workforce & Specialist Skills	Networks & Relationships	Financial Resources	Quality Systems & Processes	Information Technology	Assets & Infrastructure

COST OF SERVICE STATEMENT

Revenue and Expenditure by the Four Output Classes

	2014 Actual	2014 Budget
Income		
Prevention Services	9,228	9,519
Early Detection and Management Services	192,875	186,311
Intensive Assessment and Treatment	557,314	553,969
Rehabilitation and Support	114,479	112,334
Total income	**873,897**	**862,131**
Expenditure		
Prevention Services	9,228	9,519
Early Detection and Management Services	194,400	186,693
Intensive Assessment and Treatment	571,840	562,181
Rehabilitation and Support	116,251	112,778
Total expenditure	**891,718**	**871,171**
Surplus/(Deficit) for the year	**(17,822)**	**(9,039)**

Figure 7: Expenditure by Output Class



HEALTH TARGETS

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

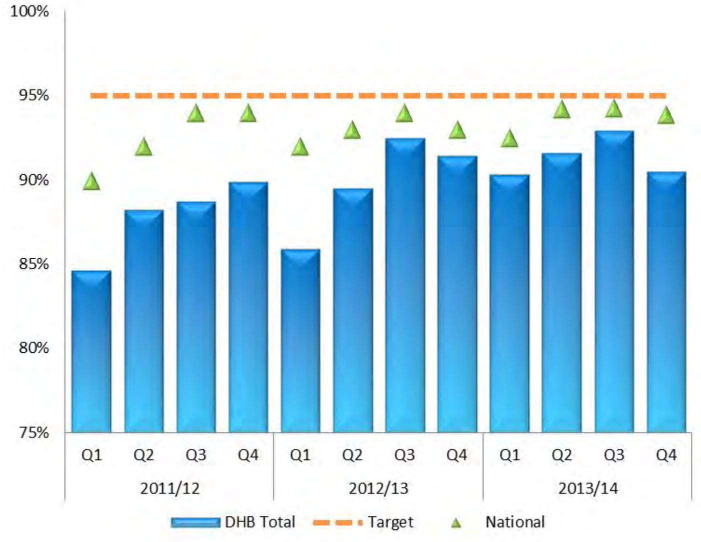
- HT1 – SHORTER STAYS IN EMERGENCY DEPARTMENTS
- HT2 – IMPROVED ACCESS TO ELECTIVE SURGERY
- HT3 – SHORTER WAITS FOR CANCER TREATMENT
- HT4 – INCREASED IMMUNISATION
- HT5 - BETTER HELP FOR SMOKERS TO QUIT (HOSPITAL AND PRIMARY CARE)
- HT6 – MORE HEART AND DIABETES CHECKS

SHORTER STAYS IN EMERGENCY DEPARTMENTS

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

2013/14 RESULTS				
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
DHB	90.3%	91.6%	92.9%	90.5%
New Zealand	92.5%	94.3%	94.3%	94.0%

Figure 8: Health Target - Shorter Stays in Emergency Departments



Southern DHB did not meet the ED target but there has been an improved and more consistent result over the past 12 months. There are many variables that contribute to ED waiting times. The DHB continues to strive for an emergency and urgent care system involving primary care that is adaptable and responsive, irrespective of patient numbers, acuity or complexity.

What contributed to this result?

Improved inpatient flow after reviewing the discharge process in the acute ward areas to facilitate more beds being made available.

Work commenced to investigate and implementation of alternative workforce models, roles and configurations based on positive experiences in Dunedin and Invercargill Hospitals.

Introduced daily reporting and analysis identifying the specific areas or teams within the hospital that contributed to any patient exceeding the six hour limit.

Identified frequent attendees to ED and in conjunction with primary care looked at appropriate support options to keep them away from ED. This included referring to the wraparound service provided within the Southern PHO integrated primary care (IPC) programme.

IMPROVED ACCESS TO ELECTIVE SURGERY

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

Figure 9: Health Target - Improved Access to Elective Surgery

2013/14 RESULTS				
	Q1	Q2	Q3	Q4
Target	100%	100%	100%	100%
DHB	98.3%	101%	102%	106%
New Zealand	105%	105%	105%	106%

Southern DHB has again exceeded the target (10,347) for elective surgery for 2013/14. A total of 10,948 elective surgical procedures were completed in 2013/14 which was 601 more than the target, and an increase of 678 elective surgical procedures over 2012/13.

What contributed to this result?

An improved production planning model for Southern Elective Services developed with Information Systems (IS).

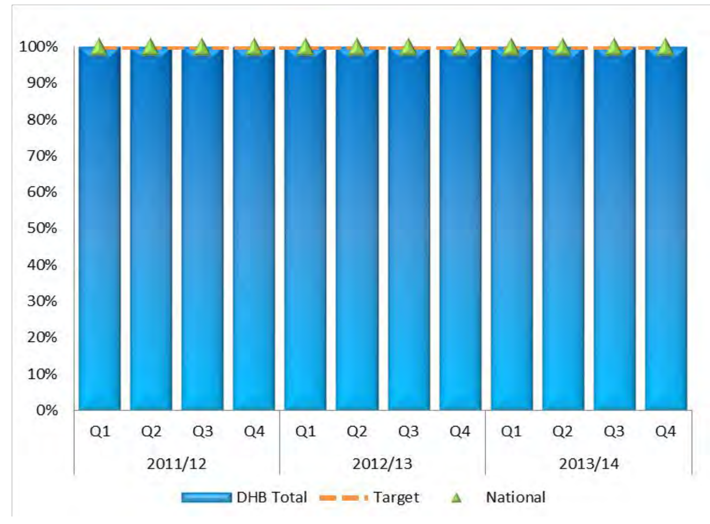
Monitoring of the service capacity and capability to meet demand across the district and ensure resource is appropriate.

Orthopaedic Pathways Programme (OPP) commencing the redesign and implementation of improved referral procedures from primary care.

SHORTER WAITS FOR CANCER TREATMENT

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

Figure 10: Health Target - Shorter Waits for Cancer Treatment



2013/14 RESULTS				
	Q1	Q2	Q3	Q4
Target	100%	100%	100%	100%
DHB	100%	100%	100%	100%
New Zealand	100%	100%	100%	100%

The Southern Blood and Cancer Service continues to meet the target times for patients commencing radiotherapy or chemotherapy. Over the past seven years the target times have reduced from an initial 8 weeks to 4 weeks.

What contributed to this result?

Commissioned a new linear accelerator to provide an increase in capacity required for the next 5 years.

Introduced electronic prescribing to streamline the delivery of chemotherapy.

Established nurse led clinics for patients receiving adjuvant treatment for breast and bowel cancer.

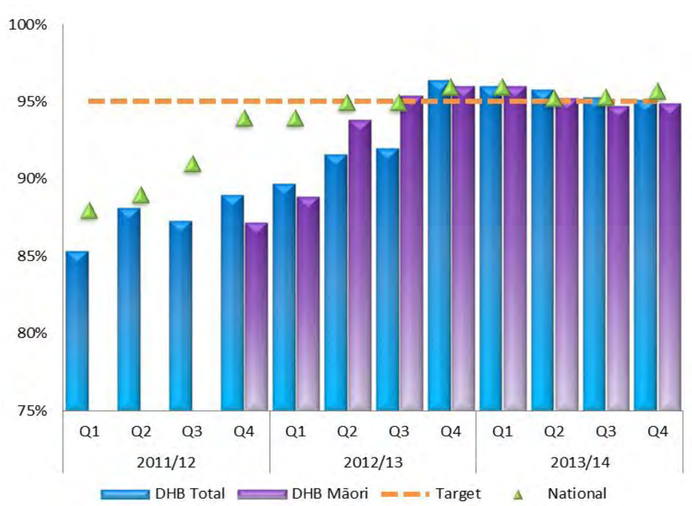
Reduced the heterogeneity in practice by developing common radiation care plans with other South Island Cancer Centres.

BETTER HELP FOR SMOKERS TO QUIT - HOSPITAL

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

2013/14 RESULTS				
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
DHB	96.0%	95.8%	95.3%	95.1%
Māori	96.0%	95.2%	94.7%	94.9%
New Zealand	96.0%	95.3%	95.3%	95.7%

Figure 11: Health Target - Better Help for Smokers to Quit (Hospital)



Southern DHB continues to meet the target for offering brief advice and support to quit smoking in hospitals.

What contributed to this result?

ABC part of staff orientation.

Daily auditing undertaken for any wards achieving <100% to provide timely feedback to clinical staff.

Weekly reports detailing weekly target result for Southern District Health Board sent to Nurse Directors and Rural Hospital Trust Managers.

Smokefree seminars for healthcare professionals in primary, secondary care and community.

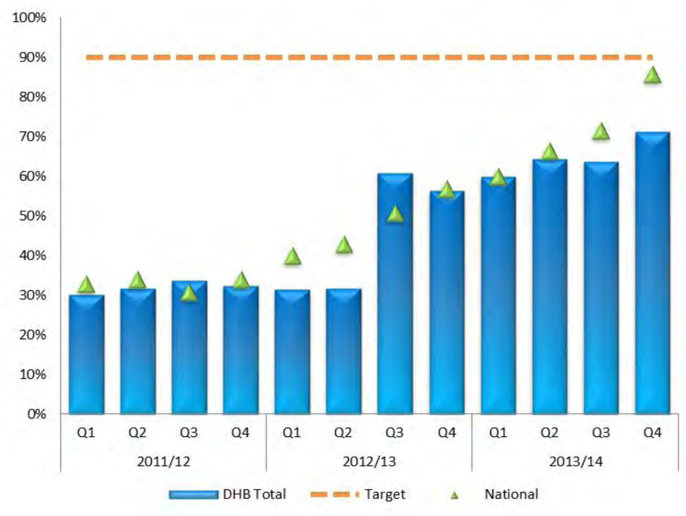
Post-discharge follow-up to be undertaken for wards where ABC was unable to be completed during in-patient admission. This is being progressively phased out as ABC becomes embedded into everyday processes.

BETTER HELP FOR SMOKERS TO QUIT – PRIMARY CARE

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

2013/14 RESULTS				
	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
DHB	59.9%	64.2%	63.5%	71.2%
New Zealand	60.0%	66.5%	71.6%	85.8%

Figure 12: Health Target - Better Help for Smokers to Quit (Primary)



Primary care performance in offering brief advice and support to quit smoking continues well below both the target and the achievements elsewhere in New Zealand. However there have been modest increases and the foundations have been established to meet the target in the coming year.

What contributed to this result?

DHB and PHO jointly manage 'Primary Better Help for Smokers to Quit' activity.

Additional Primary Smokefree Coordination FTE to increase support for Southern PHO and general practice.

Establishment of a "Text to Remind" service in general practice, providing another mechanism to capture smoking status of enrolled populations who do not regularly access primary care.

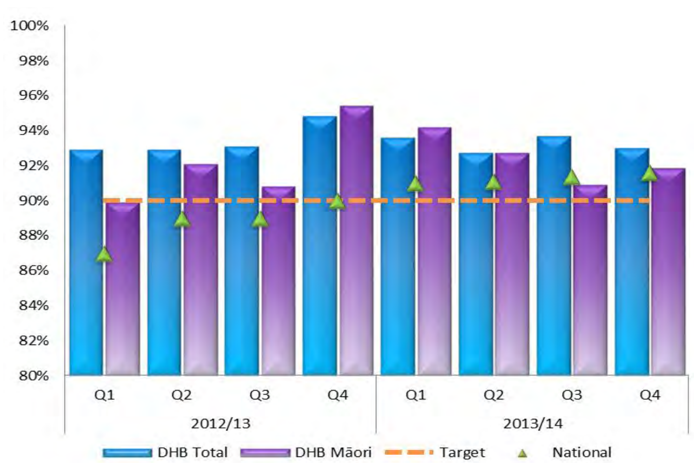
Introduction on new IT tools to assist during the consultation and collation of data.

INCREASED IMMUNISATION

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

2013/14 RESULTS				
	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
DHB	93.6%	92.7%	93.7%	93.0%
Māori	94.2%	92.7%	90.9%	91.9%
New Zealand	91.0%	91.1%	91.4%	91.6%

Figure 13: Health Target - Increased Immunisation



Southern continues to be a leader in meeting and exceeding childhood immunisation targets. The majority of childhood immunisation is done in general practice with support from immunisation outreach services.

What contributed to this result?

Working with primary care partners to improve newborn enrolment rates.

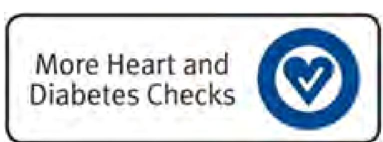
Improved systems for seamless handover of mother and child as they move from maternity care services to general practice and Well Child and Tamariki Ora (WCTO) services.

Identify immunisation status of children presenting at hospital and refer for immunisation as required.

Improved monitoring and evaluation of immunisation coverage at DHB, PHO and practice level; manage identified service delivery gaps.

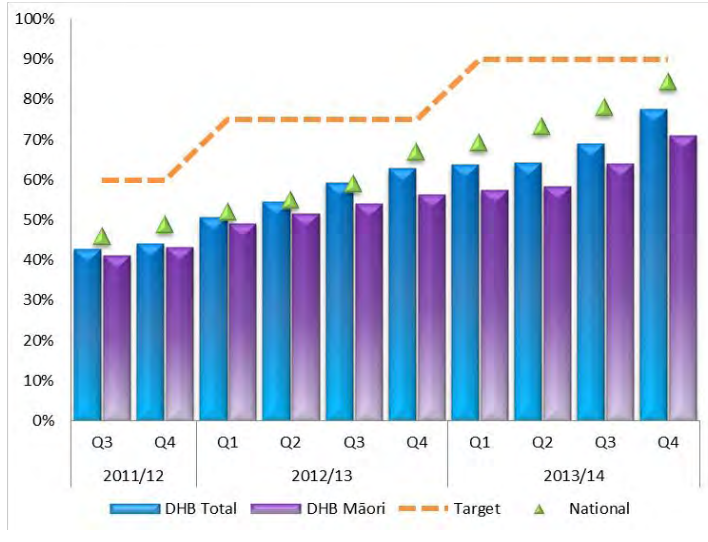
MORE HEART AND DIABETES CHECKS

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



2013/14 RESULTS				
	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
DHB	63.8%	64.2%	69.1%	77.6%
Māori	57.4%	58.3%	64.0%	71.1%
New Zealand	69.2%	73.2%	78.2%	84.4%

Figure 14: Health Target - More Heart and Diabetes Checks



Primary care under the guidance of Southern PHO has made gains in the number of eligible people who have received a cardiovascular risk assessment in the past five years.
There has been significant investment to improve the number of heart and diabetes checks. However there is still work to be done to achieve the target and match the performance of the rest of the country.

What contributed to this result?

Increased PHO support available to practices to enable them to manage and fully utilise their diabetes registers and effectively recall eligible patients.

Increased training and education opportunities for GPs and practice nurses. These include one-on-one sessions, seminars and online tools such as an online diabetes education resource for practice nurses.

A number of providers outside general practice have been accredited to do cardiovascular disease risk assessments (CVDRAs) with the data captured by Southern PHO.

OUTCOMES AND IMPACTS: IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

WHAT ARE WE TRYING TO ACHIEVE?

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

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

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

OUTCOME 1: PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH

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

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

OUTCOME - REDUCTION IN SMOKING RATES

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

Supporting our population to say 'no' to tobacco smoking is our foremost opportunity to reduce inequalities and target improvements in the health of our population.

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

The rate of smoking for Southern is higher than New Zealand with a rate of 21.5%, which is over 66,600 people in our community. The Southern rate, above the national rate, equates to more than 10,800 smokers.

There are two approaches to reducing smoking.

1. Prevent people starting smoking. This is one area where there has been some success. There has been a significant decrease in the number of year 10 children starting smoking (refer to page 24)
2. Supporting people to quit. This is an area where we have not had the success as anticipated. Whilst 95% of people who are admitted to hospital are offered support to quit, the majority of people are seen in primary care. Primary care has struggled to introduced and embed good processes where the offer to support someone to quit smoking is routinely made and recorded.

   However primary care is now working hard to make the smoking question routine and the evidence of doing this indicates we can see a more pronounced reduction in smoking rates.

	2002/03	2006/07	2011/12	2012/13
DHB	-	-	21.8%	21.5%
South Island	-	19.5%	17.9%	-
New Zealand	22.9%	19.9%	18.4%	18.0%

Data source: New Zealand Health Survey (NZHS)

Note: The NZHS became a continuous survey in 2011; prior to this the NZHS was undertaken every 4-5 years.

Figure 15: Smoking rates

Outcome - Reduction in Obesity Rates

Outcome Measure: The percentage of the population (15+) who are obese.

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

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

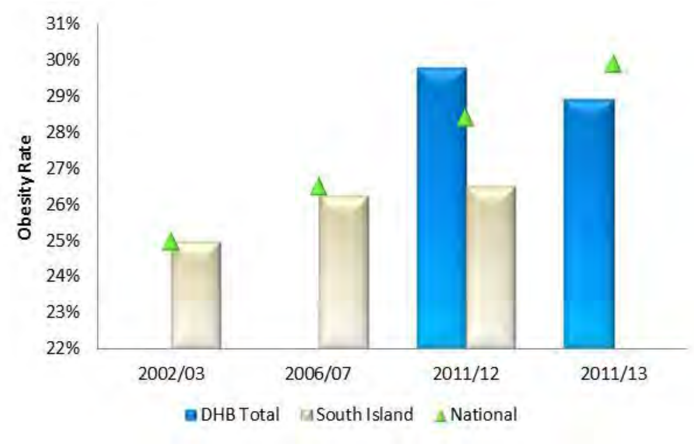
Specific funded activities include Active Families and Green Prescriptions which people in need of lifestyle modifications are referred to for a specific activity programme.

	2002/03	2006/07	2011/12	2012/13
DHB	-	-	29.8%	28.9%
South Island	25.0%	26.2%	26.5%	-
New Zealand	25.0%	26.5%	28.4%	29.9%

Data source: New Zealand Health Survey (NZHS)

Note: The NZHS became a continuous survey in 2011; prior to this the NZHS was undertaken every 4-5 years.

Figure 16: Obesity rates



Impact - More Babies are Breastfed

Outcome Measure: The percentage of babies fully/exclusively breastfed at 6 weeks.

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

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

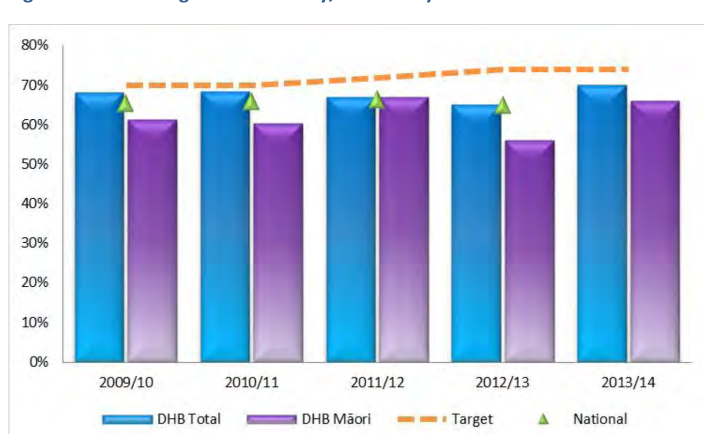
All Maternity facilities in Southern continue to attain Baby Friendly Hospital accreditation.

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

	2010/11	2011/12	2012/13	2013/14
Target	70%	72%	74%	74%
DHB	68%	67%	65%	70%
Māori	60%	67%	56%	66%
New Zealand	66%	66%	65%	NA

Data source: Plunket via Ministry of Health

Figure 17: Percentage of babies fully/exclusively breastfed



Impact - Fewer Young People Take Up Tobacco Smoking

Outcome Measure: The percentage of 'never smokers' among Year 10 students

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.

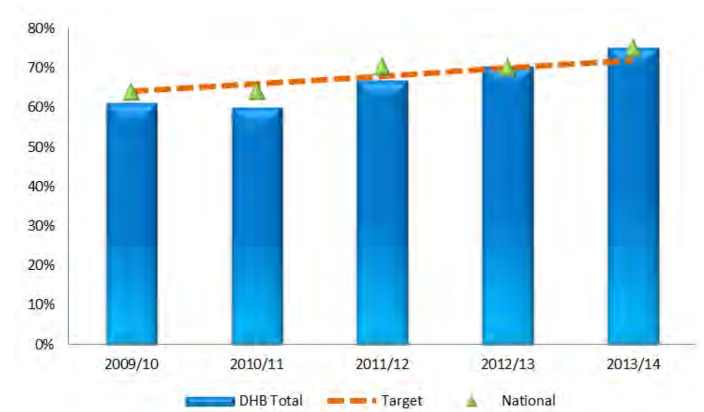
The increase in year 10 students who have never smoked has been dramatic over the past five years. Southern DHB rates have now increased to match the national rate. Preventing people taking up smoking is a foundation for New Zealand to fulfil the goal of being smokefree by 2025 (Smokefree Aotearoa 2025).

There has been considerable investment in health promotion, both a national level and local level. 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.

	2010/11	2011/12	2012/13	2013/14
Target	66%	68%	70%	72%
DHB	60%	67%	70%	75%
New Zealand	64%	70%	70%	75%

Data source: National Year 10 'Action on Smoking and Health' (ASH) Survey

Figure 18: The percentage of 'never smokers' among Year 10 students



OUTCOME 2: PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES

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

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

OUTCOME - REDUCTION IN ACUTE MEDICAL ADMISSIONS

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

The rate of acute medical admissions to hospital continues to rise. A large number of people admitted acutely will be through the emergency department (ED); the increase in numbers to ED correlates to the number of acute admissions.

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

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

Acute medical admissions can be used as a proxy measure of improved conditions management by indicating that fewer people are experiencing an escalation of their condition leading to an urgent (acute) or complex intervention. They can also be used to indicate access to appropriate and effective care and treatment in the community.

	2010/11	2011/12	2012/13	2013/14
DHB	5833	7137	7680	8038
South Is.	5225	5658	5840	6155
New Zealand	6917	7197	7308	7426

Data source: National Minimum Data Set (NMDS).

Figure 19: Rate of acute medical admissions to hospital

Outcome - Reduction in Premature Ischemic Heart Disease Mortality Rates

The Premature Mortality Rate Due to Ischaemic Heart Disease (Per 100,000)

Cardiovascular Diseases (CVD) such as heart disease and stroke are the leading causes of death in the Southern district.

Premature mortality due to CVD is largely preventable with lifestyle change, early intervention and effective treatment. By detecting people at risk and improving the ongoing management of their condition, the more harmful impacts and complications of CVD can be reduced.

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

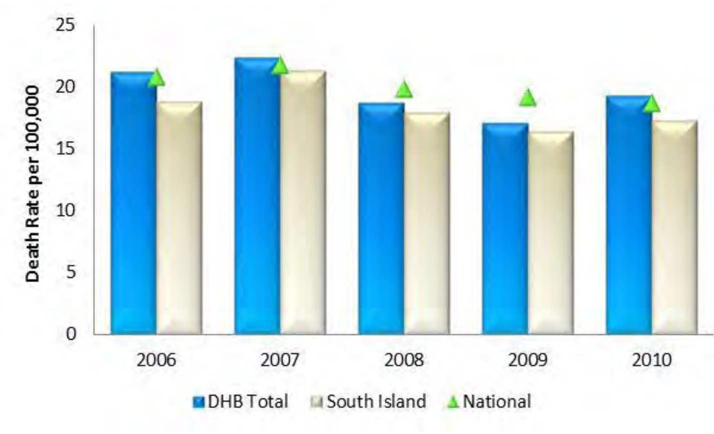
CVD is significantly more prevalent amongst Māori and Pacific groups and so improved CVD outcomes are an opportunity to reduce inequalities and target improvements in the health of our more vulnerable populations.

The rate of premature death due to ischemic heart disease can be used as a proxy measure of improved conditions management and access to effective treatment.

	2007	2008	2009	2010
DHB	22.38	18.75	17.09	19.29
South Island	21.38	18.02	16.41	17.31
New Zealand	21.80	19.86	19.26	18.77

Data source: Ministry of Health

Figure 20: Rates of premature mortality due to ischaemic heart disease



Impact - Children Have Good Oral Health

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

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

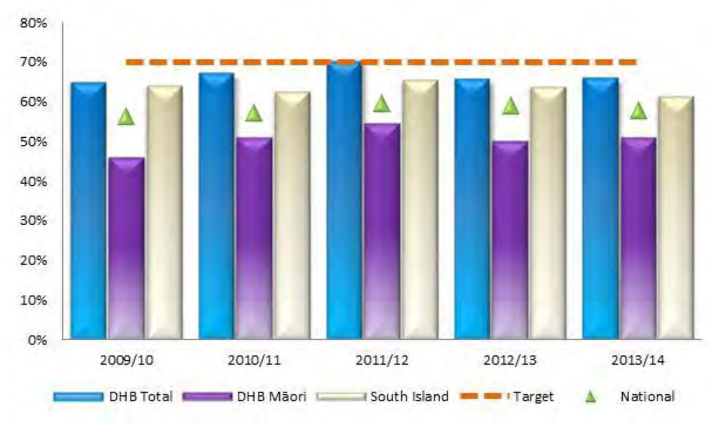
The number of preschool children enrolled in the community oral health service continues to increase (see page 37). There has been a notable increase in the number of Māori children enrolled.

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

	2010/11	2011/12	2012/13	2013/14
Target	70%	70%	70%	70%
DHB	67.2%	70.3%	65.7%	66.0%
Māori	51.0%	54.5%	50.1%	51.0%
South Island	62.4%	65.6%	63.8%	61.4%
New Zealand	57.2%	59.6%	58.9%	57.8%

Data source: Ministry of Health

Figure 21: The percentage of children caries free at age 5



IMPACT - PEOPLE ACCESS URGENT CARE WHEN THEY NEED IT

The percentage of the population presenting at ED.

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

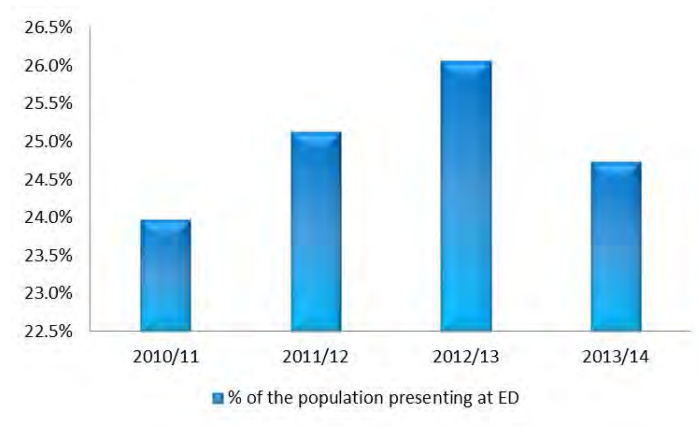
Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.

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

	2010/11	2011/12	2012/13	2013/14
Target	-	-	-	-
DHB	24.0%	25.1%	26.1%	24.7%

Data source: Southern DHB

Figure 22: Percentage of population presenting at ED



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

The rate of avoidable hospital admissions per 100,000 population (<75 years).

Ambulatory Sensitive Hospitalisations (ASH), commonly known as avoidable hospitalisations, has remained relatively steady over a period of time.

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

ASH rates for Southern have been relatively consistent. Rates for the total population 0-74 years are below the national rate; however the ASH rate for Māori is well above the rest of the population.

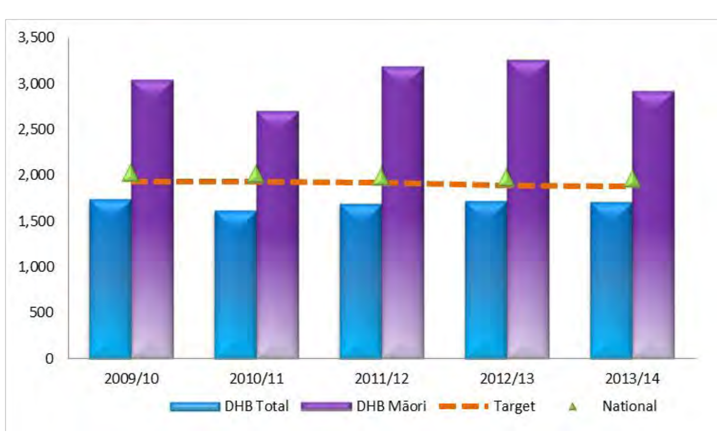
Within the 0-74 years ASH rate is also the 0-4 years ASH rate (see page 36). Against the rest of New Zealand, the Southern ASH rate is not as good. Improving access to primary care is a focus for Southern DHB and Southern PHO.

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

	2010/11	2011/12	2012/13	2013/14
Target	1933	1919	1891	1881
DHB	1617	1691	1718	1711
Māori	2705	3185	3264	2919
New Zealand	2020	1990	1980	1971

Data source: Ministry of Health

Figure 23: The rate of avoidable hospital admissions per 100,000 population (<75 years).



OUTCOME 3: PEOPLE WITH COMPLEX ILLNESS HAVE IMPROVED HEALTH OUTCOMES

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

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

OUTCOME - REDUCTION IN PREMATURE CANCER MORTALITY RATES

The Premature Mortality Rate Due to Cancer (Per 100,000)

Cancer is the second leading cause of death in Southern. Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer. Early detection increases the options for treatment, and early treatment increases the chances of survival.

There has been a focus on reducing waiting times for radiotherapy or chemotherapy to under four weeks (see health target for cancer waiting times on page 19). This has streamlined the patient pathway to treatment once a diagnosis has been made.

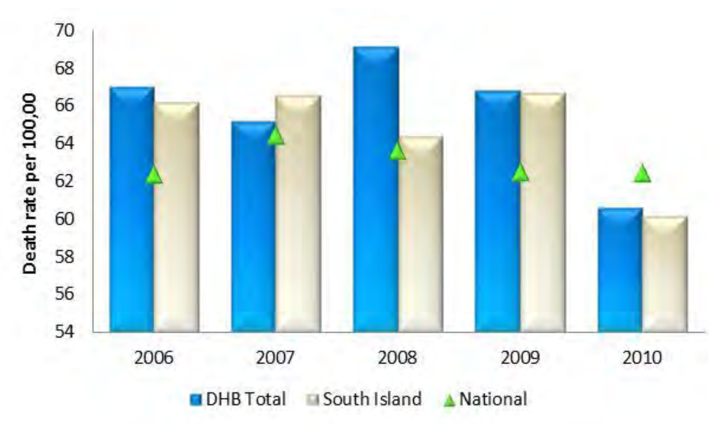
There is a change to the health target in quarter 2 of 2014/15. The new faster cancer treatment health target will focus on patients referred with a high suspicion of cancer waiting 62 days or less to receive their first treatment.

The rate of premature death due to cancer can be used as a proxy measure of improved specialist care and access to treatment for people with complex illness.

	2010/11	2011/12	2012/13	2013/14
DHB	65.2	69.1	66.8	60.6
South Island	66.6	64.4	66.7	60.2
New Zealand	64.5	63.6	62.5	62.4

Data source: Ministry of Health mortality collection.

Figure 24: Rate of premature mortality due to cancer



OUTCOME - REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.

Acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration; ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.

Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.

	2010/11	2011/12	2012/13	2013/14
DHB Total	-	-	6.75%	7.35%
NZ Total	-	-	-	8.18%
DHB 75+	-	-	9.42%	9.76%
NZ 75+	-	-	-	11.54%

Data source: Ministry of Health.

A new definition for acute readmission rates was introduced for 2013/14. Results are not comparable with previous years.

IMPACT - PEOPLE HAVE SHORTER WAITS FOR TREATMENT

The percentage of patients presenting in ED who are admitted, discharged or transferred within six hours.

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

Southern DHB continues to not meet the ED target but there has been an improved and more consistent result over the past 12 months.

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

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

	2010/11	2011/12	2012/13	2013/14
Target	95%	95%	95%	95%
DHB	83.0%	89.9%	91.4%	90.5%
New Zealand	91.6%	94.0%	93.0%	93.9%

Note: more detailed ED data by quarter is available on page 18.

Data source: Southern DHB

Figure 25: Shorter stays in Emergency Departments

Impact - People Have improved timeliness to Elective Services

The time people wait from referral to First Specialist Assessment (ESPI 2), and commitment to treat until treatment (ESPI 5).

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

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

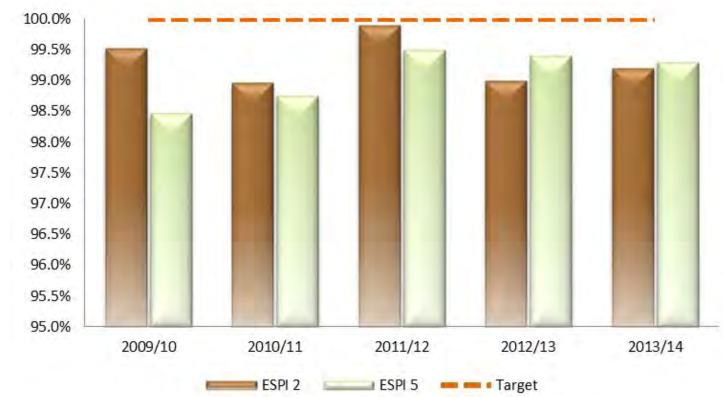
The Elective Services Patient Flow Indicators (ESPIs) are a series of six measures on meeting the required performance standard for elective surgery. In July 2013 the waiting times standard for ESPI 2 (FSA) and ESPI 5 (treatment) reduced to a maximum of 5 months (from 6 months).

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

	2010/11	2011/12	2012/13	2013/14
Target	100%	100%	100%	100%
ESPI2	99.0%	99.9%	99.0%	99.2%
ESPI5	98.7%	99.5%	99.4%	99.3%

Data source:Ministry of Health.

Figure 26: The time people wait from referral to First Specialist Assessment and Treatment



Impact - People Stay Safe in Hospital

The rate of Severity Assessment Code (SAC) level 1 and 2 fall incidents in Southern Hospitals.

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

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

A multi-disciplinary and inter-sectorial falls governance group has been established in 2014 (see page 31). This group is focused on prevention; falls assessments for at risk individuals and a fracture liaison service to reduce the risks of a secondary fracture (see page 46).

A key factor in reducing adverse events is the engagement of staff and clinical leaders in improving processes and championing change. Achievement against this measure is therefore also seen as a proxy indicator of an engaged and capable workforce with the capacity and capability to improve service delivery.

	2010/11	2011/12	2012/13	2013/14
Target			0.04	0.03
DHB	0.04	0.06	0.06	0.06

Data source: Southern DHB

OUTCOME 4: PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE

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

OUTCOME – INCREASED PROPORTION OF THE OLDER POPULATION (65+ YEARS) SUPPORTED TO STAY WELL IN THEIR OWN HOME

Outcome Measure: The percentage of the older population (65+) living in ARC compared against those receiving HBSS.

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

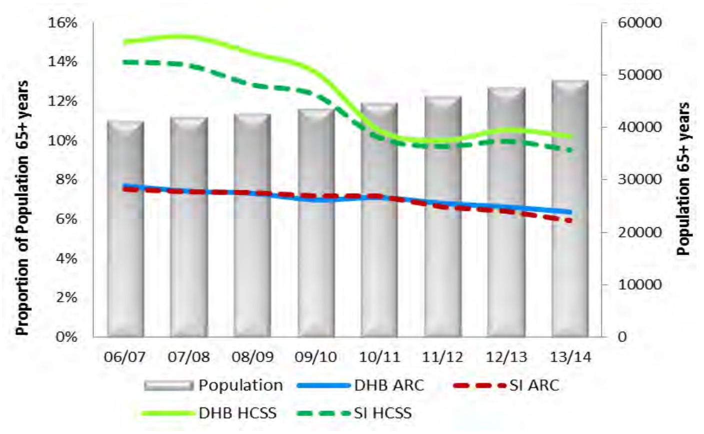
A greater number of older people with complex care requirements are now being cared for in their own homes through the new Home and Community Support Services (HCSS). This is seeing fewer people entering 'rest-home' level ARC. If ARC is required then people are more complex and usually require 'hospital'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

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

	2010/11	2011/12	2012/13	2013/14
DHB ARC	7.1%	6.8%	6.6%	6.4%
SI ARC	7.2%	6.6%	6.4%	5.9%
DHB HCSS	10.5%	10.0%	10.5%	10.2%
SI HCSS	10.2%	9.7%	10.0%	9.5%
Population	44593	45983	47510	49008

Data source: Client claim payments via SIAPO

Figure 27: Rates of older people being supported in their own home (home and community support services) and those who have moved into aged residential care



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

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

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

In April 2014, Southern DHB established a multi sector Southern Alliance Falls and Fracture Prevention Steering Group with a vision of over 65 year olds being free of injury from falls and fractures.

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

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

	2010/11	2011/12	2012/13	2013/14
Target				8.0%
DHB	7.6%	8.5%	8.6%	9.3%
South Island	7.8%	8.2%	8.1%	8.7%
National	8.5%	8.6%	8.7%	9.0%

Data source: National Minimum Data Set (NMDS)

Figure 28: The percentage of the population (75+) admitted to hospital as a result of a fall

OUTPUT CLASS MEASURES

PREVENTION SERVICES

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

HEALTH PROMOTION AND EDUCATION SERVICES

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

HEALTH PROMOTION AND EDUCATION SERVICES							
SUB-OUTPUT CLASS	OUTPUT MEASURES		RESULTS			TARGET 2013/14	COMMENTS
			2011/12	2012/13	2013/14		
HEALTH PROMOTION AND EDUCATION SERVICES	Smokers receive advice and support to quit smoking in hospital.	Total	87%	96%	95%	95%	See 1 & Figure 29
		Māori	87%	96%	95%	95%	
	Smokers receive advice and support to quit smoking in primary care.	Total	32%	56%	71%	90%	See 2 & Figure 29
		Māori	35%	59%	74%	90%	
	Smokers seeking quit advice from Quitline services.		4886	3598	3099	4880	See 3
	Infants fully and exclusively breastfeed at 6 weeks.	Total	66%	65%	68%	74%	See 4 & Figure 30
		Māori	67%	56%	63%	74%	
	Infants fully and exclusively breastfeed at 6 months.	Total	29%	28%	31%	30%	See 4 & Figure 30
		Māori	22%	15%	18%	30%	

Figure 29: Percentage of smokers receiving advice and support to quit smoking

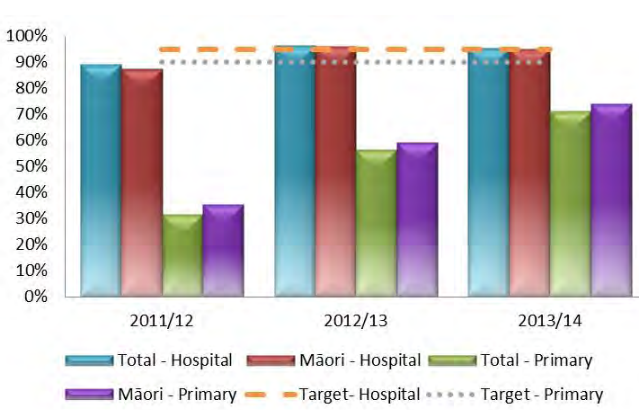
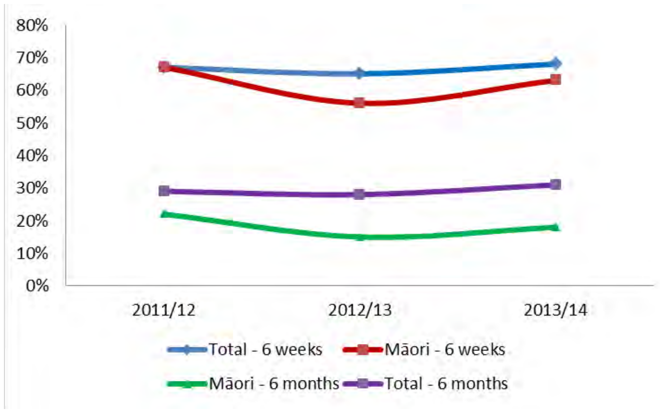


Figure 30: Percentage of infants breastfed



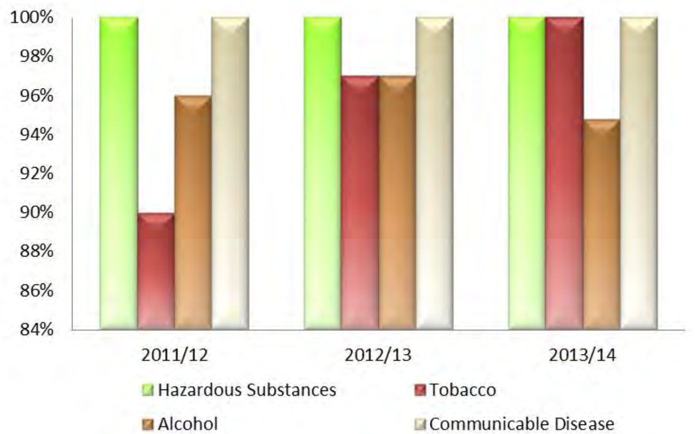
1.	The DHB has been meeting and exceeding the 95% target for offering advice and support to all smokers, including Māori, in our hospitals for the past 2 years. The focus for 2013/14 has been to consolidate processes and embed ABC into business as usual for all staff that comes into contact with patients. More details on the hospital smoking health target are on page 20.
2.	Primary care has made steady progress on providing advice and support to smokers to quit, but there is still significant work required to achieve the health target. More details on the primary care smoking health target are on page 20.
3.	The number of smokers seeking advice from Quitline continues to decline, but is due to the increased number of alternative options and opportunities. Overall more smokers are being offered the opportunity to stop. The significant increase in smokers being offered advice and support to quit smoking whilst in hospital or attending their GP has led to the reduction in Quitline utilisation.
4.	Breast feeding is promoted by lead maternity providers (LMCs), Plunket and Well Child Tamariki Ora (WCTO) providers, and general practice. The Ministry of Health currently collects data from Plunket and is working to gather the data from WCTO providers to show a more comprehensive picture.

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.

Statutory Regulation						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Statutory Regulation	Tobacco retailers are compliant with current legislation.	90%	97%	100%	85%	See 5 & Figure 31
	Alcohol retailers are compliant with current legislation.	96%	97%	95%	95%	See 5 & Figure 31
	The proportion of communicable disease notifications investigated.	100%	100%	100%	100%	See 6 & Figure 31
	The proportion of hazardous substances inspections and audits completed.	100%	100%	100%	100%	See 7 & Figure 31

Figure 31: Public Health Unit Statutory Activity



5.	Retailers selling tobacco and alcohol must comply with all legal requirements including selling to only people who meet the age restrictions. The Public Health Unit provides education and awareness to retailers about the legal restrictions and requirements. Compliance monitoring by the Public Health Unit demonstrates very good retailer awareness and compliance which has consistently exceeded the Ministry of Health requirements.
6.	The Medical Officers of Health and the Public Health Unit fulfilled the statutory requirement to investigate all (100%) of communicable disease notifications within the required timeframe.
7.	The Public Health Unit fulfilled the statutory requirement to complete all (100%) of hazardous substances inspections and audits within the required timeframe.

Population Based Screening

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

Population Based Screening							
Sub-Output Class	Output Measures		Results			Target 2013/14	Comments
			2011/12	2012/13	2013/14		
Population Based Screening	The proportion of the eligible population (45-69) receiving breast screen examinations.	Total	70%	74%	81%	70%	See 8 & Figure 32
		Māori	-	61%	70%	70%	
	Women are re-screened between 20 and 24 months from their previous breast screen examination.		70%	69%	37%	75%	See 9
	The proportion of the eligible population (45-69) receiving cervical cancer screens.	Total	78%	78.8%	79.4%	80%	See 10 & Figure 32
		Māori	-	60.0%	61.6%	80%	
	The percentage of eligible children receiving Before School Checks (B4SC).	Total	83.2%	91.1%	98.8%	80%	See 11 & Figure 33
		Quintile 5	86.6%	91.7%	95.6%	80%	

Figure 32: Cervical and Breast Screening Rates

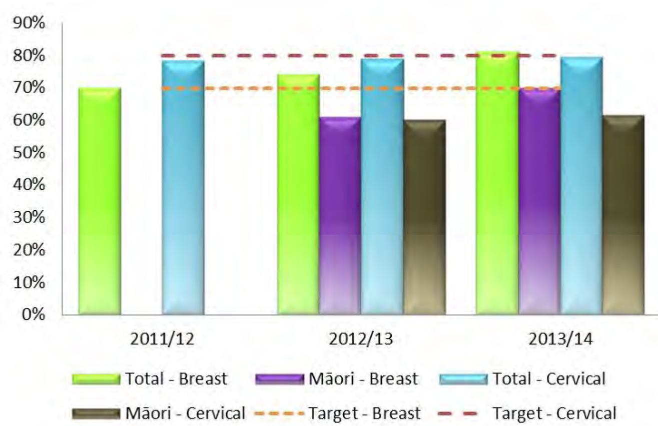


Figure 33: Rates of Before School Checks

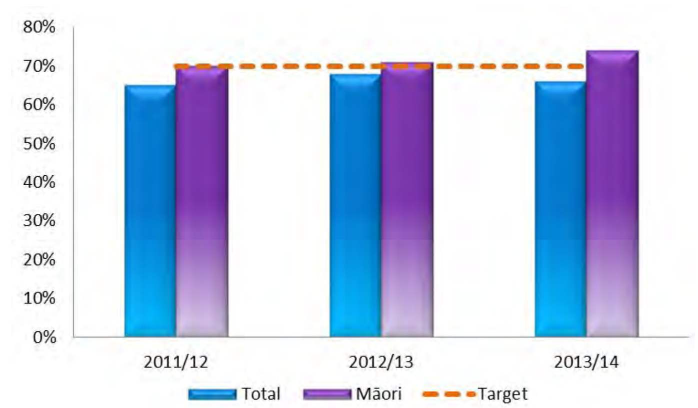
8.	The target for breast screening eligible women has been met for both total population and Māori for the first time.
9.	Only 37% of eligible women received their two-yearly breast screen mammogram within the target 24 months. However 97% received their two-yearly breast screen mammogram within 27 months. This slight delay was due to ongoing workforce capacity issues and the imminent change in provider. Breast screening was passed on to a new provider in July 2014.
10.	There have been incremental increases in cervical screening rates. Māori cervical screening rates continue well below the total population. Cervical screening is one of five initial measures in the new integrated performance and incentive framework (IPIF). Performance based funding is available to primary care once the targets (Total and Māori) are achieved.
11.	The percentage of children receiving their Before School Checks (B4SC) continues to exceed the Ministry targets. B4SC are undertaken by DHB public health nurses.

Immunisation Services

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

Immunisation Services							
Sub-Output Class	Output Measures		Results			Target 2013/14	Comments
			2011/12	2012/13	2013/14		
Immunisation Services	Children fully immunised at age 8 months.	Total	-	94.8%	93.0%	90%	See 12
		Māori	-	95.0%	91.9%	90%	
	Children fully immunised at age 2 years.	Total	95%	94.7%	93.9%	95%	See 13
		Māori		95.0%	94.9%	95%	
	Children 'reached' by immunisation services.	8 months	-	96.0%	97.1%	99%	See 14
		2 years	99%	98.2%	98.7%	99%	
	Eligible young women (12-18 years) engaged (receiving first dose) in the HPV vaccination programme.	Total	65%	68%	66%	70%	See 15 & Figure 34
		Māori	70%	71%	74%	70%	
	People aged over 65 having received a flu vaccination.	Total	66%	69%	68.3%	70%	See 16

Figure 34: HPV vaccination rates



12.	The 90% target for children aged eight months receiving their primary course of immunisation (six weeks, three months and five months immunisation events) on time has continued to be exceeded but raising performance has been a challenge. The number of parents declining childhood immunisation is increasing. This measure is a health target and the target increases to 95 percent by December 2014.
13.	Immunisation rates children aged 2 years continue to meet the 95% target. Rates for the total population and Māori are very similar.
14.	The majority of parents take their children to their general practice for immunisations. General practice will schedule the appointments as they fall due. A small percentage of parents will 'decline' the immunisations; some parents cannot be contacted and some do not attend these appointments for a variety of reasons. The Immunisation Outreach team spends considerable time identifying and locating children that have not received their immunisations according to schedule.
15.	Data presented is for the 2013 calendar year. The vaccination for Human papillomavirus (HPV) is three doses over a 6 month period and is offered to girls at year 8 over the school year. Southern PHO and Public Health South work in partnership to deliver the three dose HPV vaccinations to year 8 girls. Immunisation against HPV prevents the spread of HPV in the population and reduces the risk of cervical cancers.
16.	People over the age of 65 are recommended to have a free influenza vaccination as they have a higher risk of complications from the flu virus as their immune systems are comparatively weaker. This improves well-being and reduces potentially avoidable hospitalisations.

EARLY DETECTION AND MANAGEMENT

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

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

PRIMARY HEALTH CARE SERVICES

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

PRIMARY HEALTH CARE SERVICES							
SUB-OUTPUT CLASS	OUTPUT MEASURES		RESULTS			TARGET 2013/14	COMMENTS
			2011/12	2012/13	2013/14		
PRIMARY HEALTH CARE SERVICES	The percentage of the DHB population enrolled in a Primary Healthcare Organisation.	Total	92.5%	92.5%	93.2%	95%	See 17 & Figure 35
		Māori	74.6%	75.8%	83.4%	95%	
	The number of skin lesions removed in primary care (by a GP with special interest – GPSI) without the need for a hospital appointment.		697	830	1269	1200	See 18
	The number of people receiving a brief intervention from the primary mental health service.		-	3923	4356	3800	See 19
	Ambulatory Sensitive Hospital (ASH) admission rates for children aged 0-4 years are reduced.	Total	111%	116%	117%	115%	See 20 & Figure 36
		Māori	183%	208%	183%	169%	

Figure 35: Percentage of DHB population enrolled in a PHO

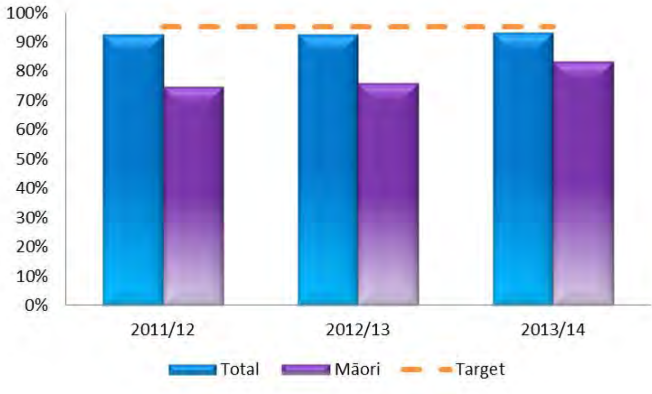
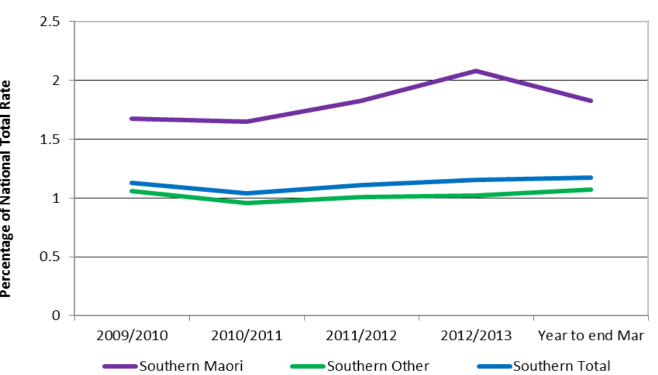


Figure 36: Ambulatory Sensitive Hospitalisation (ASH) rates for children aged 0-4 years



17.	The number of people enrolled in the PHO continues to increase towards the 95% target with a notable increase in the number of people identifying as Māori. Note that the University of Otago Student Health Services are not part of Southern PHO; significant cohorts of the population who are engaged with primary care are not enrolled in a PHO.
18.	The number of skin lesions removed in primary care (by a GP with special interest – GPSI) continues to increase. Fewer procedures are now being done in the hospital, freeing up capacity for more complex procedures. Demand for removal of skin lesions is also increasing.
19.	The primary mental health brief intervention service is a free service for individuals who need help with emotional well-being. Brief intervention includes an initial assessment and up to 5 free sessions on a case by case basis
20.	Ambulatory Sensitive Hospital (ASH)admissions (avoidable hospitalisations) for children continue to be an issue for Southern, especially for Māori children. The DHB and PHO have been working on improving access for children with more practices offering 'free under sixes' care for regular consultations and after-hours.

Oral Health

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

Oral Health							
Sub-Output Class	Output Measures		Results			Target 2013/14	Comments
			2011/12	2012/13	2013/14		
Oral Health	Eligible preschool children enrolled in school and community oral health services.	Total	16,357	16007	17691	16,500	See 21 & Figure 37
		Māori	-	1952	2420	-	
	The number of eligible children from Year 1 to Year 8 enrolled in school and community oral health services.	Total	26152	26260	28090	27,000	See 22 & Figure 37
		Māori	-	2994	4300	-	
	The percentage of eligible children from Year 1 to Year 8 enrolled in school and community oral health services.	Total	83.3%	83.6%	89.4%	-	See 22 & Figure 38
		Māori		54.2%	77.8%	-	
	The percentage of eligible adolescents who access funded oral health services.		82%	85%	83%	85%	See 23 & Figure 38

Figure 37: Number of preschool and primary school children enrolled in oral health services

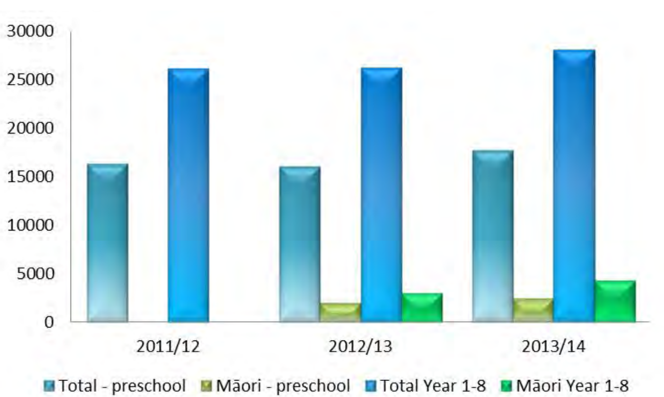
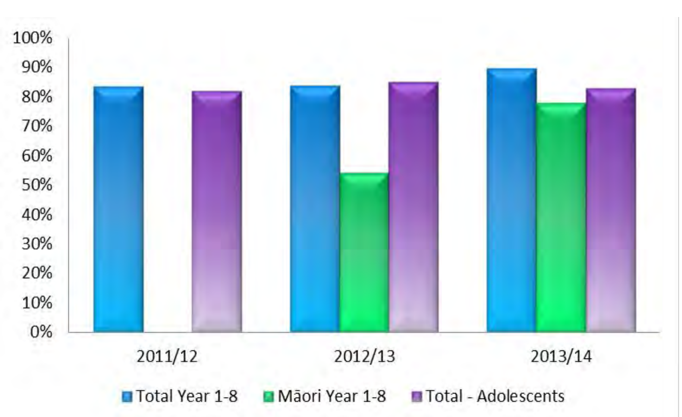


Figure 38: School aged children access to funded oral health services



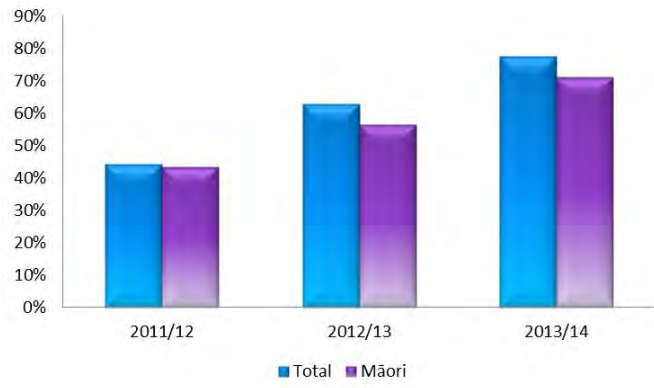
21.	One of the key objectives of the reconfiguration of community oral health services over the past 5 plus years was to effectively engage with children from a younger age. From birth parents are encouraged by the midwife, Plunket or Well Child Tamariki Ora provider, and general practice to enrol their child in the community oral health service. The increase in preschool enrolment over 2013/14 is most notable for the significant increase in the number of Māori children enrolled. Māori historically have poorer oral health and this increase in enrolment and subsequent engagement with oral health services is crucial to improved oral health in the future.
22.	The number of enrolled primary school children (year 1 to year 8) increased to over 28,000, well above the forecast target of 27,000.The percentage of Māori primary school children enrolled has increased substantially. These results are the culmination of increased promotion and engagement of the community oral health service in schools, and increasing opening hours of clinics suitable to more parents who are then able to accompany their children.
23.	The majority of adolescent's access funded oral health services through visiting a dentist in the community. Some adolescent's visit the community oral health service where they are unable to access a dentist.

Long-Term Conditions Management

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

Long-Term Conditions Management							
Sub-Output Class	**Output Measures**		**Results**			**Target 2013/14**	**Comments**
			2011/12	**2012/13**	**2013/14**		
Long-Term Conditions Management	The proportion of the eligible population (45-79) having a CVD risk assessment in the last five years.	Total	44%	63%	78%	90%	See 24 & Figure 39
		Māori	43%	56%	71%	90%	
	Percentage of enrolled patients coded as diabetic that have an HbA1c ≤64mmol/mol.	Total	-	78.6%	55.4%	>78.6%	See 25
		Māori	-	-	51.1%	>78.6%	
	Percentage of patients with diabetes with maintained or improved appropriate management of microalbuminuria.	Total	-	-	NA	-	See 26
		Māori	-	-	NA	-	
	Percentage of potentially eligible stroke patient's thrombolysed.		-	-	6.7%	6%	See 27

Figure 39: Percentage of completed Cardiovascular Risk Assessments for eligible population



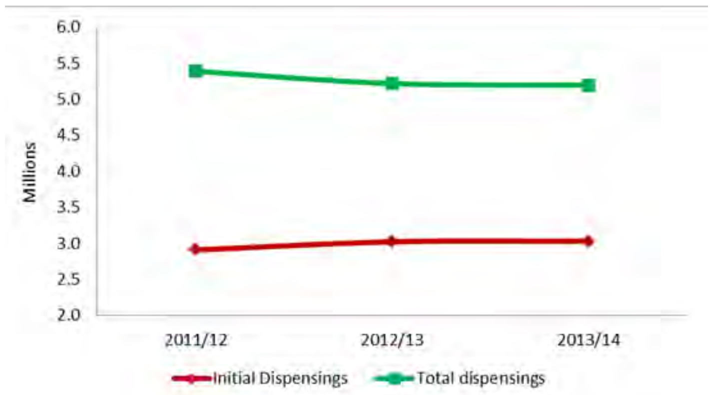
24.	This measure for CVD risk assessment is one of six health targets. Southern PHO has invested significant resources towards increasing the number of completed CVD risk assessments. Increased training and education, plus changes to improve data integrity and quality, have started to make an impact on the result with notable progress towards the 90% target. The PHO has also introduced new strategies such as working more closely with Māori providers to increase the uptake by Māori. This measure is one of the foundation measures for the integrated performance and incentive framework (IPIF) and Southern PHO is confident the 90% target will be achieved in 2014/15.
25.	The definition for this measure changed for 2013/14 and cannot be accurately compared with previous years. The numerator is the same but the denominator has changed from the people tested to the enrolled population on the Virtual Diabetes Register (VDR). This now includes the patients who have not engaged. The measurement of HbA1c is linked to the Diabetes Care Improvement Package (DCIP) undertaken by general practice. The percentage of well managed diabetics (HbA1c ≤64mmol/mol) in the DCIP at 76% could be improved. The biggest impact for improving performance for this measure is a greater number of diabetics participating in the DCIP.
26.	The measure for the management of microalbuminuria has not been implemented. The measure was originally proposed by the Ministry of Health as part of the DHB's measure of performance.
27.	Commencement of appropriate thrombolysis is time critical. Rapid triage and transport to hospital is crucial for people with suspected stroke. The rate of thrombolysis is an indication of responsiveness to people with suspected stroke. Stroke thrombolysis is currently offered in Dunedin, Invercargill and Oamaru. Dunstan Hospital is currently establishing a thrombolysis service. Dunedin Hospital provides a backup service for areas where the local provider cannot offer the thrombolysis service 24/7.

Pharmacist Services

These services include dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, demand for pharmaceuticals will likely increase. To improve service quality, we will introduce medication management for those on multiple medications to reduce potential negative interactive effects.

Pharmacist Services						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Pharmacist Services	Number of patients registered in the 'long-term conditions' (LTC) programme.	-	-	7552	New measure	See 28
	Total number of prescription items dispensed.	5.389M	5.217M	5.195M	<5.0m	See 29
	Total number of initial prescription items dispensed.	2.910M	3.024M	3.032M	<2.5m	See 30

Figure 40: Number of prescription items dispensed



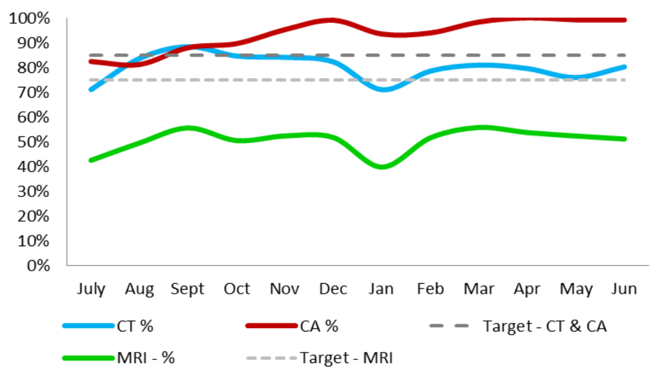
28.	Registering patients in the 'long-term conditions' (LTC) programme is an important and significant change in the new Community Pharmacy Services Agreement introduced in mid-2012. This was a move away from a purely 'fee for service' model to a payment mechanism that was more focussed on medication management.
29.	The new Community Pharmacy Services Agreement was introduced in mid-2012. This removed the need for the prescriber to endorse a prescription with 'close control' and empowered pharmacists to work with patients focussing on medication management. The total number of prescription items has decreased but not to the extent as originally anticipated with earlier forecasts. There are many variables that would contribute to this but the number of LTC registrations is less than forecast (see 8a).
30.	The rate of growth in initial prescription numbers has reduced significantly to 0.26% in 2013/14.While less than forecast, the result is an important achievement in reducing the unsustainable growth rate of over 3% per annum over the past five years.

Community Referred Testing and Diagnostics

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

Community Referred Testing and Diagnostics							
Sub-Output Class	Output Measures		Results			Target 2013/14	Comments
			2011/12	2012/13	2013/14		
Community Referred Testing and Diagnostics	Percentage of accepted referrals for coronary angiography receiving procedure within 90 days.		-	-	93%	85%	See 31 & Figure 41
	Percentage of patients, ready for treatment, waiting less than four weeks for radiotherapy or chemotherapy.		100%	100%	100%	100%	See 32
	Percentage of accepted referrals for CT scans receiving procedure within 42 days.		-	-	80%	85%	See 33 & Figure 41
	Percentage of accepted referrals for MRI scans receiving procedure within 42 days.		-	-	50%	75%	See 34 & Figure 41
	Percentage of people receiving an echocardiogram within 90 days of referral.		-	-	NA	70%	See 35
	Laboratory test turnaround times	Biochemistry	<24 hours	<24 hours	<24 hours	<24 hours	See 36
		Immunology	<48 hours	<48 hours	<48 hours	<48 hours	
		Haematology	<24 hours	<24 hours	<24 hours	<24 hours	
		Histology	<72 hours	<84 hours	<72 hours	<72 hours	
		Microbiology	<72 hours	<72 hours	<72 hours	<72 hours	

Figure 41: Percentage of diagnostic tests completed within target timeframes



31.	There has been sustained performance improvement for completing coronary angiography tests over the past 12 months. The Ministry of Health introduced new measures in 2013/14 on a number of diagnostic modalities including the percentage of coronary angiography testing completed within 90 days.
32.	See page 19 for comments on the health target for shorter waits for cancer treatment.
33.	There has been a sustained performance in delivering CT scans within the 42 day timeframe, which over the year has been just below the target. A review of radiology services has commenced in early 2014/15 to look at service delivery and how capacity can be maximised.
34.	The DHB is well short of achieving the 42 day target for MRI scans. Performance has been relatively consistent but there is an issue with capacity (MRI machines & workforce) meeting demand. A review of radiology services has commenced in early 2014/15 to look at service delivery and how capacity can be maximised.
35.	Confirmed echocardiogram data is not available at the time the report was completed.
36.	All regular laboratory tests are handled by Southern Community Laboratories (SCL). The contract contains expectations on completing and reporting on tests within specific timeframes.

INTENSIVE ASSESSMENT AND TREATMENT

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

As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services.

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.

Specialist Mental Health Services

Sub-Output Class	Output Measures		Results			Target 2013/14	Comments
			2011/12	2012/13	2013/14		
Specialist Mental Health Services	Access rates to specialist mental health services for children and young people (aged 0-19 years).	Total	4.05%	3.49%	4.02%	≥3.49%	See 37 & Figure 42
		Māori	3.95%	3.73%	4.10%	≥3.31%	
	Access rates to specialist mental health services for adults (aged 20-64 years).	Total	4.09%	3.61%	4.04%	≥3.63%	See 37 & Figure 42
		Māori	7.79%	7.26%	7.66%	≥5.52%	
	The percentage of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment for two years or more, who have a current relapse prevention plan.	Total	94.50%	94.30%	93.2%	95%	See 38
		Māori	98.10%	94.80%	98.1%	95%	
	The percentage of children and young people who have been receiving secondary care for one year or more, who have a current relapse prevention plan.	Total	93.50%	89.30%	83.7%	95%	See 38
		Māori	86.40%	78.80%	86.4%	95%	
	The percentage of people referred for non-urgent mental health or addiction services are seen in a timely manner: 3 weeks.	0 - 19 years	-	74.8%	72.4%	70%	See 39 & Figure 43
		20 - 64 years	-	82.2%	82.1%	70%	
		65+ years	-	84.9%	86.2%	70%	
		Total	-	80.2%	79.0%	70%	
	The percentage of people referred for non-urgent mental health or addiction services are seen in a timely manner: 8 weeks	0 - 19 years	-	94.7%	93.1%	95%	See 39 & Figure 44
		20 - 64 years	-	95.0%	94.7%	95%	
		65+ years	-	96.6%	94.0%	95%	
		Total	-	95.0%	94.1%	95%	

SPECIALIST MENTAL HEALTH SERVICES						
SUB-OUTPUT CLASS	OUTPUT MEASURES	RESULTS			TARGET 2013/14	COMMENTS
		2011/12	2012/13	2013/14		

Figure 42: Access Rates to Specialist Mental Health Services

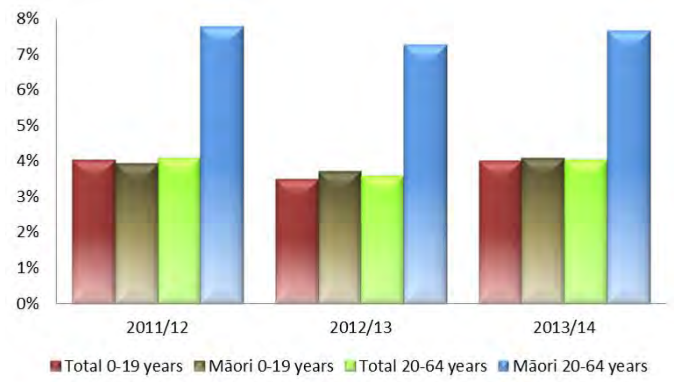


Figure 43: Referrals to Non-Urgent Mental Health and Addiction Services within 3 Weeks

Figure 44: Referrals to Non-Urgent Mental Health and Addiction Services within 8 Weeks

37.	Access to specialist mental health services has been maintained at or above the target levels.
38.	A current relapse prevention plan is important for people and their families/whanau to manage during a relapse. Engaging with youth continues to be a challenge with a relatively high number of 'did not attends' (DNAs). As part of the Prime Minister's Youth Mental Health Initiative, there is now a focus on more youth friendly services.
39.	The time to be seen upon referral for non-urgent mental health or addiction services is relatively quick with nearly 80% seen within 3 weeks and 95% within 8 weeks. The percentage of youth being seen within the target times continues to be a challenge with a relatively high number of 'did not attends' (DNAs). As part of the Prime Minister's Youth Mental Health Initiative, there is now a focus on more youth friendly services.

Elective Inpatient Services

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

Elective Inpatient Services						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Elective Inpatient Services	The number of medical and surgical First Specialist Appointments (FSA).	36,700	34,565	37,618	35,659	See 40
	Theatre utilisation - proportion of resourced theatre minutes used to total resourced theatre minutes.	85.6%	86.1%	85.3%	88%	See 41
	The number of elective surgical services discharges (incl. dental and cardiology).	11,044	11,750	12,390	11,451	See 42
	The number of elective surgical services discharges (excl. dental and cardiology).	10,432	10,270	10,948	10,347	See 42
	The number of elective surgical services caseweights (CWDs) delivered.	14,186	14,948	15,646	14,790	See 42
	The proportion of people receiving elective or arranged surgery on the day of admission.	86.3%	89.5%	90.0%	95%	See 43
	Average elective and arranged inpatient length of stay (days) is maintained.	3.25	3.79	3.03	<3.21	See 44
	Outpatient 'Did Not Attend' (DNA) rates are reduced.	8.8%	8.2%	5.7%	<8.00%	See 45
	Rates of central line associated bacteraemia (CLAB) in the intensive care unit (ICU).	0	0	0	0	See 46

40. The number of medical and surgical First Specialist Appointments (FSA) continues to increase in line with increasing demand and the increased level of elective surgery.

41. Improving theatre utilisation increases throughput and productivity. Changes to theatre schedules have the biggest impact on theatre utilisation. Acute surgery has the biggest impact of theatre scheduling. The DHB is about to introduce a new production planning methodology which will proactively manage the theatre resources to improve theatre utilisation.

42. Elective surgery continues to increase at a steady rate which is closely aligned to forecast demand and production planning (and hence capacity and workforce).

Elective surgical service discharges is measured in a number of ways.

- elective surgical services discharges (excl. dental and cardiology) – Health target
- elective surgical services discharges (incl. dental and cardiology) – all elective surgery
- elective surgical services caseweights (CWDs) – incorporates the complexity of the surgery.

43. Performance on providing elective or arranged surgery on the day of admission has been sustained (90%) but is still short of the 95% goal. There is a balance between performing acute surgery as required and elective surgery as planned.

44. Average elective inpatient length of stay has reduced to 3.03 days.

45. The Outpatient 'Did Not Attend' (DNA) rates have reduced significantly. DNAs have been a focus over the past year with a check if appointments are still required and a text service to remind patients of outpatient appointments.

46. Central line associated bacteraemia (CLAB) is an important indicator of the quality of care. The Health Quality and Safety Commission (HQSC) have introduced a new CLAB quality measure that targets 90% compliance in Central Line Insertion Bundle to reduce Central Line Associated Bacteraemia (CLAB).

Acute Services

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

Acute Services							
Sub-Output Class	Output Measures		Results			Target 2013/14	Comments
			2011/12	2012/13	2013/14		
Acute Services	People are assessed, treated or discharged from the emergency department (ED) in under six hours.		89.9%	91.4%	90.5%	95%	See 47 & Figure 45
	Number of people presenting at ED.		77,106	80,275	76,618	<83,300	See 48 & Figure 45
	The acute readmission rate to hospital.	Total	-	6.75%	7.35%	≤6.60%	See 49 & Figure 46
		75+ years	-	9.42%	9.76%	9.00%	
	The acute inpatient average length of stay (days) in hospital.		3.94	4.00	3.76	<4.25	See 51 & Figure 46

Figure 45: Attendances at DHB Emergency Departments - Numbers and Waiting Times

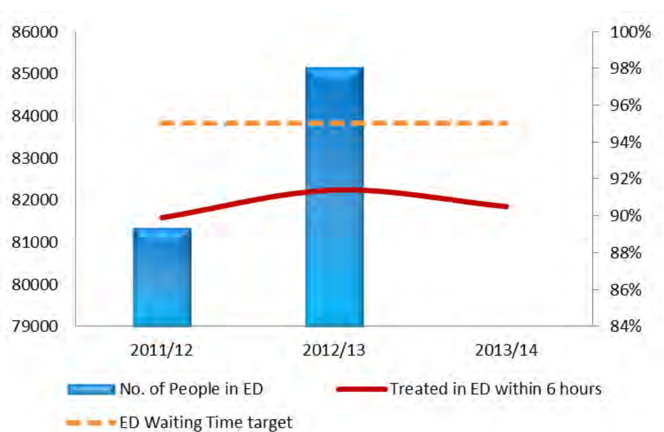
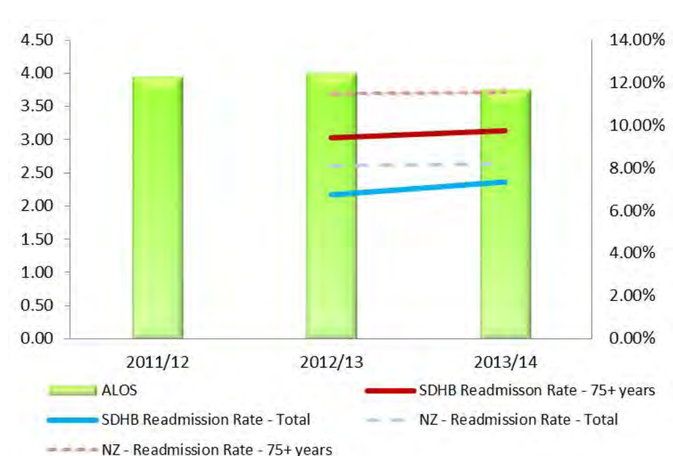


Figure 46: Average Length of Stay (acute) and Readmission Rates to Hospital



47.	Southern DHB continues to not meet the ED target but there has been an improved and more consistent result over the past 12 months. See page 18 for more details on the ED health target.
48.	The total number of people attending the DHB hospital emergency departments (ED) has reduced by 4.5% in 2013/14. This is in line with plans and expectations to reduce the high ED utilisation rates. The number of people attending the ED has been redefined and aligned with the ED health target. This has removed some perceived inconsistencies between years and allows for more direct comparisons between years.
49.	The acute readmission rate to hospital is one of a number of indicators that show system performance. Southern has consistently achieved one of the lowest acute readmission rates in New Zealand. The definition for acute readmission to hospital was amended for 21013/14 and the 2013/14 results are not directly comparable with previous years. Data for the previous 12 months is used to calculate the result for each quarter, and is reported 3 months in arrears i.e. quarter four results uses data to 31 March.
50.	The acute inpatient average length of stay has decreased from 2012/13 and is below target.

Maternity Services

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

Maternity Services

Sub-Output Class	Output Measures		Results 2011/12	Results 2012/13	Results 2013/14	Target 2013/14	Comments
Maternity Services	The number of births in the DHB region.	Total	3,555	3,503	3,384	3,500	See 51 & Figure 47
		Māori		515	542	-	
	New mothers have established breastfeeding on discharge from hospital.	Total	83%	83.1%	81.5%	85%	See 52 & Figure 48
	Baby friendly hospital accreditation is maintained.		100%	100.0%	100.0%	100%	See 53 & Figure 48

Figure 47: Number of births in Southern

Figure 48: Baby friendly hospitals and breastfeeding rates on discharge

51.	In line with Statistics New Zealand forecasts for 2013/14, the total number of births reduced slightly, and the number of births for Māori increased.
52.	Establishing breastfeeding in hospital or maternity facility increases the likelihood of babies being exclusively breastfed for the first six months.
53.	All Maternity facilities in Southern continue to attain Baby Friendly Hospital accreditation. The Baby Friendly Hospital Initiative is a global campaign of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Maternity facilities attain accreditation by implementing policies and procedures to support the goal to increase breastfeeding initiation and duration rates by protecting, promoting and supporting breastfeeding.

Assessment Treatment and Rehabilitation (AT&R)

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

Assessment Treatment and Rehabilitation						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Assessment Treatment and Rehabilitation	Average length of stay (days) for inpatient AT&R services (65 years and over).	17.35	18.7	18.2	≤17.35	See 54
	Average length of stay (days) for inpatient AT&R services (under (65 years).	25.0	28.3	28.3	≤25.0	See 54
	AT&R patients have improved functionality on discharge (65 years and over).	16.3	16.9	17.1	≥16.3	See 55 & Figure 49
	AT&R patients have improved functionality on discharge (under (65 years).	26.1	24.2	24.2	≥26.1	See 55 & Figure 49
	Percentage of patients aged 75 and over (Māori and Pacific People age 55 and over) that are given a falls risk assessment.	52.5%	86%	83%	70%	See 56 & Figure 50

Figure 49: Improved functionality for AT&R patients

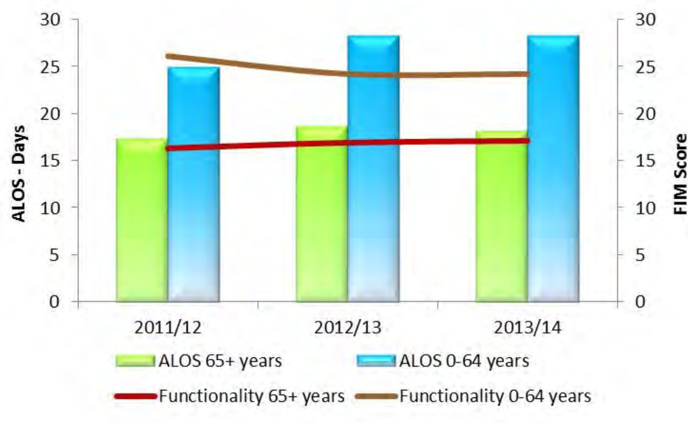
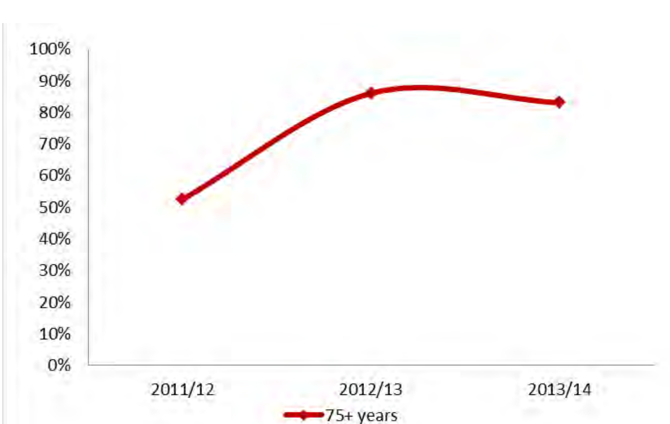


Figure 50: Percentage of hospital inpatients aged over 75 that receive a falls risk assessment



54.	There was a marginal improvement in the average length of stay (ALOS) for inpatient AT&R services for patients over 65 years but the target was not achieved. AT&R services for patients under 65 years performed similar to previous years. Average length of stay for inpatient AT&R services is measured by the Australasian Rehabilitation Outcomes Centre (AROC) which has developed a benchmarking system to improve clinical rehabilitation outcomes.
55.	AT&R functionality is measured by the FIM™ instrument, which is a basic indicator of severity of disability. The functional ability of a patient changes during rehabilitation and the FIM™ instrument is used to track those changes which are a key outcome measure of rehabilitation episodes. The FIM™ scores for both patients under 65 years and 65 years and over were similar to previous years.
56.	The DHB is performing well in providing a falls risk assessments to eligible people. Reducing harm from falls is a key quality indicator from the Health Quality and Safety Commission (HQSC). A falls risk assessment and care planning are the processes fundamental to ensuring that individual patients receive the interventions and support which address their particular risks.

REHABILITATION AND SUPPORT SERVICES

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

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering. Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

NEEDS ASSESSMENT AND SERVICE COORDINATION 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 own home or community. The number of assessments completed is indicative of access and responsiveness.

NEEDS ASSESSMENT AND SERVICE COORDINATION SERVICES

SUB-OUTPUT CLASS	OUTPUT MEASURES	RESULTS			TARGET 2013/14	COMMENTS
		2011/12	2012/13	2013/14		
NEEDS ASSESSMENT AND SERVICE COORDINATION SERVICES	Number of people 65 years and over provided with a Clinical Assessment of need.	-	5565	4069	-	See 57 & Figure 51
	Percentage of people 65 years and over receiving long-term home and community support services (HCSS) who had had a Comprehensive Clinical Assessment and a completed care plan.	40%	60.2%	94.15%	75%	See 57 & Figure 51

Figure 51: Number of people 65 years and over provided with a Clinical Assessment of need.

57.	A regular clinical assessment of need using InterRAI is a cornerstone of the new restorative based home and community support service (HCSS). InterRAI was introduced in 2012/13 and required all existing as well as new clients to be assessed which resulted in 5565 clients being assessed. The process for clinical assessment of need is now well embedded and the national goal of 95% is being reached. Non-complex clients are assessed by the HCSS providers, and complex clients are assessed by the DHB Care Coordination Centre.

Palliative Care Services

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

Palliative Care Services						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Palliative Care Services	Hospice services assess and support people with the Liverpool Care Pathway.	-	73%	68.6%	-	See 58
	ARC facilities are trained to provide the Liverpool Care Pathway.	-	70%	67.7%	90%	See 58 & 59

58.	'Last days of life" national working group have been formed to review the appropriateness of the Liverpool Care Pathway in the New Zealand setting. The national 90% target is an aspirational target and guidance will be provided on a realistic target expectation in the future. The original target on the number of facilities has been removed and measurement now aligns with national expectations.
59.	Changes in ownership and new facilities with 'hospital' level care has seen subtle changes in the percentage but overall there has been minimal change in the utilisation the LCP in 'hospital' level care.

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.

Rehabilitation Services						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Rehabilitation Services	People are referred to cardiac rehabilitation services after an acute event.	69%	68%	NA	70%	See 60
	The number of people who are discharged from inpatient services, and who receive a community mental health contact in the seven days immediately following discharge (not including the day of discharge).	54%	61%	NA	73%	See 61

60.	Confirmed cardiac rehabilitation service data is not available at the time the report was completed.
61.	Confirmed 2013/14 results are due November 2014. The Ministry of Health sources data from PRIMHD. PRIMHD (pronounced 'primed') is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers.

Home and Community Support Services

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

Home and Community Support Services						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Home and Community Support Services	Number of eligible complex clients receiving home and community support services (HCSS) per head of population aged over 65 years.	-	-	4.37%	-	See 62
	Number of eligible non-complex clients receiving HCSS per head of population aged over 65 years.	-	-	3.83%	-	See 63
	Percentage of HCSS clients aged over 65 years with goals based care plans.	-	-	90.9%	25%	See 64
	Percentage of HCSS support workers who have completed minimum training requirements.	-	-	46.3%	50%	See 65

62.	This measure was introduced to establish a baseline for the new restorative based home and community support service (HCSS). Complex clients are assessed by the DHB Care Coordination Centre using InterRAI.
63.	This measure was introduced to establish a baseline for the new restorative based home and community support service (HCSS). Non - complex clients are assessed by the HCSS providers using InterRAI.
64.	This measure was introduced to establish a baseline for the new restorative based home and community support service (HCSS). Goals based care plans informed by InterRAI assessments are an integral part of the restorative model of HCSS.
65.	46.3% of support workers have completed training to level 2 or above. A more skilled workforce is a cornerstone of the new restorative based home and community support service. A better trained workforce leads to better quality care.

Age Related Residential Care

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

Age Related Residential Care						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Age Related Residential Care	Number of Rest Home Bed Days per capita of the population aged over 65 years.	9.3	8.29	7.89	<9.0	See 66
	Percentage of residential care facilities using InterRAI assessment tool.	-	21%	21%	-	See 67

66.	Southern DHB has improved the effectiveness of home and community support services to enable a greater number of elderly to remain in their own home. Over time this has resulted in a reduction in the number of people entering residential care. The South Island, including Southern, still has a greater utilisation of aged residential care than the rest of New Zealand. The longer term goal is a utilisation rate similar to the rest of New Zealand. InterRAI is now used as the assessment tool for eligibility to aged residential care.
67.	InterRAI is the needs assessment tool introduced across New Zealand over the past five years. The next phase of the roll-out is into aged residential care facilities, which are all engaged in the training process. As of 30 June, 21% had completed the training and have been assessed as fully competent in InterRAI. The national goal is for all aged residential care facilities to be trained, competent and using InterRAI as the primary clinical assessment tool by July 2015. The original target on the number of facilities has been removed and measurement now aligns with national expectations.

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.

Respite and Day Services						
Sub-Output Class	Output Measures	Results			Target 2013/14	Comments
		2011/12	2012/13	2013/14		
Respite and Day Services	The ratio of number of days of respite care allocated to number of days used.	74%	83%	80%	78%	See 68
	The total number of eligible clients accessing Dementia Day Activity Programmes.	-	0	15	-	See 69

68.	A total of 10,513 respite care days were utilised in 2013/14. Changes have been made to the processes in the assessment and allocation of respite care, which are now made on an 'as required' basis. This allows for a more responsive respite care service and better management and utilisation of respite care beds.
69.	The dementia day activity programme was introduced in 2013/14 and provides respite to the primary carer and therapeutic service to the client. A total of 15 clients are receiving a weekly respite service in 2013/14 and this is planned to increase to provide for 21 clients in 2014/15.

STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 2014

	Note	2014 Actual $000	2014 Budget $000	2013 Actual $000
Revenue	2	862,496	851,322	839,075
Other operating income	3	9,583	8,589	8,419
Interest income		1,818	2,220	2,211
Total income		**873,897**	**862,131**	**849,705**
Employee benefit costs	5	336,753	329,292	323,413
Depreciation and amortisation expense	7,8	19,758	18,860	14,122
Outsourced services		19,051	18,161	19,013
Clinical supplies		74,260	79,677	73,253
Infrastructure and non-clinical expenses		41,230	32,721	41,795
Other district health boards		35,938	34,202	34,981
Payments to non-health board providers		346,697	338,365	336,886
Other operating expenses	4	3,699	4,608	2,944
Interest expense		4,517	4,808	5,330
Capital charge	6	9,816	10,476	9,602
Total expenses		**891,719**	**871,170**	**861,339**
Share of surplus /(deficit) in associates	10 c		-	(255)
Surplus/(deficit) for the year	14	**(17,822)**	**(9,039)**	**(11,889)**
Other Comprehensive income				
Items that will not be reclassified to surplus/ (deficit)				
Revaluation of land and buildings	14	10,056	-	(847)
Total other comprehensive income/ (expense)		10,056	-	(847)
Total Comprehensive income/ (expense)	22	**(7,766)**	**(9,039)**	**(12,736)**

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2014

	Note	2014 Actual $000	2014 Budget $000	2013 Actual $000
Equity at beginning of the year		**128,688**	**134,322**	**124,481**
Comprehensive income/ (expense)				
Surplus/ (deficit) for the year		(17,822)	(9,039)	(11,889)
Other Comprehensive income/ (expense)		10,056	-	(847)
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	14	9,000	14,720	17,650
Other equity movements	14	(707)	(707)	(707)
Equity at end of the year		**129,215**	**139,296**	**128,688**

STATEMENT OF FINANCIAL POSITION

As at 30 June 2014

	Note	2014 Actual $000	2014 Budget $000	2013 Actual $000
Assets				
Property, plant and equipment	7	297,344	298,542	286,566
Intangible assets	8	9,589	14,379	8,663
Investments in associates	10 d	-	280	-
Total non-current assets		**306,933**	**313,201**	**295,229**
Inventories held for distribution	9	4,792	4,422	4,817
Trade and other receivables	11	31,662	33,253	23,026
Cash and cash equivalents	12	12,441	12,257	27,242
Non-current assets held for sales	13	1,099	-	-
Total current assets		**49,994**	**49,932**	**55,085**
Total assets		**356,927**	**363,133**	**350,314**
Equity				
Crown equity	14	78,839	89,346	70,546
Property revaluation reserves	14	94,571	85,362	84,515
Accumulated surpluses/ (deficits)	14	(44,195)	(35,412)	(26,373)
Total equity		**129,215**	**139,296**	**128,688**
Liabilities				
Interestbearing loans and borrowings	15	89,805	88,569	93,959
Employee benefits	16	15,212	16,064	15,469
Total non-current liabilities		**105,017**	**104,633**	**109,428**
Interestbearing loans and borrowings	15	15,306	18,483	11,749
Trade and other payables	17	46,787	43,406	43,560
Employee benefits	16	60,602	57,315	56,889
Total current liabilities		**122,695**	**119,204**	**112,198**
Total liabilities		**227,712**	**223,837**	**221,626**
Total equity and liabilities		**356,927**	**363,133**	**350,314**

STATEMENT CASH FLOWS

For the year ended 30 June 2014

	Note	2014 Actual $000	2014 Budget $000	2013 Actual $000
Cash flows from operating activities				
Cash receipts from Ministry of Health and patients		863,535	858,351	845,375
Cash paid to suppliers		(513,251)	(505,280)	(512,957)
Cash paid to employees		(333,712)	(328,220)	(320,724)
Cash generated from operations		**16,572**	**24,851**	**11,694**
Interest received		1,818	2,220	2,211
Interest paid		(4,514)	(5,107)	(5,330)
Net taxes refunded/ (paid) (goods and services tax)		1,166	(69)	(2,649)
Capital charge paid		(14,547)	(10,499)	(4,870)
Net cash flows from operating activities	12	**495**	**11,396**	**1,056**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		67	-	102
Acquisition of property, plant and equipment		(19,974)	(28,724)	(28,104)
Net cash movement in investments		(1,746)	(1,747)	22
Net cash flows from investing activities		**(21,653)**	**(30,471)**	**(27,980)**
Cash flows from financing activities				
Proceeds from equity injection		8,292	14,014	16,943
Drawdown (repayment) of borrowings		(1,935)	(1,833)	(2,549)
Net cash flows from financing activities		**6,357**	**12,181**	**14,394**
Net increase in cash and cash equivalents		(14,801)	(6,894)	(12,530)
Cash and cash equivalents at beginning of year		27,242	19,151	39,772
Cash and cash equivalents at end of year	12	**12,441**	**12,257**	**27,242**

STATEMENT CONTINGENCIES AND COMMITMENTS

As at 30 June 2014

Contingent Liabilities	2014 Actual $000	2013 Actual $000
Legal proceedings against Southern DHB	-	20
Personal grievances	-	-
	-	**20**

Contingent Assets	2014 Actual $000	2013 Actual $000
Legal proceedings by Southern DHB	-	-
	-	**-**

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

As at 30 June 2014

	2014 Actual $000	2013 Actual $000
Capital Commitments	**13,971**	**15,603**

	2014 Actual $000	2013 Actual $000
Non-cancellable commitments - operating lease commitments		
Not more than one year	2,042	1,101
One to two years	1,248	838
Two to three years	1,144	588
Three to four years	321	164
Four to five years	-	37
Over five years		47
	4,755	**2,775**

NOTES TO THE FINANCIAL STATEMENTS

1. STATEMENT OF ACCOUNTING POLICIES FOR THE YEAR ENDED 30 JUNE 2014

REPORTING ENTITY

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

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

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

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

The financial statements presented for the year ended 30 June 2014 are for the Southern DHB only. They were approved by the Board on 2 October 2014. The owner, the Crown, does not have the power to amend the financial statements after issue.

BASIS OF PREPARATION

STATEMENT OF COMPLIANCE

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

GOING CONCERN

The Board has prepared the financial statements on a going concern basis. The Board of the DHB has received a letter of support from the Ministers of Health and Finance that the Government is committed to working with the Board 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 Board has yet to receive approval for its annual plan from the Ministry of Health.

FUNCTIONAL AND PRESENTATION CURRENCY

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

MEASUREMENT BASE

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

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

- where modified by the revaluation of land and buildings
- non-current assets 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.

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

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

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the Southern DHB is

classified as a Tier 1 reporting entity. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. This means the Southern DHB will transition to the new standards in preparing its 30 June 2015 financial statements.

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

The Southern DHB anticipates that these standards will have no material impact on the financial statements in the period of initial application. It is likely that the changes arising from this framework will affect the disclosures required in the financial statements. However, it is not practicable to provide a reasonable estimate until a detailed review has been completed.

Critical Accounting Estimates and Assumptions

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

The estimates and underlying assumptions are reviewed on an 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.

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

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

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

Significant Accounting Policies

Associates

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

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

Revenue

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

MOH Revenue

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

Revenue from the MoH is recognised as revenue when earned.

ACC Contract Revenue

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

Revenue from Other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Southern DHB region is domiciled outside of Southern. The MoH credits Southern DHB with a monthly amount based on estimated patient treatment for non-Southern residents within Southern. An annual 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 Relating to Service Contracts

Southern DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Southern DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Leases

FinanceLeases

A finance lease is a lease that transfers to the lessees substantially all risks and rewards incidental to ownership of the asset. 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 of 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.

Operating Leases

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

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

Foreign Currency Transactions

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

Cash and cash equivalents

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

Trade and other receivables

Trade and other receivables are recorded at face value less any provisions for impairment. Bad debts are written off during the period in which they are identified.

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value plus transaction costs.

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

Inventories

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

Inventories Held for Distribution

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

Non-current assets held for sale

Non-current assets held for sale are measured at the lower of their carrying amount and fair value less cost to sell. Any increases in fair value (less cost to sell) are recognised up to the level of any impairment losses previously recognised. Impairment losses are recognised in the surplus and deficit. Non-current assets held for sale are not depreciated or amortised while held for sale.

Property, Plant and Equipment

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

- land
- buildings
- plant, fixture and fittings
- clinical, computer and other equipment
- motor vehicles

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

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

Revaluations

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

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

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

Disposal of Property, Plant and Equipment

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

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

Additions

The cost of an item of property, plant and equipment is recognised as an asset if it is probable that future economic benefits or service potential associated with the item will flow to Southern DHB and the cost of the item can be reliably measured. In most instances, an item of property, plant and equipment is recognised at its cost. Where an asset is acquired at no cost, or for nominal cost, it is recognised at fair value as at date of acquisition.

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

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

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

Intangible Assets

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

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

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

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

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

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

Amortisation

Amortisation is charged to the surplus and deficit on a straightline basis over the estimated useful lives of intangible assets with finite useful lives. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Amortisation starts when the asset is available for use and ceases when the asset is derecognised. The estimated useful lives are as follows:

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

Impairment

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

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 income 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 income and increases the asset revaluation reserve for that class of assets. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus and deficit.

Trade and other payables

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

Borrowings

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

Employee Benefits

Defined Contribution Plans

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

Long Service Leave, Sabbatical Leave and Retirement Gratuities

Southern DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated by AON New Zealand Ltd, using accepted actuarial principles and complies with all requirements of NZ IAS. The discount rates adopted are in accordance with NZ IAS 19.

Annual Leave, Conference Leave, Sick Leave and Medical Education Leave

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

Provisions

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

Restructuring

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

Onerous Contracts

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

ACC Partnership Programme

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

illnesses occurring up to the balance sheet date for which Southern DHB has responsibility under the terms of the Partnership Programme.

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

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

Income tax

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

Budget Figures

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

Goods and services tax

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

Custodial/Trust and Bequest Funds

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

Financial Instruments

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

Cost of Service Statements

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

Cost Allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

2. REVENUE

	2014 Actual $000	2013 Actual $000
Health and disability services (MOH contracted revenue)	822,816	801,490
ACC contract	10,261	8,932
Inter district patient flows	19,139	19,363
Other revenue	10,280	9,290
	862,496	**839,075**

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

3. OTHER OPERATING INCOME

	2014 Actual $000	2013 Actual $000
Gain on sale of property, plant and equipment	67	52
Donations and bequests received	1,248	466
Rental income	1,802	1,814
Other	6,466	6,087
	9,583	**8,419**

4. OTHER OPERATING EXPENSES

	Note	2014 Actual $000	2013 Actual $000
Impairment of trade receivables (doubtful debts)		647	144
Bad debts written off		2	30
Loss on disposal of property, plant and equipment		340	49
Audit fees (for the audit of financial statements)		171	166
Audit related fees (for assurance and related services)		-	-
Fees paid to other auditors for assurance and related services including internal audit		82	79
Board member fees		345	341
Operating lease expenses	18	2,110	2,133
Koha		2	2
		3,699	**2,944**

5. EMPLOYEE BENEFIT COSTS

	2014 Actual $000	2013 Actual $000
Wages and salaries	333,040	320,416
Increase/ (decrease) in employee benefit provisions	3,713	2,997
	336,753	**323,413**

6. CAPITAL CHARGE

Southern DHB pays capital charge to the Crown twice yearly. This is based on closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the period ended 30 June 2014 was 8 per cent. The amount charged during the period was $9.82 million (2013: $9.60 million).

7 PROPERTY, PLANT AND EQUIPMENT

Cost	Freehold land (at valuation) $000	Freehold buildings (at valuation) $000	Plant and equipment $000	Vehicles $000	Library books $000	Work in progress $000	Total $000
Balance at 1 July 2012	25,231	212,395	139,239	692	-	20,869	**398,426**
Additions	-	4,151	11,227	30	32	14,214	**29,654**
Disposals	(73)	-	(10,143)	(22)	-	-	**(10,238)**
Transfers	-	18,228	6,800	784	-	(28,885)	**(3,073)**
Revaluations & impairment	-	(904)	-	-	-	-	**(904)**
Balance at 30 June 2013	**25,158**	**233,870**	**147,123**	**1,484**	**32**	**6,198**	**413,865**
Balance at 1 July 2013	25,158	233,870	147,123	1,484	32	6,198	**413,865**
Additions	-	771	8,680	20	7	12,435	**21,913**
Disposals	-	(2)	(11,489)	-	-	-	**(11,491)**
Transfers	(560)	8,937	962	839	1	(12,100)	**(1,921)**
Revaluations & impairment	2,889	(20,722)	-	-	-	(1,956)	**(19,789)**
Balance at 30 June 2014	**27,487**	**222,854**	**145,276**	**2,343**	**40**	**4,577**	**402,577**
Depreciation and impairment losses							
Balance at 1 July 2012	-	15,203	105,436	269	-	-	**120,908**
Depreciation charge for the year	-	7,615	5,429	144	1	-	**13,189**
Impairment losses	-	-	-	-	-	-	**-**
Reversal of impairment losses	-	-	-	-	-	-	**-**
Disposals	-	-	(6,674)	(22)	-		**(6,696)**
Transfers	-	-	-	-	-	-	**-**
Revaluations	-	(102)	-	-	-	-	**(102)**
Balance at 30 June 2013	**-**	**22,716**	**104,191**	**391**	**1**	**-**	**127,299**
Balance at 1 July 2013	-	22,716	104,191	391	1	-	**127,299**
Depreciation charge for the year	-	8,146	10,114	220	7	-	**18,487**
Impairment losses	-	-	-	-	-	-	**-**
Reversal of impairment losses	-	-	-	-	-	-	**-**
Disposals	-	(2)	(10,265)	-	-	-	**(10,267)**
Transfers	-	-	(290)	290	-	-	**-**
Revaluations	-	(30,286)	-	-	-	-	**(30,286)**
Balance at 30 June 2014	**-**	**574**	**103,750**	**901**	**8**	**-**	**105,233**
Carrying amounts							
At 1 July 2012	25,231	197,192	33,803	423	-	20,869	**277,518**
At 30 June 2013	**25,158**	**211,154**	**42,932**	**1,093**	**31**	**6,198**	**286,566**
At 1 July 2013	25,158	211,154	42,932	1,093	31	6,198	286,566
At 30 June 2014	**27,487**	**222,280**	**41,526**	**1,442**	**32**	**4,577**	**297,344**

The net carrying amount of assets held under finance leases is $3.88 million (2013 $3.73 million) for plant and equipment

IMPAIRMENT

There was no impairment losses recognised in the 2014 year.

REVALUATION

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

The revaluation of land and buildings of Southern District Health Boards was carried out as at 30 April 2014 by Tony Chapman, an independent registered valuer with Chapman Consultancy and a member of the New Zealand Institute of Valuers. That valuation conformed to International Valuation Standards and was based on an optimised depreciation replacement cost methodology. The valuer was contracted as an independent valuer.

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

RESTRICTIONS

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

8 INTANGIBLE ASSETS

	FSPC	Software	Total
Cost	**$000**	**$000**	**$000**
Balance at 1 July 2012	-	13,404	13,404
Additions	1,841	3,477	5,318
Disposals	-	(124)	(124)
Balance at 30 June 2013	**1841**	**16757**	**18598**
Balance at 1 July 2013	1,841	16,757	18,598
Additions	1,745	452	2,197
Disposals		-	-
Balance at 30 June 2014	**3,586**	**17,209**	**20,795**
Amortisation and impairment losses			-
Balance at 1 July 2012	-	9,002	9,002
Amortisation charge for the year	-	933	933
Impairment losses	-	-	-
Reversal of impairment losses	-	-	-
Disposals	-	-	-
Balance at 30 June 2013	**0**	**9,935**	**9,935**
Balance at 1 July 2013	-	9,935	9,935
Amortisation charge for the year	-	1,271	1,271
Impairment losses	-	-	-
Reversal of impairment losses	-	-	-
Disposals	-	-	-
Balance at 30 June 2014	**-**	**11,206**	**11,206**
Carrying amounts			
At 1 July 2012	-	4,402	4,402
At 30 June 2013	**1,841**	**6,822**	**8,663**
At 1 July 2013	1,841	6,822	8,663
At 30 June 2014	3,586	6,003	9,589

At 30 June 2014, the DHB had made payments totalling $3,586,000 (2013: $1,841,000) to HBL in relation to the Finance, Procurement and Supply Chain ("FPSC")programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

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

It is expected that the final costs of the FPSC programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC programme will proceed as originally planned. In this scenario, the DRC of the FPSC rights is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC programme is uncertain and any future decision to re-scope or discontinue the FPSC programme will require a reassessment of the recoverable amount (i.e. DRC) of the FPSC rights.

9. INVENTORIES HELD FOR DISTRIBUTION

	2014 Actual $000	2013 Actual $000
Pharmaceuticals	1,057	1,128
Surgical & Medical supplies	3,735	3,689
	4,792	**4,817**

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2014 was $4.792 million (2013 $4.817 million).

The write-down of inventories held for distribution amounted to $0 for 2014, while reversals of write-downs were $0 for 2014 (2013: $0 and $0). No inventories are pledged as security for liabilities but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

10. ASSOCIATED ENTITIES

a) General information

Name of entity	Principal activities	Interest held at 30 June 2014	Balance Date
South Island Shared Service Agency Limited	South Island Shared Service Agency Limited is a non-operating company	30%	30 June

In 2013, SISSAL is no longer operating and will be held as a non-operating company. The functions of SISSAL are being conducted by South Island DHB's under an agency arrangement.

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

2014 Actual ($000)	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
South Island Shared Service Agency Limited	-	-	-	-	-
	-	-	-	-	-

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

c) Share of profit of associate entities

	2014 Actual $000	2013 Actual $000
Share of surplus/ (deficit) before tax	-	(255)
Less: tax expense		
Share of surplus/ (deficit) after tax	**-**	**(255)**

d) Investment in associate entities

	2014 Actual $000	2013 Actual $000
Carrying amount at beginning of year	-	277
Acquisition of new investments	-	-
Disposal of investments	-	(22)
Share of total recognised revenue and expenses	-	(255)
Dividends	-	-
Other movements	-	-
	-	**-**

e) Share of associates' contingent liabilities and commitments

	2014 Actual $000	2013 Actual $000
Contingent liabilities	-	-
Contracted capital commitments	-	-
Other contracted commitments	-	-

11. TRADE AND OTHER RECEIVABLES

	2014 Actual $000	2013 Actual $000
Trade receivables from non-related parties	4,329	3,089
Ministry of Health receivables	3,619	2,591
Accrued income	21,599	15,707
Prepayments	2,115	1,639
	31,662	**23,026**

Trade receivables are shown net of provision for doubtful debts amounting to $2.49 million arising from identified debts unlikely to be recovered (2013: $1.84 million).

12. CASH AND CASH EQUIVALENTS

	2014 Actual $000	2013 Actual $000
Bank balances	-	-
Cash and cash equivalents	15	15
Demand Funds with HBL	12,426	27,227
Cash and cash equivalents in the statement of cash flows	**12,441**	**27,242**

WORKING CAPITAL FACILITY

At 30 June 2014, the Southern DHB held no bank overdraft facilities.

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

12. CASH AND CASH EQUIVALENTS (CONTINUED)

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

	Note	2014 Actual $000	2013 Actual $000
(Deficit) / surplus for the period		(17,822)	(11,889)
Add back non-cash items:			
Depreciation and assets written off		19,758	14,122
Share of (surplus) / deficit after tax from associate companies	10 c	-	255
Other non-cash items			
Increase/ (decrease) in fair value		1,818	88
Increase/ (decrease) in provision for doubtful debts		647	144
Add back items classified as investing activity:			
Net loss/ (gain) on disposal of property, plant and equipment		273	(3)
Movements in working capital:			
(Increase)/ decrease in trade and other receivables		(9,283)	(1,636)
(Increase)/ decrease in inventories		25	(552)
Increase/ (decrease) in trade and other payables		1,623	(1,775)
Increase/ (decrease) in employee benefits		3,456	2,302
Net movement in working capital		**(4,179)**	**(1,661)**
Net cash inflow/ (outflow) from operating activities		**495**	**1,056**

13. NON-CURRENT ASSETS HELD FOR SALE

The Southern DHB owns land and buildings at High Street and Union Street in Dunedin which have been classified as held for sale following the Board approval to sell the properties, as they will hold no future use to the DHB. The sale is expected to be completed within the next 12 months

Non-current assets held for sale include:	2014 Actual $000	2013 Actual $000
Land	560	-
Buildings	539	-
Total non-current assets held for sale	**1,099**	-

14. CAPITAL AND RESERVES

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2012	53,603	85,362	(14,484)	124,481
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	17,650	-	-	17,650
Equity repayment to the crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	-	-	-
Transfers from revaluation of land and buildings on impairment	-	(802)	-	(802)
Transfers from revaluation of land and buildings on disposal	-	(45)	-	(45)
Deficit for the period	-	-	(11,889)	(11,889)
Balance at 30 June 2013	**70,546**	**84,515**	**(26,373)**	**128,688**
Balance at 1 July 2013	70,546	84,515	(26,373)	128,688
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	9,000	-	-	9,000
Equity repayment to the crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	10,056	-	10,056
Transfers from revaluation of land and buildings on impairment	-	-	-	-
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Deficit for the period	-	-	(17,822)	(17,822)
Balance at 30 June 2014	**78,839**	**94,571**	**(44,195)**	**129,215**

Equity is made up of

	2014 Actual $000	2013 Actual $000
Equity	124,268	123,603
Restricted Equity	4,947	5,085
Total Equity	**129,215**	**128,688**

15. INTEREST-BEARING LOANS AND BORROWINGS

	2014 Actual $000	2013 Actual $000
Non-current		
Secured loans	88,116	90,765
Unsecured loans	134	249
Finance lease liabilities	1,555	2,945
	89,805	**93,959**
Current		
Current portion of secured loans	12,850	10,600
Current portion of finance lease liabilities	2,330	943
Current portion of unsecured loans	126	206
	15,306	**11,749**
	105,111	**105,708**

Secured loans

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

The details of terms and conditions are as follows:

Interest rate summary	2014 Actual	2013 Actual
Crown loans - fixed interest	2.61% to 6.55%	2.61% to 6.55%

Repayable as follows:	2014 Actual $000	2013 Actual $000
Within one year	12,976	10,806
One to two years	16,723	12,976
Two to three years	600	16,720
Three to four years	6,600	625
Four to five years	25,100	16,600
Later than five years	39,015	44,954
	101,014	**102,681**

Term loan facility limits	2014 Actual $000	2013 Actual $000
Crown loans	97,400	97,400
Term loan facility	-	-

SECURITY AND TERMS

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

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

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

16. EMPLOYEE BENEFITS

	2014 Actual $000	2013 Actual $000
Non-current liabilities		
Liability for long-service leave	3,030	3,085
Liability for sabbatical leave	1,320	1,237
Liability for retirement gratuities	10,862	11,147
	15,212	**15,469**
Current liabilities		
Liability for long-service leave	3,360	3,302
Liability for sabbatical leave	131	137
Liability for retirement gratuities	2,551	2,341
Liability for annual leave	33,641	32,150
Liability for sick leave	251	221
Liability for continuing medical education	6,075	6,018
Salary and wages accrual	14,593	12,720
	60,602	**56,889**

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 3.7% (2013 2.71%) and an inflation factor of 2.1% (2013 1.9%) were used.

17. TRADE AND OTHER PAYABLES

	2014 Actual $000	2013 Actual $000
Trade payables due to associates	-	-
Trade payables to non-related parties	7,141	3,872
GST payable	5,350	4,192
Income in advance relating to contracts with specific performance obligations	539	892
Capital charge due to the Crown	-	4,731
Other non-trade payables and accrued expenses	33,757	29,873
	46,787	**43,560**

18. OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:	2014 Actual $000	2013 Actual $000
Less than one year	2,042	1,101
Between one and five years	2,713	1,627
More than five years	-	47
	4,755	**2,775**

During the year ended 30 June 2014, $2.110 million was recognised as an expense in the statement of comprehensive income in respect of operating leases (2013: $2.133 million).

19 FINANCIAL INSTRUMENTS

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

CREDIT RISK

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 34.7 per cent). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Trade receivables	2014		2013	
	Gross Receivable $000	Impairment $000	Gross Receivable $000	Impairment $000
Not past due	30		4,531	
Past due 0-30 days	5,844	(518)	618	(5)
Past due 31-120 days	1,768	(36)	328	(16)
Past due 121-360 days	691	(37)	418	(232)
Past due more than 1 year	2,101	(1,895)	1,624	(1,586)
Total	**10,434**	**(2,486)**	**7,519**	**(1,839)**

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

Trade receivables	2014 Actual $000	2013 Actual $000
Gross trade receivables	10,434	7,519
Individual impairment	(2,486)	(1,839)
Collective impairment	-	-
Net total trade receivables	**7,948**	**5,680**

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

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

	2014 Actual $000	2013 Actual $000
Balance as at 1 July	(1,839)	(1,695)
Additional provisions made	(647)	(144)
Receivables written off	-	-
Balance as at 30 June	**(2,486)**	**(1,839)**

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

LIQUIDITY RISK

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

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

2014	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured loans	100,966	122,677	2,552	12,552	16,926	42,281	48,366
Unsecured loans	260	249	63	63	123	-	-
Finance lease liabilities	3,885	5,165	723	547	916	1,595	1,384
Trade and other payables	46,787	46,787	6,787	-	-	-	-
Total	**151,898**	**174,878**	**50,125**	**13,162**	**17,965**	**43,876**	**49,750**
Inflow	-	-	-	-	-	-	-
Outflow	151,898	174,878	0,125	3,162	7,965	3,876	49,750

2013	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured loans	101,365	122,677	2,552	12,552	16,926	42,281	48,366
Unsecured loans	455	477	143	63	126	145	-
Finance lease liabilities	3,888	5,165	723	547	916	1,595	1,384
Trade and other payables	43,560	44,792	44,792	-	-	-	-
Total	**149,268**	**173,111**	**48,210**	**13,162**	**17,968**	**44,021**	**49,750**
Inflow	-	-	-	-	-	-	-
Outflow	149,268	173,111	48,210	13,162	17,968	44,021	49,750

INTEREST RATE RISK

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

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

EFFECTIVE INTEREST RATES AND REPRICING ANALYSIS

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

	2014						
	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%	3,365	300	300	600	1,800	365
Crown loans *	4.74%	10,000	-	-	-	-	10,000
Crown loans *	2.61%	6,000	-	6,000	-	-	-
Crown loans *	6.55%	6,250	-	6,250	-	-	-
Crown loans *	2.94%	6,000	-	-	-	6,000	-
Crown loans *	4.75%	10,000	-	-	10,000	-	-
Crown loans *	5.75%	6,000	-	-	6,000	-	-
Crown loans *	6.42%	10,000	-	-	-	10,000	-
Crown loans *	3.37%	5,000	-	-	-	-	5,000
Crown loans *	3.44%	10,000	-	-	-	-	10,000
Crown loans *	4.34%	4,500	-	-	-	4,500	-
Crown loans *	4.40%	1,250	-	-	-	-	1,250
Crown loans *	4.40%	5,400	-	-	-	-	5,400
Crown loans *	5.06%	10,000	-	-	-	10,000	-
Crown loans *	5.22%	7,000	-	-	-	-	7,000
Finance lease liabilities*	9.68%	3,884	503	458	897	890	1,136
Unsecured Bank Loans	0.00%	249	63	63	123	-	-

* These assets/ liabilities bear interest at fixed rates

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

* These assets/ liabilities bear interest at fixed rates

FOREIGN CURRENCY RISK

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

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

CAPITAL MANAGEMENT

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

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

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

SENSITIVITY ANALYSIS

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

At 30 June 2014, 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 $1.026 million (2013: $1.013 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:

		Held for trading $000	Designated at fair value through profit & loss $000	Loans and receivables $000	Available for sale $000	Other amortised cost $000	Carrying amount Actual $000	Fair value Actual $000
2014	**Note**							
Trade and other receivables	11	-	-	31,662	-	-	31,662	31,662
Cash and cash equivalents	12	-	-	12,441	-	-	12,441	12,441
Secured loans	15	-	-	100,966	-	-	100,966	100,966
Finance lease liabilities	15	-	-	3,885	-	-	3,885	3,885
Unsecured liabilities	15	-	-	260	-	-	260	260
Trade and other payables	17	-	-	46,787	-	-	46,787	46,787
2013								
Trade and other receivables	11	-	-	23,026	-	-	23,026	23,026
Cash and cash equivalents	12	-	-	27,242	-	-	27,242	27,242
Secured loans	15	-	-	101,365	-	-	101,365	104,560
Finance lease liabilities	15	-	-	3,888	-	-	3,888	4,249
Unsecured liabilities	15	-	-	455	-	-	455	455
Trade and other payables	17	-	-	43,560	-	-	43,560	43,560

ESTIMATION OF FAIR VALUES ANALYSIS

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

INTEREST-BEARING LOANS AND BORROWINGS

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

FINANCE LEASE LIABILITIES

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

TRADE AND OTHER RECEIVABLES/PAYABLES

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

INTEREST RATES USED FOR DETERMINING FAIR VALUE

The entity uses the government yield curve as of 30 June 2014 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2014 Actual %	2013 Actual %	
Finance Leases	5.90%	5.49%	Reserve Bank of NZ Retail interest rate
Loans and borrowings	2.61% - 6.55%	2.55% - 5.14%	Rates per confirmation and also discount rates for FV loans

20. RELATED PARTIES

OWNERSHIP

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

IDENTITY OF RELATED PARTIES

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

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

Board Members Fees

	2014 Actual $000	2013 Actual $000
Joe Butterfield MNZM	54	53
Neville Cook	29	29
Sandra Cook	26	26
Kaye Crowther QSO	29	27
Mary Flannery	14	29
Malcolm Macpherson	14	30
Paul Menzies	18	37
Tahu Potiki	6	26
Branko Sijnja	27	27
Richard Thomson	27	27
Tim Ward	35	30
John Chambers	15	-
Mary Gamble	17	-
Anthony Hill	18	-
Tuari Potiki	16	-
	345	**341**

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

KEY MANAGEMENT TEAM REMUNERATION

The executive management remuneration is as follows*:*

	2014 Actual $000	2013 Actual $000
Salary and short-term benefits	2,545	2,427
Superannuation	40	31
	2,585	**2,458**

The compensations above excludes amounts paid to board members as these are separately shown.
The FTE associated with executive personnel was 10.4 (2013: 9.5). The information above represents the remuneration and FTE of the people on the executive management team for the period they were on the team.

EMPLOYEE TERMINATION PAYMENTS

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

The total payments were $98,000 (2013: 10 employees totalling $236,007).

2014 $000	2013 $000
20	64
18	40
18	35
17	32
9	20
5	16
5	13
3	13
3	3
-	2

EMPLOYEE REMUNERATION

The number of employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2014 were:

Total Remuneration and Other Benefits $000	Number of Employees 2014	2013
100 - 110	95	92
110 - 120	42	51
120 - 130	46	51
130 - 140	34	31
140 - 150	34	29
150 - 160	26	17
160 - 170	23	17
170 - 180	12	13
180 - 190	17	21
190 - 200	16	14
200 - 210	15	12

210 - 220	13	16
220 - 230	9	11
230 - 240	16	17
240 - 250	7	12
250 - 260	18	8
260 - 270	18	13
270 - 280	13	5
280 - 290	9	7
290 - 300	7	13
300 - 310	7	10
310 - 320	12	5
320 - 330	4	3
330 - 340	4	8
340 - 350	7	3
350 - 360	2	3
360 - 370	3	3
370 - 380	3	1
380 - 390	2	3
390 - 400	1	2
400 - 410	2	
410 - 420	-	-
420 - 430	-	1
430 - 440	-	1
450 - 460	-	1
470 - 480	1	-
480 - 490	1	
500 - 510	2	1
510 - 520	-	1

Of the 521 employees shown above, 391 were medical/dental employees (2013: 376 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 780, compared with the actual total number of 521 (2013: 692 and 496).

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

TRANSACTIONS WITH BOARD MEMBERS AND KEY MANAGEMENT PERSONNEL

	2014				2013			
	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB
Board and Exec Members	$000	$000	$000	$000	$000	$000	$000	$000
Richard Bunton								
Mainland Cardiothoracic Associates (D)	1,253	-	-	-	1,253	-	-	-
Royal Australasian College of Surgeons (C)	-	-	-	-	4	-	-	-
Joe Butterfield								
Corstorphine Baptist Community Trust (F)	2,066	-	144	-	1,902	-	147	-
Neville Cook								
Environment Southland (Co)	2	-	-	-	1	-	-	-
Norman Jones Foundation								
Invercargill Licencing Trust (B)	-	4	-	-	3	5	-	-
Southern Health Welfare Trust (T)	1	2	-		1			
Sandra Cook								
Te Runanga o Ngai Tahu (Representative)	-	-	-	-	-	-	-	-
Kaye Crowther								
Crowe Horwath NZ Ltd								

Wakatipu Plunket Charitable Trust								
Royal New Zealand Plunket Society Southland (C)	122	2	8		89		(2)	
Number 10, Youth One Stop Shop (T)	2	-	-	-	75	-	-	-
Mary Gamble								
Access Home Health Ltd (A)	8,111	-	752	-	2,642	-	183	-
Carole Heatly								
Southern Health Welfare Trust (T)	1	2	-	-	1	-	-	-
Anthony (Tony) Hill								
Southern Primary Health Organisation (A)	59,748	283	1,857	30	53,971	145	1,420	21
Lynda McCutcheon								
University of Otago (A)	9,256	3,183	137	869	9,933	3,374	254	172
Tuari Potiki								
University of Otago (E)	9,256	3,183	137	869	9,933	3,374	254	172
Dr Jim Reid								
University of Otago (E)	9,256	3,183	137	869	9,933	3,374	254	172
Leanne Samuel								
Southern Institute of Technology (B)	10	206	-	4	8	11	-	4
Southern Health Welfare Trust (T)	1	2	-	-	1			

	2014				2013			
Board and Exec Members	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB
Branko Sijnja								
Balclutha General Practitioners Limited (E)	5	-	-	-	2	-	-	-
Clutha Community Health Company Ltd (D), T/A Clutha Health First (E)	6,204	215	19	59	5,654	398	1	46
Southern Community Laboratories (D)	1,290	1,451	5	500	915	1,303	-	177
University of Otago (Rural Immersion Programme) (D)	9,256	3,183	137	869	9,933	3,374	254	172
Richard Thomson								
Dunedin City Council (Co)	657	1	-	1	585	-	-	-
Hawksbury Community Living Trust (C & T)	-	1	-	-	-	1	-	-
Healthcare Otago Charitable Trust (T)	20	-	-	-	102	-	-	-
Tim Ward								
Southern Community Laboratories (D)	1,290	1,451	5	500	915	1,303	-	177
Southern Institute of Technology (B)	10	206	-	4	8	11	-	4

	2014				2013			
Previous Board and Exec Members	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB	Purchased by Southern DHB	Purchased from Southern DHB	Owed by Southern DHB	Owed to Southern DHB
Sharon Kletchko								
Southern Cancer Network (A)	-	62	-	-	-	203	-	167
Nelson Marlborough DHB (E)	1,047	1,203	84	-	894	1,344	28	70
Mary Flannery								
Bodkins/ AWS Legal, Alexandra (E)	-	-	-	-	-	-	-	-
Malcolm Macpherson								
ACC (F)	1,546	10,676	-	1,345	1,617	10,369	-	898
Centennial Health (F)	33	-	-	-	27	-	-	-
Otago Community Hospice (T)	3,005	1	-	-	2,553	5	-	-
Otago Polytechnic (B)	17	235	-	27	43	237	-	51
Paul Menzies								
Southern Primary Health Organisation (T)	59,748	283	1,857	30	53,971	145	1,420	21
Number 10, Youth One Stop Shop (F)	2	-	-	-	75	-	-	-
Tahu Potiki								
Arai Te Uru Whare Hauora Ltd (D)	537	-	-	-	569	-	-	-
Environment Science and Research (B)	16	-	1	-	22	-	2	-

21. MENTAL HEALTH RINGFENCE

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

During the 2011/12 year there was a change in the ringfence 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 ringfence, rather than the District Health Boards' (DHBs) average demographic rate.

The year ended 30 June 2014 has resulted in a deficit of $0.3 million for Mental Health services. Additionally Southern DHB has a brought forward over spend of $2.0 million; meaning that the carry forward overspend is $2.3 million.

22. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

The favourable variance in total comprehensive income against budget for the year ended 30 June 2014 was $1.2m.

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

- $11.7m of additional revenue, most of which has costs associated with it including Electives incentive revenue, Health Workforce NZ and ACC revenue;
- $10.1m Revaluation of land and buildings;
- $1.4m of Nursing and allied health personnel, partly due to unfilled mental health positions;

- $1.0m interest and financing charges, including capital charge;
- ($0.5m) of professional fees and expenses;
- ($0.9m) of unfavourable Mental Health NGO expenditure;
- ($0.9m) of Laboratory costs, including send away and other non-contracted tests;
- ($1.0m) of unfavourable instruments and equipment expenditure and other clinical supply costs;
- ($1.3m) of unfavourable implants & prosthesis expenditure;
- ($1.7m) of unfavourable inter-district outflows;
- ($2.6m) of unfavourable outsourced costs- excluding medical outsourced costs;
- ($2.6m) of unfavourable home support cost;
- ($4.8m) of unfavourable community pharmaceuticals expenditure; and
- ($6.7m) of Medical Personnel expenses, net of outsourced costs.

23. EVENTS AFTER THE BALANCE DATE

There were no significant events after the balance date.

Independent Auditor's Report

To the readers of Southern District Health Board's financial statements and performance information for the year ended 30 June 2014

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 performance information of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 51 to 79, that comprise the statement of financial position as at 30 June 2014, the statement of financial performance, 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 that comprises the statement of service performance, and which includes outcomes on pages 15 to 50.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 51 to 79:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

The Health Board is reliant on deficit support from the Crown

We considered the adequacy of the disclosures made in note 1 on page 55 that outline that the Board, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of support received from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with deficit support, where necessary, to maintain viability. We consider these disclosures to be adequate.

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

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators) rely on information from third-party health providers, such as primary health organisations and South Link Health. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. 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 2013, which is reported as comparative information, was modified for the same reason.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 15 to 50:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
  - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
  - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 2 October 2014. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health Board's preparation of the financial statements and performance information that fairly reflect the matters to which

they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

Our audit of the financial statements involved evaluating:

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

Our audit of the performance information involved evaluating:

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

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

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

Responsibilities of the Board

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

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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