South Canterbury District Health Board

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South Canterbury District Health Board

Our Annual Report 2016/2017

Including our Quality Accounts

www.scdhb.health.nz

Presented to the House of Representatives
pursuant to section 150 of the Crown Entities Act 2004.

The South Canterbury DHB Story

Welcome to South Canterbury District Health Board's Annual Report for July 2016 to June 2017.

Annual Reports are produced annually by each District Health Board (DHB) to keep communities up-to-date on the performance and direction of their health board.

At SCDHB, we listen to your feedback to continuously improve the quality of our services. We want to make sure you have a good consumer experience that generates the greatest health outcomes for your unique situation.

This document outlines how we have achieved this by providing a snapshot of our quality initiatives, financial performance and statement of performance over the past year.

We hope you find what follows interesting.

We would love to hear what you think, so please use the feedback form or our contacts listed at the back.

What's inside?

Our South Canterbury DHB Family

South Canterbury District Health Board (SCDHB) serves the people of South Canterbury by either funding or providing health services that meet the needs of our community. We work closely with the Ministry of Health who provide some disability support services and other health services at a national level. We also form part of the South Island Alliance in which DHBs work regionally to develop innovative and efficient health services.

The SCDHB is governed by the Board who develop strategy and hold the SCDHB management team accountable for the operation of its services. The following section introduces the Board members and highlights some of the committees that contribute to providing guidance and monitoring to the Board.

"I am particularly pleased with two achievements this past year.

Firstly, the dedication and professionalism of the staff in achieving or exceeding most of our health targets for the year means that the people of South Canterbury continue to receive the best possible health care within the resources we have available.

- We are pleased to have met the National target for shorter stays in ED. The consistency in this achievement is testament to the dedication of the staff in this department.
- Earlier this year we looked to be falling behind on the elective surgery target. It is due to the excellent work by our staff that they were able to pull it back in line. The lessons learned this year are already being implemented into planning for the 2017/18 year as we look to try and overcome some of the hurdles which make this target difficult to achieve.
- We are disappointed not to have met the faster cancer measure. We look forward to the technical adjustments being made to the target definitions to support patient decision making and the delivery of clinically appropriate care.
- The team are working very hard to ensure that the processes and systems in place will enable us to achieve the new Raising Healthy Kids target by December 2017, when it comes into effect. A visit from the target champion Professor Hayden McRobbie has helped focus discussions with public health nurses and general practices.

Secondly, the decision of the Board to establish a Consumer Council to advise management on improvements and changes that can be made to the patient journey and patient care. Into the future this will provide a source of knowledge and advice that will assist in ensuring all our decisions and actions are truly patient focused and will be of benefit to all health users in both primary and secondary care."

Ron Luxton, Chair

Creating a **Healthy Balance**

Achieving the national health targets.

The Ministry of Health reports on quarterly progress towards achieving agreed annual health targets with each district health board. SCDHB maintained or improved on all health target results by the end of quarter four 2016/17 compared with last year's results.

Shorter stays in Emergency – exceeded target with 96% of patients admitted, discharged or transferred within six hours, even with an increase in volume and acuity over the last five years.

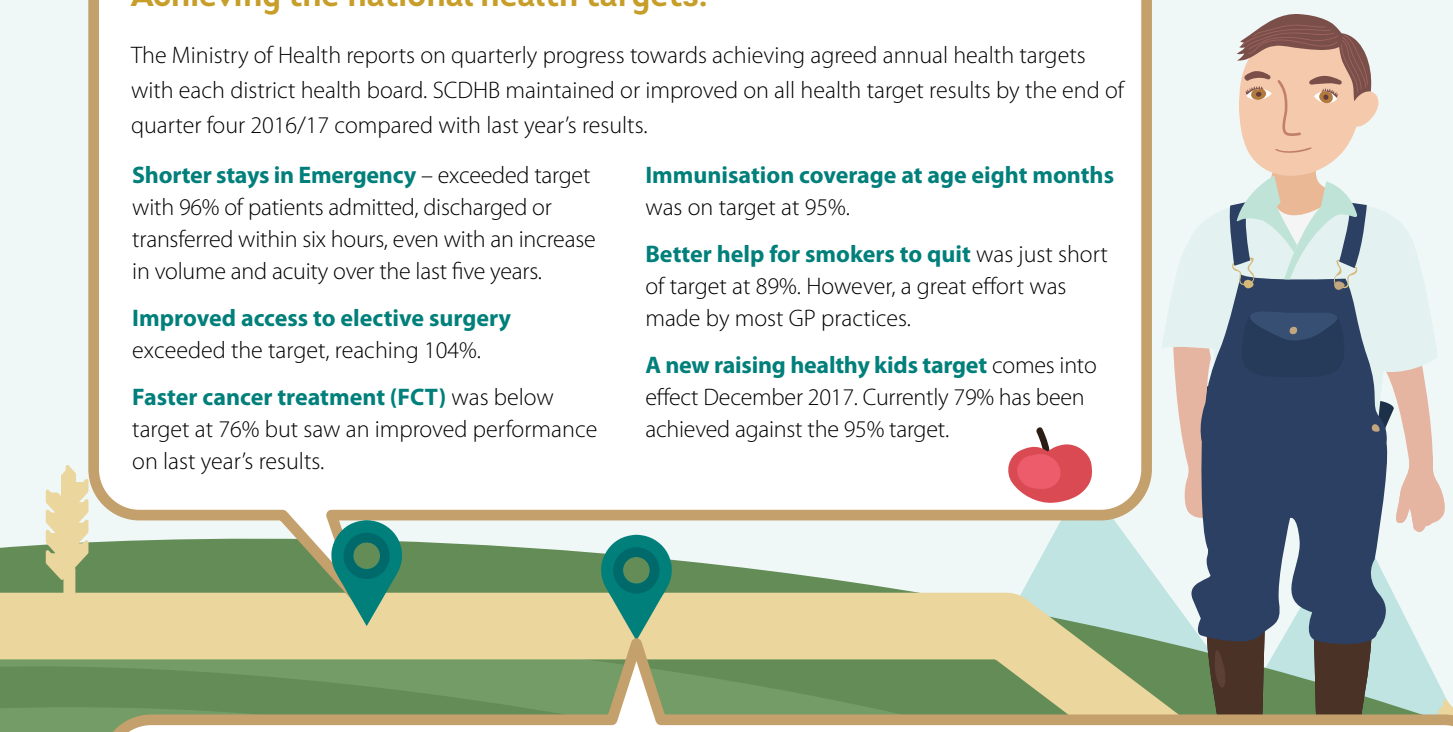
Improved access to elective surgery exceeded the target, reaching 104%.

Faster cancer treatment (FCT) was below target at 76% but saw an improved performance on last year's results.

Immunisation coverage at age eight months was on target at 95%.

Better help for smokers to quit was just short of target at 89%. However, a great effort was made by most GP practices.

A new raising healthy kids target comes into effect December 2017. Currently 79% has been achieved against the 95% target.



Improving the safety and quality of South Canterbury's health care

Quality and Safety Markers

Falls: Falls are a leading cause of injuries to older people. One out of three older people have a fall each year. The national target requires that 90% of older inpatients are given a falls risk assessment and SCDHB achieved between 96 and 100%.

Surgical Site Infection: Hip and knee replacement markers were achieved.

Hand Hygiene: The national target requires 80% compliance with good hand hygiene practice (5 moments). SCDHB results over the last year have been between 66 and 80%. This has resulted in a renewed focus on educating staff to improve their hand hygiene understanding and compliance.

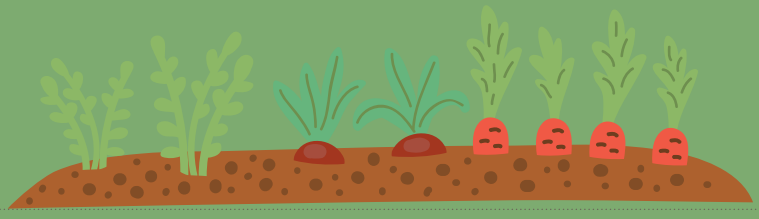
Safe Surgery and Medication Safety are new targets that will be included in coming years.

Serious Adverse Events

An adverse event is where a person using health and disability services is involved in an incident that results in harm.

For example someone within the care of the hospital who has a fall resulting in a fractured bone.

There were 21 such incidents reported at SCDHB, with better reporting on Safety 1st. The SCDHB said it was extremely important to encourage the reporting of all adverse events so that we can learn from them and ensure procedures are in place to reduce the likelihood of further incidents in the future.



Delivering care in the most appropriate settings and reducing demand by supporting health independence.

Collaboration Cross-Agency

In 2016/17 the SCDHB continued to focus on the development of integrated service models for child and youth services across primary and secondary health services working with all other agencies providing health, community support and social services for children, youth and their families.

The Integrated Child and Youth Health Alliance continued work to address priorities supported by cross agency collaboration.

System Integration / Closer to Home

SCDHB is actively working with the other South Island DHBs to implement regional Information System solutions. In the next few years SCDHB will complete implementation of electronic medicine management and e-referrals, with the other South Island DHBs. Development of a new Patient Information Care System is due for implementation at SCDHB in 2018.

These collaborative projects will enable improvements to be made to the patient journey and change the way health care is delivered to consumers enabling a sustainable and integrated service to be provided over the coming years.

Māori Health

The latest Census shows an increase in the number of people in South Canterbury identifying as Māori, currently 8.4%.

Generally, Māori in South Canterbury have better health than Māori across the country but their health is not as good as it is for non-Māori living in South Canterbury. So, improving Māori health and reducing disparities continues to be a key focus.

A Māori Cancer Action Plan has been developed with a number of actions identified to improve the Cancer Pathway for Māori in South Canterbury.

A Cultural Competency project seeks to develop and embed a set of cultural competencies, it describes how to develop knowledge and skills to deliver increased access, achieve equity and improve health services for Māori.

We are currently working on the Hauora Māori Strategic Plan which will set out the direction for the SCDHB for the next 5 years.

Casting the equity lens over all that the health board does in service planning, policy and programme design will not only tackle inequity but also avoid the creation of inequity.

Living within our means

During 2016/17 the allowance for cost growth in the funding envelope from the Ministry of Health this year was 1%.

When recognising industrial settlement pressures, step increases, and inflationary and other cost and quality pressures, the only way SCDHB was able to strengthen its financial position was by delivering financial efficiency gains.

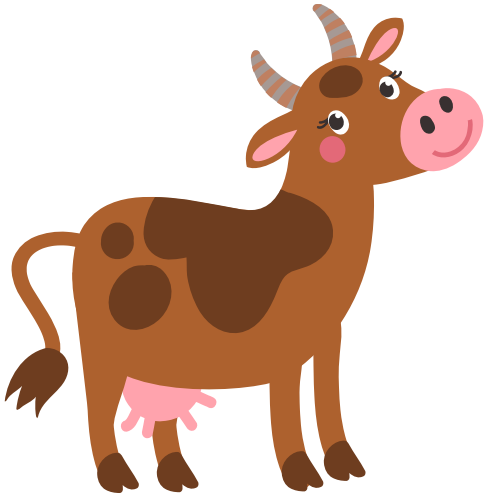
Management review and structure change resulted in a smaller, more nimble Strategic Leadership Team. It also introduced new skill sets to the team that helped to enable more timely, integrated consultation and decision making.

The Energy Performance contract drove reduced energy use, water use and maintenance costs through the control of energy use at a localised level.

Upgrade of laundry equipment and changing rostering to support customer requirements resulted in increased revenue and reduced costs, and energy usage.

Proactive maintenance meant jobs were monitored and completed within timeframes, and reactive maintenance dropped significantly resulting in cost savings.

Introduction of technology with electronic sign off of lab results, reduced printing by 22,000 pages per month. It also saved administration, and clinical records staff time, and benefitted patients with escalation of unsigned lab results.



"Significant work has gone into creating service profiles and plans throughout clinical services as well as some support services. As a result, many line managers have created and are enjoying better visibility of the drivers of their service productivity and effectiveness than ever before."

Nigel Trainor, Chief Executive

"I'm proud that Timaru Hospital is the first choice for so many newly qualified doctors seeking their first or second jobs. This is great news for medical staffing in South Canterbury for the future."

Peter Binns, Board Member

"I'm proud that we are meeting the elective targets. This is a credit to all of the staff, including those behind the scenes.

It makes a huge difference to the people of South Canterbury because it means people who require these operations and procedures are getting them sooner rather than later."

Terry Kennedy, Board Member

Highlights **2016/2017**

Electives Care

Your GP or primary care practitioner assesses your condition and may refer you to a specialist.

GPs Gaining Quality Certification

In order to keep general practices at the forefront of safe, high quality primary healthcare delivery in South Canterbury, SCDHB supported the introduction of the Foundation Standards Certification to Primary Care.

All practices engaged in either the Foundation Standards or Cornerstone Accreditation programmes and the majority have now achieved the standard.

The standards aim to improve operational effectiveness in general practice through a quality improvement framework.

In its first year, 16 practices have now achieved Foundation Standards and five have achieved Cornerstone Accreditation. The remaining three practices are also working towards the certification. It's great to see all General Practices engaging in this quality improvement initiative.

A specialist assesses your condition and decides what treatment is appropriate.

First Specialist Assessments are conducted to assess the next steps for the patient, be it surgery or other management.

More First Specialist Assessments

In 2016/17 the whole outpatient team at Timaru Hospital, including doctors, nurses and clerical staff, worked hard to deliver more outpatient first specialist attendances (FSAs) than ever before.

This was achieved through a combination of increased staffing levels and using clinic time more efficiently. Changes included the increased use of technology to perform some clinic visits remotely and new booking systems to make best use of available clinic time. Some patients were also able to have their routine follow-up care closer to home by their GP, practice nurse or physiotherapist, freeing up specialist time to see more new patients.

Highlights 2016/2017

Health of Older Person Care

If specialist treatment is needed then your priority for treatment is assessed, and you are offered public treatment or surgery.

The time spent in hospital varies for each patient. Some patients may stay in hospital for rehabilitation, while others are discharged home or to a rehabilitation facility to continue their recovery in the community.

Integrated Community Assessment Treatment Team

A new Integrated Community Assessment Treatment Team (ICATT) is being developed aimed at enabling a smoother, more efficient patient journey when accessing a range of health services from a multi-disciplinary team.

How you prepare for your operation and what you do before and after surgery can help enhance your recovery.

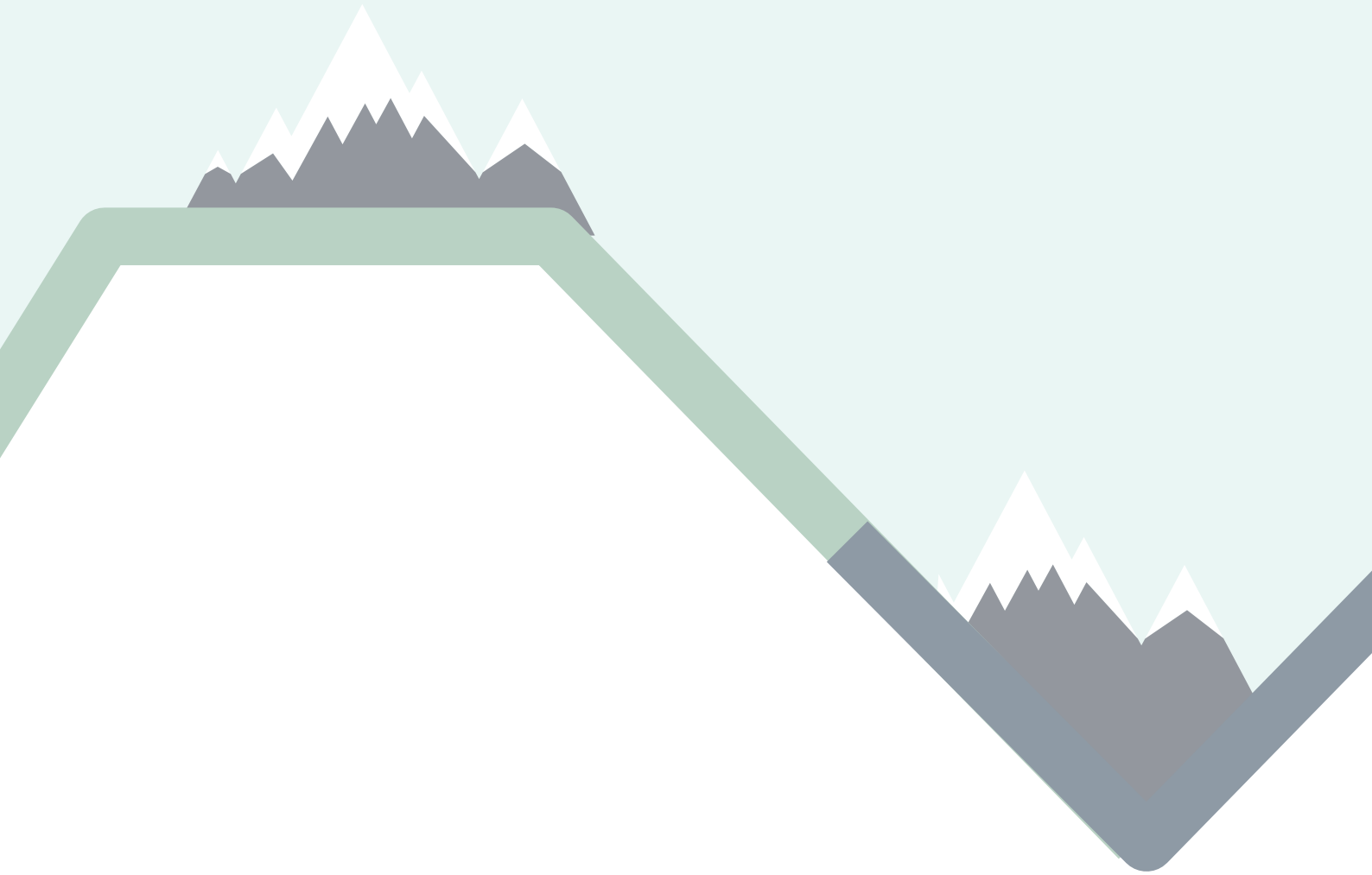
"Sit less, stand more" Calderdale Framework

Within the community, service accreditation has seen rehabilitation assistants' knowledge and skills increase to enable them to provide assistive equipment in a timely manner to ensure people are able to maintain their independence at home.

At Timaru Hospital, physiotherapists worked with the Assessment Treatment and Rehabilitation team (AT&R) to ensure that patients received the most up to date methods of exercise prescription.

Upskilling healthcare assistants in the AT&R team created a culture of increased activity on the ward and made a difference to the functional outcomes of patients leading to less time in hospital and an increased likelihood of returning home.

A learning package to improve the care and rehabilitation of bariatric patients (people who are obese) was also developed.



"I am really proud that the SCDHB has achieved three of the Ministry of Health's health targets set for 2016/17 (Shorter stays in ED – 95.6%; Improved access to elective surgery – 104%; Increased immunisation – 95%) whilst still managing to achieve a positive financial result.

The most important reason for achieving the results we have in 2016/17 is down to Management, Strategic Leadership Team, our professional clinical team and our very hard working nurses, support staff and administrators.

I must especially mention the tremendous work that Dr Khan and his staff at the SC Eye Clinic have done over the last 12 months, saving many of our senior citizens from having to travel to Christchurch for ophthalmology services.

Having a well performing District Health Board is critical to our region. Not only maintaining but continually improving our facilities and services so that our community can get timely, and the very best, health care that we can possibly deliver."

Murray Roberts, Board Member

Highlights 2016/2017

Acute Services

Timaru Hospital's ED is an increasingly busy place.

A significant proportion of these attendances are by people who could be seen and treated by a general practitioner (GP) or after-hours doctor. When in doubt ring your GP or call the 24-hour HealthLine 0800 611 116.

Trauma Group Project

A national database – the Major Trauma Registry – has been established for all DHBs to share their major trauma data. Already, the information collected has given great insight of the extent of trauma in the region and will lead to improved patient care and more efficient processes within the hospitals.

SCDHB has established a trauma committee looking at management of trauma admissions. The first major achievement has been setting up a trauma call system and development of local guidelines for procedure management.

From ED a patient might then be transferred into the Intensive Care Unit (ICU) or Medical Ward.

Emerging Leader Award

Olivia Pearson, a charge nurse manager in the medical ward at Timaru Hospital, received the Health Quality & Safety Commission's Open for Leadership Award for demonstrating excellent practice, quality improvement and leadership skills.

Changes to the ward included decluttering the environment to make it safer for patients and staff, and improving the discharge planning process, despite Olivia only being in the role for three months.

How the medical ward team came together with a strong patient-centred approach, and contributed to the everyday running of the ward , has been a real benefit.

When in the wards you may undergo a range of tests for diagnosis.

MRI software upgrade and patient support aid

Funding from St Vianney's Trust enabled clearer imaging through an MRI software upgrade and patient support aid.

The MAVRIC SL software upgrade allows for better image reconstruction around hip, knee and shoulder replacements with metal implant devices. The software allows visualisation of more tissue in the vicinity of the metal ware.

The patient support aid, a GEM Flex Coil Positioner, assists patients to keep their limb being imaged as still as possible, so there is less likelihood of movement due to prolonged straining or holding the limb in an unnatural or unrested position.

Your GP is your main point of call and you can access follow up appointments through them.

GP patient portal

SCDHB supported general practices to introduce a 'patient portal'. The patient portal allows patients to be more involved in the self-management of their care online, such as view their health record, book appointments or request repeat prescriptions. This streamlines the care for both patients and practices.

One third of general practices requested to be set up, which has enabled approximately 40% of patients across South Canterbury to have access.

Patients with long-term conditions might be seen by a clinical nurse specialist who might see them in the hospital and then support them while they are out in the community.

Diabetes Encounter Project

This project was introduced to work with newly diagnosed diabetics, those in the community commencing insulin, those persons within general practice, with known diabetes whom were not engaged with primary care, therefore had either poor glycaemic control or unknown glycaemic control. The patient received intensive input in a planned way from their GP, Practice Nurse and the Clinical Nurse Specialist Diabetes. The aim of this input was to get good glycaemic control within a short time frame.

"We are very proud of our performance in meeting the health needs of South Canterbury, consistently being recognised as the best little DHB in the country.

We are not just a hospital but we now have a truly integrated health system including hospital, primary care and our NGOs all in the same waaka.

The credit goes to all the 2000 plus people employed for their commitment and passion they bring to keeping our community healthy.

Going forward we will have to work even harder to provide proactive health strategies so we can become less re-active."

Murray Cleverley, Board Member

"It is fantastic that SCDHB remains one of the top performing DHBs with a strong commitment to financial performance and quality improvement.

A highlight for me has been the focus on community collaboration and ensuring the community has a voice through a multi-faceted approach, which includes consumer representation on advisory groups, the establishment of the Consumer Council and the focus on community relationships."

Raeleen de Joux, Board Member

Highlights 2016/2017

Maternal, Child and Youth

GP Free Child Visits

The nationwide zero fee doctors' visits for children aged under 13 is now in its second year of operation. The number of children accessing these visits in South Canterbury has remained steady during the past year. When you are pregnant you also receive free GP visits related to this care.

The SCDHB has created a single enrolment form and placed these around the district to make it easier to link all children with the various relevant health services such as oral health, well child, and to enrol at a GP, all at the point of first contact. This has been particularly helpful for newcomers to South Canterbury and has been supported by the Migrant Coordination service. A phone number has also been set up to help people to find a GP, (03) 687 2307.

Unwell babies and children requiring hospital care will be looked after in the paediatric ward.

Paediatrics

New-born life support training was provided onsite to staff to improve their skills in a localised environment.

An additional paediatrician position was advertised, due to the increased needs and complexities of care in the community. A community paediatric nurse was also employed to deliver care to patients closer to home.

A paediatrics diabetes social get together to support people with diabetes and their families was a real success.

The immunisation schedule begins before your child is born and continues at key age milestones through early childhood, early teens and adulthood.

Increased Immunisation

SCDHB achieved the national health target for immunisation, that 95% of eight month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

HPV immunisation became funded for everyone aged 9–26 (inclusive) this includes girls, boys young men and women, and a school based immunisation programme was held.

During the Immunisation Week campaign, immunisation coordinators visited local schools so students could have conversations and ask questions about immunisation. Promotion was extended to social media to raise public awareness, especially in relation to the benefits of HPV vaccinations.

In the first trimester of pregnancy you'll find a Lead Maternity Carer (LMC). Then when it's time, some people come through the Maternity unit at Timaru Hospital for the birth of their child.

Maternity Care

There were good improvements made in the maternity unit this year, particularly around staff development and communication.

For example, now each morning there is a multi-disciplinary handover meeting for the whole team of carers (including doctors, nurses, midwives etc).

A midwife educator has been made available to provide training on-site for midwives, for the first time. This contributes to their ongoing education, with localised content that is specific to their needs.

PROMPT training – onsite obstetric emergency multidisciplinary scenario based training is being developed, with the first exercise planned for later in the year.

Maternal wellness clinicians (social workers) are now available to work with women affected by depression.

To protect and improve your child's health, so they can grow and develop to their full potential, Well Child is a free service for all New Zealand children from birth to five years.

Well Child

SCDHB continued to work with Well Child / Tamariki Ora to provide community health services to children and their whanau.

A new health target was introduced regarding the percentage of obese children identified in the B4 School Check programme offering a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

A free community youth clinic provides access to a range of health services for youth.

Youth Clinic

Whether its Home, Education and Employment, Eating, Activities with peers, Drugs, Sexual activity, Suicide and Depression or Safety, assessments are available in the community youth clinic and alternative education settings.

SCDHB also continued to work with local alternate education providers to progress scheduled access to youth clinics at each site and to promote the availability of all local youth health services.

Children can participate in a wellbeing programme either at an early childhood education facility or at school.

WAVE

WAVE (Well-being and Vitality in Education) is a partnership between education settings and health organisations. WAVE was initiated in 2006 by SCDHB and Community and Public Health.

An extensive evaluation of the WAVE programme was completed using both key informant interviews and a survey of all participating education settings. Results showed that all education settings in South Canterbury were participating in WAVE. This included 44 early childhood education settings, 36 primary schools, 10 high schools and 4 tertiary providers, with approximately 14,000 students in total. Settings reported a high level of engagement with WAVE and almost all settings reported being satisfied or very satisfied with WAVE. Other significant results were noted, including in the areas of school policy and professional development.

WAVE
WELL-BEING AND VITALITY IN EDUCATION

"From a Board perspective, I'm most proud of the progress with the organisational culture programme and, particularly due to my role as deputy chair of Hospital Advisory Committee (HAC), the progress with the future hospital development.

Leadership which recognises challenges and staff input in the solution of these have been critical in progressing both issues.

These are big issues which affect the long-term culture and service of the SCDHB in delivering on the health needs for all in South Canterbury. By getting them right it will also ensure we can meet Ministry service and financial requirements thereby securing long-term locally based and led provision of health services."

Mark Rogers, Board Member

"The inaugural South Canterbury Health Gala in May was a true success thanks to the effort and vision of a large team of people who knew how important it is to take a moment to recognise and value the people and teams who make a real difference every day.

Nearly 400 people came out to celebrate the 'unsung heroes' of our health system workforce. Planning for next year is already underway."

Rene Crawford, Board Member

Mental Health and Addiction Services

All services are available through a single point of entry process. This means from your first contact, you will be connected with all the services you need. There is no cost for these services.

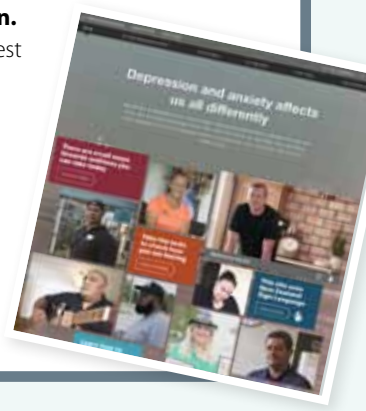
GP Brief Intervention Counselling

SCDHB was one of the first in the country to offer a primary care mental health service. This provides people with access to four free sessions with a mental health expert, aimed at preventative care and early intervention.

The national Health Promotion Agency offers online resources with a mental health focus.

Mental Health Online Tools

The website **depression.org.nz** provides a self-test to help people identify their next steps, while **thelowdown.co.nz** is focussed on providing guidance to youth on anxiety and depression.



Thoughts of suicide are frightening and overwhelming and also quite common. Many people have suicidal thoughts and get better with help. Although it can be hard it is VERY important that you ask for help.

Suicide Prevention Training

SCDHB has a Suicide Prevention Plan which includes access to training to support people to identify when others may be at risk of suicide and provides guidance on referral pathways.

Suicide Prevention training was undertaken in five rural settings, in ten community settings and in a range of workplaces. The training was well received.

When youth are experiencing mild to moderate mental health or addiction issues, there are a range of NGOs funded to help get them back on track.

Youth Initiatives

Youth continue to experience good access rates and waiting times for mental health and addiction services. Local youth have access on referral to a mental health brief intervention service, the Adventure Development Programme, and youth alcohol and drug addiction services.

The SCDHB also holds a contract with the YMCA to deliver the Non-Participating Youth Programme. The aim of this programme is to provide physical activity opportunities and develop a health conscience with the 'at risk' youth in South Canterbury and to link these young people to further sporting opportunities in the community.

For those experiencing a severe mental health issue, the Acute Inpatient Unit at Kensington provides intensive treatment.

Acute Inpatient Unit Refurbished

The 14 bed inpatient unit, or ward, is situated at the eastern end of the Kensington facility. A team comprising of Registered Mental Health Nurses, a Social Worker and an Occupational Therapist is there to assist with the recovery process.

The refurbishment of the unit has created a positive, welcoming environment.

When you want to stop smoking, help is at hand. Evidence shows you have more chance of quitting with support from a group than you do alone.

Time to Kick Ash

The new stop smoking service was launched, branded Kick Ash South Canterbury to connect with the younger target audience. The free service offers advice to stop smoking, support and NRT treatments to help people stop smoking for good.

Arowhenua Whanau Services was engaged as a partner provider to reach priority groups and employed a Māori health provider, stop smoking practitioner and whanau navigators to work with families.

Health targets for the number of people enrolled in the service and the number of people quitting were both achieved.

Kick Ash SOUTH CANTERBURY

www. facebook.com/kickashsc

Being a Good Employer

There is a clear relationship between the wellbeing of staff and the wellbeing of patients.

Equal Employment Opportunities (EEO)

A newly formed workforce development group is looking at the principles of equal employment opportunity and how this is embedded across the DHB. A cultural competency framework, although only in the development stage, is already starting to see changes in the recruitment process to ensure the SCDHB is reflective of the culture of our community.

Treaty of Waitangi

As an agent of the Crown, we are committed to the principles of the Treaty of Waitangi, in particular Māori participation and partnership in health planning and services.

Creating a culture of safety

The Board, unions and senior management listened to feedback about unprofessional behaviour being tolerated in many parts of the DHB. They have supported a whole of organisation culture change programme, starting with a "Speaking Up for Safety" programme commencing later this year.

National
Health Targets

National **Health Targets**

Health targets are national performance measures set by the Ministry of Health, specifically designed to improve the performance of health services. They provide a focus for action.

Key

- ✓ All quarters met national target
- ! Some quarters outside national target
- ✗ No quarters met national target

Shorter stays in Emergency Departments

The target is 95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within 6 hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

The confirmed national result for the shorter stays in emergency departments target shows that 96% of patients were admitted, discharged or transferred from an ED within six hours this quarter.

We are pleased to have met the National target for shorter stays in ED. SCDHB has an excellent history with the six hour target, and even with the increase in volume and acuity over the last five years we have managed to maintain this achievement. The consistency in this achievement is testament to the dedication of the staff in this department.

National Target **95%**

Our Results

	2015/16	2016/17
Q1	96	96
Q2	96	96
Q3	95	96
Q4	96	96
Target Met	✓	✓

Improved Access to Elective Surgery

The target is an increase in the volume of elective surgery by an average of 4000 discharges per year.

We were able to exceed the target for improved access to elective surgery reaching 104%.

Earlier this year we looked to be falling behind on this target. It is a testament to our good staff that we have pulled it back in line. The lessons learned this year are already being implemented into planning for the 2017/18 year as we look to try and overcome some of the hurdles which make this target difficult to achieve.

National Target **100%**

Our Results

	2015/16	2016/17
Q1	98	91
Q2	101	93
Q3	98	96
Q4	101	104
Target Met	!	✓

Increased Immunisation

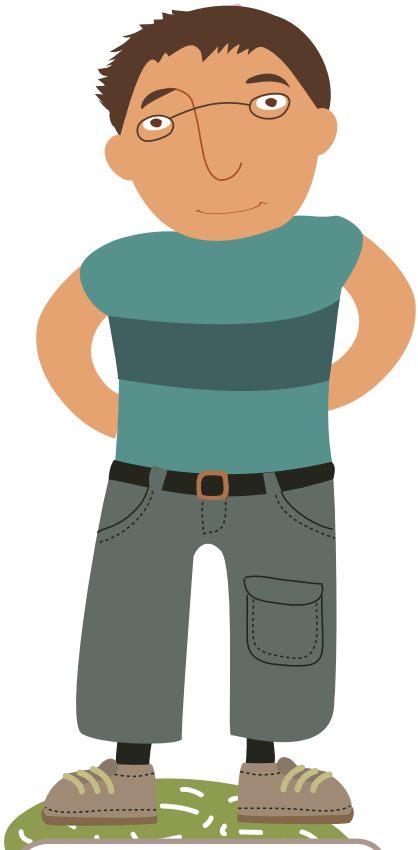
The national immunisation target is 95% of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time.

National immunisation coverage at age eight months was on target at 95%. South Canterbury has a good history with the immunisation target and we are very pleased with this.

National Target **95%**

Our Results

	2015/16	2016/17
Q1	93	95
Q2	92	92
Q3	91	96
Q4	93	95
Target Met	✗	!



Better Help for Smokers to Quit

The target is 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

At 89% we were just short of the better help for smokers to quit target. SCDHB is disappointed that we only just missed this target, a great effort was made by most GP Practices.

National Target 90%

Our Results

	2015/16	2016/17
Q1	84	86
Q2	87	87
Q3	86	85
Q4	89	89
Target Met	✗	✗

Raising Healthy Kids

The target is that by December 2017, 95% of obese children identified in the B4 School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

The raising healthy kids target is not required to be met until December 2017. We are still embedding the new target and as such were only able to achieve 79% against the 95% target. The team is working very hard to ensure that the processes and systems in place will enable us to achieve this target by December. A visit from the target champion Professor Hayden McRobbie has helped focus discussions with public health nurses and general practice.

National Target 90%

Our Results

	2015/16	2016/17
Q1	NA	71
Q2	NA	87
Q3	NA	79
Q4	NA	79
Target Met	NA	✗

Faster Cancer Treatment

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

Our faster cancer treatment (FCT) is below target at 76% but has seen improved performance on last year's results.

We are disappointed not to have met the faster cancer measure. In April we met the target by 100%, in May we had two patients miss due to being medically unfit for treatment and in June we had three patients miss, all with difficult diagnosis or treatment plans not being fully determined.

We look forward to the technical adjustments being made to the target definitions so that it supports timing around patient decision making and the delivery of clinically appropriate care.

National Target 85%

Our Results

	2015/16	2016/17
Q1	63	77
Q2	74	90
Q3	72	81
Q4	66	76
Target Met	✗	!

Our **Financial Performance**

In this section you will find:

Statement of Responsibility

For the Year Ended 30 June 2017

1. The Board and management of South Canterbury District Health Board accept responsibility for the preparation of the annual financial statements and statement of service performance and the judgments used in them.
2. The Board and management of South Canterbury District Health Board accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.
3. In the opinion of the Board and management of South Canterbury District Health Board, the annual financial statements and statements of service performance for the year ended 30 June 2017 fairly reflect the financial position and operations of South Canterbury District Health Board.

Ron Luxton
Chair
27 October 2017

Paul Annear
Deputy Chair
27 October 2017

Nigel Trainor
Chief Executive
27 October 2017

Independent Auditor's Report

To the readers of South Canterbury District Health Board and group's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of South Canterbury District Health Board and its subsidiary (the Health Board and group). The Auditor-General has appointed me, Ian Lothian, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information of the Health Board and group on his behalf.

We have audited:

- the financial statements of the Health Board and group on pages 31 to 67, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, 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 and group on pages 78 to 94.

Opinion

Unmodified opinion on the financial statements

- In our opinion, the financial statements of the Health Board and group on pages 31 to 67:
  - present fairly, in all material respects:
    - its financial position as at 30 June 2017; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior year

In respect of the 30 June 2016 comparative information only, some significant performance measures of the Health Board (including some of the national health targets and the corresponding district health board sector averages used as comparators), relied on information from third-party health providers, such as primary health organisations. The Health Board and group's control over much of this information was limited, and there were no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the statement of performance for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the Health Board and group's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the Health Board and group on pages 78 to 94:

- presents fairly, in all material respects, the Health Board and group's performance for the year ended 30 June 2017, including:
  - for each class of reportable outputs:
    - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
    - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
  - what has been achieved with the appropriation; and
  - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 27 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Health Board and group for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board and group for assessing the Health Board and group's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board and group or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board and group's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board and group's framework for reporting its performance.
- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board and group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board and group to cease to continue as a going concern.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board and group to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the of the group audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 30, 68 to 77 and 95 to97, but does not include the financial statements and the performance information, and our auditor's report thereon.

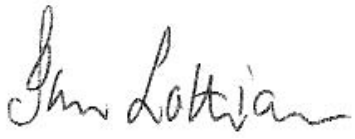
Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board and group in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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



Ian Lothian

Audit New Zealand

On behalf of the Auditor-General

Christchurch, New Zealand

Statement of Significant Accounting Policies

For the Year Ended 30 June 2017

Reporting Entity

South Canterbury District Health Board (SCDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. SCDHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. SCDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013. The DHB's ultimate parent is the New Zealand Crown.

The group consists of the ultimate parent, South Canterbury District Health Board, and its subsidiary, South Canterbury Eye Clinic Limited.

SCDHB has designated itself as a public benefit entity (PBE) for financial reporting purposes.

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

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

Reporting period

The financial statements for the DHB are for the year ended 30 June 2017, and were approved by the Board on 27th October 2017.

Statement of Compliance

The financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZGAAP).

These financial statements have been prepared in accordance with Tier 1 PBE Accounting Standards and comply with those standards.

These financial statements have been authorised for issue by the Board of SCDHB. The Board and management are responsible for ensuring that the Financial Statements are prepared using appropriate assumptions and that all disclosure requirements have been met.

Basis of Preparation

The financial statements are prepared on a going concern basis, using historical costs, except that land and buildings are stated at their fair value. Accounting policies have been applied consistently throughout the period.

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

The preparation of the financial statements in conformity with PBE accounting standards requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. Further details are given in the Accounting Policies for 'Critical accounting estimates and assumptions' and 'Critical judgements in applying accounting policies'.

Basis for Consolidation

SCDHB is required under the Crown Entities Act 2004 (the "Act") to prepare consolidated financial statements in relation to the group for each financial year. The consolidated financial statements are prepared by adding together like items of assets, liabilities, equity, revenue, and expenses in the group on a line-by-line basis. All intragroup balances, transactions, revenues, and expenses are eliminated on consolidation.

Subsidiaries

SCDHB consolidates in the group financial statements all entities where the DHB has the capacity to control their financing and operating policies so as to obtain benefits from the subsidiary. This power exists where the DHB controls the majority voting power on the governing body or where such policies have been irreversibly predetermined by the DHB or where the determination of such policies is unable to materially affect the level of potential ownership benefits that arise from the activities of the subsidiary.

The DHB will recognise goodwill where there is an excess of the consideration transferred over the net identifiable assets acquired and liabilities assumed. This difference reflects the goodwill to be recognised by the DHB. If the consideration transferred is lower than the net fair value of the DHB's interest in the identifiable assets acquired and liabilities assumed, the difference will be recognised immediately in the surplus or deficit.

The investment in subsidiaries is carried at cost in the DHB's parent entity financial statements. Information on the subsidiaries is separately disclosed in the notes to the financial statements.

Accounting Policies

The following particular accounting policies which materially affect the measurement of financial results and financial position have been applied consistently in preparing these Financial Statements:

1. Revenue

Crown Funding

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

Goods Sold and Services Rendered

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

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

Revenue relating to Service Contracts

SCDHB 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 SCDHB, 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.

Interest Revenue

Interest revenue is accrued using the effective interest rate method. The effective interest rate exactly discounts estimated future cash receipts through the expected life of the financial asset to that asset's net carrying amount. The method applies this rate to the principle outstanding to determine the interest income each period.

Donated or Subsidised Assets

Donations and bequests to SCDHB are dealt with by the Aoraki Foundation through the Health Endowment Fund.

Where a physical asset is acquired for nil or nominal consideration the fair value of the asset received is recognised as revenue in the Statement of Comprehensive Revenue and Expenses. The fair value of donated assets is determined as follows:

- For new assets, fair value is usually determined by reference to the retail price of the same or similar assets at the time the asset was received.
- For used assets, fair value is usually determined by reference to market information for assets of a similar type, condition and age.

2. Expenditure

Interest expense

Interest expense is accrued using the effective interest rate method. The effective interest rate exactly discounts estimated future cash payments through the expected life of the financial liability to that liability's net carrying amount. The method applies this rate to the principal outstanding to determine the interest expense each period.

Capital Charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Borrowing Costs

Borrowings costs are recognised as an expense in the financial year in which they are incurred.

3. Leases

Finance leases

Leases which effectively transfer to SCDHB substantially all the risks and benefits incidental to ownership of the leased items are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments. The leased assets and corresponding lease liabilities are recognised in the Statement of Financial Position. The leased assets are depreciated over the period SCDHB is expected to benefit from their use.

Operating leases

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

4. Financial Instruments

Financial Assets

Financial assets held for trading and financial assets designated at fair value through profit and loss are recorded at fair value with any realised and unrealised gains or losses recognised in the Statement of Comprehensive Revenue and Expenses. A financial asset is designated at fair value through profit and loss if acquired principally for the purpose of selling in the short term. It may also be designated into this category if the accounting treatment results in more relevant information because it either significantly reduces an accounting mismatch with related liabilities or is part of a group of financial assets that is managed and evaluated to fair value basis. Gains or losses from interest, foreign exchange and fair value movements are separately reported in the Statement of Comprehensive Revenue and Expenses.

Available-for-sale financial assets are stated at fair value, with any resultant gain or loss, expected for impairment losses, recognised directly in equity. When these assets are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the Statement of Comprehensive Revenue and Expenses.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Loans and receivables are recognised initially at fair value plus transaction costs and subsequently measured at amortised cost using the effective interest rate method. Loans and receivables issued with duration less than 12 months are recognised at their nominal value, unless the effect of discounting is material. Allowances for estimated recoverable amounts are recognised when there is objective evidence that the asset is impaired. Interest, impairment losses and foreign exchange gains and losses are recognised in the Statement of Comprehensive Revenue and Expenses.

5. 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 SCDHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

6. Trade and Other Receivables

Trade and other receivables are recorded at their face value, less any provision for impairment.

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

Bad debts are written off during the period in which they are identified.

7. Investments

Bank Term Deposits

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

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Equity investments

SCDHB's investment in Health Benefits Limited is stated at cost less impairment losses.

SCDHB'S investment in the South Canterbury Eye Clinic is stated at cost.

8. Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis is measured at the lower of cost and current replacement cost.

The cost of purchased inventory held for distribution is determined using the weighted average cost formula.

Any write down from cost to current replacement cost, or reversal of such a write down, is recognised in surplus or deficit in the period of the write down.

9. Property, Plant and Equipment

Classes of Property, Plant and Equipment

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

- freehold land
- freehold buildings
- plant, equipment and vehicles
- fixture and fittings
- work in progress

Owned assets

Land is measured at fair value and buildings are measured at fair value less accumulated depreciation. Except for the assets vested from the hospital and health service (see below), all other asset classes are stated at cost, less accumulated depreciation and impairment costs.

Fixed assets vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Health South Canterbury Limited (a Hospital and Health Service) vested in SCDHB on 1 January 2001. Accordingly, assets were transferred to SCDHB at their net book values as recorded in the books of Health South Canterbury Limited. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of Health South Canterbury Limited. The vested assets will continue to be depreciated over their remaining useful lives.

10. Revaluation of Land and Buildings

Land and Buildings are revalued with sufficient regularity, and at least every five years, to ensure that the carrying amount at balance date is not materially different to fair value. Fair value is determined by an independent registered valuer and based upon market evidence land and net replacement cost for buildings. If there is evidence supporting a material difference, then the asset class will be revalued. Revaluation movements are accounted for on a class-of-asset basis. The results of any revaluing are credited or debited to an asset revaluation reserve for that class of asset. Where this results in a debit balance in the asset revaluation reserve, this balance is expensed in the Statement of Comprehensive Revenue and Expenses. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the Statement of Comprehensive Revenue and Expenses will be recognised first in the Statement of Comprehensive Revenue and Expenses up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

11. Additions to Fixed Assets

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

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

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

Costs incurred subsequent to initial acquisition are capitalised only it is probable that future economic benefits or service potential associated with the item will flow to SCDHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

12. Disposal of Fixed Assets

When a fixed asset is disposed of, any gain or loss is recognised in the Statement of Comprehensive Revenue and Expenses and is calculated as the difference between the sale price and the carrying value of the fixed asset. When revalued assets are sold, the amounts included in the revaluation reserves in respect of those assets are transferred to general funds.

13. Depreciation of Fixed Assets

Depreciation is provided on a straight line basis on all fixed assets, other than freehold land, at rates which will write-off the cost (or revaluation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Buildings	33 to 65 years	1.5 – 3.0%
Building Fit-outs	3.5 to 20 years	5 – 28.6%
Plant and Equipment	2 to 10 years	10 – 50%
Motor Vehicles	3 to 5 years	20 – 33.3%

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.

14. Intangible Assets

Software

Computer software that is acquired by SCDHB is stated at cost less accumulated amortisation 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 software development employee costs and, if applicable, an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with development and maintenance of SCDHB's website are recognised as an expense when incurred.

Amortisation

Amortisation is charged to the Surplus or Deficit on a straight-line basis over the estimated useful lives of intangible assets from the date they are available for use. The estimated useful lives are as follows:

Software	2 to 10 years	10-50%

15. Impairment of Property, Plant and Equipment and Intangible Assets

SCDHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating Assets

Property, plant and equipment and intangible assets held at cost that have a finite useful life are reviewed at each balance date to determine whether there is any indication of impairment. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

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

If the recoverable amount of an asset is less than its carrying amount, the asset is regarded as impaired and the carrying amount is written down to its recoverable amount and an impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

16. Payables

Short term payables are recorded at their face value.

17. Borrowings

Borrowings are recognised initially at fair value plus transaction costs. Subsequent to initial recognition, all borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

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

18. Employee Entitlements

Short term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date and annual leave earned to but not yet taken at balance date.

Entitlements for retirement gratuities, senior doctor conference and sabbatical leave, long service leave, sick leave and senior doctor costs that are expected to be settled within 12 months after balance date are calculated on an actuarial basis.

Long term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as retirement gratuities, senior doctor conference and sabbatical leave, long service leave, sick leave, and senior doctor study costs are calculated on an actuarial basis.

The actuarial calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlement information, and
- assumptions of discount rates, salary escalation rates, resignation rates and (for sabbatical leave) the take up rate.

Superannuation Schemes

Defined contribution schemes

Obligations for contributions to Kiwisaver, the Government Superannuation Fund and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

SCDHB belongs to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

19. Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in "finance costs".

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Onerous contracts

A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract.

The provision is measured at the present value of the lower of the expected cost of terminating the contract and the expected net cost of continuing with the contract.

20. Equity

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

- General Funds (contributed capital);
- Accumulated surplus/(deficit);
- Equity from donated assets; and
- Property revaluation reserves

Property revaluation reserves

These reserves relate to the revaluation of land and buildings to fair value.

21. Goods and Services Tax

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the IRD is included as part of the receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from, the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

22. Taxation

SCDHB is exempt from income tax as it is a public authority.

23. Budget Figures

The budget figures are those approved by the Board and published in its Annual Plan, which is the external accountability document prepared by SCDHB under the Crown Entities Act 2004. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of the financial statements.

24. Cost Allocation

SCDHB has arrived at the net cost of service for each significant activity using the following cost allocation system. Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information. The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers, such as actual usage, staff numbers and floor area.

25. Critical Accounting Estimates and Assumptions

In preparing these financial statements, SCDHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of the assets and liabilities within the next financial year are discussed below.

Estimating the fair value of land and buildings

Land and buildings were revalued, by a registered valuer, as at 30 June 2016 to fair value. SCDHB have relied upon this valuation and the assumptions made by the valuer in determining the fair value of land and buildings. The significant assumptions applied in determining the fair value of land and buildings are disclosed in note 7.

Estimating useful lives and residual values of property, plant and equipment

At each balance date, the useful lives and residual values of property, plant and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by SCDHB and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the Statement of Financial Position. SCDHB minimises the risk of this uncertainty by:

- Physical inspection of assets;
- Asset replacement programs.

SCDHB has not made significant changes to past assumptions concerning useful lives and residual values.

Employee entitlements

SCDHB has relied upon actuarial assessment for retirement gratuities, long service leave and some other employee entitlements.

26. Critical Judgements in Applying Accounting Policies

Management has exercised the following critical judgements in applying accounting policies.

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to SCDHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the Statement of Financial Position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

SCDHB has exercised its judgement on the appropriate classification of the lease for the MRI scanner and has determined it to be a finance lease.

27. Changes in Accounting Policies

There have been no changes in accounting policies during the financial year.

Statement of Comprehensive Revenue And Expenses

for the year ended 30 June 2017
In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2017	Actual 2017	Actual 2016	Actual 2017	Actual 2016
Ministry of Health Revenue	*1*	184,002	185,508	180,165	185,514	180,361
Other Government Revenue	*1*	1,877	1,831	1,953	1,831	1,953
Other Revenue	*2*	4,271	4,170	4,019	4,271	4,069
Finance Revenue	*4a*	1,542	1,162	1,490	1,162	1,490
Total Revenue		191,692	192,671	187,627	192,778	187,873
Personnel Costs	*3*	64,909	62,426	63,161	62,275	63,150
Outsourced Services		8,271	9,214	8,791	9,351	8,888
Clinical supplies		9,616	10,198	10,123	10,269	10,166
Infrastructure and non-clinical expenses		10,168	10,088	10,585	10,240	10,697
Payments to non-DHB health providers		90,378	94,218	89,344	94,218	89,344
Depreciation and amortisation expense	*7&8*	4,234	4,286	4,179	4,299	4,191
Finance costs	*4b*	449	254	422	256	424
Capital charge	*5*	2,345	1,729	2,167	1,729	2,167
Total Expenditure		190,370	192,413	188,772	192,637	189,027
SURPLUS/(DEFICIT)		1,322	258	(1,145)	141	(1,154)
Other Comprehensive Revenue and Expenses						
Item that will not be reclassified to surplus or (deficit)						
Gain on property revaluation		-	-	1,210	-	1,210
Total Other Comprehensive Revenue and Expenses		-	-	1,210	-	1,210
TOTAL COMPREHENSIVE REVENUE AND EXPENSES		1,322	258	65	141	56

The notes form an integral part of and should be read in conjunction with these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2017
In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2017	Actual 2017	Actual 2016	Actual 2017	Actual 2016
Balance at 1 July 2016		28,680	28,734	28,885	28,725	28,885
Comprehensive revenue/ (expense)						
Net Surplus/(Deficit) for the year	9	1,322	258	(1,145)	141	(1,154)
Other Comprehensive Revenue	9	-	-	1,210	20	1,210
Total comprehensive revenue		1,322	258	65	161	56
Capital Movements						
Repayment to Crown	9	(281)	(217)	(216)	(217)	(216)
Contribution from Crown	9	-	12,778	-	12,778	-
Total of Capital Movements		(281)	12,561	(216)	12,561	(216)
Balance at 30 June 2017		29,721	41,553	28,734	41,447	28,725

The notes form an integral part of and should be read in conjunction with these financial statements.

Statement of Financial Position

as at 30 June 2017
In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2017	Actual 2017	Actual 2016	Actual 2017	Actual 2016
Public Equity						
General Funds	*9*	3,970	16,617	4,056	16,617	4,056
Accumulated Surplus	*9*	12,571	10,506	10,207	10,400	10,198
Equity from Donated Assets	*9*	1,607	1,647	1,688	1,647	1,688
Revaluation Reserve	*9*	11,573	12,783	12,783	12,783	12,783
Total Equity		29,721	41,553	28,734	41,447	28,725
REPRESENTED BY:						
ASSETS						
Current Assets						
Cash and cash equivalents	*10*	18,766	12,556	19,157	12,552	19,180
Financial Assets	*11*	-	12,778	-	12,778	-
Debtors and other receivables	*12*	5,245	6,697	5,800	6,604	5,809
Inventories	*13*	900	1,163	905	1,163	905
Patient Trust Funds	*10*	-	13	10	13	10
Total Current Assets		24,911	33,207	25,872	33,110	25,904
Non Current Assets						
Financial Assets	*11*	13,769	991	13,770	734	13,512
Property, plant and equipment	*7*	34,476	35,814	35,766	35,883	35,826
Intangible assets	*8*	2,051	2,168	1,934	2,368	2,134
Total Non Current Assets		50,296	38,973	51,470	38,985	51,472
TOTAL ASSETS		75,207	72,180	77,342	72,095	77,376
LIABILITIES						
Current Liabilities						
Creditors and other payables	*14*	13,816	12,164	15,083	12,140	15,090
Employee entitlements	*15*	9,814	9,518	9,952	9,562	9,988
Borrowings	*16*	66	66	66	66	66
Finance Lease Liability	*17*	169	169	169	169	169
Patient Trust Funds	*10*	-	13	10	13	10
Total Current Liabilities		23,865	21,930	25,280	21,950	25,323
Non Current Liabilities						
Term Loans	*16*	12,994	115	12,959	115	12,959
Finance Lease Liability	*17*	1,180	674	843	675	843
Employee Entitlements	*15*	7,447	7,908	9,526	7,908	9,526
Total Non Current Liabilities		21,621	8,697	23,328	8,698	23,328
TOTAL LIABILITIES		45,486	30,627	48,608	30,648	48,651
NET ASSETS		29,721	41,553	28,734	41,447	28,725

The notes form an integral part of and should be read in conjunction with these financial statements.

Statement of Cashflows

as at 30 June 2017
In thousands of New Zealand Dollars

	Note	Parent			Group	
		Budget 2017	Actual 2017	Actual 2016	Actual 2017	Actual 2016
CASH FROM OPERATING ACTIVITIES						
Cash was provided from:						
Receipts from Ministry of Health & Other Revenue		191,691	192,350	186,284	192,547	186,521
Interest Received		1,542	1,162	1,490	1,162	1,490
		193,233	193,512	187,774	193,709	188,011
Cash was applied to:						
Payments to suppliers & employees		184,992	192,484	178,765	193,256	179,000
Capital Charge		1,520	1,729	2,167	1,729	2,167
Interest Paid		412	253	422	256	424
GST (net)		-	638	(183)	65	(219)
		186,924	195,104	181,171	195,306	181,372
Net cash inflow/(outflow) from operating activities	*18*	6,309	(1,592)	6,603	(1,597)	6,639
CASH FROM INVESTING ACTIVITIES						
Cash was provided from:						
Proceeds from the sale of assets		-	10	10	10	10
Proceeds from Sale of Investment		-	-	-	-	-
Term Deposits Matured		-	-	3,000	-	3,000
Decrease in Special Funds		-	-	-	-	-
		-	10	3,010	10	3,010
Cash was applied to:						
Purchase of fixed assets		9,114	4,568	6,210	4,590	6,280
Purchase of Investments		-	-	257	-	-
Purchase of Goodwill		-	-	-	-	200
Term Deposits over 1 year		-	-	-	-	-
		9,114	4,568	6,467	4,590	6,480
Net cash inflow/(outflow) from investing activities		(9,114)	(4,558)	(3,457)	(4,580)	(3,470)

The notes form an integral part of and should be read in conjunction with these financial statements.

	Note	Parent			Group	
		Budget 2017	Actual 2017	Actual 2016	Actual 2017	Actual 2016
CASH FLOWS FROM FINANCING ACTIVITIES						
Cash was provided from:						
New Borrowings - MOH		-	-	-	-	-
New Borrowings - Energy Efficiency		-	-	-	-	-
New Finance Lease		-	-	-	-	-
Proceeds from Equity injections		-	-	-	-	-
		-	-	-	-	-
Cash was applied to:						
Finance Lease repayment		-	169	168	169	168
Repayment of Loans		-	66	68	66	68
Repayment of Equity		216	216	216	216	216
		216	451	452	451	452
Net cash inflow/(outflow) from financing activities		(216)	(451)	(452)	(451)	(452)
Net increase/(decrease) in cash held		(3,021)	(6,601)	2,694	(6,628)	2,717
Opening cash and cash equivalents		21,787	19,157	16,463	19,180	16,463
Closing cash and cash equivalents	*10*	18,766	12,556	19,157	12,552	19,180
Made up of:						
Balances at bank		18,766	12,556	19,157	12,552	19,180

The GST (net) component of operating activities reflects net GST paid and received with the Inland Revenue Department. The GST (net) component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statements purposes.

On 15 February 2017 the Crown loan of $12,778,000 was converted into Crown equity by a non-cash transaction.

The notes form an integral part of and should be read in conjunction with these financial statements.

Notes to the Financial Statements

for the year ended 30 June 2017
In thousands of New Zealand Dollars

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
1. Revenue				
MOH Contracted Revenue	181,140	176,047	181,146	176,243
Inter District Patient Inflows	4,368	4,118	4,368	4,118
	185,508	180,165	185,514	180,361
ACC Contracted Revenue	1,831	1,953	1,831	1,953
	187,339	182,118	187,345	182,314

Under the Public Finance Act, South Canterbury District Health Board is required to disclose the appropriation of the revenue provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of the funding. The appropriation revenue received by the DHB in the financial year 2016/17 is $179,360,000 (2015/16: $167,795,000), which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the Statement of Service Performance.

2. Other Revenue				
Patient and consumer sourced revenue	1,807	1,723	1,908	1,773
Gain on sale of property, plant and equipment	11	11	11	11
Donations and bequests received	-	-	-	-
Rental Income	168	128	168	128
Other Revenue	2,184	2,157	2,184	2,157
	4,170	4,019	4,271	4,069
3. Personnel Costs				
Wages, salaries and outsourced personnel	63,021	61,315	62,858	61,287
Contributions to defined contribution plans	1,457	1,311	1,464	1,317
Increase /(decrease) in employee benefit provisions	(2,052)	535	(2,047)	546
	62,426	63,161	62,275	63,150

Employer contributions to defined contribution plans include contributions to Kiwisaver, State Sector Retirement Savings Scheme and the DPB Contributors Scheme

4a Finance revenue				
Interest Revenue	1,162	1,490	1,162	1,490
	1,162	1,490	1,162	1,490
4b Finance costs				
Interest Expense	254	422	256	424
	256	422	256	424

for the year ended 30 June 2017
In thousands of New Zealand Dollars

5. Capital charge

SCDHB pays a monthly capital charge to the Crown based on the greater of its actual or planned closing equity balance for the month. An annual washup adjustment is done after 30 June each year. The capital charge rate for the year ended 30 June 2017 was 7% for the first six months and 6% for the remainder of the year (2016: 8%).

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
6. Other operating expenses				
Fees to Auditor:				
Audit fees for financial statement audit	122	119	135	133
Directors' fees and expenses	317	333	317	333
Impairment of receivables (bad & doubtful debts)	4	29	4	29
Write down of inventory	46	92	46	92
Operating Lease Expense	743	856	814	896
	1,232	1,429	1,316	1,483

Operating Leases. The DHB leases a number of residential buildings and equipment (including office and clinical equipment). The leases terms vary, typically from one to 5 years. None of the leases include contingent rentals.

for the year ended 30 June 2017
In thousands of New Zealand Dollars

7a. Property, plant and equipment - Group

	Land	Buildings	Plant & equipment	Leased Assets	Motor vehicles	Work in Progress	TOTAL
Cost or Valuation							
Balance at 1 July 2015	2,938	21,484	28,839	1,686	2,108	3,479	60,534
Additions	-	3,816	3,783	-	43	(2,848)	4,794
Revaluations	400	(2,207)	-	-	-	-	(1,807)
Disposals	-	-	(393)	-	(151)	-	(544)
Balance at 30 June 2016	3,338	23,093	32,229	1,686	2,000	631	62,977
Balance at 1 July 2016	3,338	23,093	32,229	1,686	2,000	631	62,977
Additions	-	749	2,295	-	-	990	4,034
Revaluations	-	-	-	-	-	-	-
Disposals	-	-	(73)	-	(47)	-	(120)
Balance at 30 June 2017	3,338	23,842	34,451	1,686	1,953	1,621	66,891
Accumulated depreciation and impairment losses							
Balance at 1 July 2015	-	1,534	23,343	379	1,587	-	26,843
Depreciation expense	-	1,550	1,978	168	174	-	3,870
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	(393)	-	(151)	-	(544)
Revaluations	-	(3,017)	-	-	-	-	(3,017)
Balance at 30 June 2016	-	67	24,928	547	1,610	-	27,152
Balance at 1 July 2016	-	67	24,928	547	1,610	-	27,152
Depreciation expense	-	1,495	2,152	169	159	-	3,975
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	(73)	-	(46)	-	(119)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2017	-	1,562	27,007	716	1,723	-	31,008
Carrying amounts							
At 1 July 2015	2,938	19,950	5,496	1,307	521	3,479	33,691
At 30 June and 1 July 2016	3,338	23,027	7,301	1,139	390	631	35,826
At 30 June 2017	3,338	22,280	7,444	970	230	1,621	35,883

for the year ended 30 June 2017
In thousands of New Zealand Dollars

7b. Property, plant and equipment – Parent

	Land	Buildings	Plant & equipment	Leased Assets	Motor vehicles	Work in Progress	TOTAL
Cost or Valuation							
Balance at 1 July 2015	2,938	21,484	28,839	1,686	2,108	3,479	60,534
Additions	-	3,816	3,712	-	43	(2,848)	4,723
Revaluations	400	(2,207)	-	-	-	-	(1,807)
Disposals	-	-	(393)	-	(151)	-	(544)
Balance at 30 June 2016	3,338	23,093	32,158	1,686	2,000	631	62,906
Balance at 1 July 2016	3,338	23,093	32,158	1,686	2,000	631	62,906
Additions	-	749	2,273	-	-	990	4,012
Revaluations	-	-	-	-	-	-	-
Disposals	-	-	(73)	-	(47)	-	(120)
Balance at 30 June 2017	3,338	23,842	34,358	1,686	1,953	1,621	66,798
Accumulated depreciation and impairment losses							
Balance at 1 July 2015	-	1,534	23,343	379	1,587	-	26,842
Depreciation expense	-	1,550	1,966	168	174	-	3,859
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	(393)	-	(151)	-	(544)
Revaluations	-	(3,017)	-	-	-	-	(3,017)
Balance at 30 June 2016	-	67	24,916	547	1,610	-	27,140
Balance at 1 July 2016	-	67	24,916	547	1,610	-	27,140
Depreciation expense	-	1,495	2,140	169	159	-	3,963
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	(73)	-	(46)	-	(119)
Revaluations	-	-	-	-	-	-	-
Balance at 30 June 2017	-	1,562	26,983	716	1,723	-	30,984
Carrying amounts							
At 1 July 2015	2,938	19,950	5,496	1,307	521	3,479	33,691
At 30 June and 1 July 2016	3,338	23,026	7,242	1,139	390	631	35,766
At 30 June 2017	3,338	22,280	7,375	970	230	1,621	35,814

for the year ended 30 June 2017
In thousands of New Zealand Dollars

Impairment

Impairment testing carried out has not revealed any assets requiring write-down due to impairment losses.

Valuation

Land and Buildings were valued to fair value as at 30 June 2016 by an independent registered valuer, John Dunckley, of Colliers International, a Fellow of the Property Institute and Institute of Valuers of New Zealand. The total fair value of land and buildings valued by the valuer amounted to $26,161,695 as at 30 June 2016. The valuation conforms to International valuation standards and was based on an optimised depreciated replacement cost methodology.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the "unencumbered" land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensely.

Restrictions on the DHB's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the replacement with modern equivalent assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For the DHB's earthquake prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost.
- The remaining useful life of the assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates are applied to reflect market value. These valuations include adjustments for estimated building strengthening costs for earthquake prone buildings and the associated lost rental during the time to undertake the strengthening work.

Restrictions on title

South Canterbury District Health Board does not have full title to Crown land it occupies, but transfer is arranged if and when land is sold. Some of the Board's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to SCDHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1988). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

for the year ended 30 June 2017
In thousands of New Zealand Dollars

8. Intangible Assets

Parent & Group	Software	Other	TOTAL
Cost			
Balance at 1 July 2015	2,296	-	2,296
Additions	1,487	200	1,687
Disposals	-	-	-
Balance at 30 June 2016	3,783	200	3,983
Balance at 1 July 2016	3,783	200	3,983
Additions	559	-	559
Disposals	-	-	-
Balance at 30 June 2017	4,342	200	4,542
Accumulated amortisation and impairment losses			
Balance at 1 July 2015	1,528	-	1,528
Amortisation expense	321	-	321
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2016	1,849	-	1,849
Balance at 1 July 2016	1,849	-	1,849
Amortisation expense	325	-	325
Disposals	-	-	-
Impairment losses	-	-	-
Balance at 30 June 2017	2,174	-	2,174
Carrying amounts			
At 1 July 2015	768	-	768
At 30 June and 1 July 2016	1,934	200	2,134
At 30 June 2017	2,168	200	2,368

Other intangible assets comprises goodwill paid on the purchase of the business of Timaru Eye Clinic Limited. The business has been incorporated into South Canterbury Eye Clinic Limited.

There are no restrictions over the title of SCDHB's intangible assets, nor are any intangible assets pledged as security for liabilities. All software has been purchased.

for the year ended 30 June 2017
In thousands of New Zealand Dollars

9. Public equity

9a) Reconciliation of movement in capital and reserves – Group

Group	General funds	Accumulated Surplus	Equity from donated assets	Revaluation reserve - land	Revaluation reserve - buildings	Total equity
Balance at 1 July 2015	4,272	11,319	1,721	2,560	9,013	28,885
Surplus/(deficit) - DHB	-	(1,145)	-	-	-	(1,145)
Surplus/(deficit) - Subsidiary	-	(9)	-	-	-	(9)
Transfer from accumulated surplus	-	33	(33)	-	-	-
Revaluation of land and buildings	-	-	-	400	810	1,210
Contributed capital from the Crown	-	-	-	-	-	-
Repayment to the Crown	(216)	-	-	-	-	(216)
Balance at 30 June 2016	4,056	10,198	1,688	2,960	9,823	28,725
Balance at 1 July 2016	4,056	10,198	1,688	2,960	9,823	28,725
Surplus/(deficit) - DHB	-	258	-	-	-	258
Surplus/(deficit) - Subsidiary	-	(117)	-	-	-	(117)
Subsidiary (prior year adjustment)	-	20	-	-	-	20
Transfer from accumulated surplus	-	41	(41)	-	-	-
Revaluation of land and buildings	-	-	-	-	-	-
Conversion of Crown loan to Crown equity	12,778	-	-	-	-	12,778
Repayment to the Crown	(217)	-	-	-	-	(217)
Balance at 30 June 2017	16,617	10,400	1,647	2,960	9,823	41,447

9b) Reconciliation of movement in capital and reserves – Parent

	General funds	Accumulated Surplus	Equity from donated assets	Revaluation reserve - land	Revaluation reserve - buildings	Total equity
Balance at 1 July 2015	4,272	11,319	1,721	2,560	9,013	28,885
Surplus/(deficit)	-	(1,145)	-	-	-	(1,145)
Transfer from accumulated surplus	-	33	(33)	-	-	-
Revaluation of land and buildings	-	-	-	400	810	1,210
Contribution from the Crown	-	-	-	-	-	-
Repayment to the Crown	(216)	-	-	-	-	(216)
Repayment of equity	-	-	-	-	-	-
Balance at 30 June 2016	4,056	10,207	1,688	2,960	9,823	28,734
Balance at 1 July 2016	4,056	10,207	1,688	2,960	9,823	28,734
Surplus/(deficit) - DHB	-	258	-	-		258
Transfer from accumulated surplus	-	41	(41)	-	-	-
Revaluation of land and buildings	-	-	-	-	-	-
Conversion of Crown loan to Crown equity	12,778	-	-	-	-	12,778
Repayment to the Crown	(217)	-	-	-	-	(217)
Balance at 30 June 2017	16,617	10,506	1,647	2,960	9,823	41,553

The unspent mental health ring-fence portion of retained earnings decreased to $0.524 million (30 June 2016: $0.580 million).

for the year ended 30 June 2017
In thousands of New Zealand Dollars

10. Cash and cash equivalents

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Cash on hand and at bank	(1)	2	(5)	25
Cash equivalents – term deposits	-	-	-	-
Other cash and cash equivalents	12,557	19,155	12,557	19,155
Total cash and cash equivalents	12,556	19,157	12,552	19,180

The carrying value of cash at bank and term deposits with maturity dates of three months or less approximates their fair value.

SCDHB administers certain funds on behalf of patients. These funds are held in a separate bank account and total $13,258 (2016: $10,253)

11. Investments

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Current investments are represented by:				
Term deposits	12,778	-	12,778	-
Total current portion	12,778	-	12,778	-
Non-current investments are represented by:				
Term deposits	-	12,778	-	12,778
Shares in NZ Health Partnership Limited	734	734	734	734
Investment in Subsidiary	257	258	-	-
Total non-current portion	991	13,770	734	13,512
Total Investments	13,769	13,770	13,512	13,512

Unlisted Shares

The DHB had an equity investment in NZ Health Partnership Limited ("HPL"). HPL proposes to implement finance, procurement and supply chain shared services on behalf of all New Zealand District Health Boards ("DHBs"). Capital contributions have been made to HPL by the DHBs by the issue of B Class shares. NZ Health Partnership Limited is an unlisted company. Accordingly, there are no published price quotations for this investment.

Investment in Subsidiary

South Canterbury Eye Clinic Limited ("SCEC") is a wholly owned subsidiary company of the DHB. SCEC was incorporated on 6 August 2015 with a share capital of $10,000, for the purpose of taking over the business of an existing ophthamology practice. The Company provides public and private ophthamology services in South Canterbury. The investment is valued at cost.

There were no impairment provisions for investments.

Maturity Analysis and Effective Interest Rates of Term Deposits

SCDHB maintains deposits on call with NZ Health Partnership Limited at variable rates of interest and these are measured at cost.

Two term deposits have been taken for a term longer than 12 months. The deposits mature in June 2018 and have an effective average interest rate of 4.57%.

The carrying amounts of call and term deposits with maturities less than 12 months approximate their fair value.

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12. Debtors and other receivables

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Trade Debtors	1,124	780	1,031	789
Less: Provision for impairment	-	6	-	6
	1,124	774	1,031	783
Accrued Income	4,622	4,972	4,622	4,972
Prepayments	951	54	951	54
Total receivables & prepayments	6,697	5,800	6,604	5,809
Receivables from sale of goods and services (exchange transactions)	3,766	2,859	3,673	2,868
Receivables from grants (non-exchange transactions)	2,931	2,941	2,931	2,941

The carrying value of receivables approximates their fair value.

Trade debtors have been evaluated for impairment and, where impairment has been identified, provision has been made. Movements in the provision for impairment of receivables are as follows:

Balance at 1 July	(6)	(4)
Additional provisions made	-	(6)
Receivables written off	6	4
Recovery of amounts already provided	-	-
Balance at 30 June	-	(6)

13. Inventories

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Pharmaceuticals	236	219	236	219
Theatre supplies	511	466	511	466
Central stores	328	126	328	126
Other supplies	88	94	88	94
Total inventories	1,163	905	1,163	905

The write-down of inventories held for distribution amounted to $149,181 (2016: $91,714). There have been no reversals of write-downs.

No inventories are pledged as security for liabilities but some inventories are subject to retention of title clauses (Romalpa clauses).

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14. Creditors and other payables

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Trade creditors	1,382	1,584	1,337	1,591
Capital Charge due	-	36	-	36
Income in advance	1,006	205	1,006	205
Accrued expenses	8,088	10,721	8,104	10,721
Taxes payable (GST and PAYE)	1,688	2,537	1,693	2,537
Total Payables and Accruals	12,164	15,083	12,140	15,090
Payables for goods and services (exchange transactions)	10,476	12,546	10,447	12,553
Payables for taxes payable (non-exchange transactions)	1,688	2,537	1,693	2,537

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of creditors and other payables approximates their fair value.

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15. Employee entitlements

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Current employee entitlements are represented by:				
Accrued salaries and wages	1,235	1,578	1,240	1,582
Annual Leave	6,016	6,236	6,042	6,255
Maternity Leave	-	(3)	-	(3)
Sick Leave	175	214	188	227
Retirement Gratuities	1,109	843	1,109	843
Senior Doctor Conference Leave	200	201	200	201
Senior Doctor Sabbatical Leave	29	21	29	21
Long Service Leave	442	251	442	251
Senior Doctor Study Costs	312	368	312	368
Restructuring Provision	-	243	-	243
Total current portion	9,518	9,952	9,562	9,988
Non-current employee entitlements are represented by:				
Sick Leave	369	404	369	404
Retirement Gratuities	3,976	4,610	3,976	4,610
Senior Doctor Conference Leave	400	402	400	402
Senior Doctor Sabbatical Leave	481	391	481	391
Long Service Leave	738	1,012	738	1,012
Senior Doctor Study Costs	624	736	624	736
Restructuring Provision	1,320	1,971	1,320	1,971
Total non-current portion	7,908	9,526	7,908	9,526
Total employee entitlements	17,426	19,478	17,470	19,514

Employee entitlements for retirement gratuities, senior doctor conference leave, senior doctor sabbatical leave, long service leave, sick leave and senior doctor study costs were actuarially revalued as at 30 June 2017 by Aon Consulting services NZ Ltd. The most important key assumptions used in calculating this liability include the discount rates, the salary escalation rate, resignation rates and (for sabbatical leave) the take up rate. Any changes to these assumptions will affect the carrying amount of the liability.

The private and public sector have experienced widespread payroll issues relating to the Holiday's Act and employment agreements. This is particularly applicable for a workforce with rostered employees working on varying work patterns. A proactive approach to finding a long term pay process solution is currently being undertaken by management to identify risk areas focusing on systems, reporting and analytics, people and processes.

Since the issues are currently being reviewed the holiday pay provision recognised is estimated based on the best information available at the date of this annual report. Once the issues have been resolved the actual liability may be different.

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	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Restructuring provision				
Balance at 1 July	2,214	2,070	2,214	2,070
Additional provision made	-	306	-	306
Amounts used	(894)	(9)	(894)	(9)
Disused amounts reversed	-	(153)	-	(153)
Balance at 30 June	1,320	2,214	1,320	2,214

The restructuring provision represents the estimated cost for redundancy payments arising from the management restructure, which was announced in June 2016 and the Talbot Park restructure.

16. Borrowings

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Current borrowings are represented by:				
Secured Crown loan - Ministry of Health (MOH)				
Current portion	-	-	-	-
Non current portion	-	12,778	-	12,778
	-	12,778	-	12,778
Energy Efficiency and Conservation Authority (EECA)				
Current portion	66	66	66	66
Non current portion	115	181	115	181
	181	247	181	247
Repayable as follows:				
Not later than one year	66	66	66	66
Later than one, not later than two years	66	66	66	66
Later than two, not later than five years	49	12,893	49	12,893
Beyond five years	-	-	-	-
	181	13,025	181	13,025
Interest rates:				
Ministry of Health interest rates	3.23%	3.23%	3.23%	3.23%

Crown Loans
Crown loans are secured by a negative pledge. Without the MOH's prior written consent, SCDHB cannot perform the following actions:

a. Security Interest: Create any security interest over its assets except in certain defined circumstances or

b. Loans and Guarantees: Lend money to another person (except in the ordinary course of business and then only on commercial terms), or give a guarantee, or

c. Change of Business: Make a substantial change in the nature or scope of its business as presently conducted, or

d. Disposals: Dispose of any of its assets except disposals made in the course of its ordinary business or disposals for full year value.

Conversion of existing Crown loans to Crown equity
In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity. The conversion is disclosed in Note 9.

On the 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.As a consequence of the changes there has been a decrease in the 2017 financial year for the interest costs avoided from the conversion date until the 30 June 2017 and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

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17. Finance Lease Liability

SCDHB has entered into a finance lease with Aoraki MRI Charitable Trust for the purchase of MRI scanner equipment. The lease is over a period of ten years from April 2013 and no interest or finance charges are payable.

Finance lease liabilities are payable as follows:

	Parent and Group	
	Actual 2017	**Actual 2016**
Not later than one year	169	169
Later than one year and not later than five years	674	674
Later than five years	-	169
Total present value of minimum lease payments	843	1,012
Current portion	169	169
Non current portion	674	843
Total present value of minimum lease payments	843	1,012

Finance Lease

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default.

18. Reconciliation of net surplus/(deficit) to net cash from operating activities

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Net surplus/(deficit) after taxation	258	(1,145)	141	(1,154)
Add/(less) non-cash items:				
Depreciation and amortisation expense	4,286	4,179	4,299	4,190
Total non cash items	4,268	4,179	4,299	4,190
Add/(less) item classified as investment activity:				
Increase (decrease) in investments	-	-	-	-
Total investing activity items	-	-	-	-
Add/(less) movements in working capital items:				
(Increase)/decrease in receivables and prepayments	(898)	80	(795)	70
(Increase)/decrease in inventories	(257)	(40)	(257)	(40)
Increase/(decrease) in payables and accruals	(3,352)	3,342	(3,356)	3,385
Increase/(decrease) in employee entitlements	(1,618)	198	(1,618)	198
Net working capital movement	(6,125)	3,580	(6,026)	3,613
Add/(less) movements in other items:				
Loss/(Gain) on sale of fixed assets	(11)	(10)	(11)	(10)
	(11)	(10)	(11)	(10)
Net cash (outflow)/inflow from operating activities	(1,592)	6,603	(1,597)	6,639

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19. Capital Commitments and Operating Leases

	Parent		Group	
	Actual 2017	**Actual 2016**	**Actual 2017**	**Actual 2016**
Capital Commitments				
Buildings	-	191	-	191
Plant and equipment	-	-	-	-
Information technology	2,534	3,448	2,534	3,448
Total Capital Commitments	2,534	3,639	2,534	3,639

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

Operating Leases as Lessee

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

Not later than one year	357	266	396	266
Later than one year and not later than five years	367	681	409	681
Later than five years	-	-	-	-
Total Non-cancellable Operating Leases	724	947	805	947

The DHB leases a number of buildings, vehicles and office equipment under operating leases.

20. Contingencies

Contingent Liabilities

Superannuation Schemes

SCDHB is a participating employer in the National Provident Fund's Defined Benefit Plan Contributors' Scheme (the scheme) which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the scheme, the DHB could be responsible for the entire deficit of the scheme. Similarly if a number of the employers ceased to participate in the scheme, SCDHB could be responsible for an increased share of the deficit.

As at 31 March 2012, the Scheme had a past surplus of $19.833 million (exclusive of Employer Superannuation Contribution Tax). This surplus was calculated using a discount rate equal to the expected return on net assets, but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 25.

The actuary of the Scheme has recommended that the employer contributions be suspended with effect from 1 April 2013.

Lawsuits against the DHB

There is a legal dispute outstanding (SCDHB v Sanderson & Ors). This matter is a dispute regarding the employee's claim that they should have been paid the minimum wage whilst on call. According to DHB's lawyers (Dundan Street Employment Lawyers) the estimated maximum financial exposure could be up to $350,000 and that there is a reasonable chance that SCDHB will be unsuccessful in this proceeding, and will therefore become liable for damage.

Contingent Assets

The DHB has no contingent assets (2016 $nil).

21. HSC Charitable Trust

SCDHB's predecessor was the settlor of HSC Charitable Trust (the "Trust") and the Board has the right to appoint one of four trustees. The Trust is therefore deemed to be controlled by SCDHB in accordance with IPSAS 6. The purposes of the Trust are:

- To purchase and maintain facilities and equipment for use in the Timaru and Talbot Hospitals.
- To actively foster, promote, encourage and develop the continuing education of health professionals working at or from Timaru or Talbot Hospitals in whatever area and in whichever manner the trustees may time to time decide.
- To fund, foster, promote and encourage medical research and clinical quality assurance by health professionals at Timaru and Talbot Hospitals.

The Trust has not been consolidated. For the year ended 30 June 2017, the Trust had total revenue of $6,379 (2016 $3,791) and a net surplus of $2,003 (2016 net deficit $7,226). The Trust had assets of $135,975 (2016 $133,972) and liabilities of $nil (2016 $nil) as at 30 June 2017. These figures are unaudited and it is planned to wind up the Trust in 2018.

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22. Related party transactions and key management personnel

South Canterbury District Health Board is a wholly owned entity of the Crown. The Government significantly influences the role of the Board as well as being its major source of revenue.

South Canterbury District Health Board enters into transactions with Government departments, state-owned enterprises and other Crown entities. Those transactions that occur within a normal supplier or client relationship on terms no more or less favourable than those which it is reasonable to expect South Canterbury District Health Board would have adopted if dealing with that entity at arm's length in the same circumstances have not been disclosed as related party transactions.

The following transactions were carried out with related parties other than those outlined above:

Shared Support Services

NZ Health Partnership Limited has been set up to implement Finance, Procurement and Supply Chain Services for all New Zealand District Health Boards. The programme will be funded by the District Health Boards making operating and capital contributions. The capital contributions are to be contributed by the issue of "B" Class shares.

During the year South Canterbury District Health Board paid NZ Health Partnership Limited $142,247 (2016: $275,965) as a contribution to operating expenditure and $nil (2016 $nil) for "B" Class shares. The balance outstanding at year end was $nil (2016: $26,058).

HSC Charitable Trust

During the year ended 30 June 2017 the DHB invoiced the Trust a total of $nil (2016 $337). The balance outstanding at year end was $nil (2016 $nil).

Key management personnel

Key management personnel include all Board members, the Chief Executive, and the other seven members of the senior leadership team.

There have been no transactions between the members or senior leadership with the Board in any capacity other than that in which they are employed except as follows:

- Ron Luxton is the chairperson of Aoraki MRI Charitable Trust ("the Trust"). The Trust was established to raise funds for the provision of an MRI scanner, building and associated equipment for the benefit of the people of South Canterbury. In 2013 the Trust donated $1.2M to SCDHB for a building to house the MRI scanner, purchasing associated anaesthetic equipment and implementing the MRI service. The Trust also entered into a lease with the DHB for the provision of an MRI scanner. Details of the lease are disclosed in Note 17.

There are close family members of key management personnel employed by SCDHB. The terms and conditions of those arrangements are no more favourable than the DHB would have adopted if there were no relationship to key management personnel.

No provision has been required, nor any expense recognised for impairment of receivables from related parties (2016 nil).

Key management personnel compensation

	Actual 2017	Actual 2016
Board Members		
Remuneration	279	274
Full-time equivalent members	1.3	1.3
Leadership Team		
Remuneration	1,401	2,233
Full-time equivalent members	8.0	11.0
Total key management personnel remuneration	1,680	2,507
Total Full-time equivalent personnel	9.3	12.3

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23. Board Member Remuneration and Committee Member Payments

Board Members Payments & Attendance

Member	Fees Paid	Attendance
Paul Annear (acting deputy chairperson)	$17,680	11
Peter Binns	$16,320	11
Michael Boorer	$16,320	11
Murray Cleverley (chairperson part year)	$29,200	7
Rene Crawford	$16,320	10
Raeleen de Joux	$16,320	10
Terry Kennedy	$16,320	11
Ron Luxton (acting chairperson part year)	$25,900	10
Edie Moke	$16,320	11
Murray Roberts	$16,320	10
Mark Rogers	$8,160	6
Ngaire Whytock	$8,160	5
TOTAL	$203,340	

The Board met 11 times in 2016/17

Committee Members Payments

Member	Fees Paid
Paul Annear	$6,094
Peter Binns	$5,000
Michael Boorer	$5,000
Wendy Buchanan	$682
John Christie	$417
Murray Cleverley	$10,417
Rene Crawford	$5,000
Jane Cullimore	$909
Raeleen De Joux	$10,104
Suzanne Eddington	$5,379
Sally Feely	$416
Kevin Foley	$1,250
Gareth Ford	$208
Janet Gilbert	$1,250
Tony Gilchrist	$1,250
Suzanne Harrex	$417
Suzanne Hollick	$417
David Jack	$1,250
Rebecca Jackson	$417
John Keenan	$417
Karen Kennedy	$682
Terry Kennedy	$5,000
Neil Kiddey	$909
Lik W Loh	$682
Ronald Luxton	$9,166
Mary McSherry	$1,818
Edie Moke	$5,833
Pamela Niles	$1,667
Diane Nutsford	$1,250
Wendy Odey	$833
Roberta Paterson	$208
Murray Roberts	$5,625
Mark Rogers	$5,000
Juliette Stevenson	$2,083
Karl Te Raki	$2,083
Joanne Tinkler	$909
Koriana Waller	$2,083
Brenda Warren	$417
Deborah Whaturia	$833
Ngaire Whytock	$3,021
Margaret Wiberg	$1,250
TOTAL	$107,646

Member Liability Insurance

SCDHB has effected Directors and Officers Liability, General Liability, Employers Liability and Professional Indemnity insurance cover during the financial year, in respect of the liability or costs of Board members and employees.

Termination Benefits

During the year ended 30 June 2017, no Board members received compensation or other benefits in relation to cessation of employment (2016: nil).

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24. Employee remuneration

Range	Actual 2017	Actual 2016
$480,001 - $490,000	-	1
$410,001 - $480,000	-	-
$400,001 - $410,000	1	-
$390,001 - $400,000	-	1
$370,001 - $380,000	3	1
$360,001 - $370,000	1	1
$350,001 - $360,000	2	3
$340,001 - $350,000	-	2
$330,001 - $340,000	2	2
$320,001 - $330,000	3	1
$310,001 - $320,000	1	2
$300,001 - $310,000	3	2
$290,001 - $300,000	3	3
$280,001 - $290,000	2	3
$270,001 - $280,000	3	2
$260,001 - $270,000	2	1
$250,001 - $260,000	2	3
$240,001 - $250,000	4	3
$230,001 - $240,000	3	3
$220,001 - $230,000	1	4
$210,001 - $220,000	1	1
$200,001 - $210,000	3	-
$190,001 - $200,000	-	-
$180,001 - $190,000	2	-
$170,001 - $180,000	-	1
$160,001 - $170,000	2	2
$150,001 - $160,000	3	2
$140,001 - $150,000	1	4
$130,001 - $140,000	3	3
$120,001 - $130,000	8	3
$110,001 - $120,000	13	9
$100,001 - $110,000	22	23
TOTAL	94	86
Clinical staff	73	60
Management and other staff	21	26

The current Chief Executive's salary is in the $330,001 to $340,000 range.

Termination Benefits (IPSAS 25)

During the year ended 30 June 2017, 74 employees (2016: ten) were paid or were payable compensation and other benefits in relation to the cessation of their employment to the valueof $684,950 (2016: $328,679).

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25. Financial instrument risks

South Canterbury District Health Board is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, trade creditors and loans.

The Board has a series of policies providing risk management for interest rates, operating and capital expenditures denominated in a foreign currency, and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury activites. Its policies do not allow any transactions which are speculative in nature to be entered into.

Market risk

The interest rates on SCDHB's cash and investments are disclosed in notes 10 and 11. Interest rates on borrowings are disclosed in note 16.

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. SCDHB's exposure to fair value interest rate risk is limited to its bank deposits and borrowings which are held at fixed rates of interest.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from a financial instrument will fluctuate because of a change in market interest rates. Investments and borrowings issued at variable interest rates expose SCDHB to cash flow interest rate risk.

SCDHB's treasury policy requires a spread of investment and borrowing maturity dates and a limit on variable rate percentages of total investments or borrowings. SCDHB currently has no variable interest rate investments or borrowings.

SCDHB's treasury policy is conservative and as such tends not to adopt a view as to interest rate outlook. Interest rate derivates are thus not used to manage interest rate risk.

Sensitivity analysis

As at 30 June 2017, if the 90 day bank bill rate had been 50 basis points higher or lower, with all other variables held constant, the surplus for the year would have been $64,000 (2016 $96,000) higher or lower. This movement is attributable to increased or decreased interest revenue on cash at bank and short term bank deposits. Borrowings and longer term deposits are at fixed rates.

Foreign currency risk:

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. SCDHB's Treasury policy allows for exchange hedging. However, there were no foreign currency forward exchange contracts (or option agreements) in place as at 30 June 2017 (30 June 2016 Nil), nor were any hedged transactions undertaken during the course of the last two financial years.

Credit Risk:

Credit risk is the risk that a third party will default on its obligation to the Board, causing the Board to incur a loss.

Financial instruments which potentially subject the Board to concentrations of risk consist principally of cash and short term investments, and trade receivables. The maximum exposure to credit risk exposure for each class of financial instrument is as follows:

	Parent		Group	
	Actual 2017	Actual 2016	Actual 2017	Actual 2016
Cash at bank, term deposits and patients funds	25,347	19,168	25,343	19,190
Debtors and Other Receivables	6,697	5,800	6,604	5,809
	32,044	24,968	31,947	24,999

The Board invests in high quality financial institutions, local and government stock and limits the amount of credit exposure to any one financial institution. Accordingly, the Board does not require any collateral or security to support financial instruments with organisations it deals with.

Concentration of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health for 96% (2016: 96%) of South Canterbury District Health Board's revenue. However the Ministry of Health is a high credit quality entity, being the Government-funded purchaser of health and disability support services.

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Credit Quality of Financial Assets:

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates.

	Parent		Group	
	Actual 2017	Actual 2016	Actual 2017	Actual 2016
COUNTERPARTIES WITH CREDIT RATINGS				
Cash at bank and term deposits				
AA - rating	25,347	19,168	25,343	19,190
Total cash at bank and term deposits	25,347	19,168	25,343	19,190

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

	Parent			
	Gross Receivables 2017	Impairment 2017	Gross Receivables 2016	Impairment 2016
Trade receivables				
Not past due	893	-	570	-
Past due 0-30 days	22	-	32	-
Past due 31-120 days	209	-	178	6
Past due more than 1 year	-	-	-	-
Total	1,124	-	780	6

	Group			
	Gross Receivables 2017	Impairment 2017	Gross Receivables 2016	Impairment 2016
Trade receivables				
Not past due	**790**	-	579	-
Past due 0-30 days	27	-	32	-
Past due 31-120 days	214	-	178	6
Past due more than 1 year	-	-	-	-
Total	1,031	-	789	6

All impairments stated above have been calculated on individual accounts. No collective impairments have been included.

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Liquidity risk

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

Contractual maturity analysis of financial liabilities

	Parent			
	Carrying Amount	**Contractual Cash Flows**	**Less than 1 Year**	**More than 1 Year**
2017				
Payables	12,164	12,164	12,164	-
Borrowings	181	181	66	115
Finance Leases	843	843	169	674
Total	13,188	13,188	12,399	789
2016				
Payables	15,083	15,083	15,083	-
Borrowings	13,025	13,025	66	12,959
Finance Leases	1,012	1,012	169	843
Total	29,120	29,120	15,318	13,802

	Group			
	Carrying Amount	**Contractual Cash Flows**	**Less than 1 Year**	**More than 1 Year**
2017				
Payables	12,140	12,140	12,140	-
Borrowings	181	181	66	115
Finance Leases	843	843	169	674
Total	13,164	13,164	12,375	789
2016				
Payables	15,090	15,090	15,090	-
Borrowings	13,025	13,025	66	12,959
Finance Leases	1,012	1,012	169	843
Total	29,127	27,103	15,325	13,802

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Classification and fair values

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

		Parent		
	Note	Loans and Receivables	Available For Sale	Amortised Cost
2017				
Financial Assets				
Cash and cash equivalents	*10*	12,556	-	-
Term Deposits >3 <12 months	*11*	12,778	-	-
Term Deposits >12 months	*11*	-	-	-
Trade and other receivables	*12*	6,697	-	-
Patient Trust Funds	*10*	13	-	-
Equity investments at Cost	*11*	-	991	-
Total		32,044	991	-
Financial Liabilities				
Trade and other payables	*14*	-	-	12,164
Patient Trust Funds	*10*	-	-	13
Borrowings	*16*	-	-	181
Total		-	-	12,358

	Note	Loans and Receivables	Available For Sale	Amortised Cost
2016				
Financial Assets				
Cash and cash equivalents	*10*	19,157	-	-
Term Deposits >3 <12 months	*11*	-	-	-
Term Deposits >12 months	*11*	12,778	-	-
Trade and other receivables	*12*	5,800	-	-
Patient Trust Funds	*10*	10	-	-
Equity investments at Cost	*11*	-	992	-
Total		37,745	992	-
Financial Liabilities				
Trade and other payables	*14*	-	-	15,083
Patient Trust Funds	*10*	-	-	10
Borrowings	*16*	-	-	13,025
Total		-	-	28,118

for the year ended 30 June 2017
In thousands of New Zealand Dollars

		Group		
	Note	Loans and Receivables	Available For Sale	Amortised Cost
2017				
Financial Assets				
Cash and cash equivalents	*10*	12,552	-	-
Term Deposits >3 <12 months	*11*	12,778	-	-
Term Deposits >12 months	*11*	-	-	-
Trade and other receivables	*12*	6,604	-	-
Patient Trust Funds	*10*	13	-	-
Equity investments at Cost	*11*	-	734	-
Total		31,947	734	-
Financial Liabilities				
Trade and other payables	*14*	-	-	12,140
Patient Trust Funds	*10*	-	-	13
Borrowings	*16*	-	-	181
Total		-	-	12,334

	Note	Loans and Receivables	Available For Sale	Amortised Cost
2016				
Financial Assets				
Cash and cash equivalents	*10*	19,180	-	-
Term Deposits >3 <12 months	*11*	-	-	-
Term Deposits >12 months	*11*	12,778	-	-
Trade and other receivables	*12*	5,809	-	-
Patient Trust Funds	*10*	10	-	-
Equity investments at Cost	*11*	-	734	-
Total		37,777	734	-
Financial Liabilities				
Trade and other payables	*14*	-	-	15,090
Patient Trust Funds	*10*	-	-	10
Borrowings	*16*	-	-	13,025
Total		-	-	28,125

for the year ended 30 June 2017
In thousands of New Zealand Dollars

26. Capital management

SCDHB's capital is it's equity, which comprises accumulated funds and other reserves. Equity is represented by net assets.

SCDHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which imposes restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

SCDHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure SCDHB effectively achieves its objectives and purpose, whilst remaining a going concern.

27. Post balance date events

There have been no significant post balance date events.

28. Explanation of significant variances against budget

Explanations for significant variations from SCDHB's budgeted figures in the Statement of Intent are as follows:

Health and Other Government Revenue was greater than budget by $1.461m. There was a significant increase in In-between travel funding, resulting in a favourable variance of $1.336m. Finance income was $380k less than budget due to a decrease in interest bearing deposits.

Total Expenditure was $2.043m greater than budget.

- Personnel costs were $2.483m less than budget. There were significant savings arising from the management reorganisation and the partial closure at Talbot Park in relation to hospital level care. A reduction in medical staff wages ($2.057m) was partially offset by outsourced medical staff, where vacancies were unfilled ($1.198m).
- Outsourced services were $943k greater than budget. The main variances are in radiology ($242k) where budgeted savings did not occur during the year and ophthamology ($276k), driven by additional cataract surgery volumes delivered.
- Clinical Supply expenditures were $583k greater than budget. Relating to higher drug costs ($241k) and patient aids and implants ($315k) due to volume increases and efficiency savings not achieved.
- Payments to Non-DHB Providers were $3.84m more than budget (including inter-district flows). With the increase in funding for Home Base Support, the DHB was able to increase spending over budget on disability support ($2.95m). Inter District Flows were $1.778m greater than budget due to increased demand. There were savings over budget on Personal Health of $978k, including $428k for pharmaceuticals.
- Capital charge was $616k less than budget due to a change in the rate during the year.

29. South Canterbury Eye Clinic Limited

The South Canterbury Eye Clinic was purchased by SCDHB in 2015 and is a subsidiary of the DHB. The Chief Executive Officer and the Board Chair are the Directors of South Canterbury Eye Clinic Limited.

The South Canterbury Eye Clinic's financial results for 2016/17 and 2015/16 have been consolidated into the SCDHB financial accounts and form part of the disclosure. For the year ended 30 June 2017, the South Canterbury Eye Clinic had total revenue of $1.236m (2016: $876k) and total expenditure of $1.354m (2016: $885k) which resulted in a net deficit of $117k (2016: surplus $11k). South Canterbury Eye Clinic Limited had assets of $198k (2016: $195k) and liabilities of $247k (2016: $147k) as at 30 June 2017.

Related party disclosure

The South Canterbury Eye Clinic received clinical services revenue in 2016/17 from the SCDHB of $1,129,332 (2016: $724,553). The balance outstanding at year end was $105,644 (2016: $103,723), SCDHB received revenue from SCEC for supplies and services in 2016/17 of $116,354 (2016: $14,309).

Cost of Services

	Budget 2016/17	Actual 2016/17
REVENUE	**TOTAL $'000**	**TOTAL $'000**
Prevention	3,477	3,477
Early detection and management	43,035	43,035
Intensive assessment and treatment	107,858	107,858
Support and rehabilitation	37,321	38,408
Grand Total	**191,691**	**192,778**
EXPENDITURE	**TOTAL $'000**	**TOTAL $'000**
Prevention	3,460	3,271
Early detection and management	42,827	43,335
Intensive assessment and treatment	106,928	106,387
Support and rehabilitation	37,154	39,644
Grand Total	**190,369**	**192,637**
Surplus/(Deficit)	**1,322**	**141**

Our Statement of **Service Performance**

In this section you will find:

Improving Health Outcomes for our Population

What are we trying to achieve?

DHBs are expected to deliver against the national health sector outcomes: 'All New Zealanders lead longer, healthier and more independent lives' and 'The health system is cost effective and supports a productive economy' and to meet their objectives under the New Zealand Public Health and Disability Act to "improve, promote and protect the health of people and communities'.

The mission statement of the South Canterbury District Health Board (SCDHB) is "to enhance the health and independence of the people of South Canterbury". Over the long term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in South Canterbury, the decisions we make about which services will be delivered have a significant impact on our population and, if coordinated and planned well, improve the efficiency and effectiveness of the whole South Canterbury health system.

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 DHBs do, so a mix of population health and service access indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing its strategic framework, the South Island DHBs identified three shared strategic high-level outcome goals where collectively we can change and deliver on the expectations of Government, our communities and our patients by making a positive change in the health of our populations.

Alongside these outcome goals are a number of associated outcomes indicators, which will demonstrate success over time. These are long-term outcome indicators (5-10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target.

- **Outcome Goal 1: People are healthier and take greater responsibility for their own health.**

  A reduction in smoking rates.

  A reduction in obesity rates.

- **Outcome Goal 2: People stay well in their own homes and communities.**

  A reduction in the rate of acute admissions to hospital.

  An increase in the proportion of people living in their own homes.

- **Outcome Goal 3: People with complex illnesses have improved health outcomes.**

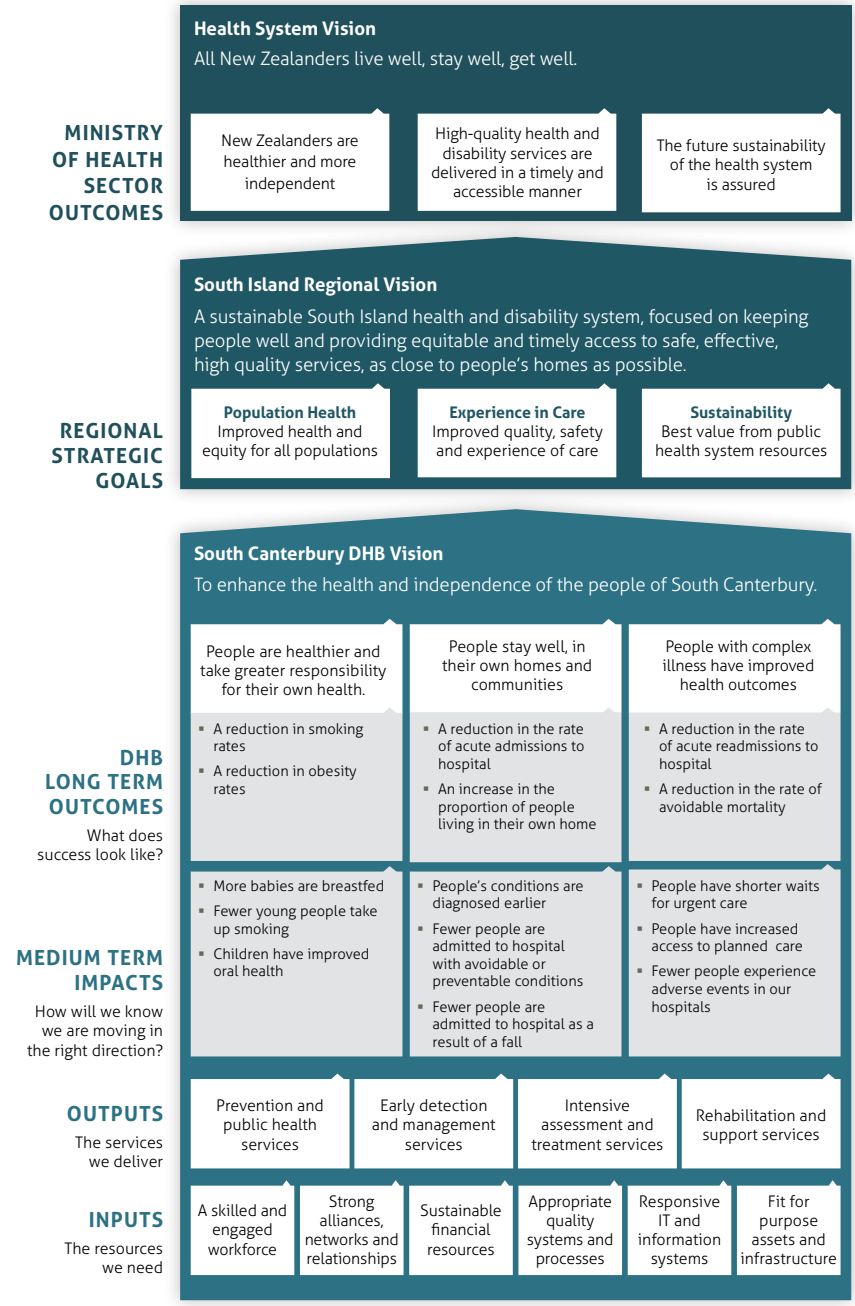
  A reduction in the rate of acute readmission to hospital.

  A reduction in rate of avoidable mortality.

South Island Intervention Logic Framework

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

Overarching intervention logic



Te Tiriti O Waitangi

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

How have we performed?

STRATEGIC OUTCOME GOAL 1: people are healthier and take greater responsibility for their own health

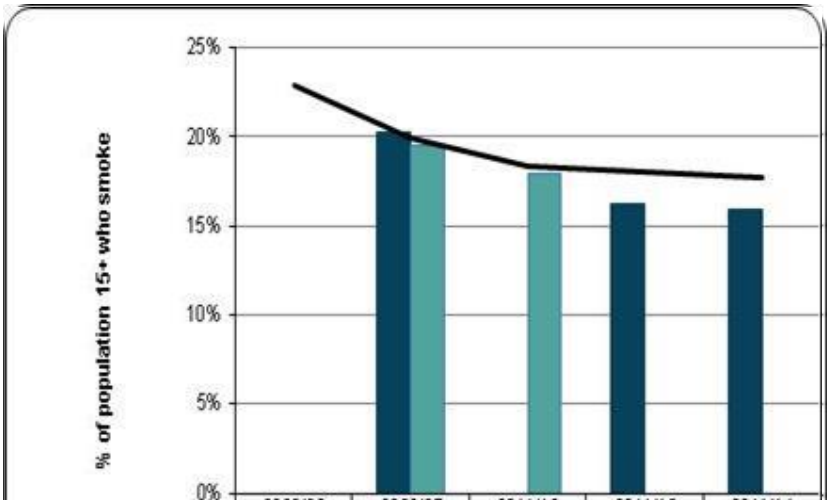
Outcome: A reduction in smoking rates.

Comment

There is no update from the report published for 2011/14 which was based on the previous three years' data pooled and showed a result for South Canterbury which was below that recorded for the national average. The NZHS was first undertaken in 1992/93, with further surveys in 1996/97, 2002/03 and 2006/07. The Ministry of Health's wider health survey programme also included surveys on adult and child nutrition; tobacco, alcohol and drug-use; mental health; and oral health. From 2011 the Ministry integrated the NZHS and surveys from its wider survey programme into a single survey, which is now in continuous operation. The 2013 Census result which is based on population based data collection was 16.2%. It is important to note that the NZHS data collection is sample based and that this sample size is very small.

Data sourced from the National Health Survey (NZHS)

Outcome Measure Long Term (5 – 10 years): The percentage of the population (15+) who smoke.



	2002/03	2006/07	2011/12	2011/13	2011/14
South Canterbury		20.2%		16.2%	15.9%
SI		19.5%	17.9%		
National Average	22.9%	19.9%	18.4%	18.0%	17.7%

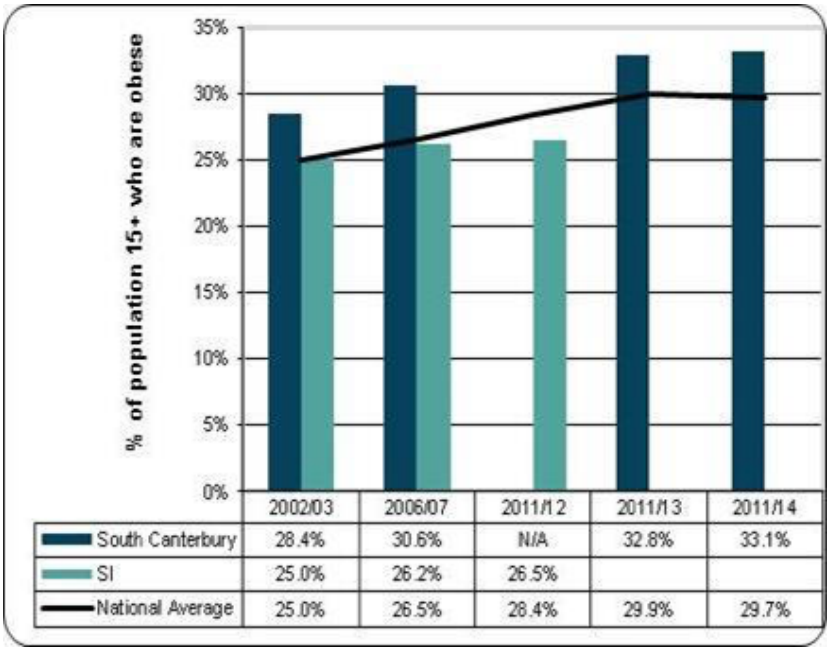
Outcome: A reduction in obesity rates.

Comment

The NZHS was first undertaken in 1992/93, with further surveys in 1996/97, 2002/03 and 2006/07. The Ministry of Health's wider health survey programme also included surveys on adult and child nutrition; tobacco, alcohol and drug-use; mental health; and oral health. From 2011 the Ministry integrated the NZHS and surveys from its wider survey programme into a single survey, which is now in continuous operation. There is no update from the report published for 2011/14 which was based on the previous three years' data pooled. At this time, the DHB's result sat slightly above that recorded for the national average however it is important to note that the NZHS data collection is sample based and that this sample size is very small. Obesity remains a major issue in the health sector.

Data sourced from the National Health Survey (NZHS)

Outcome Measure Long Term (5 – 10 years): The percentage of the population (15+) who are obese.



	2002/03	2006/07	2011/12	2011/13	2011/14
South Canterbury	28.4%	30.6%	N/A	32.8%	33.1%
SI	25.0%	26.2%	26.5%		
National Average	25.0%	26.5%	28.4%	29.9%	29.7%

STRATEGIC OUTCOME GOAL 2: people stay well in their own homes and communities

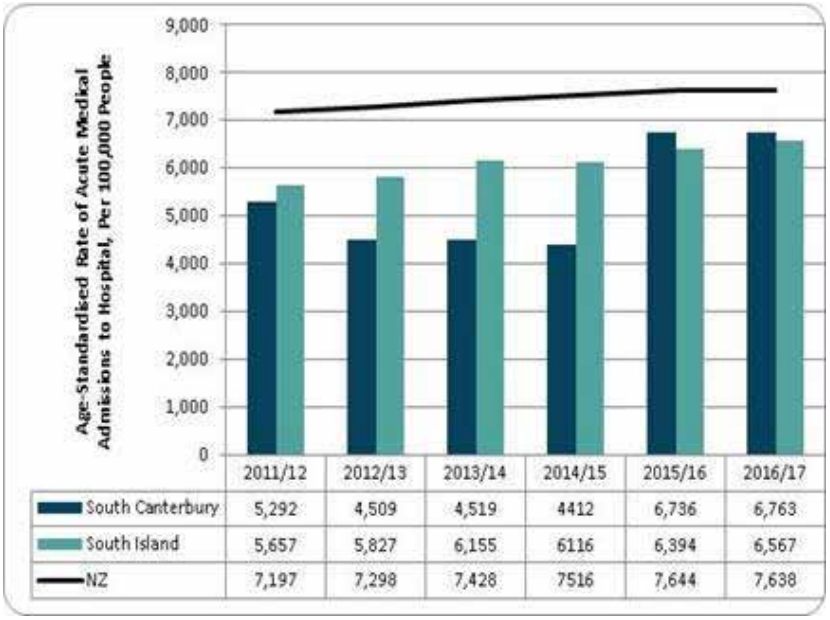
Outcome: A reduction in acute medical admissions.

Comment

SCDHB's result for 2016/17 is unchanged from the previous year with the gap between ourselves and the South Island as a whole narrowing. It also continues to remain below the national result.

Data sourced from the South Island Alliance Programme Office

Outcome Measure Long Term (5 – 10 years): The rate of acute medical admissions to hospital (age-standardised, per 100,000).



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
South Canterbury	5,292	4,509	4,519	4412	6,736	6,763
South Island	5,657	5,827	6,155	6116	6,394	6,567
NZ	7,197	7,298	7,428	7516	7,644	7,638

Outcome: An increase in the proportion of the population living in their own home.

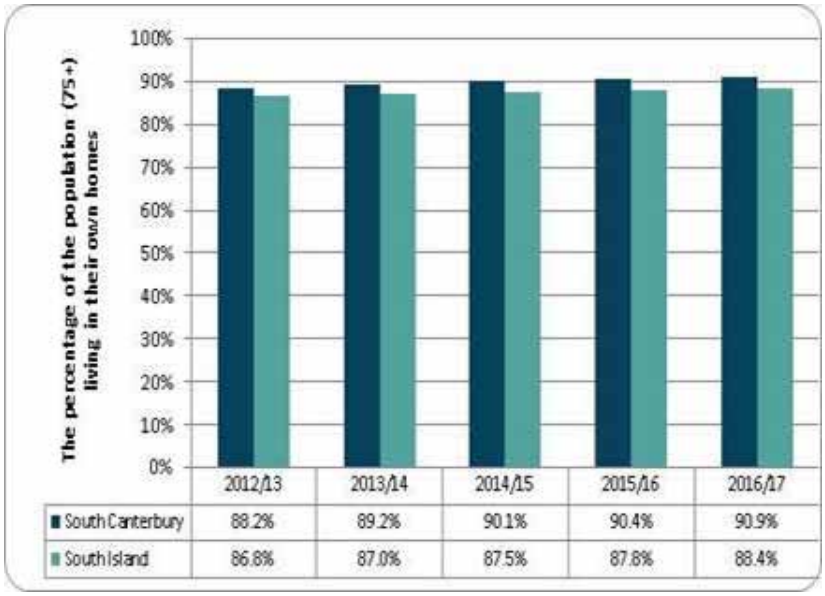
Comment

SCDHB's result for 2016/17 continues the upward trend seen in previous years. It remains above the South Island rate.

Note: The data for each of the years has been amended to align with consistent population data for the South Island.

Data sourced from the South Island Alliance Programme Office

Outcome Measure Long Term (5 – 10 years): The percentage of the population (75+) living in their own homes.



	2012/13	2013/14	2014/15	2015/16	2016/17
South Canterbury	88.2%	89.2%	90.1%	90.4%	90.9%
South Island	86.8%	87.0%	87.5%	87.8%	88.4%

STRATEGIC OUTCOME GOAL 3: people with complex illness have improved health outcomes

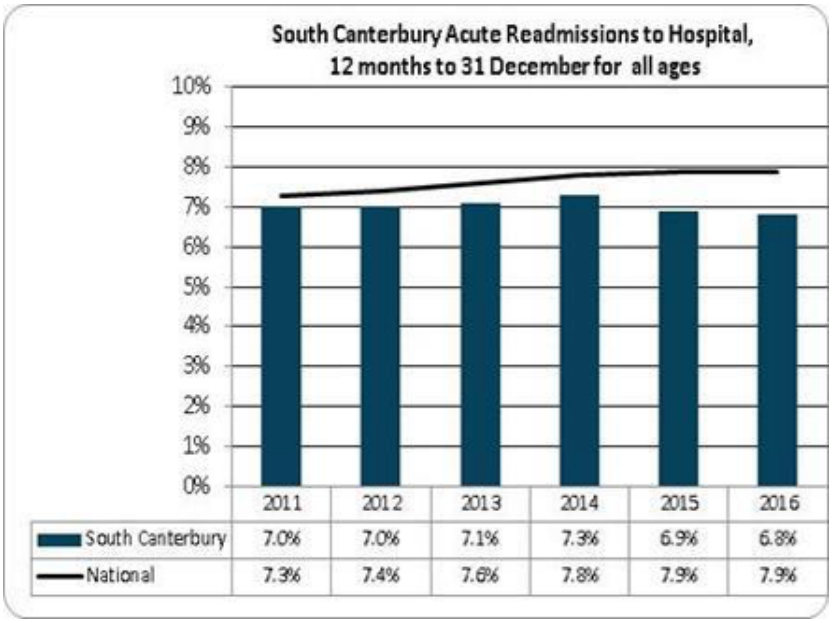
Outcome: A reduction in acute readmissions.

Comment

SCDHB's result for 2016 is consistent with the previous year and remains below the national result.

Data sourced from the Ministry of Health

Outcome Measure Long Term (5 – 10 years): The standardised rate of acute readmissions to hospital within 28 days of discharge.



	2011	2012	2013	2014	2015	2016
South Canterbury	7.0%	7.0%	7.1%	7.3%	6.9%	6.8%
National	7.3%	7.4%	7.6%	7.8%	7.9%	7.9%

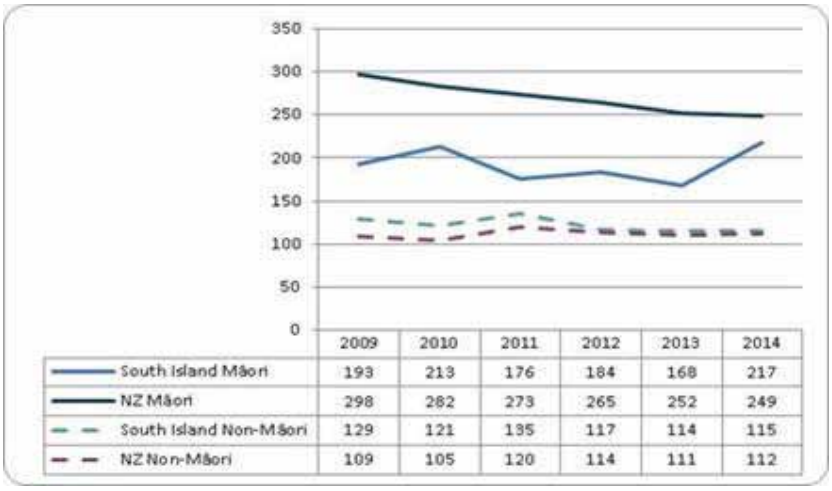
Outcome: A reduction in mortality rates.

Comment

Mortality rates were last published in 2014. Results are presented for the South Island population rather than at DHB level. Rates for South Island Māori sit well below NZ Māori whilst South Island Non- Māori results are comparable with those published nationally.

Data sourced from the South Island Alliance Programme Office

Outcome Measure Long Term (5 – 10 years): The rate of all-cause mortality for people aged under 65 (age standardised per 100,000).



	2009	2010	2011	2012	2013	2014
South Island Māori	193	213	176	184	168	217
NZ Māori	298	282	273	265	252	249
South Island Non-Māori	129	121	135	117	114	115
NZ Non-Māori	109	105	120	114	111	112

What difference have we made for our population?

Nine impact measures (3-5 years) supporting the three strategic goals demonstrate where we have made a measurable contribution to the longer-term outcomes we are seeking. Chosen impacts reflect areas of activity where the DHB can influence change and corresponding impact measures help demonstrate the difference we are making in the health of the South Canterbury population. Targets have been set against these impact measures in order to evaluate the impact of service delivery over a three-year period. This section provides an update on our progress.

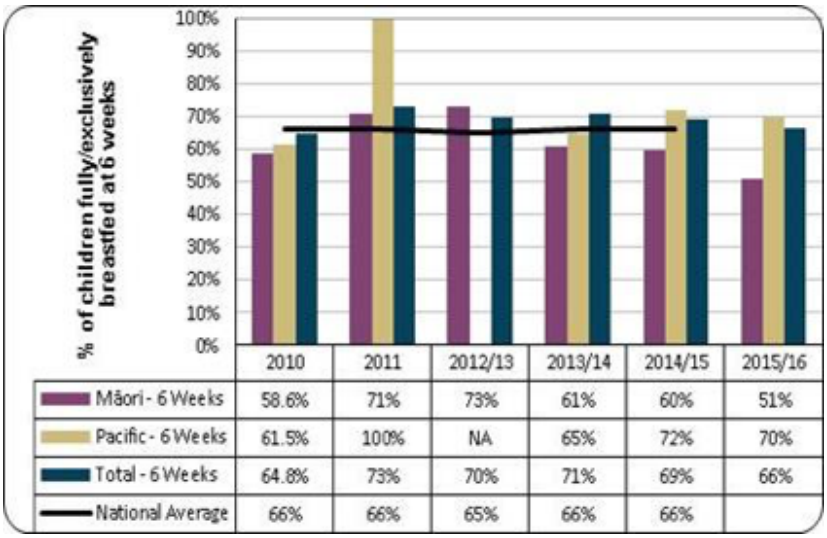
STRATEGIC OUTCOME GOAL 1: people are healthier and take greater responsibility for their own health

Impact: More babies are breastfed.

Comment

Data for 2016/17 is not yet available. Data for 2015/16 is from different data source and as such may not be comparable with previous years.

Impact Measure Medium Term (3-5 years): The percentage of babies fully/exclusively breastfed at six weeks.



	2010	2011	2012/13	2013/14	2014/15	2015/16
Māori - 6 Weeks	58.6%	71%	73%	61%	60%	51%
Pacific - 6 Weeks	61.5%	100%	NA	65%	72%	70%
Total - 6 Weeks	64.8%	73%	70%	71%	69%	66%
National Average	66%	66%	65%	66%	66%	

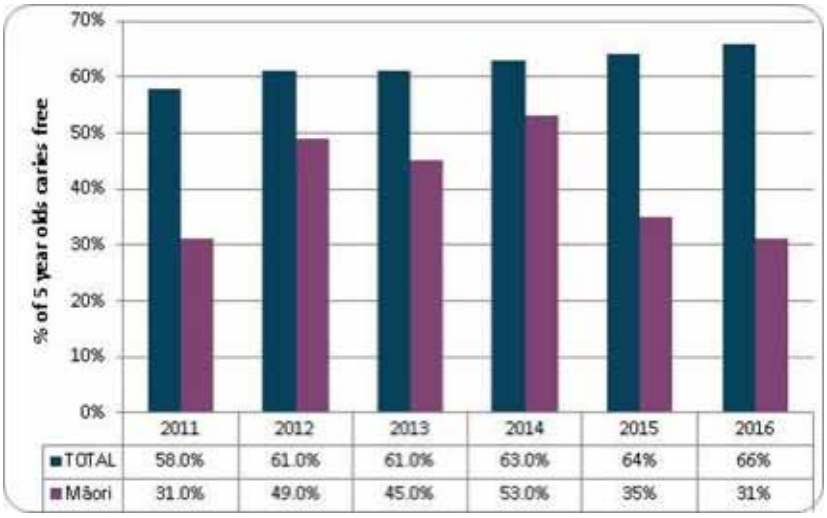
Impact: Children have improved oral health.

Comment

SCDHB's result for 2016 achieved target and shows a further improvement for the total population compared to previous years. However, a further decline is noted for the Māori population. This remains an area of focus for the DHB including interventions by the oral health promoter.

Data sourced from Ministry of Health.

Impact Measure Medium Term (3-5 years): The percentage of children caries-free at age 5 (no holes or fillings).



	2011	2012	2013	2014	2015	2016
TOTAL	58.0%	61.0%	61.0%	63.0%	64%	66%
Māori	31.0%	49.0%	45.0%	53.0%	35%	31%

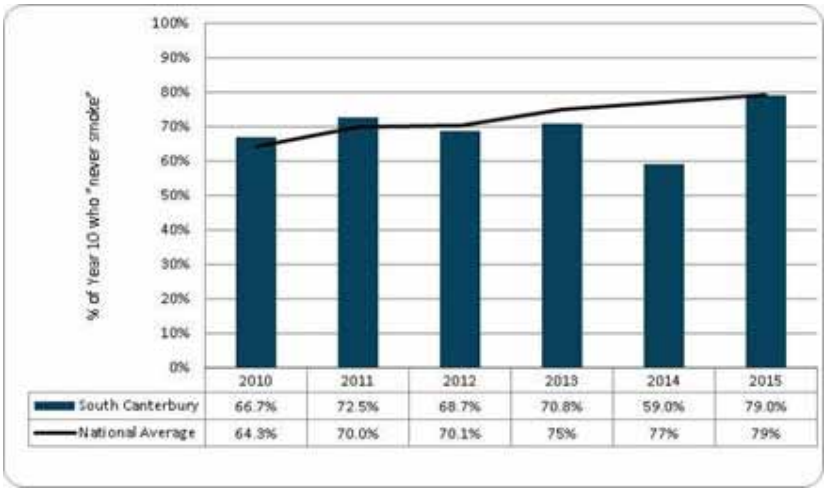
Impact: Fewer young people take up tobacco smoking.

Comment

This report was last published in 2015 where SCDHB's result was the highest in the last five years and was a significant improvement on the previous year. It is important to note however that the fluctuation of results for this measure is due to very small numbers for South Canterbury included in this survey. Participation by local schools is voluntary and there is the potential that the same schools are not included each year.

ASH NZ Year 10 Survey

Impact Measure Medium Term (3-5 years): The percentage of 'never smokers' among Year 10 students.



	2010	2011	2012	2013	2014	2015
South Canterbury	66.7%	72.5%	68.7%	70.8%	59.0%	79.0%
National Average	64.3%	70.0%	70.1%	75%	77%	79%

STRATEGIC OUTCOME GOAL 2: People stay well in their own homes and communities

Impact: People receive timely access to diagnostics.

Comment

SCDHB's results for the 2016/17 year are comparable to the previous year and exceed target for both measures.

Data sourced from the Ministry of Health

Impact Measure Medium Term (3-5 years): The percentage of people waiting no more than six weeks for their CT or MRI Scan

	2012/13	2013/14	2014/15	2015/16	2016/17
SCDHB CT	87.1%	99.3%	92.0%	96.0%	95.0%
SCDHB MRI	83.6%	99.4%	90.2%	98.0%	98.0%
NZ CT		81%	85%	87%	87%
NZ MRI		61%	54%	70%	61%

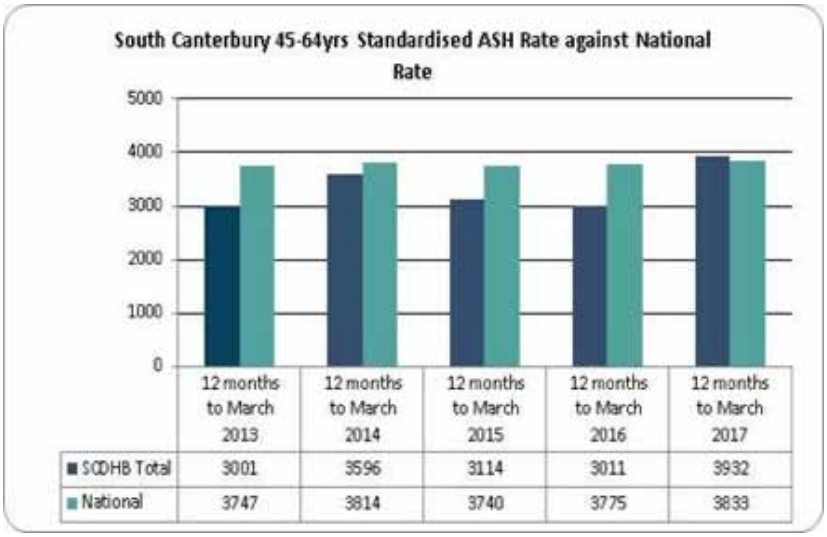
Impact: Fewer people are admitted to hospital with conditions considered 'avoidable' or preventable.

Comment

SCDHB's result slightly exceeded the national result for the 12 months to March 2017. Results are now presented as a number therefore results for previous years have been updated to provide comparison.

Data sourced from the Ministry of Health

Impact Measure Medium Term (3-5 years): The standardised rate of avoidable hospital admissions for the population aged 45-64 years (per 100,000).



	12 months to March 2013	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017
SCDHB Total	3001	3596	3114	3011	3932
National	3747	3814	3740	3775	3833

Impact: Fewer people are admitted to hospital as a result of a fall.

Comment

SCDHB's result for 2016/17 is an improvement on last year and returns to a level seen in previous years. It remains well below both South Island and national results.

Note: The data for each of the years has been amended to align with consistent population data for the South Island.

Data sourced from the South Island Alliance Programme Office

Impact Measure Medium Term (3-5 years): The percentage of the population (75+) admitted to hospital as a result of a fall.

	2012/13	2013/14	2014/15	2015/16	2016/17
SCDHB	3.1%	3.4%	3.6%	4.5%	3.5%
South Island	4.6%	5.3%	5.2%	5.2%	4.8%
New Zealand	4.8%	5.1%	5.0%	5.1%	5.0%

STRATEGIC OUTCOME GOAL 3: People with complex illness have improved health outcomes

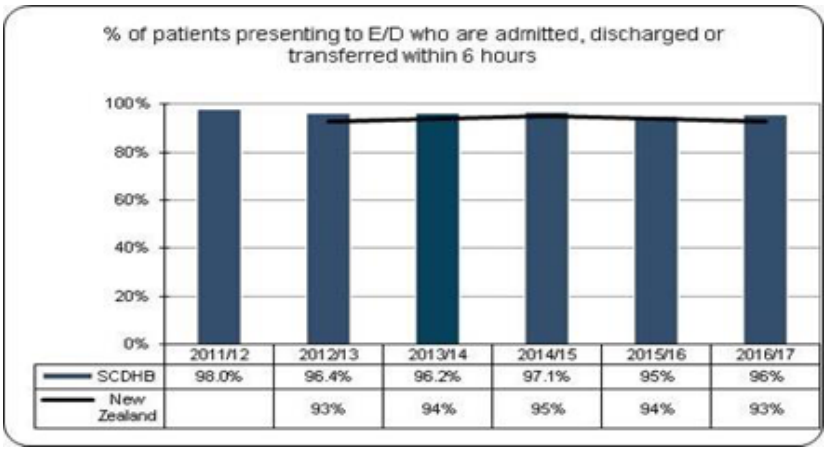
Impact: People have shorter waits for treatment.

Comment

SCDHB continues to consistently meet this target.

Data sourced from SCDHB

Impact Measure Medium Term (3-5 years): The percentage of people presenting at ED who are admitted, discharged or transferred within six hours.



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
SCDHB	98.0%	96.4%	96.2%	97.1%	95%	96%
New Zealand		93%	94%	95%	94%	93%

Impact: People have increased access to elective services.

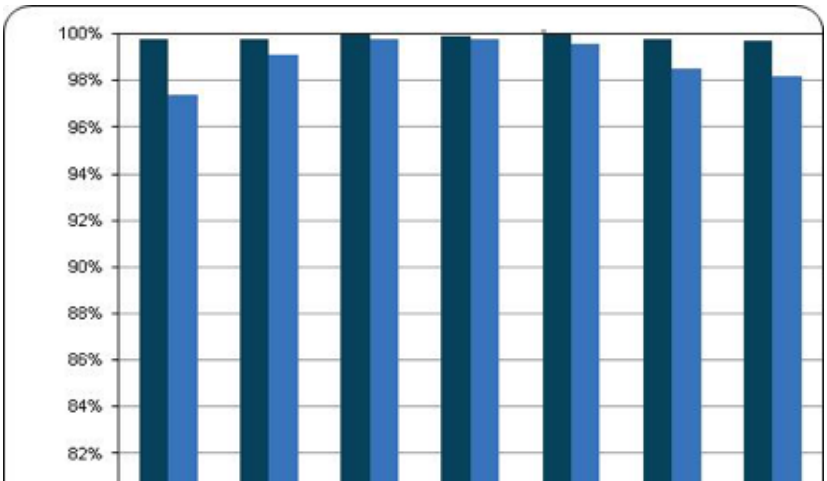
Comment

Elective Service Performance Indicator 2 relates to the percentage of patients provided with a First Specialist Appointment within 4 months of referral. This timeframe was reduced from 5 to 4 months from the 2014/15 year onwards. The 2016/17 result was close to target.

Elective Service Performance Indicator 5 relates to the percentage of patients given a commitment to treatment within 4 months (also reduce from the previous year timeframe of 5 months). The DHB fell slightly short of target for 2016/17 and was down on the previous year. The DHB continues to perform favourably compared to the national result.

Data sourced from SCDHB

Impact Measures Medium Term (3-5 years): The percentage of people receiving their specialist assessment (ESPI 2) or agreed treatment (ESPI 5) in under four months.



	2010/11 within 6m	2011/12 within 6m	2012/13 within 5 mths	2013/14 within 5mths	2014/15 within 4mths	2015/16 within 4mths	2016/17 within 4mths
ESPI 2	99.8%	99.8%	100.0%	99.9%	100.0%	99.8%	99.7%
ESPI 5	97.4%	99.1%	99.8%	99.8%	99.6%	98.5%	98.2%

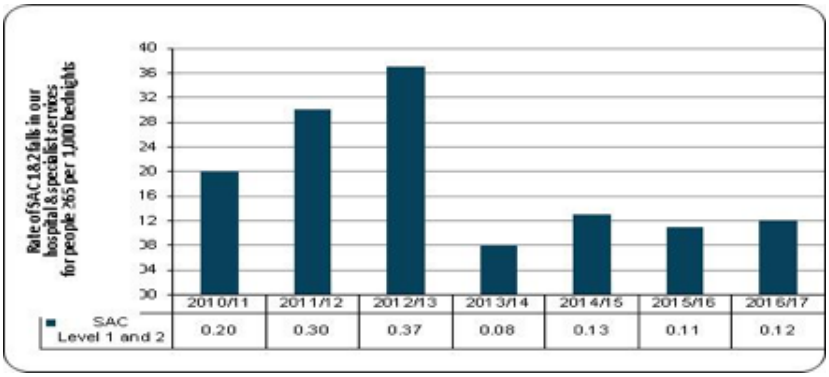
Impact: People stay safe in hospital.

Comment

SCDHB's result for 2016/17 is comparable to the previous year and includes events reported from the DHB's Aged Related Residential Care facility. There were changes to Talbot Park bed numbers during 16/17 as the DHB commenced exiting from this service.

Data sourced from SCDHB

Impact Measure Medium Term (3-5 years): The rate of SAC level 1 and 2 falls in hospital (per 1,000 inpatient bed-days)



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
SAC Level 1 and 2	0.20	0.30	0.37	0.08	0.13	0.11	0.12

Measuring our Non-Financial Performance

Over the long-term, we aim to make positive changes in the health status of our population. As part of evaluating our performance, we provide an annual forecast of the services we plan to deliver and report actual delivery against that forecast at the end of each year. The following section presents our actual performance against the forecast outputs presented in our Statement of Performance for 2016 – 2017.

Identifying a set of appropriate measures is difficult. We cannot not simply measure 'volumes' as the number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'.

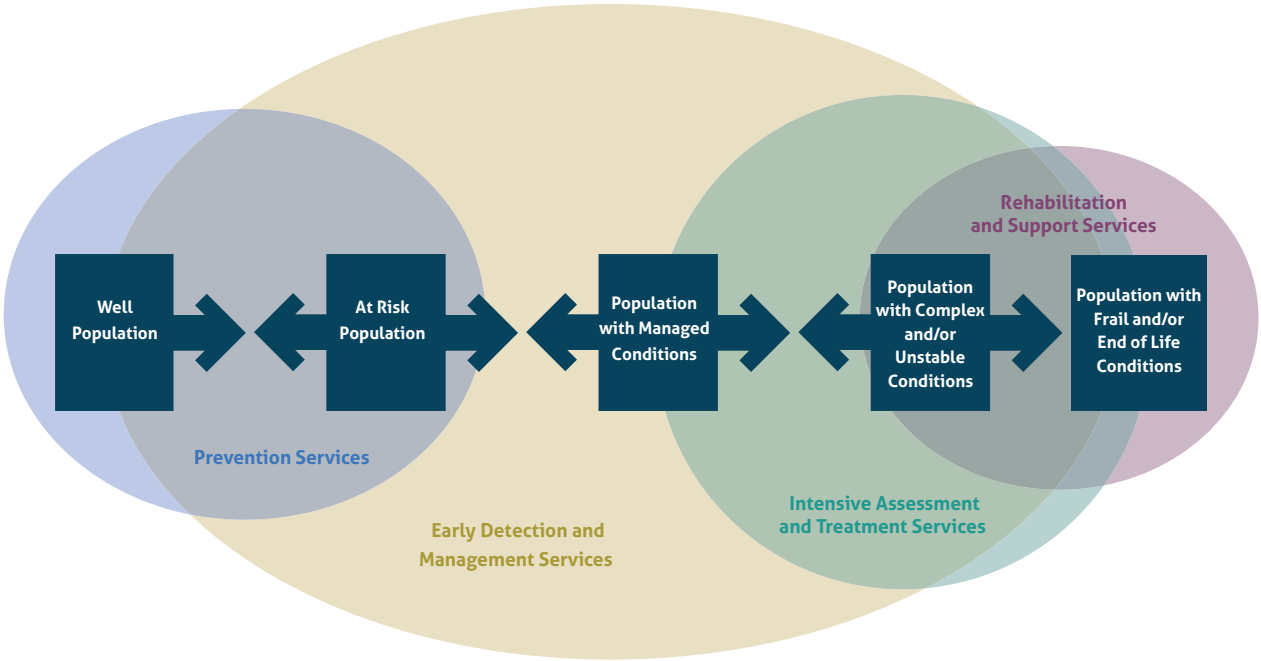
The output measures chosen are those activities which reflect a reasonable picture of activity across the whole of the South Canterbury health system and have the potential to make the greatest contribution to the health and wellbeing of our population in the shorter term and to the health outcomes we are seeking over the longer term.

We have used a mix of measures of Quantity (V), Quality (Q), Coverage (C) and Timeliness (T) – all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected. Quantity measures demonstrate capacity and 'how much' of a service we are delivering. Quality measures demonstrate 'how well' we are delivering the service. Coverage demonstrates the scope and scale of services provided and Timeliness measures demonstrate where services are delivered within recommended timeframes.

Where appropriate we have set targets for output measures to demonstrate the expected standard. Where available we have included prior year's baseline data to support evaluation of our performance over time as well as national results for 2016/17 to give context in terms of what we are trying to achieve.

In order to present a representative picture of performance, outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum of care and are applicable to all DHBs: Prevention Services, Early Detection and Management Services, Intensive Assessment and Treatment Services, and Rehabilitation and Support Services.

Output Grouping Set Against the Continuum of Care for Our Population



Access to a significant proportion of public health services e.g. laboratory tests, emergency care, maternity services and palliative care is unrestricted or demand-driven. Estimated delivery volumes set for these measures are simply a forecast or estimate of expected demand with actual use of these services included to give the reader a picture of what is happening across our health system.

Some data is collected on calendar rather than financial years and where this occurs is indicated as such. Results are based on data available at the time of producing this report and may be subject to change as additional coding and invoicing is completed. Any other irregularities have been footnoted.

What have we delivered – performance results

South Canterbury District Health Board continues to perform well against a range of performance measures. Health Targets were met for shorter stays in emergency departments, improved access to elective services and increased immunisation. The target for help to quit smoking in primary care was only just missed at again this year end by one percent. Targets were not achieved for faster cancer treatment and the new raising healthy kids measure with results well below the results for 'All DHBs'. These measures remain a focus for the DHB.

Where the targets set out in the following tables has been achieved this has been indicated with a ✓ in the status column. For those measures where target has not been achieved these results have been indicated with an ✗ and a comment explaining variance to target has been included as a footnote. Those measures purely relating to estimated service delivery which are demand driven have been indicated with a ∞.

Output class – prevention services

Preventative 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 that engage, 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 individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

By improving environments and raising awareness, these services support people to make healthier choices, reducing the major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. High need and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population.

Well Child/Tamariki Ora (WCTO) Quality Improvement Framework indicator breast feeding results for the 2016/17 year are yet to be published. Targets relating to smoking cessation were either reached or close to target. Promotion of the concept of Green Prescriptions has seen an increase in referrals. All education settings remain engaged in WAVE. A further audit of the Family Violence Intervention Programme is not due till the end of 2017.

Population screening results are variable. Whilst breast screening results were favourable cervical screening was comparable to the previous year and fell below target for both total population and Māori. The DHB's performance for completion of B4 School Checks has been sustained, however the Before Schools Check (B4SC) target for referral was not reached. Efforts will continue in order to reach this target within the expected timeframe of December 2017, specifically by improving the accuracy of our data collection.

Immunisation targets were all met with the exception of HPV uptake. This remains an area of focus for the DHB. It is pleasing to see that uptake of the Pneumovax remains high.

Health Promotion and Education Services

These services inform people about risks and support them to be healthy. Success is measured by greater awareness and engagement, reinforced by programmes that support people to maintain wellness, change personal behaviours and make healthier choices.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
Percentage of babies breast-fed (exclusive and full) in the district at 6 weeks of age	*C,Q*[1]	69% (pub. March 2015)	78% (pub. March 2016)	NA	≥75%	-	NA
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age	*C,Q*[1]	57% (pub. March 2015)	55% (pub March 2016)	NA	≥60%	-	NA
Percentage of being fed breast milk in the district at 6 months of age	*C,Q*[1]	63% (pub. March 2015)	61% (pub March 2016)	NA	≥65%	-	NA
No. of people in South Canterbury accessing smoking cessation programmes	*V*[2]	574	587	519	≥500	-	✓
Percentage of people who receive brief invention to quit smoking in the hospital setting	*C*	98.9%	98%	95.9%	≥95%	94.6%	✓
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health practitioner in the last 15 months.	*C*[3]	NEW	89.2%	88.9%	≥90%	89.3%	✗
No. of Green Prescription referrals	*V*[4]	427	428	474	≥557	-	∞
Percentage of education settings engaged with WAVE	*C*	99.1%	100%	100%	≥100%	-	✓
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to child abuse above the national benchmark score of 80	*Q*[5]	93*	93	NA	≥91	-	NA
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to partner abuse above the national benchmark score of 80	*Q*[5]	91*	91	NA	≥92	-	NA

1. Ministry of Health WCTO Quality Indicators results for 2016/17 have not been published.
2. These volumes relate to MOH/DHB funded programmes and do not include those referred to programmes such as Quitline.
3. SCDHB's result for 2016/17 was comparable to the previous year and below target. DHB continue to support practices to use tools and processes to give brief advice as part of their business as usual service. This has resulted in an improvement and embedding this work further will see continued progress and achievement of the target.
4. SCDHB's result for 2016/17 has increased on previous years and is demand driven. This intervention continues to be promoted.
5. The target for the FVIP score increased in 2015/16 to '80'. *Results for 2014/15 have been corrected. The last audit for the 2015-16 year was completed on the 29/06/16 with the audit for the 2016-17 year not due till the 12/12/17.

Population Based Screening

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

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years	*T*[1]	75.8%	76.3%	77.1%	≥80%	75%	✗
Percentage of Māori enrolled women aged 25 – 69 years who have had a cervical screen in the last three years	*T*[1]	48.8%	60.1%	59.6%	≥80%	65.3%	✗
Percentage of enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	*T*[2]	79.1%	78.4%	77.3%	≥70%	71.8%	✓
Percentage of Māori enrolled women aged 50 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	*T*[2]	73.6%	78.3%	72.3%	≥70%	65.4%	✓
Percentage of eligible population provided with a B4 School Check	*C*[3]	108%	102%	105%	≥90%	-	✓
Percentage of eligible 'high needs' population provided with a B4 School Check	*C*[3]	110%	105%	93%	≥90%	-	✓
Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	*C*[4]	NEW	NEW	79%	95% (By December 2017)	94%	✗

1. Whilst the target has not been met for this performance measure the result is comparable with previous years and promotion is ongoing. A further issue relating to data integrity continues to impact on the result. General practices remain committed to ensuring all eligible women are offered a cervical smear. Free smears are available where there is a financial barrier to having this completed.
2. The Breast Screening Aotearoa (BSA) screening programme is for women aged 45 – 69 years however their target is to screen 70 percent of eligible women aged 50 – 69 every two years. BSA does not have a target for women aged 45 – 49 years because there is less evidence of the benefits of this age group's participation in a population health breast screening programme.
3. The results for 2014/15, 2015/16 and 2016/17 for total exceed 100% because the target set (i.e.90%) is below 100% but more children over and above those required to meet the target of 90% have been provided with a B4 School Check resulting in a performance in excess of 100%.
4. The DHB continues towards meeting this target by December 2017 with a focus on utilising electronic solutions to ensure the integrity of data collection.

Immunisation

These services reduce the transmission and impact of vaccine-preventable diseases including unnecessary hospitalisations. 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, successful service.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
Percentage of 8 months old fully immunised on time	*T,C*	91.9%	92.9%	95%	≥95%	94.7%	✓
Percentage of 2 years old fully immunised on time. Ref PP21.	*T,C*	95.3%	94.3%	95%	≥95%	95.2%	✓
Percentage of 5 years old fully immunised on time. Ref PP21	*T,C*	92%	92%	95%	95%	94.8%	✓
Percentage of the eligible population receiving the flu vaccination	*C*[1]	67.3%	70%	68.4%	≥70%	-	✗
No. ≥ 65 year olds immunised for pneumonia	*C*	517	416	697	≥300	-	✓
Percentage of eligible girls fully immunised with three doses of HPV vaccine	*V*[2]	122 (2014)	53.9%	51%	70% for dose 3	66%	✗

1. The timeframe has been extended into August/September and target is expected to be reached at the conclusion of the flu season.
2. The definition for this measure was changed in 2015/16. Results for the 2015/15 financial year relate to the number of HPV vaccinations completed for consenting adolescents through the school based programme and as such are not comparable with the 2015/16 onwards result which relates to the total population. The target for this indicator increased to 70% in 2016/17. The DHB result is well below target and is one of the lowest of the DHBs. It is the 'other' ethnicity category that has low vaccine uptake at 47%. We are working to address this through strengthening our relationships with schools and increasing trust in the School Based Immunisation Programme (SBIP) as well as working with Primary Care to encourage recall of young people who did not participate in the SBIP.

Output class – early detection & management

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

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, 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.

By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes.

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

Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services. Increases in access to diagnostics and agreed referral pathways and reductions in avoidable hospital admissions also reflect improvement.

Slow growth is noted in the enrolled population. Utilisation of Care Plus for those eligible shows further improvement this year. The ASH rate for 0 – 4-year olds is well below the national result whilst an increase is noted for the 45 – 64 years age group.

Access to programmes supporting self-management of long-term conditions exceeded planned levels and the CVDRA target was met.

Performance against the enrolment of children in DHB funded dental services was below target but is expected to improve as enrolment at birth is embedded. Whilst the target for adolescent access to DHB funded oral health services was not met the result exceeded the national average and the DHB was rated as the best performer for this measure. It is pleasing to note that both the caries free at five years of age and oral health indicator at year eight targets were both reached this year. Progress was also made on reducing the percentage of children overdue for their scheduled examination.

The medicines reconciliation result is not available due to a data extraction issue. Use of the community INR monitoring programme is demand driven. Whilst the target for the percentage of patients with results within the control range was meet, timeliness for completing testing fell below target. Performance in this area is expected to continue to improve during 2017/18.

Performance against waiting times for MRI, CT and urgent diagnostic colonoscopies has been sustained with all targets met.

Primary Health Care

These services are offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare 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.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
No. people in the district enrolled with a Primary Care Provider	*V,C*	57,142	57,423	57,559	≥57,500	-	∞
Percentage of eligible people enrolled in the Care Plus Programme	*C*[1]	86%	89%	117%	≥86%	-	✓
Avoidable Hospital Admission (ASH) 0 – 4 years (Total) rate. Refer SI1.	*Q*[2]	4,000 (March 15)	4,271 (March 16)	4,261 (March 17)	TBC	6,474	✓
Avoidable Hospital Admission (ASH) 45 - 64 years (Total) rate. Refer SI1.	*Q*[2]	3,114 (March 15)	*3,011* (March 16)	*3,932* (March 17)	*80%*	3,833	NA

1. This result is above 100% as there were more people eligible for Care Plus and subsequently enrolled than had been predicted.
2. Results for previous years have been updated to allow comparison and are for the period 12 months 1 April – 31 March.

   The target for the 45 – 64 age group was set by the Ministry of Health at 80%, however subsequent to that the reporting requirement changed to numbers without a revision of the target. Whilst there was no target set for the 0-4 years age group the DHB result is well below the national total.

Long Term Conditions Programme

These services are targeted at people with high 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, self-management 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.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
No. of patients who have completed the Multi-Condition Rehabilitation Programme	*V*[1]	76%	99	94	≥75	-	✓
No. of patients enrolled in the Diabetes Encounter Programme	*V*[2]	162	200	157	≥150	-	✓
Percentage of the eligible population who have had their cardiovascular risk checked in the last 5 years	*C*[3]	87.7%	90.8%	90.2%	≥90%	89.8%	✓

1. The definition for this measure was updated for 2015/16 to reflect the actual number of patients rather than percentage as this was considered to be a more meaningful measure. Subsequently results for previous years are not comparable with the 2015/16 result onwards.
2. An intensive programme for diabetics to better self-manage lifestyle and medication requirements and to allow for a better quality of life and improved metabolic control.
3. This refers to CVD risk assessments undertaken in primary care. This measure is no longer a Health Target.

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. Results are presented by calendar year in line with the school year.

	Notes	2014 Result	2015 Result	2016 Result	Target/ Estimated Delivery 2016	Current National Average	Achievement Against Target
Percentage of children under five years enrolled in DHB funded dental services. Refer PP13.	*C*[1]	69.8%	82.4%	82.4%	≥95%	N/A	✗
Percentage of adolescents accessing DHB funded oral health services. Refer PP12.	*C*[2]	86%	84.2%	83.1%	≥91%	67.1%	✗
Percentage of children caries free at five years of age. Refer PP11.	*C*	63%	64%	66%	≥65%	N/A	✓
Oral Health Decayed, Missing and Filled Teeth score at year eight. Refer PP10.	*C*	1.07	0.88	0.85	≤0.85	N/A	✓
Percentage of enrolled preschool and primary school children overdue for their scheduled examination. Refer PP13.	*T*[3]	13%	14%	12%	≤9%	N/A	✗

1. The result is comparable with the previous year but remains below target. The practice is now to enrol children at birth, however, it will take a couple of years before all children under five years will be consistently captured through this change in practise.
2. Whilst this target was not met the DHB remains significantly above the national average. Interim results indicate South Canterbury as the top performer for this measure.
3. The 2016 result is an improvement on the previous year and is expected to continue to improve.

Pharmacy

As Long-Term Conditions (LTC) become prevalent, demand for pharmaceuticals will likely increase. The LTC service was introduced to provide a greater hands-on role of community patient's pharmaceutical management. To improve service quality in the hospital setting we have also introduced medicines interventions monitoring along with medicines reconciliation to reduce the number of New Zealanders harmed each year by medication errors in our hospital.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
Percentage of medicines reconciliations completed	*Q*[1]	10.7%	44.28% (Feb – June 2016)	NA	50%	-	N/A
No. people enrolled in the Community Pharmacy INR Monitoring Programme	*V*[2]	NEW	173	161	220	-	∞
Percentage of people enrolled in the Community Pharmacy INR Monitoring Programme with results in the control range.	*Q*[2]	NEW	76%	75.2%	70%	-	✓
Percentage of Community Pharmacy INR Monitoring Programme testing completed on time.	*T*[2]	NEW	80.7%	79.4%	85%	-	✗

1. This lack of result is due to a data extraction issue. There is a planned focus for 2017/18 through implementing MedFix. This is also in response to a recent Certification corrective action requirement.
2. The number of people enrolled in the community pharmacy INR programme is demand driven. Whilst the level of control is favourable the timeliness of completing testing on time fell short of target. The DHB will continue to work with community pharmacies to improve this result.

Community Referred Tests and Diagnostic Services

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, and radiographers. To improve performance, we will target improved primary care access to diagnostics without the need for a hospital appointment to improve clinical referral processes and decision making. Community referred laboratory tests are demand driven.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
No. community referred laboratory tests	*V*	286,241	302,753	303,268	Est. 350,000	-	∞
No. community referred radiology examinations	*V*	10,455	10,771	9,922	Est. 10,500	-	∞
Percentage of accepted referrals for a MRI scan receive their scan within six weeks. Refer PP29.	*T*	90.2%	97.8%	98%	85%	60.8%	✓
Percentage of accepted referrals for a CT scan receive their scan within six weeks. Refer PP29.	*T*	92%	95.5%	94.9%	95%	87.4%	✓
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 14 calendar days. Refer PP29.	*T*	87.5%	89.3%	100%	85%	91.6%	✓
Percentage of people accepted for a non-urgent diagnostic colonoscopy who receive their procedure within six weeks. Refer PP29.	*T*	52.4%	53.5%	71.3%	70%	65.8%	✓
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date. Refer PP29.	*T*	35.8%	50%	89.5%	70%	71.9%	✓

Output class – intensive assessment and treatment services

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.

We provide an extensive range of intensive treatment and complex specialist services to our population and we also fund some intensive assessment and treatment services for our population that are provided by other DHBs. A proportion of these services are driven by demand which we must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or through corrective action. Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed.

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

Success is defined by a reduction in acute demand, increased access to services and timely treatment and increased access to less complex care in the community setting.

Performance against the Health Target for 'Shorter Stays in Emergency Departments' was sustained throughout 2016/17. There was a further growth in acute discharges. The result for acute length of stay was an improvement on the previous year but remains below target and the national result. Further work is planned to be undertaken in 2017-18 year in this area as part of the System Level Measures.

All patients received their radiation or chemotherapy within the target timeframe. Whilst performance against the Health Target for 'Faster Cancer Treatment' had improved on the previous year it fell short of both target and the national result. As processes are refined throughout the patient journey, the DHB will continue to strive to meet this target in 2017/18.

Whilst the target for falls assessment was met the DHB fell short on its internal target for developing individualised care plans. This remains a focus for clinical areas. Timeliness for complaint management has improved and further progress is expected following a review of the complaint management process. Some improvement is noted for compliant moments of hand hygiene and this is expected to improve further with expanded auditing capacity. Hospital acquired blood stream infection rates remain above target but are susceptible to small numbers. Other infection control targets were met.

Elective services indicators were met by the DHB with the exception of secondary services non-contact surgical First Specialist Appointments (FSAs). The target for receipt of prophylactic antibiotics 0 – 60 minutes was not achieved as numbers included four revisions and antibiotics are not given locally until tissue samples have been taken in these cases.

The number of births in the maternity unit was up on the previous year. The target for the percentage of births delivered by caesarean was decreased on previous years and met target. The DHB continues to maintain its Baby Friendly Hospital Initiative accreditation status.

Most ATR activity is below estimated volumes with the exception of outpatient attendances.

The result for percentage of child and youth with a transition plan was below target. This result reflects client/family choice to continue engagement with the mental health service.

Acute Services

These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly creating an urgent need for care. For more complex acute conditions, hospital based services include emergency services, acute medical and surgical services and intensive care services. Productivity measures such as length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
No. of patients seen at ED that are not admitted	*V*	12,894	12,697	12,330	Est ≤. 12,500	-	∞
Percentage of patients discharged or transferred from ED within 6 hours	*T*	97.1%	96.3%	95.6%	≥95%	93%	✓
No. of acute medical/surgical patients discharged from Timaru Hospital	*V*[1]	6,625	7,497	7,676	Est ≤ 7,000	-	∞
Standardised length of stay for acute patients. Refer OS3.	*T*[2]	4.03 (March 2015)	2.88 (March 2016)	2.72	≤2.35	2.53	✗
Percentage of patients who receive requiring radiation or chemotherapy who receive this treatment within four weeks	*T*	100%	100%	100%	100%	-	✓
Percentage of patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	*T*[3]	62.5%	65.9%	75.8%	85%	81.4%	✗
Percentage of older patients assessed for the risk of falling	*Q*[4]	99% (March 2015)	99% (June 2016)	96.1%	90%	-	✓
Percentage of older patients assessed as at risk of falling who received an individualised care plan that addressed these risks	*Q*[4]	94% (March 2015)	87.2% (March 2016)	88%	98%	-	✗
Number of falls in the hospital categorised as a SAC 1 or 2	*Q*	5	5	4	≤5	-	✓
Percentage of complaints responded to within 23 working days	*Q*[5]	79%	81%	91%	100%	-	✗
Percentage of compliant moments of hand hygiene	*Q*[6]	84% (March 2015)	67.3% (March 2016)	76%	80%	83.8%	✗
Hospital acquired blood stream infection rate	*Q*[7]	0.7	0.9	1.1	≤0.5	-	✗
Percentage of ICU central line insertions fully compliant with bundle	*Q*	100%	100%	100%	90%	-	✓
Number of central line acquired bacteraemia	*Q*	0	0	0	0	-	✓

1. The result for 2016/17 shows continued growth in the number of acute admissions.
2. The definition for average length of stay for acute admissions was updated for 2015/16 and therefore results are not comparable with previous years. This result remains above target. In-depth analysis has been undertaken and further work is planned to be undertaken in 2017-18 year as part of the System Level Measures Quality Improvement Plan.
3. The result for 2016/17 shows an incremental improvement on the previous year. Results have been variable throughout the year as these are subject to small numbers. As processes are refined throughout the patient journey, the DHB will continue to strive to meet this target in 2017/18.
4. Whilst the DHB achieved target for falls assessment the result for care planning against our local target was not reached. Areas where compliance is not met are requested to complete an action plan which is monitored.
5. This result is a further improvement on previous years. Complaints are now processed through the Safety 1st programme and the complaint management process is being reviewed.
6. SCDHB's result for 2016/17 is an improvement on the previous year but fall short of target. The DHB audit programme has been expanded to eight clinical areas and more auditors will be trained by December 2017. This will increase opportunities for audit activity and education in changing practise.
7. The result for 2016/17 was not met. It remains sensitive to small numbers. Changes to the Safety 1st programme has also seen increased reporting.

Elective Services

These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes surgery and specialist assessments. National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing population need.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
Total no. of elective First Specialist Assessments (FSA)	*V*	9,313	9,825	10,395	≥9,349	-	✓
No. non-contact secondary services surgical FSAs	*V,T*[1]	766	804	727	≥800	-	✗
No. non-contact secondary services medical FSAs	*V,T*	511	511	883	≥503	-	✓
No. of Cost Weight Deliveries CWDs	*V*	3,788	3,704	3,886.5	≥3,600	-	✓
No. of elective surgical discharges (incl. cardiology & dental)	*V*	3,050	3,093	3,236	≥2,885	-	✓
No. Health Target surgical elective discharges	*V*	2,761	3,169	3,305	≥3,175	-	✓
Standardised length of stay for elective patients. Refer OS8.	*T*[2]	3.27 (March 2015)	1.44 (March 2016)	1.42	≤1.55	1.56	✓
Did Not Attend (DNA) rate for medical/ surgical	*Q*	2.5%	2.9%	2.7%	≤3.3%	-	✓
Percentage of hip and knee replacement patients who receive cefazolin ≥1.5g as surgical prophylaxis	*Q*[3]	95%	93% (June 2016)	100% (December 2016)	95%	-	✓
Percentage of hip and knee replacement patients who receive prophylactic antibiotics 0-60 minutes before incision	Q[3]	95%	93% (June 2016)	90% (December 2016)	95%	-	✗

1. This result has been impacted by locum cover however it is more than offset by the over delivery in face to face FSAs.
2. The definition for average Length of stay for arranged admissions was updated for 2015/16 and therefore results are not comparable with previous years.
3. This safety marker programme has a delayed reporting period with a reporting timeframe 90 day following surgery. The latest result available to the DHB is December 2016. The target for receipt of prophylactic antibiotics 0 – 60 minutes was not achieved as numbers included four revisions and antibiotics are not given until tissue samples have been taken.

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

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2015/16	Current National Average	Achievement Against Target
No. deliveries in the SCDHB Maternity Unit	*V*	582	576	607	Est. ≤ 600	-	∞
Percentage of births delivered by Caesarean Section	*Q*	25%	24.6%	23%	≤24%	-	✓
Post-natal average length of stay	*T*[1]	2.36 days	2.23 days	2.17 days	≥2.5 days	-	✗
Baby Friendly Hospital Accreditation is maintained	*Q*	Yes	Yes	Yes	Yes	-	✓

1. The result for 2016/17 is similar to the previous year and continues to reflect women's choice with encouragement given to remain in the unit until breast feeding and confidence in mother-craft is established. Breast feeding support continues in the home.

Assessment, Treatment and Rehabilitation Services (AT&R)

These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered from a specialist inpatient unit, outpatient clinic and also in the home environment.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
No. of ATR bed days utilised > 65years	*V*	3,672	3,217	2,980	Est. ≤ 3,900	-	∞
No. of ATR bed days utilised <65years	*V*	252	666	282	Est.288.91	-	∞
No. of ATR bed days utilised – psycho-geriatric	*V*	243	183	152	Est. ≤ 200	-	∞
No. of AT&R outpatient attendances	*V*	138	140	190	Est. ≥ 155	-	∞
No. of AT&R domiciliary visits	*V*	1,804	619	833	Est. ≥ 960	-	∞

Specialist Mental Health Services

These are services for the most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services. Ref PP6.	C[1]	5.9% (March 2015)	5.75% (March 2016)	5.48% (March 2017)	6.2%	3.79% (March 2017)	✗
Percentage of people (aged 20 – 64) who have accessed specialist mental health services. Ref PP6.	C[1]	4.19% (March 2015)	4.3% (March 2016)	4.23% (March 2017)	4.4%	3.9% (March 2017)	✗
Percentage of people (aged 65+) who have accessed specialist mental health services. Ref. PP6.	C	2.4% (March 2015)	1.81% (March 2016)	2.01% (March 2017)	1%	1.92% (March 2017)	✓
Percentage of people 0 – 19 referred for non-urgent mental health services seen within three weeks. Refer PP8.	T	85.7% (March 2015)	90.2% (March 2016)	85.4% (March 2017)	80%	69% (March 2017)	✓
Percentage of people 0 – 19 referred for non-urgent mental health services seen within eight weeks. Refer PP8.	T	96.4% (March 2015)	98.3% (March 2016)	95.3% (March 2017)	95%	91% (March 2017)	✓
Percentage of people 0 – 19 referred for non-urgent addiction services seen within three weeks. Refer PP8.	T[2]	96.7% (March 2015)	83.3% (March 2016)	73.9% (March 2017)	80%	86% (March 2017)	✗
Percentage of people 0 – 19 referred for non-urgent addiction services seen within eight weeks. Refer PP8.	T[2]	100% (March 2015)	94.4% (March 2016)	91.3% (March 2017)	95%	97% (March 2017)	✗
Percentage of child and youth with a transition (discharge) plan. Ref PP7.	Q[3]	94.6% (March 2015)	89.2% (March 2016)	84.7% (March 2017)	95%	-	✗

1. The DHB responds to all identified need, including the provision of a walk-in service. A single point of entry utilising the Choice & Partnership Approach (CAPA) approach is employed and there is no waiting list.
2. The main factors influencing this result are client/family choice and staff vacancies.
3. Data collected measures completed transition plans and this result is impacted by those clients who disengage with the service prior to the plan being completed. The client's general practitioner is informed of the client's disengagement.

OUTPUT CLASS – 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 with appropriate end of life care irrespective of the setting where this occurs.

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

Palliative Care service provision in the home is driven by demand.

Timeliness in the completion of InterRAI assessments exceeded target.

Total volumes for Home and Community Support Services are demand driven and were slightly above estimated delivery.

Palliative Care

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.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
No. clients accessing a South Canterbury Hospice bed	*V*	155	175	163	Est. ≥ 150	-	∞

Needs Assessment & Support

These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
Percentage of InterRAI first assessments completed within target timeframe	*T*	90%	95%	96%	90%	-	✓

Home & Community Support

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.

	Notes	2014/15 Result	2015/16 Result	2016/17 Result	Target/ Estimated Delivery 2016/17	Current National Average	Achievement Against Target
No. people (total) supported by Home Based Support Services	*V*[1]	1,022	1,090	1,140	Est. 1,000	-	∞
No. high and complex dementia patients supported by Home Based Support Services	*V*[1]	18	20	28	Est. 20	-	∞

1. These results relate to the average number of clients supported each month.

Getting Better

Our Annual Report 2016/2017

Your feedback

In order to continue to improve on the information we provide to you, we welcome your feedback on this document.

Please complete your contact details and your feedback on the next page, cut along the dotted line and post it back to us at:

Annual Report Feedback

South Canterbury District Health Board
Private Bag 911
High Street, Timaru

Alternatively, you can email your feedback to:

nhoskins@scdhb.health.nz

South Canterbury
District Health Board

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My feedback

Our Values

Integrity

We will always act with the utmost integrity.

Collaboration

We will actively collaborate with others.

Accountability

We promote accountability.

Respect

We will show respect to all.

Excellence

We strive for excellence in everything we do.

South Canterbury
District Health Board

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