Southern District Health Board
Piki Te Ora

Annual Report

Quality and Performance Account

2017/18

This Southern District Health Board Annual Report 2017/18 is presented to the House of Representatives pursuant to section 150(3) of the Crown Entities Act 2004.

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Contents

From the Commissioner & Chief Executive

It has now been three years since the Commissioner team was appointed to oversee Southern District Health Board. Where the first years were focused on understanding the priorities of the community through our Southern Future programme, achieving greater stability and putting in place the structures for sustainable success, 2017/18 could be described as the year of gathering momentum.

Over generations, numerous health care structures have been established across our geographically vast district to enable us to take care of one another. The challenge we share is to ensure that all of these efforts combine in the best possible way to provide the care our communities need, in the right place, at the right time, while demand for services increases.

We have made some good progress in areas including virtual telehealth, reducing need for patients to travel for specialist appointments, and working with the Community Health Council to ensure the patient perspective is central to everything we do.

This year's Annual Report outlines areas where we performed strongly and have made gains, such as supporting smokers to quit and maintaining high participation rates in screening programmes, which now include bowel screening. These are important foundations for a healthy community and we acknowledge the efforts of everyone who has contributed to this. There are however areas where there are challenges, including timely access to diagnostics and specialist assessments.

We also need to address the widening equity gap between health outcomes for Māori and non-Māori in our district, and are reshaping Māori leadership and governance roles across our primary and secondary systems to support an integrated, whole-of-system approach to this important challenge.

Over the past year a stronger, comprehensive roadmap has taken shape to take us from our current state, to a truly integrated health system that sets us up for the future and is aligned with national priorities.

At the heart of this was the launch of the Primary and Community Care Strategy and Action Plan (see p53). Developed through extensive research and consultation with the community, the Strategy envisages a health system that is more coordinated, accessible and delivered closer to home where possible. It spells out the practical steps required to achieve this and, importantly, calls upon all providers of health services in our district to present our services in a way that makes it easier for our communities to navigate. Building a stronger shared identity as members of the Southern health system reinforces our shared purpose, commitment to working together, and delivering care in a seamless and integrated way. The Alliance Leadership Team has now been reformed to support this work.

As we reconsider the patient journey through our services, we have also needed to examine our secondary services. Our ongoing clinical service design programmes have been collected under the banner Valuing Patients' Time (see p57). This work is concerned with patient flow through our hospital system, including ensuring appropriate interfaces with primary care, to remove steps that add time with no value to our patients. Developing this programme further will become a significant focus in 2018/19.

A particular area for attention in 2017/18 has been streamlining our surgical processes. We have also needed to address critical service challenges, including long delays in care in our urology and ophthalmology services that had led to harm to our patients. We are pleased to report that we have significantly reduced the number of ophthalmology patients waiting longer than the clinically acceptable wait times, and have sustained zero waiting lists on the Southland site for several months. The backlog of those waiting for follow up urology appointments was cleared through a series of weekend super-clinics assisted by clinicians from around New Zealand, and there have been no further serious adverse events in our urology service reported.

In order for all of our service design programmes to succeed long term, we know we need to ensure our technology and business systems provide the right support, and our people are appropriately developed and supported for our future needs. We have therefore progressed the development of digital and workforce strategies (see p66) to provide ongoing guidance for our investments in developing our internal culture and work environment, organisational capability and leadership, business and IT systems, quality improvement processes and communications with our communities.

We have also been working extensively on planning our facilities for the future (see p72). Most publicly, we have been planning for the rebuild of Dunedin Hospital, and this year welcomed the announcement of a city site near the existing hospital, and have dedicated our efforts to developing the functional brief for this facility. We also celebrated the opening of a new

gastroenterology department at Dunedin Hospital, in time for the roll-out of the national bowel screening programme at Southern DHB.

We are also committed to improving our facilities in the fast-growing Queenstown-Lakes area, finalising the design and gaining resource consent to develop the emergency, diagnostics and transfer capabilities at the hospital. The primary and community care strategy is further providing a roadmap to help us plan the additional facilities we need, including a network of community health hubs across the district.

By addressing both primary and secondary care infrastructure in tandem, we have a unique opportunity to ensure our whole health system is designed to meet the needs of our community, and set us up for the future.

All of this needs to be built on a foundation of ensuring a society that makes staying well more likely. The work of our public health team and others in nurturing wellness remains critical.

While making investments in these areas have slowed our pathway to a break-even financial position, we have continued to contain costs, and are reporting a similar financial result to last year, at $21.4 million deficit (slightly less than the $21.9 million deficit reported in 2016/17).

In all this work, we value our partnerships with the rural hospital trusts, primary and community care providers across the district, and iwi and education partners. By working together, and drawing upon the exceptional capability of our 4,600 staff and partners in the community, we are committed to delivering the health system the people of our district have asked us for.

Kathy Grant
Commissioner

Chris Fleming
Chief Executive Officer

Statement of Responsibility

For the 12 months ended 30 June 2018

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

The Commissioner team and management of Southern DHB accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non-financial reporting. In the opinion of the Commissioner team and management of Southern DHB the financial statements and statement of service performance for the year ended 30 June 2018 fairly reflect the financial position and operations of Southern DHB.

Chris Fleming
Chief Executive Officer
29 October 2018

Kathy Grant
Commissioner
29 October 2018

Our History

Better Health, Better Lives, Whānau Ora

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

Our Story

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

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

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

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

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

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

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

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

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

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

Partnership with Iwi

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

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

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

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

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

Mauri ora ki a tātou katoa.

Our Purpose

Better Health, Better Lives, Whānau Ora

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

The statutory (NZPHD Act 2000) purpose of Southern DHB is to:

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

This is achieved through:

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

Our Governance

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

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

Our Present

Highlights from 2017/18

Southern DHB and WellSouth's Primary and Community Care Strategy and Action Plan launched, reshaping services

The national bowel screening programme was launched for the Southern district

The planned rebuild of the new Dunedin Hospital, and central city site, was announced

The Home as my First Choice initiative was launched, promoting options for older people wanting to stay in their homes

The Oranga-Pepi programme was introduced, to improve whānau awareness of entitlements for newborn babies, so they can get the best start in life

4,655 staff employed at Southern DHB

About us

OUR POPULATION:
We are the DHB in New Zealand with the largest geographical area

The Southern district has a population of 326,280 residents, the majority living in Dunedin and Invercargill

There were a total of 3,379 babies born in the Southern DHB last year with the majority of these occurring at Dunedin Public Hospital and Southland Hospital

Highlights from 2017/18

84,110
presentations to Emergency Departments

Ethnically the Southern district is predominantly European, at 81%. 10% are Māori, 7% Asian and 2% Pacific

Our population is slightly older when compared to the national average
54,860 people are aged 65 and over

elective procedures

Speak Up programme, promoting a positive workplace culture, exceeds 2,500 participants

New gastroenterology department opened

The number of teenagers who have never smoked continues to rise

Southern DHB met the Faster Cancer Treatment target for the first time

Resource consent was gained for redevelopment of Lakes District Hospital

Significant improvement in supporting smokers to quit in a hospital setting

Our Pathway

The Southern district is a vast landscape, where resourceful and capable people have built health care structures to enable us to take care of each other. **Now we need to bring it all together.**

What have our people asked for?

Southern Future
It's up to us

- Better coordinated care across providers, with less wasted time
- Care closer to home
- Communication that makes sense and is respectful
- A calm, compassionate and dignified experience
- High quality, equitable health services and outcomes

How will we get there?

THE SOUTHERN STRATEGIC HEALTH PLAN:

IMPROVING EXPERIENCE & OUTCOMES

Creating an environment for good health
The environment and society we live in supports health and well-being

Primary & Community Care
Care is more accessible, coordinated and closer to home

Clinical service design - 'Valuing Patients' Time'
Patients experience high quality, efficient services that respect their time

ENABLING SUCCESS

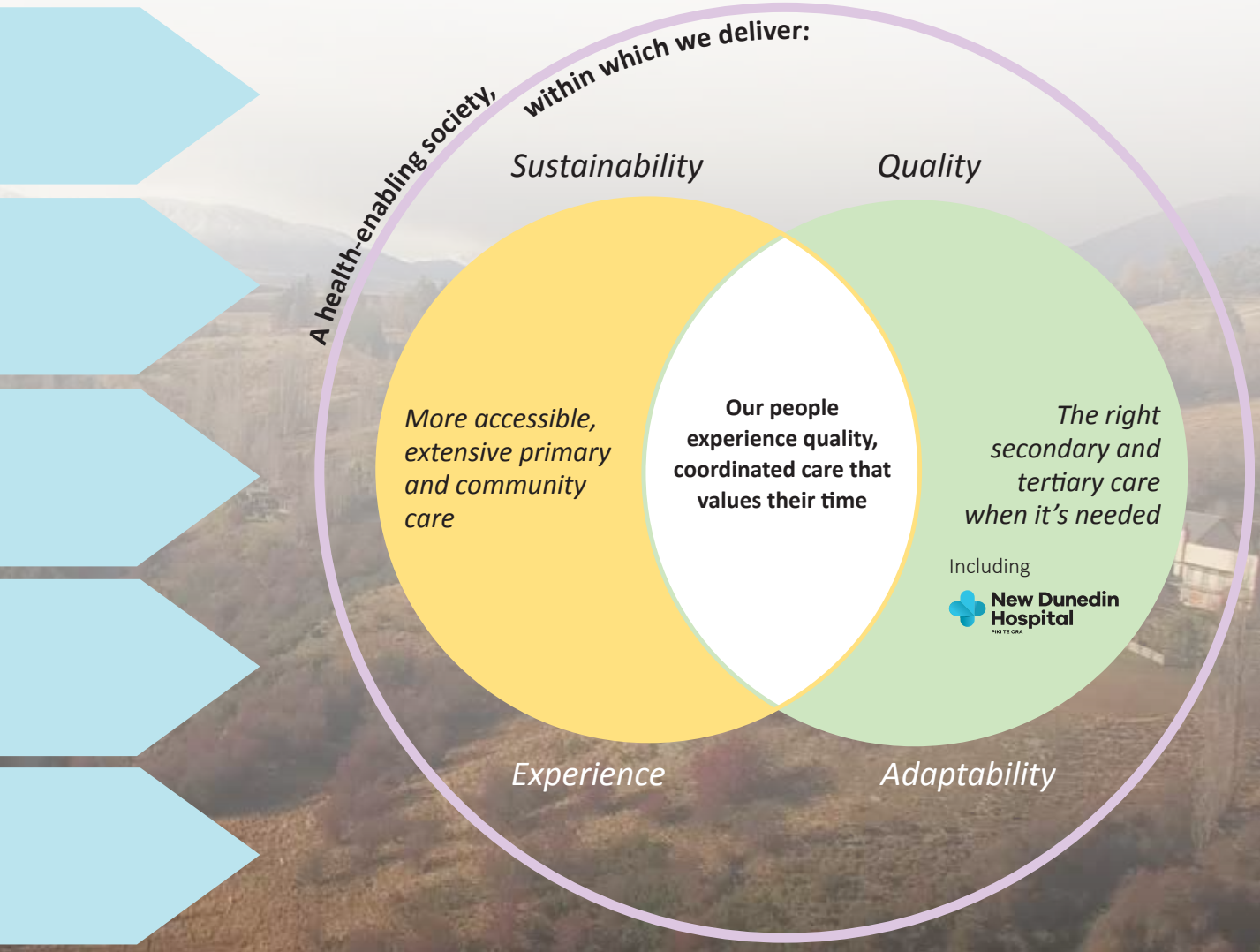
Enabling people & systems
People have the skills, support and passion to deliver the care our communities have asked for. Our systems make it easy for our people to manage care, and to work together

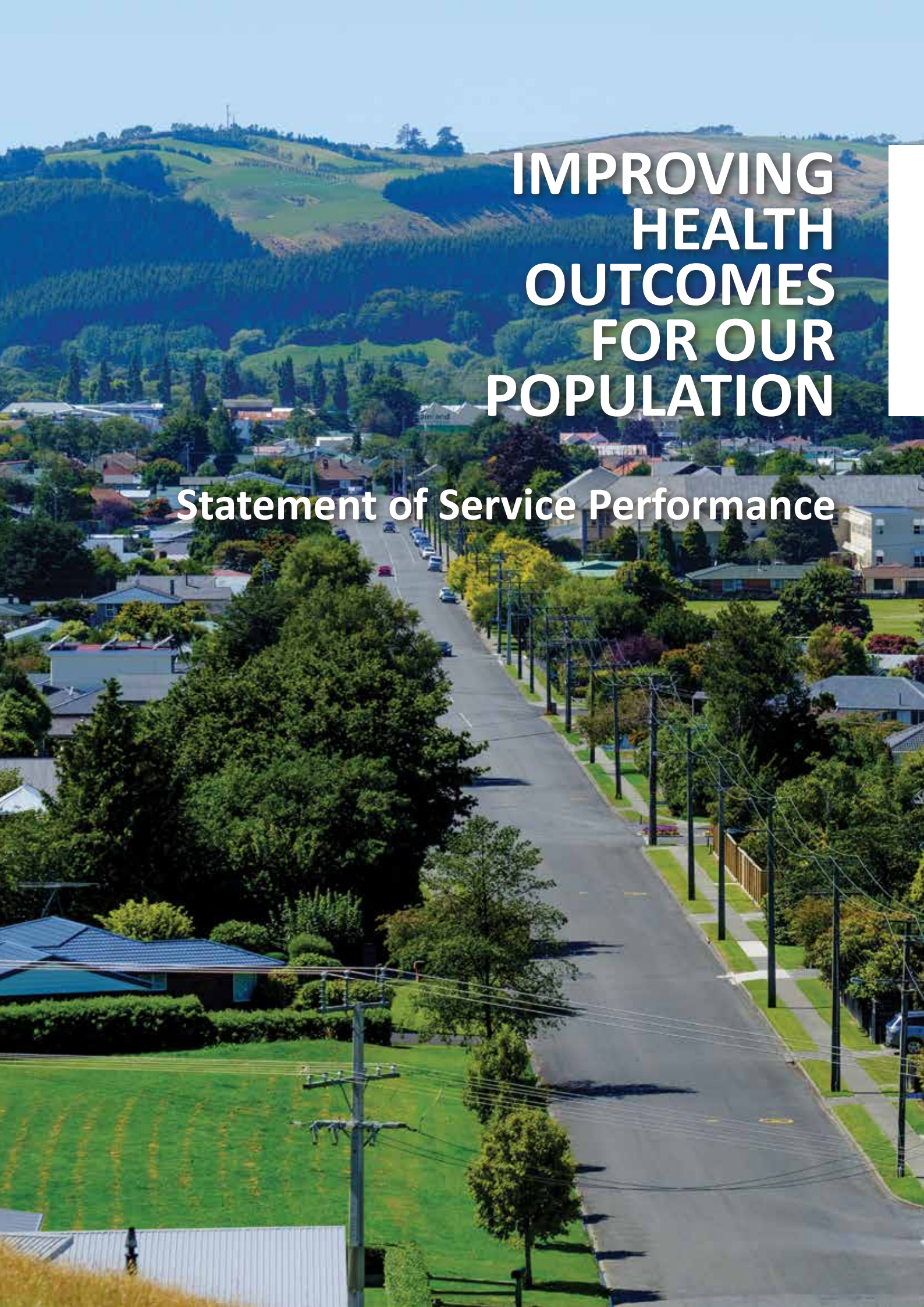
Facilities for the future
Including Dunedin Hospital, Lakes District Hospital redevelopment and community hubs to accommodate and adapt to new models of care

So that our people:

- are healthier and take greater responsibility for their own health (p15)
- stay well in their own homes and communities (p20)
- with complex illness have improved health outcomes (p27)

By 2026: We work in partnership to build:





IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

Statement of Service Performance

Statement of Service Performance

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

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

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

Improving Health Outcomes for Our Population

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

The South Island DHBs have collectively identified three strategic outcomes and a core set of associated indicators, which demonstrate whether we are making a positive change in the health of our populations.

These are long-term outcomes (5-10 years in the life of the health system) and, as such, we are aiming for a measurable change in the health status of our populations over time, rather than a fixed target.

The three strategic outcomes outlined in the 2017/18 Annual Plan with associated outcome and impact measures are shown below.

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

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

Why is this important?

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

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

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

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

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

How did we perform?

To date we have seen varied performance in the measured areas. Uptake of smoking by youth (as measured by the year 10 ASH survey) has declined, but smoking rates have increased in the general population for those aged 15+. Breastfeeding rates exceed our target for the general population but rates have fallen for Māori. A range of different initiatives are being pursued to improve performance across these areas.

Outcome: Smoking

New Zealand has comprehensive tobacco control policies and programmes, yet smoking remains the leading modifiable risk factor for many diseases, such as cancer, respiratory disease and stroke. In addition, tobacco and poverty are inextricably linked.

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

Southern DHB's smoking rate data is acquired from the NZ Health Survey; unfortunately the 2017/18 data is yet to be published. 2016/17 data, published in the last year, saw a rise in reported number of smokers and Southern's rate continues to remain above the national average.

We have continued to focus on assisting people to quit smoking including incentivising commitment to quit, and increasing access by improving referral pathways to smoking cessation services. Over the past year, 91 per cent of smokers in primary care were provided with brief advice and offered cessation support.

Percentage of the population (15+) who smoke

	2013/14	2014/15	2015/16	2016/17	2017/18
Southern DHB	15.4%	15.9%	14.90%	19.30%	Not available
New Zealand	17.4%	16.6%	16.30%	15.70%	Not available

Data sourced from national NZ Health Survey.

17/18 data not yet available. Note the Ministry of Health has changed its reporting methodology compared to what has been previously reported.

Celebrating smokefree outdoor dining

Market Kitchen on George Street Dunedin offers a healthy environment inside and out. Owner Alison Lambert was presented with a Smokefree Otago award on World Smokefree Day on 31 May for making the outdoor area of her café smokefree.

Photo of Alison Lambert and Sophie Carty, Cancer Society Health Promotion & Advocacy Manager

Outcome: Obesity

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand.

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

Southern has continued investing in a number of programmes to tackle obesity in our district, including Green Prescription (GRx) and Active Families. Health professionals can refer clients or people can self-refer themselves to GRx or Active Families for support to increase their physical activity.

Additional resources, in the form of the "Be Smarter" tool and Ministry of Health tip sheets, have also been shared and promoted with the WellChild Networks and Physical Activity and Nutrition Networks (Otago and Southland) for those who are working with children to achieve healthy weight.

Refinement of programmes and resources has meant consistent messages for healthy living across all periods of the life course (pregnancy, infancy, childhood, adulthood):

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

Southern DHB has additionally been supporting healthy public policies, such as improving the built and food environments in which people live and work. Examples include promoting breastfeeding friendly public spaces, venues and retailers, and working with venues to encourage simple steps to make people feel comfortable about breastfeeding when they need to.

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

	2013/14	2014/15	2015/16	2016/17	2017/18
Southern DHB	28.1%	29.1%	29.60%	31.40%	Not available
New Zealand	29.9%	30.7%	31.60%	32.20%	Not available

Data sourced from national NZ Health Survey

17/18 data not yet available. Note the Ministry of Health has changed its reporting methodology compared to what has been previously reported.

Impact Indicator: Breastfeeding

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

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

73%

of mothers have established breastfeeding at LMC discharge following birth

A new online newborn enrolment form was launched in 2017/18 and includes enrolment with General Practice, PHO, WellChild and immunisation services. This provides opportunities for mothers to be offered support and advice from the many health services their newborn baby is eligible for.

To guide future planning, in 2017/18 the DHB participated in a South Island stocktake of breastfeeding promotion activities, which sought to identify opportunities to improve access and availability of community-based breastfeeding support services.

Actions from this stocktake will progress in 2018/19.

Percentage of babies fully/exclusively breastfed at 6 weeks

	2015/16	2016/17	2017/18	
	Actual	Actual	Target	Actual
Southern DHB	75%	73%	>70%	73%
Southern DHB Māori	70%	73%	>70%	67%
New Zealand	73%	73%	>70%	72%

Impact Indicator: Oral Health

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

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

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

Good access to care will increase the likelihood of improved oral health, which is measured as the percentage of children aged five years who are caries free (have no holes or fillings).

Southern DHB continues to offer family appointment bookings, as well as providing services over the school holidays. Caries-free rates have fluctuated slightly in the last year, attributable to staffing shortages in the health promotion and dental therapist teams. Workforce shortages are not limited to Southern DHB however, indicating a broader challenge in staffing.

Percentage of 5-year-olds who are caries free

	2015	2016	2017	
	Actual	Actual	Target	Actual
Southern DHB	60%	69%	>70%	67%
Southern DHB Māori	64%	58%	>70%	53%
New Zealand	59%	60%	>70%	Not available

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

67%

of 5-year-olds have no holes or fillings

Medium Term Indicator: Reduced Smoking

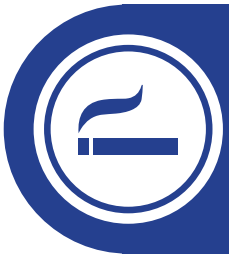
Most people who smoke will begin by 18 years of age, and the highest prevalence of smoking is among younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up smoking.

The number of Year 10 students who have 'never smoked' continues to rise in Southern. A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Percentage of Year 10 students who have 'never smoked'

	2015	2016	2017	
	Actual	Actual	Target	Actual
Southern DHB	80%	81%	>70%	83%
New Zealand	79%	79%	>70%	82%

Data Source: ASH Year 10 Survey



83%

of Year 10 students have never smoked

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

Why is this important?

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

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

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

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

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

How did we perform?

We are supporting more people to stay in their own homes for longer. In 2017/18 the number of people aged 75 and over living in their own home increased slightly to 87.3 per cent. This is in the context of the number of people aged over 65 being supported at home by community support services also increasing. This indicates that the investments and changes to primary and community services are having the desired effects.

There are however still significant opportunities for improvement. Growth in demand for MRIs has led to the decrease in target performance for MRI access, an issue that requires ongoing management. The rate of hospital admissions caused by a fall has also risen slightly by 0.7 per cent for those aged over 75 years, and needs to be an area of focus.

Outcome: Acute Medical Admissions

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

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

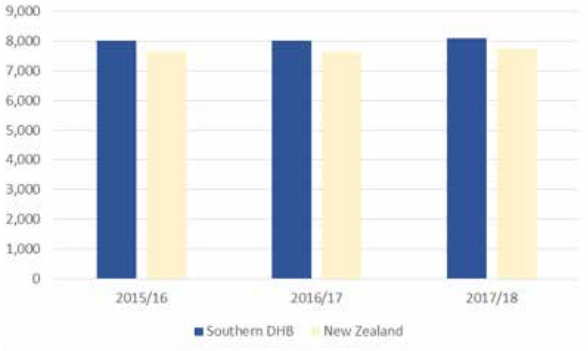
The Internal Medicine Assessment Unit (IMAU) opened at Dunedin Hospital in 2017/18 relieves some pressure on the Emergency Department (ED), meaning reduced waiting times for patients. The majority of patients the IMAU will receive are likely to be older patients with multiple medical conditions from the ED, who often require further investigations and care, but not emergency treatment.

By expanding Primary Options for Acute Care (POAC), patients are able to access care closer to their homes. This also mitigates the need for some hospital admissions.

Finally, the Client-Led Integrated Care programme developed by the Long-Term Conditions Network utilises a range of assessment tools to help determine the types of support patients may require to best manage their long-term conditions – preventing the need for acute medical admissions.

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

	2015/16	2016/17	2017/18
Southern DHB	8,028	8,023	8,109
New Zealand	7,644	7,638	7,759



Data sourced from National Minimum Data Set.

81,124
presentations to Emergency Departments across the Southern district

Outcome: People Living at Home

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

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

In the coming years we are expecting to see more people entering directly into hospital and dementia level care services, as they live longer in their own homes rather than entering a residential care facility at rest home level first.

87%

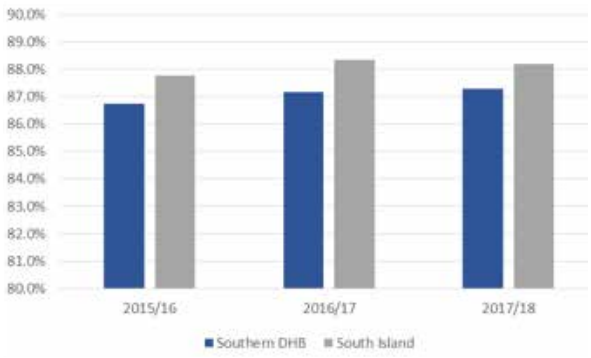
of people aged 75+ live in their own home

99%

people on long-term Home and Community Support Services have received a comprehensive clinical assessment

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

	2015/16	2016/17	2017/18
Southern DHB	86.7%	87.2%	87.3%
South Island	87.8%	88.4%	88.2%
New Zealand	88.0%	89.0%	Not available



Medium Term Indicator: Earlier Diagnosis

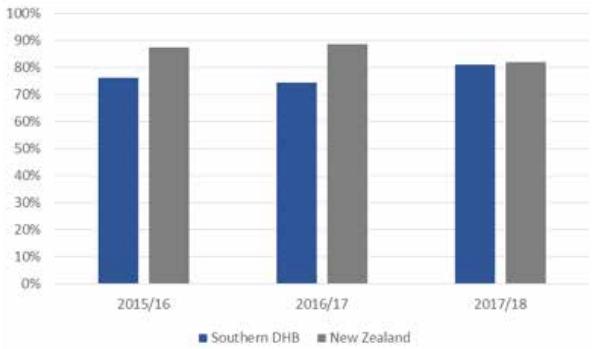
Diagnostics are an important part of the health-care system. Timely access improves clinical decision-making and enables early and appropriate intervention, ultimately affecting quality of care and outcomes for our population.

The radiology service continues to experience increasing levels of demand which is negatively impacting on timeliness. While improvements were made in relation to waiting times for CT scans, Southern did not meet the specified targets despite focusing on hours of operation, improving utilisation of CT resource across the whole catchment, and further recruitment and training of staff.

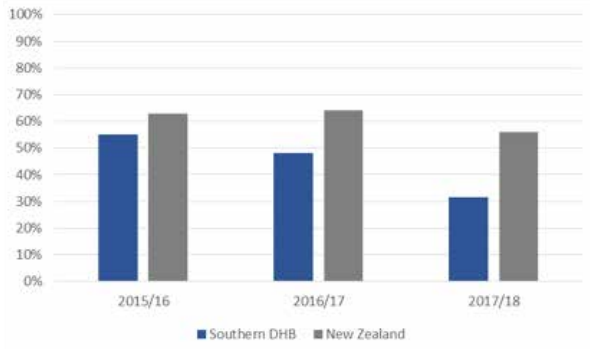
MRI performance continues to be lower than required to meet the target, with several factors contributing to this shortfall. Acute MRI demand at Dunedin Hospital has increased over this period and continues to be at high levels. It is also noted that the complexity of examinations requested is increasing. There have been ongoing staffing shortages at Southland Hospital. With two, soon to be three MRI Technologists now being on the roster, the situation is improving, but the service is still extremely vulnerable to unplanned staff absence or resignations.

Southern DHB is undertaking measures to increase MRI performance. Southland Hospital MRI has utilised additional general X-ray staffing to release MRI staff to perform additional shifts in MRI and the waitlist at this site is now reducing. The proposal to introduce an MRI weekend shift at Dunedin has been approved with recruitment expected to be complete by December 2018. Alongside this Southern DHB is exploring the potential for utilisation of other MRI scanners. Southland Hospital MRI will be replaced in the 2018/19 year.

Percentage of CT scans within 6 weeks



Percentage of MRI scans within 6 weeks



Data source: Individual DHB patient management systems.

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

	2015/16	2016/17	2017/18	
	Actual	Actual	Target	Actual
Southern DHB	76%	74%	>95%	81%
New Zealand	87%	88%	>95%	82%

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

	2015/16	2016/17	2017/18	
	Actual	Actual	Target	Actual
Southern DHB	55%	48%	>95%	32%
New Zealand	63%	64%	>95%	56%

81%

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

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

Medium Term Indicator: Avoidable Hospital Admissions

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

Lower avoidable hospital admission rates, measured as Ambulatory Sensitive Hospitalisation (ASH) rates, are seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

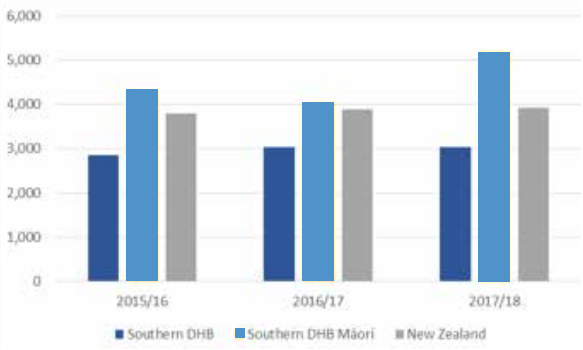
Total ASH rates have increased slightly in Southern, as they have across New Zealand. The reasons for this are not fully understood but could be related to increased demand for urgent care and Emergency Department (ED) attendances. Despite declining in recent years, the ASH rate for Māori in Southern rose significantly in 2017/18. Further work needs to be undertaken to understand why rates have suddenly increased, despite work underway to improve primary care access and scope – such as expansion of Primary Options for Acute Care (POAC), and further development of Long-Term Condition support (now CLIC).

There was an increase in the most prevalent clinical conditions contributing to Southern DHB's ASH rate for children aged 0 to 4 years in 2017/18, including upper/ENT respiratory infections, dental conditions and gastroenteritis/dehydration. However, it should be noted that the rate of hospitalisation related to asthma significantly decreased in this time period. Hospitalisation for respiratory infections could result from a number of different factors such as inability to heat homes and the poor quality of housing. Southern DHB is addressing this through initiatives such as Cosy Homes, stop smoking programmes, outreach teams, immunisation and provision of more POAC consultations in a general practice environment.

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

	2015/16	2016/17	2017/18	
	Actual	Actual	Target	Actual
Southern DHB	2,851	3,026	<2,844	3,034
Southern DHB Māori	4,295	4,003	<2,844	5,164
New Zealand	3,795	3,881	N/A	3,925

Prior year results may differ from those previously reported. The MOH recalculates prior year ASH rates based on updated extracts from the National Minimum Dataset (NMDS) and updated population estimates



This indicator is based on the national performance indicator SI[1] and covers hospitalisations for a range of conditions which are considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis.

Medium Term Indicator: Falls Prevention

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

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

In 2017/18 we have experienced an increase in the rate of falls. Contributing factors include the increase in the number of frail elderly living at home, which is seen in the reduction in rest home bed days per capita and increase in the total number of eligible people aged over 65 years supported by home and community support services (HCSS). We may also be experiencing the consequences of a lack of falls prevention services five to ten years ago.

A number of initiatives are being undertaken to address the number of falls in the Southern district:

In July 2017, with leadership from our Southern Alliance Falls & Fracture Steering Group, we commenced work with WellSouth, our Primary Health Network to:

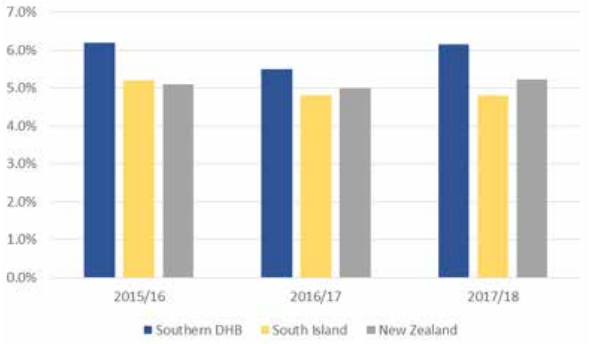
- Establish in-home Strength and Balance (a new programme supported by ACC funding)
- Integrate our Falls Portal/Fracture Liaison Service into our Primary Care Client-Led Integrated Care (CLIC) programme
- Expand the options for community Strength and Balance classes, supported by the lead agency.

These programmes are being implemented gradually across our district. It is anticipated that greater benefit will result from service provision over a number of years, by targeting interventions at those that have the most to gain and by delivering the programme on scale, rather than through small-scale projects.

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

	2015/16	2016/17	2017/18	
	Actual	Actual	Target	Actual
Southern DHB	6.2%	5.5%	<5.0%	6.2%
South Island	5.2%	4.8%	<5.0%	4.8%
New Zealand	5.1%	5.0%	-	5.2%

Data Source: National Minimum Data Set



849

people referred to the Fracture Liaison Centre

42

people attended ARRC falls prevention education sessions focused on quality improvement

324

hip fracture ACC claims in 2016

Outcome 3.
People with Complex Illness Have Improved Health Outcomes

Why is this important?

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

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

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

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

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

How did we perform?

We continue to keep people well in the community as demonstrated by the relatively stable hospital readmission rate, which mirrors the New Zealand average.

Timeliness to access some services such as the Emergency Department and elective surgery is an ongoing challenge, however Southern was able to meet the ED target in Quarter 2 of 2017/18.

Outcome: Acute Readmissions

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

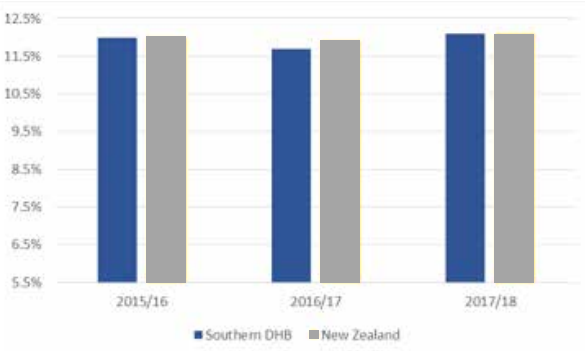
The key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge. Therefore, they are a useful marker of the quality of care being provided and the level of integration between services.

Southern readmission rates largely reflect the national average; both rates have increased slightly in the last year.

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

	2015/16	2016/17	2017/18
Southern DHB	12.0%	11.7%	12.1%
New Zealand	12.0%	11.9%	12.1%

Data source: Ministry of Health Performance Reporting OS8. The results differ to those previously published following a further reset of the definition by the Ministry of Health in 2017/18.



Outcome: Mortality Rates

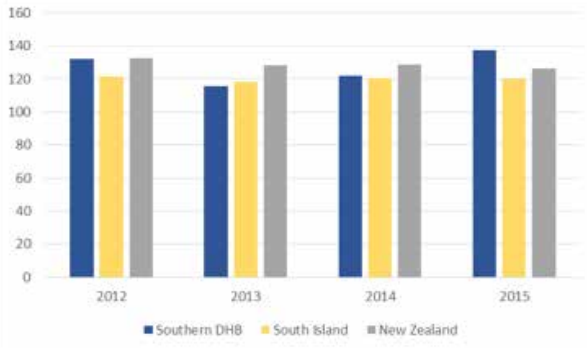
Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced. Southern has seen an overall reduction in preventable mortality since 2011. However rates have climbed slightly in 2014 and 2015 , indicated to be due to increases in rectal and prostate cancer. The combination of the bowel screening roll-out which commenced late 2017/18, and Faster Cancer Treatment initiatives improving timeliness to treatment are expected to improve outcomes in this area.

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

	2012	2013	2014	2015
Southern DHB	132	115	122	137
South Island	121	118	120	120
New Zealand	132	128	129	126

Data source: Ministry of Health Mortality Collection. There is a delay in mortality data as the cause of death has to be established for all reported deaths. Data is currently only available to 2015.



Medium Term Indicator: Waits for Urgent Care

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

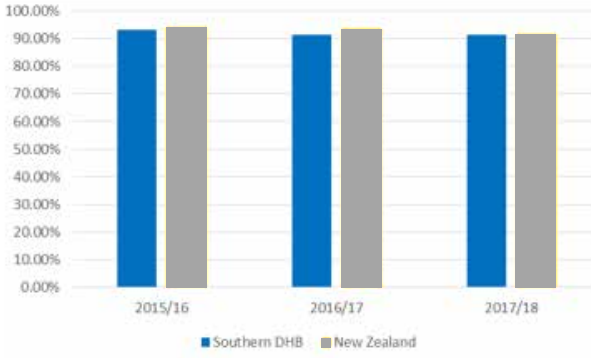
Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.

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

Increasing numbers of people attending EDs in the Southern district continue to place pressures on the system. The Internal Medicine Assessment Unit (IMAU) opened at Dunedin Hospital in 2017/18 in order to take some pressure off the Emergency Department. The majority of patients the IMAU will receive are likely to be older patients with multiple medical conditions from the Emergency Department, who often require further investigations and care, but not emergency treatment.

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

	2015/16	2016/17	2017/18	
	Actual	Actual	Target	Actual
Southern DHB	93.2%	91.5%	>95.0%	91.4%
New Zealand	94.1%	93.5%	>95.0%	91.8%



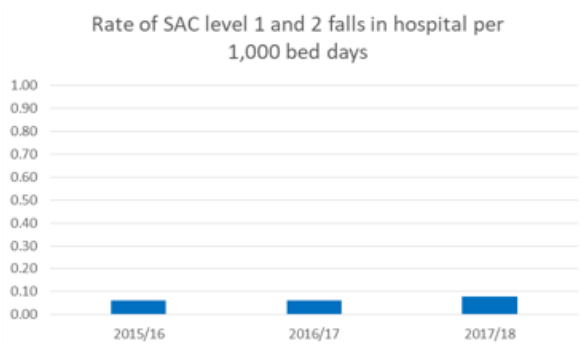
Medium Term Indicator: Adverse Events

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

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

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

	2015/16	2016/17	2017/18	
	Actual	Actual	Target	Actual
Southern DHB	0.06%	0.06%	0.05%	0.08%



Data Source: Individual DHB Quality Systems

Medium Term Indicator: Access to Planned Care

Each year, Southern DHB receives an allocation of funding for elective (planned) surgery and for specialist assessments, based on our population. We monitor the time it takes to see and to treat our patients, so that we can effectively manage our patient flow processes in line with the principles of clarity, timeliness and fairness.

We know how long each patient waits from a referral for a specialist appointment to the actual appointment date. This should be no longer than four months, although some patients will be seen much sooner than that because of their clinical priority. We also know how long it takes from when the decision is made that a patient will benefit from surgery (and the patient meets the minimum clinical priority score for surgery), to the date of surgery. Again this should be no longer than four months; some patients are assessed as having very high clinical need and they will be seen sooner.

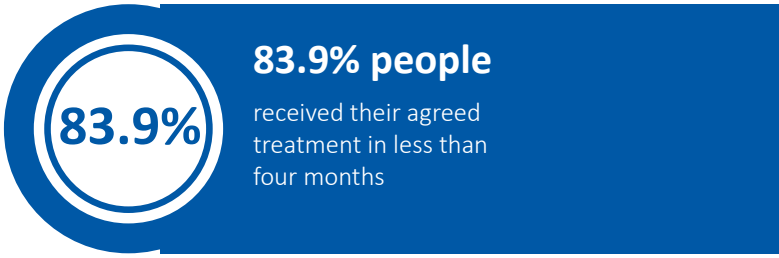
2017/18 saw an increase in the number of patients who have had to wait longer than four months for their specialist appointment (to 9.4 per cent) and for surgery (to 16.1 per cent). Contributing factors include the increase in the volume of referrals and follow up appointments for some services, as well as some difficulties in timely recruitment of health professionals in some specialties. We are working in several areas to improve the situation, with a particular focus to increase our capacity to see patients (more clinics and more theatre time) and to improve our efficiency in providing the clinical service (use of technology such as telehealth, providing "see and treat" appointments, and introducing Nurse Specialist Clinics).

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

	2015/16	2016/17	2017/18	
ESPI 2	Actual	Actual	Target	Actual
Southern DHB	98.8%	97.8%	100.0%	90.6%
New Zealand	99.2%	99.4%	100.0%	97.8%

	2015/16	2016/17	2017/18	
ESPI 5	Actual	Actual	Target	Actual
Southern DHB	99.2%	92.0%	100.0%	83.9%
New Zealand	99.4%	97.9%	100.0%	90.1%

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



National Health Targets

During the 2017/18 year Southern DHB saw variable performance across the health targets. Some of these targets involve work being undertaken in primary care with our health partners.

Shorter stays in Emergency Departments

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

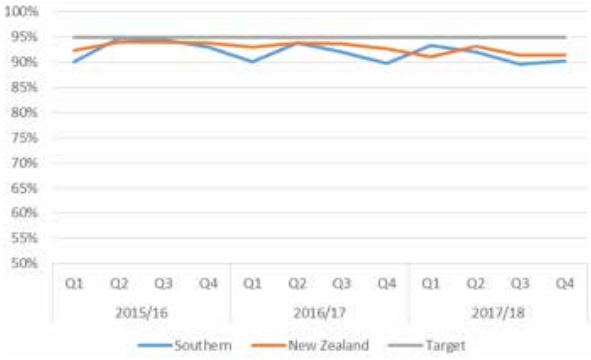
The number of people accessing the Emergency Departments continues to increase. This is putting increased pressure on existing staff and resources to consistently manage patients in a timely way.

To reduce the number of people turning up at the Emergency Department, a number of initiatives have been implemented or are planned. Work was undertaken with Student Health to decrease non-urgent ED attendances, while the development of the Internal Medicine Assessment Unit has enabled short stay medical patients to be transferred, aiding flow and ensuring right-time/right-place care.

Clinical Nurse Specialists have also been deployed to work in the early assessment zone of the Emergency Department, enabling earlier triage of patients into the right pathway of care.

	2017/18			
	Q1	Q2	Q3	Q4
Target	>95%	>95%	>95%	>95%
SDHB	93%	92%	90%	90%
NZ	91%	93%	91%	91%

Figure 1: Shorter stays in Emergency Departments



Improved Access to Elective Surgery

Nationally, DHBs will deliver an increase in the volume of elective surgery by an average of 4,000 per year. Southern will deliver at least 13,190 elective procedures in 2017/18.

A total of 13,219 elective procedures were completed in 2017/18. This is against a target of 13,190.

Steps undertaken to improve performance included extending the hours for operating theatres, implementing a new production planning process, and supporting projects to further optimise theatre time.

	2017/18			
	Q1	Q2	Q3	Q4
Target	100%	100%	100%	100%
SDHB	98%	99%	99%	100%
NZ	104%	102%	102%	103%

Figure 2: Improved access to elective surgery

Faster Cancer Treatment

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

Southern DHB has shown improvement on the percentage of patients receiving their first cancer treatment within 62 days, meeting the target in Quarter 3 of 2017/18, the first time this target has been achieved.

The DHB has been undertaking detailed analytics and refining pathways accordingly to improve performance. Changes include improving the tracking of patient journeys, establishing a one-stop first specialist appointment and diagnostic clinic in Urology, and refining inter-departmental and inter-DHB referral processes.

	2017/18			
	Q1	Q2	Q3	Q4
Target	>90%	>90%	>90%	>90%
SDHB	86%	89%	90%	85%
NZ	92%	92%	91%	91%

Figure 3: Faster cancer treatment

Increased Immunisation

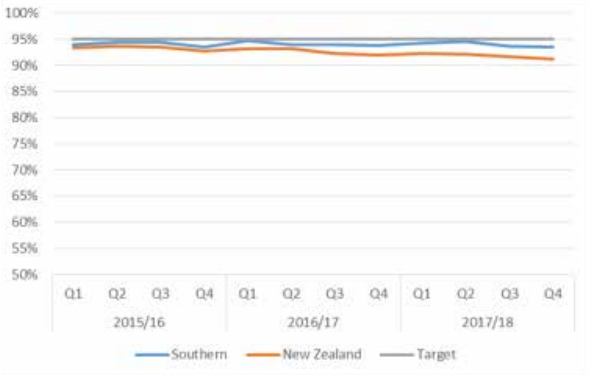
95 per cent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

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

Southern DHB is assured that they are reaching every child and that immunisations are provided at the earliest possible time.

	2017/18			
	Q1	Q2	Q3	Q4
Target	>95%	>95%	>95%	>95%
SDHB	94%	95%	94%	94%
NZ	92%	92%	92%	91%

Figure 4: Increased immunisation



Better Help for Smokers to Quit - Primary

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

Southern DHB has maintained its performance across 2017/18 in this area, exceeding the target each quarter.

Initiatives such as the WellSouth call centre and expanded referral networks are understood to be contributory factors to maintaining this performance.

	2017/18			
	Q1	**Q2**	**Q3**	**Q4**
Target	>90%	>90%	>90%	>90%
SDHB	91%	91%	91%	91%
NZ	89%	88%	89%	90%

Figure 5: Better help for smokers to quit - Hospital

Raising Healthy Kids

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

Raising Healthy Kids is a new health target that was introduced in 2016/17. Southern DHB has shown significantly improved progress against this target over the past year, and reached the target for the first time in Quarter 2 2017/18.

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

	2017/18			
	Q1	**Q2**	**Q3**	**Q4**
Target	>95%	>95%	>95%	>95%
SDHB	92%	97%	99%	96%
NZ	92%	98%	98%	98%

Figure 6: Raising healthy kids

Outputs – Short-Term Performance Measures

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

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

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

We use this grading system for the 2017/18 Statement of Service Performance to assess performance against each indicator in the Output Measures section.

A rating has not been applied to demand-driven indicators.

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

Cost of Service Statement

Table 1: Revenue and expenditure by the four output classes 2017/18

	2017/18 Actual $000	2017/18 Budget	2017/18 Variance $000
Revenue			
Prevention Services	7,475	9,096	(1,621)
Early Detection and Management Services	183,088	191,977	(8,889)
Intensive Assessment and Treatment	651,761	628,720	23,042
Rehabilitation and Support	137,644	145,022	(7,567)
Total Income	**979,988**	**974,815**	**4,965**
Expenditure			
Prevention Services	7,475	9,096	1,621
Early Detection and Management Services	190,493	194,055	3,562
Intensive Assessment and Treatment	657,132	638,228	(18,906)
Rehabilitation and Support	146,266	147,436	1,379
Total Expenditure	**1,001,366**	**988,815**	**(12,344)**
Share of profit/(loss) in associates	-		-
Surplus/(Deficit) for the year	**(21,378)**	**(14,000)**	**(7,379)**

Appropriations

Under the Public Finance Act, the DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by the DHB for the financial year 2017/18 is $844.2 million which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 13-49.

Output Class: Prevention

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

These services include education programmes and services to raise awareness of risky behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and population-based immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

Immunisation Services

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

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

How did we perform?

Southern DHB continues to provide a high performing immunisation service with 94 per cent of children aged eight months immunised against common vaccine-preventable diseases. This has been achieved by a whole-of-sector approach with a well-coordinated and functioning programme involving general practice, WellSouth, public health and the DHB. Southern DHB remains confident that we are reaching every child and that immunisations are given at the earliest possible time.

The Oranga-Pepi programme introduced in 2017/18 seeks to improve family and whānau awareness of key entitlements for all newborn babies, such as immunisations, and also automatically enrols newborn children into immunisation services.

This is the first year influenza coverage has been reported from the National Immunisation Register (NIR), capturing PHO and community pharmacists' data. The NIR team advised and supported general practices to more robustly record influenza coverage on NIR this year. The Southern DHB NIR team committed resources to strive for data accuracy and identified and corrected a data messaging error early on in the influenza season.

Higher coverage results were expected based on previous PHO data. A number of initiatives to improve data accuracy have been identified in conjunction with the PHO, including data comparison against the 'Claims Data.' Additional resource may be needed in Southern DHB in 2018/19 to ensure NIR messaging and data capture is reviewed if it can be demonstrated that data is missing. Southern DHB remains committed to achieving high influenza vaccination coverage across this age group, and all priority groups.

Table 2: 2017/18 Performance Results for Immunisation Services

Measure		2015/16	2016/17	2017/18		
		Actual	Actual	Target	Actual	
Percentage of children fully immunised at 8 months (Health Target)	Total	94%	94%	>95%	94%	●
	Māori	94%	94%	>95%	94%	●
Percentage of children fully immunised at 2 years	Total	95%	95%	>95%	94%	●
	Māori	96%	96%	>95%	92%	●
Percentage of eligible girls fully immunised with 3 doses of HPV Vaccine	Total	76%	68%	>75%	68%	●
	Māori	81%	72%	>75%	71%	●
Percentage of people aged over 65 having received a flu vaccination (PP21)[1]	Total	Not available	Not available	>75%	52%	●
	Māori	Not available	Not available	>75%	44%	●

[1] The results reported are for the period 01 March 2017 - 30 September 2017, which is in line with PP21 and takes account of the winter flu season. This is the first year results have been reported from the National Immunisation Register.

Health Promotion and Education Services

Prevention services include health promotion to help prevent the development of disease, and statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases.

Areas of concerted focus included smoking cessation advice (providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt), and breastfeeding support. Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and well-being, and potentially reducing the incidence of obesity later in life.

How did we perform?

Southern DHB met the target in 2017/18 for the percentage of enrolled patients who smoke who are seen by a health practitioner in primary care being offered brief advice and support to quit smoking.

Initiatives supporting smoking cessation have been broad in scope, focusing on maintaining commitment to quit, increasing referrals, and supporting at risk groups.

In 2016, a single Southern Stop Smoking Service (SSSS) was established by Nga Kete Matauranga Pounamu to receive referrals from multiple providers. 2017/18 saw continued development of programmes including the introduction of a voucher system to support commitment to cessation.

New referral pathways to SSSS were also developed, including working with St John to create a new pathway, and using local commissioning to create referral networks from community pharmacies to SSSS. While the referral pathways cover all groups there is an equity focus on supporting Māori and Pacifica, and reducing the rate of smoking in pregnancy.

Breastfeeding rates are gradually improving however an inequity still exists between Māori and non-Māori. In 2017/18 Southern DHB worked collaboratively to improve breastfeeding rates, including supporting the three local breastfeeding networks, and supporting workplaces to understand and comply with the code of employment practice on infant breastfeeding in the workplace.

The pēpi-pod programme which reduces the risk of Sudden Unexplained Death in Infancy (SUDI) continues. Introduced in 2016/17, this programme provides a safe space device for infants every time and place they sleep, reducing the risk of SUDI. 2017/18 saw expanded distribution of safe-sleep devices, and planning for a 2018/19 pilot of wahakura basket weaving and provision.

More generally, 2017/18 also saw the introduction of the cosy home initiative which focuses on keeping family homes warm and dry in order to prevent poor health outcomes. This initiative focused on cross-agency workforce training, development of educational resources and building awareness of subsidy and charitable networks.

Table 3: 2017/18 Performance Results for Health Promotion and Education Services

Measure		2015/16	2016/17	2017/18		
		Actual	Actual	Target	Actual	
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	Total	88%	85%	>90%	91%	●
	Māori	88%	89%	>90%	90%	●
Infants exclusively or fully breastfed at 3 months	Total	57%	58%	>60%	60%	●
	Māori	47%	50%	>60%	52%	●

Population-Based Screening

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

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

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

How did we perform?

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

To support referrals, a new electronic referral pathway has been established. This sits alongside direct reporting to General Practices detailing the eligibility of their enrolled population and associated screening status.

The establishment of an integrated one-stop consultation service for both breast and cervical screening has also been progressed. Providing the service in this way is more convenient for patients and will allow better alignment of these services for women.

Integration has been further supported with the introduction of quarterly governance meetings that amalgamate the formerly separate breast and cervical screening steering groups. The purpose of this amalgamation was to minimise duplication and provide clear direction and monitoring of performance measures.

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

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

Table 4: 2017/18 Performance Results for Population-Based Screening

Measure		2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
Percentage of eligible women (50-69 years) who have had a BSA mammogram breast screen examination in the past 2 years (MHP).	Total	74%	75%	>70%	74%	●
	Māori	65%	67%	>70%	67%	●
Percentage of eligible women (25-69 years) who have had a cervical screening event in the past 36 months (MHP).	Total	79%	78%	>80%	77%	●
	Māori	61%	63%	>80%	68%	●
Percentage of 4 year old children receiving a Before School Check (B4SC).	Total	94%	87%	>90%	91%	●
	Quintile 5[2]	99%	74%	>90%	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	Total	-	87%	95%	94%	●

[2] Quintile 5 relates to most deprived (20%) in our population based on the Deprivation Index

Output Class: Early Detection and Management

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

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

Oral Health

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

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

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

How did we perform?

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

Performance has been improving in line with this expectation, and in 2017/18 the overall target of 70 per cent of five-year-olds being caries-free was met. While the target wasn't achieved for Māori, there was a three per cent improvement from the previous year.

2017/18 initiatives to further support performance included:

- Targeting higher deprivation populations in specialised preventative care clinics in Mataura, Invercargill and Oamaru
- Maintenance of school-based tooth-brushing and education programmes.

While progress was made in these areas, Southern DHB did not meet its oral health targets surrounding enrolments. A key factor contributing to this result was the number of dental therapist, dental assistant and health promotion vacancies at the beginning of the year.

Despite the number of vacancies the staff have continued to provide a quality service for the district. Recruitment is ongoing for vacancies.

Table 5: 2017/18 Performance Results for Oral Health

Measure		2015 Actual	2016 Actual	2017 Target	2017 Actual	
Percentage of eligible preschool children enrolled in school and community oral health services (PP13a & MHP)	Total	80%	81%	>95%	79%	●
	Māori	65%	65%	>95%	68%	●
Percentage of children caries-free at five years of age (PP11)[3]	Total	60%	69%	>70%	67%	●
	Māori	64%	58%	>70%	53%	●

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

Long-term Conditions Management

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

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

How did we perform?

WellSouth continues to prioritise CVDRA for Māori men aged 35 to 44 years but Southern DHB is yet to reach the 95 per cent target for CVD checks. There were however a range of initiatives set in place in 2017/18 to favourably influence long-term outcomes.

The 'Do the Right Thing' programme led by the Long-Term Conditions Network has evolved as CLIC (Client-Led Integrated Care). This programme puts the enrolled patient population through a Risk Prediction algorithm, and utilises a range of assessment tools to help determine the types of support patients may require to best support their long-term conditions. 2017/18 saw a trial of this programme successfully completed and a district-wide roll-out is planned for 2018/19.

Primary options for acute care (POAC) have also been expanded, including provision of IV antibiotics, fluids and iron, GPSI skin lesions, pipelle biopsies, DVT D-dimer, COPD post discharge support, and urinary catheterisation. The expansion of these services results in care being closer to home for patients, and less need to travel to larger centres. These community rehabilitation/wrap-around services and acute care teams are additionally geared to holding or reducing the growth in demand on Emergency Department services.

Finally, the DHB has expanded upon the St John Ambulance referral system for any patients they treat and leave at home to now include COPD.

While the DHB is yet to meet the target of 79 per cent of the population identified with diabetes having good or acceptable glycaemic control, performance is improving – overall by 11 per cent in 2017/18. WellSouth continues to offer the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme for patients with Type 2 Diabetes, while the preventative-focused 'Walking Away' from diabetes programme is for patients identified with pre-diabetes. Looking forward, the intent is to advance diabetes care through greater integration with the CLIC programme.

Table 6: 2017/18 Performance Results for Long-Term Conditions Management

Measure		2015/16	2016/17	2017/18		
		Actual	Actual	Target	Actual	
The proportion of the eligible population (45-79) having a CVD risk assessment in the last five years (PP20 & MHP)	Total	88%	86%	>90%	84%	●
	Māori	82%	82%	>90%	83%	●
Percentage of the population identified with diabetes having good or acceptable glycaemic control (PP20)[4]	Total	53%	37%	>79%	48%	●
	Māori	46%	36%	>79%	41%	●

[4] Changes to models of care and payment for diabetes management has seen an unintended drop in reporting on glycaemic control. Performance has been improving since.

Community Referred Testing and Diagnostics

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

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

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

How did we perform?

Southern DHB continues to show improvement on the percentage of patients receiving their first cancer treatment in 62 days or less, but this is still below the 90 per cent target. The DHB has been undertaking detailed analytics and refining pathways accordingly to improve performance. Changes include improving the tracking of patient journeys, establishing a one-stop first specialist appointment and diagnostic clinic in Urology, and refining inter-departmental and inter-DHB referral processes.

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

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

Table 7: 2017/18 Performance Results for Community Referred Testing and Diagnostics

Measure	2015/16	2016/17	2017/18		
	Actual	Actual	Target	Actual	
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	77%	79%	>90%	85%	●
Percentage of accepted referrals for CT scans receiving procedure within 42 days (PP29)	76%	74%	>95%	81%	●
Percentage of accepted referrals for MRI scans receiving procedure within 42 days (PP29)	55%	48%	>85%	32%	●

Primary Health Care Services

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

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

How did we perform?

A lower level of Ambulatory Sensitive Hospital (ASH) admissions indicates the primary sector is performing well and successfully keeping people well in the community. Meeting our ASH rate targets is challenging, however a range of initiatives were commenced in 2017/18 to improve performance in this area.

Firstly, Southern DHB and WellSouth PHO commenced implementation of the Health Care Home model of care. This is a primary-oriented model, which seeks to meet the objectives of the primary care strategy. Specific initiatives to increase access include GP phone triage, retained daily acute capacity appointments and extended hours – all factors expected to favourably influence ASH rates.

Additionally, through the Alliance, Southern DHB and WellSouth PHO progressed planning for establishing community health hubs and locality networks. These networks align with our strategic aims of better access, care closer to home, integrated services and technologically supported care delivery (telehealth, GP telephone triage).

Finally, the primary care based General Practitioners with Special Interest (GPSI) skin lesion service run by WellSouth continues to exceed the 1,200 funded procedures. This work is a sustainable method of increasing volumes in primary care, and reducing the number of skin lesion procedures done in hospitals. Integration with the Primary Options for Acute Care (POAC) programme is underway.

Table 8: 2017/18 Performance Results for Primary Health Care Services

Measure		2015/16	2016/17	2017/18		
		Actual	Actual	Target	Actual	
Ambulatory Sensitive Hospital (ASH) admission rates (per 100,000) for children aged 0-4 years[5]	Total	5,509	5,450	<5,190	5,756	●
	Māori	6,080	5,437	<5,190	6,323	●
The number of people receiving a brief intervention from the primary mental health service	Total	4,735	7,418	>6,000	6,882	●

[5] Prior year results may differ from those previously reported. The MOH recalculates prior year ASH rates based on updated extracts from the National Minimum Dataset (NMDS) and updated population estimates

Output Class: Intensive Assessment and Management

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

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

Elective Services

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

How did we perform?

Southern DHB achieved above the target for the total number of elective surgical discharges achieving 13,219 discharges against a target of 13,190.

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

Additional changes in 2017/18 included:

- Implementing a new production planning process which allowed for more accurate planning and phasing of elective surgical activity during the course of 2017/18
- Increasing theatre capacity through lengthening the theatre day and adding an additional weekend theatre
- Utilising local private facilities using DHB staff
- Increasing staffing resources to facilitate these actions.

Table 9: 2017/18 Performance Results for Elective Services

Measure	2015/16	2016/17	2017/18		
	Actual	Actual	Target	Actual	
Percentage of elective and arranged surgery undertaken on a day case basis	New Measure	New Measure	>60%	67%	●
Percentage of people receiving their elective and arranged surgery on day of admission	New Measure	New Measure	>95%	83%	●
The number of elective surgical services discharges	13,324	12,756	>13,190	13,219	●
The number of elective surgical services case-weights (CWDs) delivered	15,419	15,197	>16,090	15,863	●

Acute Services

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

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

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

How did we perform?

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

Work continues to focus on ensuring we have the right models of care across the continuum of care. A number of new strategies have been implemented to enable the patient to be in the right place at the right time:

The development of the Dunedin Hospital Internal Medicine Assessment Unit has enabled short-stay medical patients to be transferred to this unit, aiding ED flow and supporting right-time/right-place care for patients.

Work is also in progress to address the delays to transfer patients from ED to the inpatient wards. The Patient flow committee is leading a number of initiatives to enable timely discharges and avoidance of readmissions.

The "HOME as your first choice" project, initiated in 2017/18, was established to actively look to provide home-based support to avoid admission into acute services. Work has also taken place to improve the links between primary care and student health to avoid non-acute patients entering ED services.

Finally, Clinical Nurse Specialists have been employed to work in the early assessment zone of the ED; this enables more timely triaging of patients into the right pathway of care.

Table 10: 2017/18 Performance Results for Acute Services

Measure	2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
People are assessed, treated or discharged from the emergency department (ED) in under six hours	93%	90%[6]	95%	90%	●
Number of people presenting at ED	80,062	80,903	<80,000	84,110	●

Maternity Services

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

How did we perform?

The number of births in the district continues to be relatively constant with minor variation from year to year. There was a slight decrease in the number of births in 2016/17 which aligns with the projections from Statistics New Zealand for decreasing birth numbers. Breastfeeding rates are also a priority focus and are gradually improving.

17/18 developments included Southern's participation in the South Island Alliance Programme Office stocktake for breastfeeding promotion activities, which sought to identify opportunities to improve access and availability of community-based breastfeeding support services. The stocktake also sought to build an increased understanding of Māori and Pacifica experiences of breastfeeding in order to improve equitable outcomes for these groups. Actions from this stocktake will progress in 2018/19.

The DHB continues to support health literacy through community workshops and the distribution of Mama Aroha cards for women, and each facility has a Baby Friendly Hospital coordinator to ensure accreditation standards are met across the district.

The Southern DHB Primary Maternity Project also progressed throughout 2017/18. This project is focussed on creating an integrated primary-maternity system of care, and the year saw extensive engagement with partner groups, consumers and key stakeholders to guide decision-making around the future system.

[6] Actuals represent Quarter 4 performance

Also introduced in 2017/18 was the Oranga-Pepi initiative designed to promote newborn enrolment in services, and general health literacy for parents. During pregnancy, expectant parents are provided with written information about newborn health service entitlements (hearing, oral health, immunisation, GP and WCTI nursing), and once parents make decisions about preferred providers, a new online enrolment form ensures babies are directly enrolled in these services.

Table 11: 2017/18 Performance Results for Maternity Services

Measure		2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
The number of births in the DHB region	Total	3,352	3,420	<3,277	3,379	
	Māori	544	559	>542	393	
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Total	New Measure	New Measure	80%	77.9%[7]	●

[7] The data for this measure relate to the 2016 financial year and are the most recent data available from the Ministry of Health.

Assessment, Treatment and Rehabilitation Services (AT&R)

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

Assessment Treatment and Rehabilitation (AT&R) functionality is measured by the FIM® instrument, which is a basic indicator for severity of disability.

The functional ability of a patient changes during rehabilitation and the FIM® instrument is used to track those changes which are a key outcome measure in rehabilitation episodes.

How did we perform?

Our ATR services continue to perform well against the two key indicators when compared to the national figures for average length of stay and functional gain for the patients.

The length of stay for under 65 years was down by 5.3 days to 21.8 days. This substantial drop has been driven primarily by a reduction in number and the length of stay for both stroke and spinal patients, which tend to be longer than the average.

Functional improvement continues to be above target and an indication of the quality of care patients receive while in the inpatient rehabilitation services.

Length of stay continues to be a concern which can be correlated to staffing vacancies for specialised rehabilitation roles. This is being addressed and the expectation is length of stay will improve.

In April 2018 Southern DHB launched the 'Home as my First Choice' campaign. The campaign aims to raise awareness of support options when an older person wants to either stay at home, or return home from hospital.

In 2017/18 we commenced working with ACC to redesign the pathways for non-acute rehabilitation and traumatic brain injury. The focus is to improve patient outcomes through reducing inpatient days and increasing supports in the community to enable affected individuals to return back into their homes sooner.

Table 12: 2017/18 Performance Results for Assessment, Treatment and Rehabilitation Services (AT&R)

Measure		2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
Average length of stay for inpatient AT&R services	<65 years	26.0	27.1	<28.3	21.8	●
	>65 years	16.7	17.0	<18.5	20.2	●
AT&R patients have improved physical functionality on discharge	<65 years	25.7	25.2	>24.2	26.1	●
	>65 years	17.6	18.8	>16.9	18.3	●

Specialist Mental Health Services

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

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

How did we perform?

Access to specialist mental health services has been maintained mostly above the target levels. There has been progress towards meeting the 95 per cent target in the number of people who have a transition (discharge) plan. This rolling target expanded this year to include adults in addition to children and young people.

We continue to experience challenges extracting accurate data from PRIMHD29 and filling specialist roles particularly as we are competing in a competitive workforce market.

Our mental health services continue to experience an increase in the number of referrals and the acuity and complexity of these referrals across the different areas of our large geographic district.

Southern DHB has continued the implementation of Raise Hope - Hāpai te Tūmanako shifting to a whole-of-system co-design approach to implementing an updated Stepped Care Model. This work will flow into the coming year.

Table 13: 2017/18 Performance Results for Specialist Mental Health Services

Measure		2015/16	2016/17	2017/18		
		Actual	Actual	Target	Actual	
Percentage of young people (0-19 years) accessing specialist mental health services	Total	4.56%	3.85%	3.75%	4.30%	●
	Māori	4.59%	3.96%	3.75%	4.90%	●
Percentage of adults (20-64 years) accessing specialist mental health services	Total	4.12%	3.60%	3.75%	3.80%	●
	Māori	7.55%	6.93%	3.75%	7.70%	●
Percentage of people who have a current transition (discharge) plan (PP[8])	Total	67%	85%	95%	30%	●
Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	<3 weeks	79%	74%	80%	67%	●
	<8 weeks	97%	88%	95%	84%	●

[8] In 17/18 PP7 coverage was expanded to include all service users. Previous targets were for children and young people only.

Output Class: Rehabilitation and Support

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

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

Needs Assessment & Service Coordination

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

How did we perform?

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

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

Table 14: 2017/18 Performance Results for Needs Assessment & Service Coordination (NASC)

Measure		2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
Percentage of people ≥ 65 years receiving long-term home support who have a Comprehensive Clinical Assessment and an Individual Care Plan (PP23)	Total	99%	99%	>95%	99%	●

Home and Community Support Services

Home and Community Support Services (HCSS) are to support people to continue living in their own homes and to restore functional independence. An increase in the number of people being supported is a result of our bulk-funded model of care with our HCSS Alliance.

How did we perform?

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

The number of support workers attaining a Level 2 qualification has dropped off slightly since 2016/17. This is understood to be the effect of a range of factors, including the gradual ageing of the workforce and retirements changing the balance of the workforce.

Despite this, HCSS providers are continuing to work with HCSS support workers, incorporating certification into induction processes and supporting staff during their period of education.

Table 15: 2017/18 Performance Results for Home and Community Support Services

Measure		2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
Total number of eligible people aged over 65 years supported by home and community support services (HCSS)	Total	4,191	4,287	>4,200	4,464	●
Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Total	70%	80%	>80%	76%	●
Percentage of clients receiving home support who are classified as complex	Total	51%	52%	>55%	50%	●

Rehabilitation Services

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

How did we perform?

For 2017/18 rehabilitation targets were revised and limited to the GP-led fracture risk assessment through the primary care portal. Southern exceeded the target for this measure. A contributory factor for the performance is the integration with CLIC (Client-led Integrated Care) meaning an increased number of older people have had the opportunity to be assessed for fracture risk. Outcomes from these assessments include multidisciplinary collaboration and preventative-focused interventions to reduce the risk and harm from falls.

Table 16: 2017/18 Performance Results for Rehabilitation Services

Measure		2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
Number of people assessed by the GP (primary care procedure) for fracture risk using the portal	Total	16	170	>100	849[9]	●

[9] The assessment portal was introduced in 15/16, with widespread adoption since.

Age-Related Residential Care

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

How did we perform?

There are minimal increases in the total number of people in aged residential care, despite an increase in the number of older people living in the Southern district.

This demonstrates that the planning behind supporting people to live independently in their own homes is working and we continue to provide more services in the community (as evidenced with the growing volumes of people supported by HCSS – see p48).

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

Table 17: 2017/18 Performance Results for Age-Related Residential Care

Measure		2015/16 Actual	2016/17 Actual	2017/18 Target	2017/18 Actual	
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	7.53	6.94	<7.5	6.7	●
Percentage of aged care residents who have had an InterRAI assessment within 6 months of admission	Total	New Measure	New Measure	>90%	97%	●

IMPROVING PATIENT EXPERIENCES AND QUALITY OF CARE

Creating an Environment for Good Health

Creating the conditions that support wellness is a core foundation of the Southern health system. This effort is significantly led by our public health unit, with the aim to improve, promote and protect the health and well-being of populations and to reduce inequities.

Over 2017/18, key initiatives from this team included:

Working collaboratively with the the South Island Public Health Partnership, with an emphasis on child-centred initiatives. These include agreeing a focus on the first 1,000 days, engaging with the six Mokopuna Ora initiatives being commissioned by Te Pūtahitanga, and presenting to the Directors of the Child Well-being and Child Poverty Directorates of the Department of the Prime Minister and Cabinet.

Emergency responses: Staff participated in emergency operations centres due to extreme weather events. This included the July 2017 flooding around the wider Otago region, support to a civil defence emergency in Central Otago which left several towns with no power or water/wastewater in the form of public health messaging, in August 2017 raw untreated water was fed into the main supply in Dunedin, and in February 2018 there was a flooding event in South Dunedin.

Disease outbreak responses: Several disease outbreaks were managed over the 12 month period, including mumps, pertussis, as well as two cases of hepatitis A linked to a kindergarten in Oamaru that were notified and followed up. Five cases of measles were also confirmed in the Southern district and a further three notified; Canterbury took on the role of incident controller for this outbreak as this was the origin of the first case.

Smokefree Invercargill: A highlight was the Invercargill City Council (ICC) making the Central Business District (CBD) a smokefree area – the result of good work from the local smokefree coalition (Smokefree Murihiku) and a council committed to making the CBD a good destination for families. In 2018 the smokefree branding was redesigned to include well known Southland images and Pacific Islands and Māori imagery.

Health in all Policies (HiAP): Following our three HiAP workshops in Queenstown, Invercargill and Dunedin in June 2017, the Broadly Speaking workshops were identified as the next step to progress this work. In October 2017 two presenters from Community and Public Health delivered these interactive workshops in Dunedin to a group that was identified as being able to positively influence health outcomes through participating in the programme. We are excited by the opportunities for improved shared understanding the programme offers and are currently exploring how we can continue to offer these workshops across the district. Health in all Policies has been identified as a key framework for use in Southern DHB in the 2018/19 year as work is scheduled in our plan and the Southern Primary and Community Strategy Action to develop a HiAP action plan for the district. This will include workforce development as well as starting a co-design process with stakeholders to develop the plan.

Drinking Water: There are considerable logistical challenges in our district to improving the drinking water. The Southern district has 263 registered water supplies; of these 75 are networked supplies serving populations over 100 – significantly higher than other PHUs in the country. Increasing drinking water assessor capacity is challenging as the drinking water training is not available in 2018. A national inaugural joint agency drinking water group meeting was well attended by all regional and local Councils, all signalling their positive intentions for working cooperatively in this area. The lack of depth of competent staff available across New Zealand, across all levels from operator to consultancy expertise is slowing progress on infrastructure design and decision-making. The group agreed to focus more on risk management rather than compliance, and interagency response plans and communication protocols including common escalation processes.

Housing: Southern DHB, with the support of the Cosy Homes Trust, ran a series of four Home Performance and Health workshops. The 71 participants from the DHB, community services and government agencies learned about the impact of cold and damp housing on health, and were introduced to the key elements of a healthy home. The aim was for these representatives to then impart this knowledge to their clients, with the overarching goal of reducing heating costs and improving health. Feedback was extremely positive, with some representatives highly motivated to advocate for change in this area. The use of hygrometers was mentioned as a very useful visual tool to measure the difference in dampness levels in a home between baseline and after improvements. The importance of a warm, dry house also featured in Southern DHB's winter wellness campaign: Plan to be Well this Winter.

Primary and Community Care

The development and launch of the Southern DHB-WellSouth Primary and Community Strategy and Action Plan this year has been a cornerstone achievement for the transformation of the health system for the Southern district.

The strategy and action plan is based on the following principles to bring a more integrated and coordinated way of delivering health services across Otago and Southland, improving equity of access to services, bringing care closer to home and giving doctors, nurses and other health care professionals more time and flexibility to work with patients.

1. Consumers, whānau and communities are empowered to drive and own their care
2. Primary and community care works in partnership to provide holistic, team-based care
3. Secondary and tertiary care is integrated into primary and community care models
4. Technology-based health care system

At the heart of the strategy is the focus on making optimal use of the skills, services and resources that are available in the district – in particular, making better use of primary and community health providers, including general practices, pharmacists, nurse practitioners, physiotherapists and other medical and health services.

The initiative includes the development of Health Care Homes – GP practices offering new, flexible approaches to care, Community Health Hubs that bring together services, including outpatient clinics and diagnostics services and more technology-enabled solutions. All of these initiatives reduce the need for people to travel to Dunedin or Invercargill.

It also aims to help patients better manage their own health and well-being, and to increase the use of technology – including telehealth and electronic health records – so people can better manage their health care information wherever they live.

Among the improvement initiatives will be an increase in the number of specialist services – those usually provided in either Southland or Dunedin hospitals – being delivered at the community level. These will start out as visiting specialist appointments, but over time may become part of the extended range of services able to be routinely accessed in community settings.

The launch of the new strategy followed a number of focus groups, wānanga and a round of public meetings outlining proposed directions last year, generating more than 300 items of written feedback.

Virtual health brings care closer to home

In a district as large as Southern, the role of virtual health technologies is vitally important in reducing the burden of travel for our patients, making specialist services more readily available and helping enhance collaboration among health care providers.

In the past year, the utilisation of telehealth has continued to increase, and is now used in areas including mental health, maternity, neonatal, diabetes clinics, anaesthetics, surgical, wound care, urology and speech language therapy. This has ranged from using the technology for one-off appointments – such as radiation oncology consultation for a Southland patient too frail to travel to Dunedin – and as regular clinics, including WellSouth's Winter Clinics. These provided video consults for Southland patients to a GP in Dunedin, enabling same-day appointments for patients who were unable to be accommodated by their own general practice at short notice.

"More and more health practitioners and patients are seeing the benefits of using video-conferencing to provide quality health care and improve equity of access to health services across the district. Our telehealth steering committee is working here to support teams wishing to make virtual health an option for their patients and bring care closer to patients' homes."

Sandra Brough, Southern DHB telehealth coordinator

Gastro telehealth initiative garners Health Research Excellence Award

An initiative exploring how telehealth can help treat and support rural patients with inflammatory bowel disease has earned a team of researchers an $89,000 research grant.

Southern DHB Specialist Nurse Christine Ho, Gastroenterologist and Associate Professor Michael Schultz and Dunedin School of Medicine's Dr Andrew McCombie, received the Health Service Delivery Award at the annual Dunedin School of Medicine and Southern DHB Health Research Excellence Awards earlier this month.

The Health Service Delivery Award is presented to a research initiative that demonstrates collaboration between the DHB and Medical School, helping to improve patient care while reducing the costs of patients being readmitted to hospital.

Pictured: Southern DHB Chief Executive Chris Fleming presents Specialist Nurse Christine Ho with the Health Service Delivery Award

Refreshed Alliance Leadership Team announced

Alliance South has been reinvigorated this year with a new Alliance Leadership Team to help support coordination and collaboration between Southern DHB and WellSouth Primary Health Network.

The leadership team is supporting the roll-out of the Primary and Community Strategy and promoting better integration of health services.

Chaired by Dunedin GP Dr Carol Atmore, the Alliance Leadership Team (ALT) includes Gore pharmacist Bernie McKone, Wanaka GP Dr Andrew McLeod, Dunstan Hospital nursing director Debi Lawry, Gore District Mayor Tracy Hicks, Bronnie Grant from the Community Health Council, Associate Professor Joanne Baxter, a public health physician leading Māori health research from the Dunedin School of Medicine, and youth mental health and addictions specialist Clive McArthur.

Southern DHB Chief Executive Chris Fleming, Clinical Leader for Dunedin for Paediatrics and Child Health Dr Liza Edmonds and Dr Hywel Lloyd, Medical Director, Strategy, Primary and Community, are the Southern DHB members of ALT while WellSouth Chief Executive Ian Macara and Director of Nursing Primary Care Wendy Findlay, represent the primary health network.

A Māori health representative will also be appointed to the leadership team.

Health care alliances were established in all health districts across the country in 2013 to help DHBs and primary health organisations better work together and promote a 'one health system' view.

"Our work is ultimately about improving people's health and sense of well-being and promoting equity for people who live in the Southern region – especially for Māori – through a more coordinated Southern Health System."

Alliance South chair and Dunedin GP Dr Carol Atmore.

Health Care Home general practices launched in the South

More options for appointments, consultations by phone, more time for patients with long-term conditions and easier access to health records are all features of the new Health Care Home programme launched in the Southern district. In the 2016/17 year, following the launch of the Primary and Community Care Strategy and Action Plan, expressions of interest were called for, inviting general practices to join the initiative.

Since then the first 16 general practices to become Southern Health Care Home practices have been announced. These include Amity Health Centre in Dunedin, Queenstown Medical Centre, Gore Health Centre and Gore Medical Centre which are the initial cohort in the district starting the Health Care Home process. The second group migrating to the new model later in 2018 includes Meridian Medical Centre, Mataora and Broadway Medical Centre in Dunedin, Waihopai Health Services in Invercargill, as well as Cromwell's Junction Health, Wanaka Medical Centre and Aspiring Medical Centre in Wanaka.

A further five practices will begin the programme in mid-2019.

In total, the new HCH general practices provide primary health care services to around 120,000 people – close to 40 percent of patients enrolled with a GP in the Southern district. Part of a growing model for primary care, the Health Care Home programme is already operating across much of New Zealand, where the model of care has helped to make health services better connected and more accessible for hundreds of thousands of patients.

"Health Care Home is a modernised general practice. The HCH model makes health care services more accessible for patients and it's a better way of working for professionals in primary care. We received more applications for the programme than we'd expected which shows GPs and practice nurses and managers in the Southern district see the value of this initiative and want their patients to benefit."

Dr Hywel Lloyd, Medical Director, Strategy, Primary and Community, Southern DHB

Integrated primary maternity system plan in place

Providing safe and equitable access to primary maternity services across the district and ensuring LMC midwives are well supported is the foundation of the new plan for Integrated Primary Maternity System of Care in the Southern district.

Developed over nearly two years of research and engagement with stakeholders and the public, the proposed system of care was shared in March 2018, generating significant feedback. The final version was released in August 2018, and will provide more services across the whole of the district for mothers and their babies.

In all, the Southern district maternity plan will mean there are eight birthing units and five primary maternal and child hubs to support women and their babies, working with community, primary and secondary care services.

It also recognises the importance of LMC midwives in ensuring a sustainable system of care, through alleviating costs and introducing additional payments for those caring for remote rural women.

Southern DHB will begin implementing the new plan, starting with a co-design process, allowing local communities to have a say in some of the details around where services are located, what will be included and how they will work.

Plan Highlights:

- Maternal and Child Hubs established in Te Anau, Lumsden and Wanaka; existing services in Tuatapere and Ranfurly enhanced. Facilities focus on antenatal and postnatal care
- Primary Maternity Birthing Units at Queenstown, Oamaru, Alexandra, Gore, Balclutha and Winton. Birthing units provide prenatal, birthing and postnatal care and inpatient support
- Secondary and tertiary care is available in Dunedin and Invercargill and supported by telehealth in other areas
- Funding support package for LMC midwives working in remote rural locations, to recognise the additional duties they perform
- Investment in technology to support access to specialist care, reducing the need to travel
- Dedicated positions and resources to provide leadership support to promote quality and safety, recruitment and retention of LMC midwives, and communication.

HealthPathways further increases consistency and equity of access to health services

Ensuring there are clear, agreed guidelines for managing a range of conditions across the Southern district is fundamental to a more integrated system of care. The development of our HealthPathways is therefore crucial. Signalling an even stronger commitment to this framework, Southern DHB this year added three new part-time staff to its clinical editorial team, significantly bolstering the number of pathways localised to the district.

New clinical editors Drs Anu Shinnamon, Kate Dixon and Margaret Charles will work together to edit the health assessment, management and referral information website for the Southern district. They join Drs Andre Smith, Peter Gent, and Jenny Maybin on the Southern HealthPathways team.

There are already more than 550 Southern HealthPathways, 111 of which have been localised within the past 12 months.

"We've brought together a knowledgeable team to make HealthPathways an even more valuable resource for clinicians in the district," says Bridget-Mary McGown, Southern HealthPathways Manager. "Not only are we increasing the number of localised pathways but also providing more opportunities for health care colleagues to participate and collaborate on their development."

Clinical Service Design – Valuing Patients' Time

The importance of delivering our services in ways that value the time of those who are using them is a driving sentiment behind a range of change initiatives at Southern DHB.

As well as the actions that have been outlined in the Primary and Community Care Strategy – that seek to provide more timely care through better integration between the primary and secondary care sectors – a collection of initiatives also aims to ensure care provided by specialists in a hospital setting is more streamlined, and emphasises quality and safety.

This means avoiding unnecessary delays, whether these are waiting times for assessments or follow-up services, or spending time in hospital waiting for the right supports to be put in place so people can be discharged.

This programme of work will remain an important priority for the coming years.

Improving waiting times for elective surgeries

Achieving elective surgery targets and reducing the time patients are waiting for care have been a challenge at Southern DHB (see p31). Over the past year, surgical theatre planning has focused on a combination of increasing capacity through more efficient theatre utilisation, outplacing surgical work with Southern DHB teams working in private facilities, and outsourcing some operations entirely to the private sector.

This was immediately challenged by low productivity in the plan's early months, impacted further by a water crisis that saw the theatres unable to be used for several days during August 2017. These experiences led to a refinement of the plan, which is now producing more accurate predictions of theatre utilisation. We have also engaged with the Francis Group to further understand how capacity may be increased, and improvements can be made across the wider patient flow challenges in our hospitals.

'Stranded' Patients Programme success

A programme to support and improve the journey of patients who are in hospital for over 21 days has saved around 1,700 bed days since it began in August 2017. Patients who have been in the medical and surgical wards, and on the 6th Floor at Dunedin hospital for more than 21 days are tracked and support is provided to these patients, their families and to staff. The patients are sometimes known as 'stranded patients' as they may face long waits for the next steps in their journey.

The team have been working to find solutions to hospital and system issues that are contributing to discharge delays, and the results show the programme is making a difference.

"The patients are often complex and very unwell. We're supporting them to make sure they are able to go home as soon as they can. This includes goal setting with the patient such as sitting up, getting dressed and moving, and when they have improved enough setting a bigger goal such as going home on leave."

Clinical Nurse Specialist, Megan Livingstone-Young and Chief Medical Officer Dr Nigel Millar

Emergency Department initiative to get patients home sooner

An initiative in the Emergency Department (ED) at Dunedin Hospital is helping to reduce hospital admissions and shorten hospital stays for elderly patients.

Elderly patients are often admitted to hospital because they do not have the support in place to enable them to go home. By having a physiotherapist, occupational therapist and a social worker (Allied Health professionals) in the ED seven days a week patients are able to be assessed, treated and connected to the right services. This means they are ready to go home straight from ED, or if they need to be admitted to hospital they will be quickly assessed by the appropriate Allied Health professionals who will be able to ensure they have support in place when they are discharged from hospital.

The initiative follows a successful pilot in the internal medicine ward at Dunedin Hospital in 2016.

‘Home as my First Choice’ launched

To enable our patients to live in the way they would like to is to truly value their time. In April 2018 Southern DHB launched the Home as my First Choice campaign, aiming to raise awareness of support options when an older person wants to either stay at home, or return home from hospital. Older people often have a desire to remain in their own home after encountering health services and the Home as my First Choice campaign recognises that this is frequently the right option. Through the campaign Southern DHB encourages individuals, families/whānau and communities to access the information, support and services that can make this possible. A ‘Home as my First Choice’ webpage has been created for older people and members of their family/ whānau to access lots of useful information about the programme and support available in the community.

“It is amazing what solutions can be found if all of us – health professionals, the older person themselves and their families/whānau - ask ‘How can we support you to stay at home?’”

Director of Nursing; Strategy, Primary and Community, Sally O’Connor.

Innovative device means care closer to home

An innovative heart recorder which takes 10 minutes to implant is saving Southland Hospital patients hours on return trips to Dunedin. Reveals are small recorders which are implanted under the skin in the chest area to monitor a patient’s heart rate and rhythm. They store recordings if the patient’s heart goes either dangerously slow or fast and can capture data around severe or infrequent symptoms to assist with diagnosis.

The data is sent via secure Wi-Fi connection to a virtual clinic, with information then forwarded to the relevant health professional to make an assessment. Previously Southland patients have had to travel to Dunedin to have the devices implanted, however since October 2017, 12 patients have had the devices implanted at Southland Hospital. The initiative has happened in collaboration with Dunedin’s Cardiology, Outpatients and Diagnostic Testing teams.

Patients often communicate via text, proving convenient and effective for both clinicians and patients.

Southland Hospital Manager Diagnostic Testing Lisa Wilson displays the Reveal implant alongside (from left) Outpatient Manager Jo Clark, Consultant Cardiologist Dr James Pemberton and Registered Nurse Jo Hunter.

“We are so pleased to be able to offer this service which allows Southland patients to access care closer to home and avoid a trip to Dunedin.”

Southland Hospital Manager Diagnostic Testing Lisa Wilson

New Internal Medicine Assessment Unit brings patient-centred care

A medical assessment unit was opened at Dunedin Hospital in September 2017 to care for patients – mostly older people – with multiple medical conditions who do not need urgent treatment in the Emergency Department, but require assessment from doctors, nurses, physiotherapists, occupational therapists and social workers. This quality initiative ensures that patients are assessed and provided with the care they need, in the best place and are supported to return home as soon as possible. The unit is open seven days a week; patients are assessed on arrival and appropriate investigations and treatment is undertaken. They are then either discharged home, stay on in the unit for further treatment/assessment, or go to an inpatient ward. Further opportunities for even more benefit from the unit are being explored, including options for locating it closer to the Emergency Department in the interim years, before the new Dunedin Hospital is opened.

More patients up, dressed and feeling their best

A 'Sit Up, Get Dressed, and Keep Moving' initiative to get patients out of their pyjamas and up and out of bed was initially rolled out in August 2017. The initiative supports and encourages patients to get up, get dressed and keep moving as soon as possible, and when safe to do so, to avoid the potential negative impact of being bed-bound while in hospital. The effect of being in a hospital bed can be far reaching, especially for older patients. Unnecessary bed rest leads to reduced muscle strength, increased risk of falls, reduced mobility and loss of confidence. This in turn may mean rehabilitation is required to get this muscle strength back which can delay discharge. In some cases it can mean the difference in patients being able to be discharged to their own home.

As part of the initiative, a #EndPJParalysis 70 day challenge was held from April to June. This saw 6754 patient days of being up, dressed and mobile at Dunedin Hospital.

The practice not only helps patients feel better, it promotes independence and aids recovery, and in many instances, shortens their length of stay. The challenge has been embraced by patients, and their whānau, the latter who loved that their relative was up and dressed when they came in to see them.

National bowel screening programme launched at Southern

In late April 2018, Southern DHB launched the National Bowel Screening Programme, becoming the first DHB in the South Island to take part in the programme.

Over 51,000 residents in Otago and Southland, aged 60–74 years of age will be invited to participate in the free programme between 2018 and April 2020. It will save lives through detecting pre-cancerous polyps, or finding bowel cancer early, when it can often be successfully treated. Those eligible will receive an invitation letter, home testing kit and consent form through the mail. The test detects minute traces of blood in a sample of faeces. This can be an early warning sign for bowel cancer, alerting health providers that further investigation is required, typically through a colonoscopy procedure.

Southern has one of the highest rates of bowel cancer in the country and New Zealand has some of the highest rates in the world. We estimate over 100 cases of bowel cancer will be detected during the first two years of the programme, many of which will be in the early stages when it is easier to treat. That means this programme will be incredibly valuable to many of our residents as it will save lives and will truly benefit individuals, as well as their families, whānau and wider community.

The anticipated 'spike' in the number of colonoscopies that will be required in the first two years of the programme will be accommodated in the new endoscopy facility that was opened in Dunedin Hospital's 8th Floor in June 2018.

The programme is already making a difference to the lives of many residents and their families. Over 2,600 test kits were distributed in the Southern district since the launch in April to 30 June. Of those that were mailed out before the 1st of July, approximately two thirds have been returned for testing. Māori residents had a participation rate of 66% during this time period. This is an excellent early result, exceeding our national target and we hope that as we roll out new promotional initiatives, we will see these numbers continue to climb.

We acknowledge all the many DHB staff who were involved in managing the preparation and successful roll out of this important programme to Southern residents and communities.

Hearing from Our Patients

Our Patient Priorities – how are we tracking?

In 2016, Southern DHB undertook an extensive engagement with the community to better understand the priorities of our communities in relation to their experience of care. This generated over 750 pages of feedback from 3,500 patients, whānau and colleagues, and led to the seven priorities for patients and whānau outlined below. This process led to a number of programmes of work, aimed at making a difference in these areas, ranging from the Releasing Time to Care initiatives within our wards, to the vision of more integrated care captured in the Primary and Community Care Strategy.

To understand the progress we are making in relation to these priorities, our Releasing Time to Care inpatient surveys enable us to gain a clearer picture of patients' experiences and identify areas for improvement. While those completing the survey are inpatients, we expect they have experienced the wider health system as part of their health journey and can therefore comment on their wider experience.

While this snapshot of feedback is positive, there remain opportunities for improving our patients' experiences by ensuring greater consistency in delivering our best care – particularly around priorities four and five. Wards are made aware of the feedback from patients and supported to address any challenges and opportunities for improvement.

Our patients are at the centre of everything we do and we are committed to continuing to listen, engage and prioritise their needs to improve the overall patient experience within the Southern health system.

Patient Priorities	Average
1. To listen, communicate more and work in partnership with them	79.3%
2. To be more consistently kind, helpful and positive	83.7%
3. To protect our patients' dignity and humanity at all times	88%
4. To value our patients', whānau and community time	70%
5. To create a calmer, more compassionate experience	62%
6. To keep improving the food we provide (Compass Group Survey)	95.8%
7. To keep listening to and learning from patients and whānau	88%

District Patient Survey: Dunedin, Southland, Lakes

April – December 2017

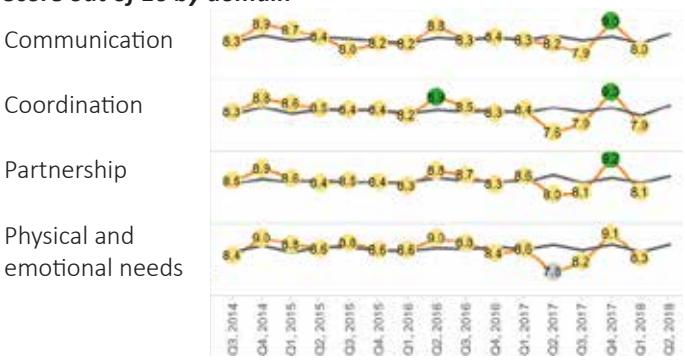
Answered: 1,106

In addition to our inpatient survey, we participate in the Health Quality and Safety Commission Adult Inpatient Survey, which measures patient experience across a range of dimensions. This shows the experiences of inpatients at Southern DHB is largely consistent with other DHBs.

Patient experience survey

Compared with NZ Average

Score out of 10 by domain



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

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

Community Health Council transforming engagement

The Community Health Council (CHC) was established as an advisory council for Southern DHB and WellSouth Primary Health Network in February 2017, enabling a stronger patient voice to be heard across the Southern district. The CHC comprises eight community members from a range of backgrounds and experiences, and the Establishment Chair, Professor Sarah Derrett.

Their work has reached into many areas, including:

Southern Health Website: Some members of the Council were involved with the procurement for a supplier to undertake this work to create a more user-focused, whole-of-health-system website. The CHC will be involved with this project as it develops.

Staff Recruitment: A number of CHC members were involved with the recruitment process for staff members during the Southern DHB restructure.

Discussion Paper on Family, Whānau Accommodation for the Dunedin Public Hospital Rebuild : The CHC developed a joint discussion paper with the Clinical Leadership Group around what accommodation requirements were needed for family/whānau in the development of the new hospital. This was accepted by the Southern DHB Facilities Redevelopment Executive.

Patient Stories: CHC members have been strong advocates for this project. The new patient series provide individuals the opportunity to tell their stories, good and bad, to help improve our services. These stories are to be used in a variety of forums (such as staff education purposes) and some will be used in a wider communication campaign where the general public can view them. Some members of the Council have even told their own personal stories.

Primary and Community Care Strategy & Action Plan: A CHC member sat on the Steering Group for this work and the Council offered advice throughout the development and engagement stages. The CHC plan to be involved with the implementation of this significant piece of work.

CHC members have also participated in external projects and outreach opportunities.

They report their greatest achievement for the year is the development of our CHC Community, Whānau and Patient Engagement Framework and Roadmap. This sets a benchmark for what the CHC believes is true community, whānau and patient engagement and puts the patient at the centre of everything we do. The CHC has a range of networks and people who want to be involved in decision-making and help to make a difference to the way the Southern health system delivers better quality services.

Read more about the Community Health Council's first year at: https://www.southerndhb.govt.nz/pages/community-health-council/

Quality Account

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

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

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

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

This section of the report – Improving Patient Experiences and Quality of Care – includes the Serious Adverse Events reported at Southern DHB during 2017/18. It also outlines processes for gaining feedback from our patients and communities, and quality improvement initiatives. This includes the significant organisational programmes aimed at creating an environment for good health, developing our primary and community care, and valuing patients' time through clinical service design focusing on qualilty and safety.

Our performance against the national health targets and other outcome measures identified in our Annual Plan is detailed in the first section of this report: Improving Health Outcomes for our Population (p13).

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

What have we learned from our adverse events - Severity Assessment Code (SAC) level 1 & 2?

Adverse Events, Severity Assessment Code (SAC) 1&2, are reported by health and disability providers in accordance with the Health Quality & Safety Commission's national reportable events policy, and in general are those incidents which have resulted in a patient suffering serious harm or death.

During 2016 and early 2017 a review of the National Adverse Events Policy was completed with the final policy released 1 July 2017. Southern DHB has aligned all its own processes to the changes.

A significant change has been the increase in reporting required for 'Always Report and Review Events (ARR)'. These events may not result in serious harm but may highlight significant patient care delivery systems problems. Southern has received feedback from the commission that we have embraced this well, reporting these events openly.

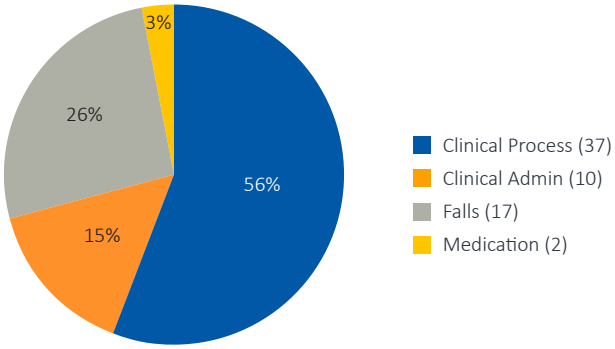
These events are not contained in the national report.

In the 2017/18 year, there were 66 events that were classified SAC 1&2 at Southern DHB. As in previous years, these are subject to a national annual release, with an annual report titled ***Making our health and disability services safer***, which is to be released in December.

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

What were the main groups of SAEs in 2017/18?

Adverse Events - 2017/2018



As indicated by the graph, the largest group of serious adverse events SAC 1&2 relates to Clinical Processes at 56 per cent (assessment, diagnosis, treatment, general care), followed by falls at 26 per cent (serious harm from falls, for example a broken hip), clinical administration at 15 per cent (handover, referral, discharge, resources/organisation), and medication error at three per cent (dispensing, prescribing or administration of medications).

Overall we have seen an increase in Adverse Events SAC 1 & 2 reported in Southern. The two main contributors to this are the increased reporting of pressure injuries and the unusual spike in SAC 1&2 for Falls during Quarters 1&2 of 2017/18.

Below is a summary of the main harms within these categories and the work to date plus work planned to reduce these.

Clinical Processes - Pressure Injuries

This year we have begun our increased focus on pressure injuries with the aim of reducing their incidence (the number of new cases). Previously these were not consistently reported in our incident reporting system. A clear set of communications and the systematic grading of the severity of harm supported by our Safety1st incident system has resulted in improved reporting. This year there were eight pressure injuries reported within the clinical processes category.

We have committed to reviewing each of these events to assess the clinical processes that either failed, or were not applied, with the aim of preventing the development of pressure injuries. A standardised concise review template has been developed to investigate each adverse event. This enables us to review the incident against the evidence-based prevention strategies. While every patient has an individualised immediate plan of care to minimise further harm and aid wound healing, by reviewing all cases we will be able to identify any recurring gaps in clinical care delivery that will require a systematic improvement.

We have also commenced the national pressure injury prevention programme. Southern DHB participated as a pilot site for the Health Quality & Safety Commission (HQSC) to develop a measurement tool to obtain a more accurate set of data of the incidence of pressure injuries. This tool could be applied across all care delivery services in the hospitals and community. The implementation of this measure has commenced in Dunedin and Southland Hospitals.

The next stage of the implementation of the National Prevention programme as led by ACC is the implementation of the 'Guiding principles for pressure injury prevention and management in New Zealand'. Southern DHB has secured funding from ACC to resource this project.

Clinical Processes - Recognition and response for deteriorating patients

Identifying that three Adverse Events SAC 1&2 highlight a delay in the recognition and response to a patient's condition deteriorating, we undertook an immediate assessment of the existing clinical processes that were in place. We found that the knowledge of the existing systems and the application of the Early Warning Scoring (EWS) and the activation of response was inconsistent. The assessment was closely followed up with a short and highly visible set of improvement actions. This included a poster campaign, educational packages both face to face and electronic, videos and tools including quick reference cards. This has now led onto the HQSC national improvement programme.

Falls

A unusual spike in the number of falls in Quarters 1 and 2 was noticed, and we are looking further at a possible special cause. We have since returned to the rate that has been static since 2011, however we continue to aim for zero falls. We have improved our documentation of patient care assessments to better identify those at risk of falls, moving from 83 per cent in 2016/17 to 93 per cent in 2017/18; however our documented care planning remains low. A streamlined assessment and plan process, with improved documents to record this, has commenced and we will report on this next year.

Medication

Southern DHB reported two medication events at the SAC 1 & 2 level this year. Both of these events have been reviewed with corrective actions put in place. Further reporting of SAC 3 & 4 highlight administration of medication continues to be a challenge. Systems, processes, policies, procedures and education have been continuously reviewed and developed, however we have commenced a more detailed analysis of what further improvements could be made.

Clinical Administration

Delay and failure to follow up has resulted in 10 Adverse Events. It is recognised that addressing this needs to be a major area of focus for the coming year. This is an important driver behind a comprehensive programme of clinical service redesign initiatives, aimed at valuing patients' time. This work is commencing and will need to consider a range of administration processes, and clinical practices to improve patient journeys through our health system.

Always Report & Review (ARR)

We have reported 18 ARR events as per the new policy process, with 15 of these relating to patient identification. The majority of these are as a result of incorrect details on a referral to radiology or incorrect image taken at radiology (for example imaging the wrong side or limb). While some immediate actions have been put in place with Policy, Procedures and Safety Signpost Alerts, further analysis of these events is in progress and we will provide an update in the 2018/19 report on the progress of the further improvement work that will be undertaken following this.

Ophthalmology

In 2015/2016 we reported 30 cases relating to our ophthalmology services, leading to an external review as we urgently sought to ensure the safety and sustainability of this service. In 2016/2017, nine serious adverse events were reported; this year we report eight ophthalmology adverse events. Six relate to delay in follow up, and two to clinical processes.

We have either implemented or made progress on most of the recommendations from the external review. The changes and quality improvements include working to improve and expand the physical environment; purchasing additional equipment; employing more skilled staff including a clinical nurse specialist, a registered nurse working at the top of her scope of practice, a technician, an ophthalmologist and a contracted optometrist to provide glaucoma assessment; changing systems to ensure referrals are assessed for acuity and responded to in a timely manner and are tracked so any delays can be identified and dealt with; having clinical staff available to answer urgent calls both during working and after hours; holding additional clinics and holding regular multidisciplinary meetings and review of treatments to ensure contemporary care is being provided to patients.

Some recommendations will take longer to implement such as the recommendation to pursue credentialing for the service.

We are pleased to report that the number of those waiting for longer than 1.5 times the recommended timeframe has now been reduced to zero at Southland Hospital for several months, and significantly reduced at Dunedin Hospital, reaching zero on occasions. However we need to finalise the configuration of the service so that we can cope with ongoing volume growth without having to depend on external providers, and we will need to periodically reassess the service as we are projecting that demand for follow up appointments will continue to increase.

Urology

In 2017, a review was initiated to address significant challenges in this service as a response to staff concerns about resourcing levels, and wider DHB concerns around the performance of this service, including lengthy waiting lists at the Dunedin site for both elective surgeries and outpatient appointments. Two serious adverse events had been reported due to these delays. The review's aim was to identify opportunities for improvements to processes, and look at resourcing needs, to ensure the sustainability of the service. Key recommendations from the review included:

District-wide (Dunedin and Southland):

- Review the service size and gain an understanding of theatre and outpatient capacity and waiting times on both sites
- Standardise protocols and policies across the whole DHB
- Establish a collaborative approach across the whole service
- Review after-hours provision across the district.

Dunedin site

- Develop a recovery plan to address backlog
- Improve outpatients environment and throughput
- Ensure theatre time is maximised
- Clarify staff roles and responsibilities
- Review SMO job sizing and job plans
- Review nursing resource supporting the service
- Address critical facility issues impacting the service.

An action plan was developed to implement the recommendations, including holding two weekend 'superclinics' in November and December 2017 to clear the backlog of patients who had been referred for a new appointment, or a follow up appointment. All patients attending the super-clinics who needed treatment received this at the time of appointment, and all those who needed urgent surgery received it.

The superclinics were also an opportunity to introduce a new model of care that streamlines the outpatients' clinics and reduces the number of outpatient visits needed. This led to implementing changes to a number of processes, to enable more appointments and surgeries through better management of staff time and theatre capacity, and better arranging our clinics so that a patient who requires a procedure that can be done in outpatients will receive it as part of the appointment, rather than come back on another day – enabling the outpatient clinics to operate as a 'one-stop-shop'.

Under this new model of care, patients are case managed by the nursing staff. Patients are triaged consistently, and most diagnostics are undertaken prior to a patient attending clinic, reducing the overall number of outpatient appointments required.

Since the superclinics, we have appointed an additional 0.4FTE nurse to the team, bringing the department to 1.4 FTE Registered Nurses with special interest in urology, and 1 FTE Clinical Nurse Specialist. The recruiting process for a 0.5FTE Consultant Urologist and a 1 FTE Registrar has been underway since late last year but appointments are yet to be made. In the meantime, the department will employ locum Urologists when needed, and the department's SMOs are working additional clinic hours.

We are pleased to report that Urology has had no adverse events this year.

ENABLING SUCCESS: ORGANISATIONAL RESILIENCE AND SUSTAINABILITY

Enabling People and Systems

The importance of ensuring our people are enabled and supported, including through high quality business and IT systems, has been highlighted as a priority for several years. The commissioner team launched the Southern Future programme as one of their earliest initiatives to underline the significance placed on a positive, collaborative workplace culture for driving change to our health systems.

Over the past year, this work has taken a step further, with the development of digital and workforce strategies, due to be finalised in 2018/19.

The initial strategies were completed to meet planning timeframes for the Dunedin hospital redevelopment process. However, their scope is broader, taking a whole-of-system perspective and aligning with other concurrent digital and workforce development processes. Ultimately, the Workforce and Digital plans will bring together complementary information in one place in a patient and staff-centric design approach. An outline of the strategies will be detailed in the 2018/19 report. They build on the initiatives and priorities already underway.

IT Projects

Business intelligence software called Board is being rolled out across Southern DHB. At present hundreds of reports are generated every month on everything from hospital discharges and theatre use to financial performance. Board will improve the visibility and functionality of this information by providing an integrated reporting platform that is easily accessible.

It will provide a quick visual display to all services to identify possible areas that need review such as ensuring targets are being met and monthly lists are managed.

This easily accessible single source of data aims to improve decision-making across the organisation. It is also expected to provide fresh insights through improved analysis of the data.

Southern Future

Strengthening our culture

The past year has seen significant momentum gained in the Southern Future programme – designed to build a strong internal culture that promotes innovation, communication and collaboration. As well as improving Southern DHB as a place to work, the programme has had a particular focus on creating a culture where staff feel safe to speak up about workplace concerns. There has been a number of initiatives to progress this important priority.

Staff supported to Speak Up

Aimed at creating a safety culture that promotes professional behaviours, accountability and alignment with the Southern DHB's values and behaviours, a new addition was launched to Southern Future's Speak Up Programme.

Speak Up Supporters were introduced as another pathway of support for staff to raise workplace concerns safely. The Supporters are trained, independent peers, who are available to all Southern DHB staff as the first point of contact for support, guidance and to discuss workplace relationship issues and patient or clinical safety concerns.

This work has been supported by the 'Speak Up' and 'Get Dotted' workshops, which continue to provide staff the opportunity to ask questions, share their experiences in the workplace, and recognise their own particular communication style.

More than 2,500 staff have been through these programmes to date.

Celebrating our staff

The Southern Future programme recognises the importance of celebrating our staff's success, and we appreciate when others do the same.

Encouragement Award for contribution to profession

This year Dunedin Hospital Medical Radiation Technologist, Sarah Aitken was awarded the national New Zealand Institute of Medical Radiation Technology (NZIMRT) Encouragement Award for services to the profession. Sarah is the Dunedin branch representative of Otago/Southland NZIMRT and has worked tirelessly to promote the role of the Institute.

Pictured: Sarah Aitken receiving the award from Tracy Hogarty

Innovation challenge winner receives leadership award

Through the 2017 Southern Innovation Challenge, a contest where staff come up with innovative ideas to improve the quality of service at the DHB, Dr Layla Hehir proposed to identify patient safety issues through an in-situ simulation programme – creating simulated medical scenarios for staff relevant to their clinical practice.

Now the Southern DHB Registrar has been recognised with a HQSC Open for Leadership Award for her patient safety in-situ pop-up simulation programme.

Southern DHB nominated Layla for the award, which recognises, celebrates and shares the work of emerging health care leaders who have made a difference to patient care.

Pictured: Registrar Dr Layla Hehir is presented with the Open for Leadership Award by Janice Wilson, Health Quality and Safety Commission Chief Executive

Living our values

Manaakitanga at work

'Pay it forward reward' coffees have taken off at Southland Hospital staff café thanks to Southland Hospital Trendcare coordinator, Rosalie Wright.

Wright came up with the idea when she shouted a colleague a coffee to congratulate her on a new job. This act of kindness can now be passed on – all staff have to do is pay in advance for an extra coffee and leave the recipient's name on the 'pick up' board by the cash register at the café. Even members of the public have joined in and paid for a coffee as a gesture of thanks to the staff for the service they and/or their families have received.

Pictured: Southland Hospital café staff Sharyn O'Donnell and Daisy Teremoana with pay it forward coffee recipient Sharon Morrison

Southern Innovation Challenge winners celebrated

Southern DHB's Innovation Challenge continues to support ideas brought forward by staff, with 29 entries in 2017.

First place was awarded to the Oncology and Haematology team for their proposal to research a revolutionary pump that delivers chemotherapy to a patient in the comfort of their own home. They received $9,000 for a research project with the goal to pilot the delivery by 2020.

Other successful entries include:

- Chief Executive Officer Award: The Power of Light – tool for recovery, improved mental health and quality of life
- Patient Priority Award: Get Fit for Surgery – optimising patients' presenting for colorectal surgery
- Staff Priority Award: In-situ Pop-Up Simulation Programme – purchasing equipment to ensure staff have the opportunity to identify patient safety issues by taking part in a simulation programme

- Community Priority Award: Instant Information Project – being able to communicate complex information quickly with a large number of people using an online communication platform.

The winners will be able to follow through with their proposal with the help of prize money and organisational support.

Pictured from left: Southern DHB Southern Innovation Challenge Winners – Oncology and Haematology Consultant Bridgett McDiarmid and Oncology and Haematology Registered Nurse Amy Suddaby with Chief Executive Chris Fleming

Skills for Change

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

Between July 2017 and June 2018, 17 project teams including 83 staff completed the programme, covering a wide range of topics from improving month-end finance processes to increasing the availability of orthopaedic outpatient processes.

A feature of Skills for Change over the last 12 months has been the inclusion of support services such as finance and IT in the progamme as well as the more traditional clinical process improvements.

Another feature has been the use of the programme by our rural hospitals as well as an increasing interest by primary care.

Good Employer Obligations Report

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

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

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

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

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

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

Our values

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

EEO

An EEO Policy was implemented in November 2015 and will be reviewed in 2018.

Leadership, accountability and culture

Investing in leadership has continued to be a significant priority for Southern DHB over the past year with the aim of strengthening our emphasis on strategic priorities, organisational culture, quality and decision-making. The ongoing investment in the Southern Future programme of work reflects the importance placed on leadership development and building our culture. The newly created position of Executive Director of Quality and Clinical Governance Solutions aims to ensure further leadership in strengthening patient-centred decision-making processes. Southern DHB takes its accountability to the community seriously, and has been developing stronger processes for understanding community needs and reporting back to them on our performance. These include the establishment of a Community Health Council, public forums, community consultation processes and inviting members of the public to ask questions directly to the Commissioner team at the public sessions of their meetings. Further initiatives are outlined in the previous section of this report, from pages 66-68.

Recruitment, selection and induction

Southern DHB is party to the ACE (Advanced Choice of Employment) programme operated by all DHBs to ensure fairness and transparency of recruitment for new graduate medical and nursing staff. These new graduate programmes are a facilitated support programme during the new graduate years, offering guidance, mentoring and professional development.

Our Orientation process for onboarding new staff members was reviewed and changed at the beginning of 2017. This has proved to be a successful welcome process with new employees enjoying a warm welcome with a mihi, meet and greet and morning tea with members of the Executive, Senior Leadership Team and line managers of attendees, followed by a presentation by the CEO. Service inductions to the area the new employee is employed in is carried out with a checklist of jobs to complete within the first six weeks of employment, including online modules.

Various targeted recruitment drives have been undertaken to ensure profession gaps are minimal and to lessen the impact on services.

Training is available to all leaders on best practice recruitment and selection practices as part of the DHB's wider Learning and Development Strategic Framework.

Employee development, promotion and exit

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

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

Remuneration, recognition and conditions

A market-based model of job evaluation is in place for all non-clinical support roles to ensure market competitiveness is maintained and Southern DHB is able to attract and retain experienced employees. In 2016, a long-service recognition programme was introduced for employees whose continuous service to Southern DHB is greater than 10 years.

Southern DHB has also recently launched the inaugural 'Southern Excellence Awards'. These Awards will recognise the outstanding contribution of our

staff in nine different categories of leadership and improvement. The winners will be recognised at an annual awards evening in October 2018.

Harassment and bullying prevention programme

Our harassment and bullying policy aims to promote and support behaviour that reflects our organisational values, and addressing issues effectively and quickly at the lowest possible level. It is supported by the 'Speak Up' Campaign, aimed at creating a culture where it is safe to highlight concerns, and through investing in training managers and HR professionals in both bullying prevention, management and investigation. Following on from the introduction of the Speak Up workshops introduced to the organisation in 2017 this year we have launched the Speak Up Supporters initiative (see p66).

Supporting collateral has been developed to illustrate the different pathways staff can access to raise concerns. These may extend beyond workplace relationship concerns and could include issues such as fraud, or substance abuse concerns. A campaign has been run and posters have been provided physically and electronically to all departments.

Safe and healthy environment

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

Current practices include:

- More than 160 elected health and safety representatives in place across Southern DHB's operation
- Critical risks are identified and risk reviews are underway to identify the efficacy of current controls and potential improvements
- Safety1st is established as the South Island-wide incident and near-miss reporting mechanism
- Tertiary accreditation and an active ACC partnership programme is in place
- Health, Safety and Welfare Governance structure in place to ensure compliance with relevant legislation
- A 24/7 employee assistance programme is available to all staff for both personal counselling and critical incident debriefing.

Employee demographics*

Southern DHB currently employs 4,655 employees across Otago, Southland and Central Otago. 21.6% of our employee base is male; 78.4 per cent are female.

There are 51.3 per cent male and 48.7 per cent female junior medical staff, and at a senior medical level female representation is 35.3 per cent of that workforce.

The nursing profession comprises 12.4 per cent male employees, whilst midwifery remains 100 per cent female. Service support staff, such as drivers, trades, security staff, are predominantly male (90.6 per cent).

Of the 4,394 employees who detailed their ethnicity, 203 (4.62 per cent) identify as Māori or Pacific.

New Zealand European/Pakeha employees represent 64.8 per cent of our employee population, which includes a total of 44 different ethnicities. Southern DHB is committed to ensuring equal employment opportunities and is continuing to look at ways to improve diversity across all levels of the organisation.

Employees with disabilities

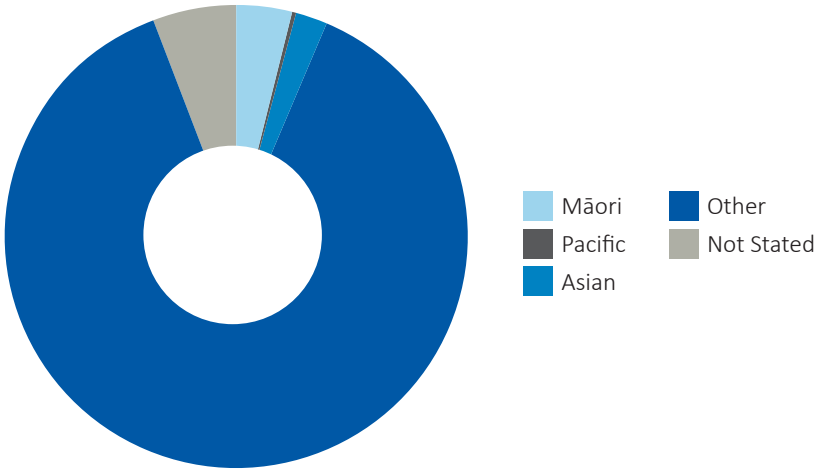
Previously, Southern DHB has not recorded details of staff with disabilities. To address this area, in 2016 the Employee Contact Details Form was revised and now invites new employees to identify as having a disability. As this data set develops we will gain more information to aid in ensuring Southern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

Age of Employees	Male	Female	% of employees identified as Māori/Pacific
0-19	0.04%	0.19%	0.49%
20-29	3.22%	11.32%	16.75%
30-39	5.22%	16.43%	21.67%
40-49	4.45%	16.97%	24.14%
50-59	4.85%	20.15%	24.63%
60-69	3.42%	12.74%	11.33%
70-79	0.39%	0.58%	0.99%
80+	0.02%	0.00%	0.00%
Grand Total	**21.61%**	**78.39%**	**4.36%**
Total Employees			**4655**

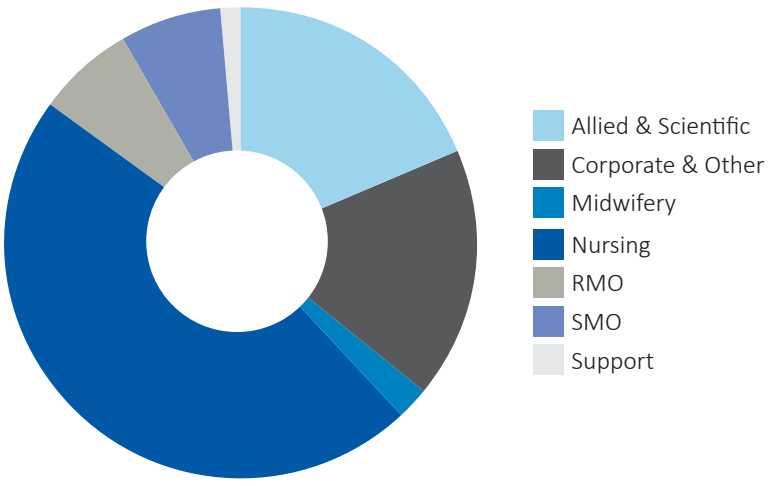
*Data correct as at 17 August 2018

Occupational Group	Sex	Grand Total	Māori	Pacific	Asian	Other	Not Stated
Allied & Scientific	F	710	27	0	7	644	32
	M	163	11	1	4	132	15
Corporate & Other	F	663	23	1	10	586	43
	M	142	9	1	2	126	4
Midwifery	F	97	4	0	0	85	8
	M	0	0	0	0	0	0
Nursing	F	1909	83	7	16	1702	101
	M	285	11	2	3	251	18
RMO	F	151	5	1	20	117	8
	M	159	5	2	20	125	7
SMO	F	114	1		2	104	7
	M	209	4	2	11	175	17
Support	F	5	1	0	0	4	0
	M	48	0	2	0	45	1
Grand Total		**4655**	**184**	**19**	**95**	**4096**	**261**

Ethnicity



Occupational Group



Facilities for the Future

Ensuring we have the right facilities to deliver our health services has been an area attracting significant attention over the 2017/18 year. The news everybody had been waiting for arrived with the announcement of the central Dunedin site for the New Dunedin Hospital, with Minister of Health David Clark announcing that it would be the most modern hospital in New Zealand, ready to serve the people of the South for decades to come. In the existing Dunedin Hospital the opening of the redeveloped Gastroenterology Department was celebrated as staff moved into to a completely transformed space. Good progress was also made on the new $14.8m Intensive Care Unit on the 5th floor of the hospital. We also made progress designing and preparing for the redevelopment of Lakes District Hospital in Queenstown.

With all of these facilities, however, the important progress has been about much more than the physical structures. Significant effort has gone into developing the models of care that determine how care will be provided in the future, to align with our Primary and Community Care Strategy and ultimately determine the design and location of the buildings we need to deliver our work.

New Dunedin Hospital

The Ministry of Health confirmed in May that the billion-dollar-plus hospital will be built across two central city blocks. They are: the block diagonally across from the current hospital site which contains the Wilson's car-park; and the site of the former Cadbury chocolate factory, including the car-park across the road on Anzac Avenue.

The site gives Southern DHB the flexibility to meet today's health care challenges and the needs of future generations. The central location is close to the University of Otago and Otago Polytechnic to maintain those important linkages, while the size of the site also gives the project valuable breathing space by removing the concerns around space constraints that might have challenged a central city location. It also means different options for how the hospital can be configured will be able to be considered as part of the detailed design phase.

In the background, significant achievements were made with the functional brief and first part of the detailed business case nearing completion.

This was supported through extensive consultation with staff, supported by the project management office, Clinical Leadership Group, Facilities Redevelopment Executive, clinical planners, health-care architects and engineers and more. In total, 73 unique User Groups were held across 190 sessions, involving 381 staff. This work helped define important aspects of the new hospital to develop a Facility Model of Care, featuring:

- Seven-day hospital with a generalist orientation of medical services
- More than one point of access for acute care
- Acute services accessible 24 hours a day
- Enhanced interventional capabilities
- Introduction of short stay assessment unit
- Enhanced care and monitoring through the Healthcare Hubs
- Differentiated planned and unplanned patient pathways.

Dunedin Hospital Transition Programme

A programme of work is being developed which will address key risks and issues at the Dunedin Hospital Campus prior to the occupation of the New Dunedin Hospital. The focus of the plan is to reduce risk of unscheduled interruptions or impacts to clinical services over the next 10 years while minimising the infrastructure work required.

Gastroenterology Department

Southern DHB's new $3.2 million Gastroenterology Department on the 8th floor of Dunedin Hospital will transform the experience for patients and staff. The timing of the unit's opening in June 2018 dovetailed with the roll-out of the National Bowel Screening Programme in the Southern district. The expanded facility gives the Southern DHB the capacity to carry out the additional 300-350 colonoscopies in 2018 as part of the programme. The new unit adds a second endoscopy suite and includes room for a third.

It has a gastrointestinal treatment room, separate admission and discharge rooms, and a 10-bed, 7-seat recovery area. As well as being quieter than the previous unit, it brings natural light, particularly in patient areas and in areas where staff are spending a lot of time. The expanded unit will mean more timely interventions for inpatients and the flexibility to ensure waiting times for outpatients can be maintained. Teaching is a key focus of the department and having the second endoscopy suite means teaching sessions can be scheduled without impacting on the service.

Intensive Care Unit

Dunedin Hospital's new $14.8 million Intensive Care Unit made good progress towards an opening date for stage one. The new facility will have 22 bed spaces and will transform the environment for critical care patients and their family/whānau.

While construction work continues on the 5th floor redevelopment, clinical staff have been exploring the 'finished' unit from top to bottom courtesy of the Building and Property department's virtual reality kit. Wearing a headset and using hand controls to move, staff can experience the dimensions and layout of the ICU, giving them a real-world idea of their new working environment.

Building the new unit has required careful co-ordination and close cooperation with staff on the 4th and 6th floors to mitigate the impacts on their areas, and their understanding is greatly appreciated.

Lakes District Hospital

Resource consent was granted for the upgrade of Lakes District Hospital. The DHB was given the green light to construct two extensions.

The larger will form part of the existing emergency department wing and will hold nine beds - including the existing seven; two resuscitation bays; a reception; waiting area; triage and consultation areas; a medical students' training room; plaster bay; decontamination area; and an isolation room to treat patients who were possibly contagious. The smaller wing will hold a 'District Nurses department', with elements of hospital and health care service activities.

A CT scanner and a clean utility room are also part of the redevelopment, while a refurbishment of the existing hospital will include telehealth facilities and a dedicated paediatric and patient care room.

Becoming a greener hospital

The need to operate in a way that reduces our impact on the environment has been increasingly recognised across the health sector. A Working Group to explore this issue at Southern DHB was established in July 2017. It developed a vision and strategic priorities for sustainable health care at Southern DHB, which was approved by the Executive Leadership Team. This paved the way for a detailed strategy and action plan, which is currently being developed. The first measurement of the DHB's carbon footprint is underway and will be completed by August 2018. Meanwhile a number of initiatives are already underway which will help to improve the DHB's carbon footprint, for example promoting the use of telehealth, PVC and gas cylinder recycling, and reducing the footprint of anaesthetic gas use. A waste committee has been established to minimise waste and improve recycling and reuse. The working group also provided input into the specifications for the new Dunedin Hospital.

Asset Performance Indicators

Improving Asset Management

Southern DHB is committed to and has commenced work on improving its asset maturity management and capability. Our first ICR was undertaken very early in our improvement process in 2017, and has identified several areas for improvement. The DHB is focusing on those that will enable us to achieve the most gains in our asset maturity management.

Asset Portfolio	Asset Classes within Portfolios	Asset Purpose	2016/17 Net Book Value ($000)	2017/18 Net Book Value ($000)
Property	Land, buildings, furniture and fittings, motor vehicles	To provide a base for the provision of health services	251,377	255,848
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	34,232	32,378
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of core health service by aiding decision-making at the point of care	5,005	4,342

Property Portfolio Performance

Asset Performance Indicators	Indicator Class	2016/17 Result	2017/18 Standard	2017/18 Result
Percentage of buildings within the DHB's property portfolio with a current Building Warrant of Fitness[1]	Condition	92%	97%	93%

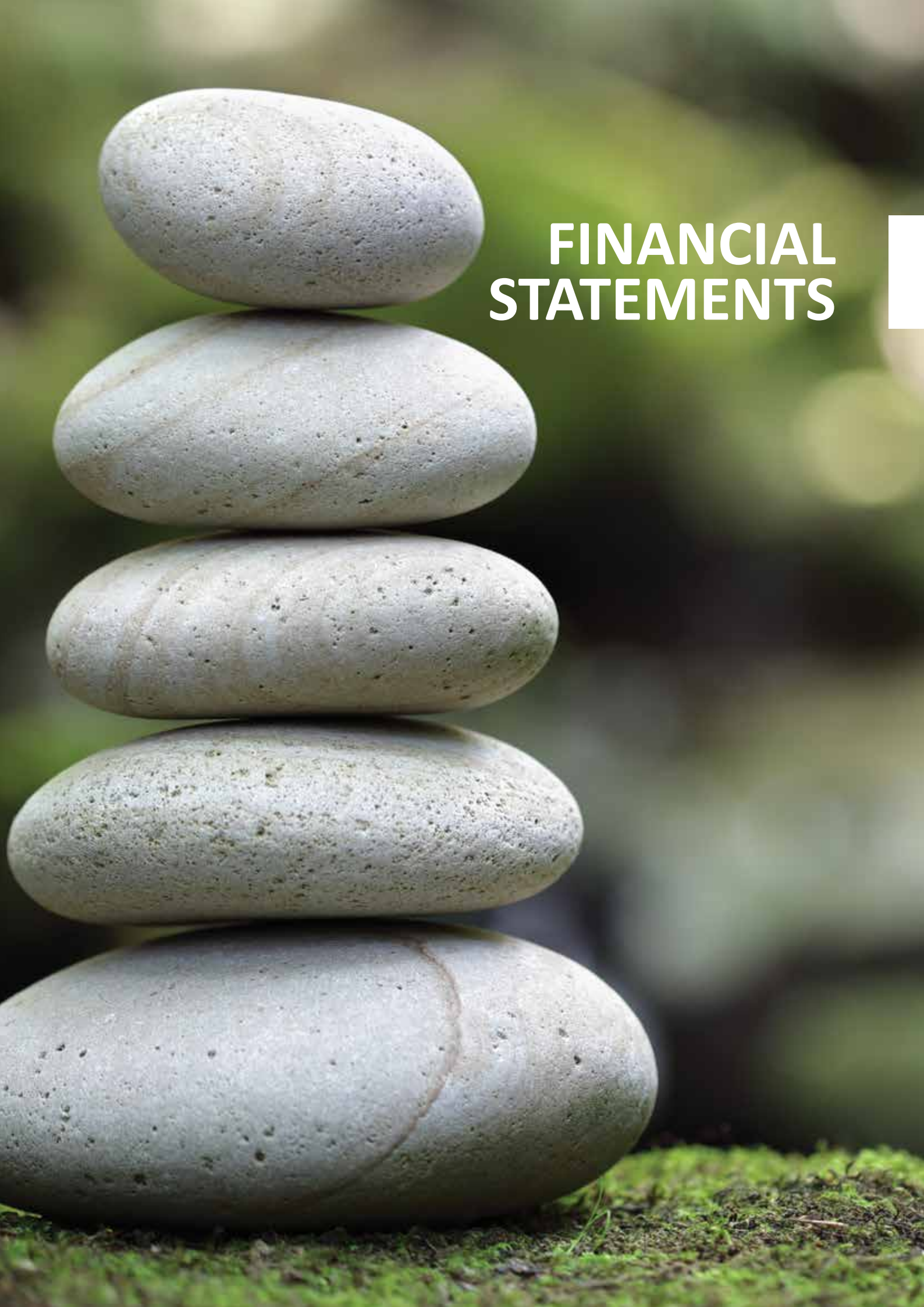
Clinical Equipment Portfolio Performance

Asset Performance Indicators	Indicator Class	2016/17 Result	2017/18 Standard	2017/18 Result
Percentage of MRIs compliant with manufacturer specification standards	Condition	100%	100%	100%
Percentage of CTs and Linacs compliant with the requirements of the Radiation Protection Act	Condition	100%	100%	100%
Percentage of MRI uptime vs. operational hours	Utilisation	96%	>98%	99.96%
Percentage of CT uptime vs. operational hours	Utilisation	99%	>98%	99.98%
Percentage of Linac uptime vs. operational hours	Utilisation	97%	>98%	new Linac being installed

Information Communication and Technology (ICT) Portfolio Performance

Asset Performance Indicators	Indicator Class	2016/17 Result	2017/18 Standard	2017/18 Result
Percentage of available capacity for storage	Condition	20%	20%	20%
Percentage uptime for critical applications	Utilisation	99%	99%	99%
Customer satisfaction level with service desk	Functionality	93%	85%	95%
Annual network penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational)	Functionality	2	2	2

[1] Southern DHB Buildings with building warrant of fitness certification in progress due to ongoing asbestos issues (Dunedin Clinical Services Building, and Dunedin Ward Block).



FINANCIAL STATEMENTS

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2018

	Note	2018 Actual $000	2018 Budget $000	2017 Actual $000
Patient revenue	2	970,662	964,301	923,973
Other revenue	2	9,007	10,107	10,007
Interest revenue		319	407	295
Total revenue		**979,988**	**974,815**	**934,275**
Personnel costs	3	369,628	374,730	361,973
Depreciation, amortisation and impairment expense	10,11	21,593	22,736	21,396
Outsourced services		45,237	36,054	42,785
Clinical supplies		84,500	76,400	80,247
Infrastructure and non-clinical expenses		48,225	46,802	45,269
Other district health boards		42,507	41,387	41,404
Payments to non-health board providers		377,050	376,098	351,120
Other expenses	6	3,369	3,647	4,241
Finance costs	5	135	135	2,668
Capital charge	4	9,122	10,826	5,042
Total expenses		**1,001,366**	**988,815**	**956,145**
Surplus/(deficit) for the year	17	**(21,378)**	**(14,000)**	**(21,870)**
Other comprehensive revenue				
Items that will not be reclassified to surplus/(deficit)				
Revaluation of land and buildings	10, 17	34,570	-	-
Impairment of land and buildings	17	-	-	(20,090)
Total other comprehensive revenue/(expense)		34,570	-	(20,090)
Total comprehensive revenue/(expense)		**13,192**	**(14,000)**	**(41,960)**

Statement of Changes in Equity
For the year ended 30 June 2018

	Note	2018 Actual $000	2018 Budget $000	2017 Actual $000
Balance at 1 July		**159,394**	**159,394**	**84,661**
Total comprehensive revenue and expense		13,192	(14,000)	(41,960)
Owner transactions				
Capital contributions from the Crown (deficit support and project equity funding)		20,705	34,000	20,000
Conversion of Crown loan to equity		-	-	97,400
Return of capital		(707)	(707)	(707)
Balance at 30 June		**192,584**	**178,687**	**159,394**

Explanations of major variances are provided in Note 23

The accompanying notes form part of these financial statements

Statement of Financial Position

As at 30 June 2018

	Note	2018 Actual $000	2018 Budget $000	2017 Actual $000
Current assets				
Cash and cash equivalents	7	8	8	8
Trade and other receivables	8	43,731	38,589	42,332
Inventories	9	5,032	4,922	4,922
Total current assets		**48,771**	**43,519**	**47,262**
Non-current assets				
Property, plant and equipment	10	311,965	304,787	269,870
Intangible assets	11	10,884	9,856	12,631
Total non-current assets		**322,849**	**314,643**	**282,501**
Total assets		**371,620**	**358,162**	**329,763**
Liabilities				
Current liabilities				
Cash and cash equivalents	7	30,385	35,222	22,848
Payables and deferred revenue	12	49,929	51,177	54,188
Borrowings	13	1,226	1,388	1,388
Employee entitlements	14	76,428	70,568	68,153
Provisions	15	464	-	2,000
Total current liabilities		**158,432**	**158,355**	**148,577**
Non-current liabilities				
Borrowings	13	2,455	2,971	3,643
Employee entitlements	14	18,149	18,149	18,149
Total non-current liabilities		**20,604**	**21,120**	**21,792**
Total liabilities		**179,036**	**179,475**	**170,369**
Net assets		**192,584**	**178,687**	**159,394**
Equity				
Contributed capital	17	231,798	245,093	211,800
Property revaluation reserves	17	108,502	73,932	73,932
Accumulated surplus/(deficit)	17	(147,716)	(140,338)	(126,338)
Total equity		**192,584**	**178,687**	**159,394**

Explanations of major variances against budget are provided in note 23

The accompanying notes form part of these financial statements

Statement of Cash Flows
For the year ended 30 June 2018

	2018 Actual $000	2018 Budget $000	2017 Actual $000
Cash flows from operating activities			
Cash receipts from Ministry of Health and patients	971,515	975,054	931,178
Payments to suppliers	(598,849)	(578,710)	(570,019)
Payments to employees	(362,774)	(374,315)	(358,281)
Interest received	319	407	295
Interest paid	(10)	(135)	(2,957)
Goods and services tax (net)	159	(1,592)	(2,562)
Capital charge	(9,122)	(10,826)	(5,042)
Net cash flow from operating activities	**1,238**	**9,883**	**(7,388)**
Cash flows from investing activities			
Proceeds from sale of property, plant and equipment	7	-	483
Purchase of property, plant and equipment	(27,415)	(54,878)	(23,544)
Net cash flow from investing activities	**(27,408)**	**(54,878)**	**(23,061)**
Cash flows from financing activities			
Capital contributions from the Crown	19,998	33,293	19,293
Drawdown/(repayment) of borrowings	(1,365)	(672)	(1,834)
Net cash flow from financing activities	**18,633**	**32,621**	**17,459**
Net increase/(decrease) in cash and cash equivalents	**(7,537)**	**(12,374)**	**(12,990)**
Cash and cash equivalents at beginning of year	(22,840)	(22,840)	(9,850)
Cash and cash equivalents at the end of the year	**(30,377)**	**(35,214)**	**(22,840)**

Explanations of major variances against budget are provided in note 23

The accompanying notes form part of these financial statements

Statement of Cash Flows
For the year ended 30 June 2018 (continued)

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

	2018 Actual $000	2017 Actual $000
Net surplus/(deficit) for the period	**(21,378)**	**(21,870)**
Add/(less) non-cash items:		
Depreciation and assets written off	21,593	21,396
Increase/(decrease) in financial liability fair value	15	28
Increase/(decrease) in provision for doubtful debts	360	943
Non-cash transactions	-	184
Total non-cash items	**21,968**	**22,551**
Add/(less) items classified as investing or financing activity:		
Net loss/(gains) on disposal of property, plant and equipment	37	(391)
Total items classified as investing or financing activites	**37**	**(391)**
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(1,759)	(8,912)
(Increase)/decrease in inventories	(110)	143
Increase/(decrease) in trade and other payables	(3,843)	(3,695)
Increase/(decrease) in employee benefits	6,323	4,786
Net movements in working capital	**611**	**(7,678)**
Net cash inflow/(outflow) from operating activities	**1,238**	**(7,388)**

The one-off non-cash transaction for Capital contributions from the Crown of $97.4 million in 2017 had no effect on the Statement of Cashflows.

The accompanying notes form part of these financial statements

Notes to the Financial Statements

1. Statement of accounting policies for the year ended 30 June 2018

REPORTING ENTITY

Southern District Health Board (Southern DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing Southern DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. Southern DHB's ultimate parent is the New Zealand Crown.

Southern DHB's primary objective is to deliver health, disability services and mental health services to the community within its district. Southern DHB does not operate to make a financial return.

Southern DHB is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

The financial statements for Southern DHB are for the year ended 30 June 2018 and were approved for issue by the Commissioner on 29 October 2018.

BASIS OF PREPARATION

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

Going concern

Southern DHB's Commissioner received a letter of support from the Ministers of Health and Finance that the Government is committed to working with them over the medium term to maintain its financial viability. It acknowledges that equity support may be required and the Crown will provide such support should it be necessary to maintain viability. The letter of support is considered critical to the going concern assumption underlying the preparation of the financial statements, as the 2018/19 annual plan has yet to receive approval from the Ministry of Health.

Statement of compliance

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

The financial statements have been prepared in accordance with and comply with Public Sector PBE accounting standards.

Presentation currency and rounding

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

Measurement base

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

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

- where modified by the revaluation of land and buildings
- inventories are stated at the lower of cost and net realisable value.

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

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

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

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

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

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

class of assets needed to be revalued when an impairment loss on damaged/unusable property, plant and equipment was recognised.

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

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

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

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

Foreign currency transactions

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

Goods and services tax

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

Income tax

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

Budget figures

The budget figures are derived from the 2017/2018 statement of performance expectations. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Commissioner in preparing these financial statements.

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

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

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

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

- asbestos impairment, note 10
- fixed assets revaluations, note 10
- employee entitlements, note 14
- deferred maintenance impairment, note 10
- remaining useful lives, note 10.

Comparative data

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

2. REVENUE

ACCOUNTING POLICY

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

MoH revenue

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

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

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

ACC contract revenue

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

Revenue from other DHBs

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Donations and bequests

Donated and bequeathed financial assets are recognised as revenue, unless there are substantial use or return conditions. A liability is recorded if there are substantive use or return conditions and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Revenue from grants

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

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

Research revenue

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

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

Breakdown of patient revenue

	2018 Actual $000	2017 Actual $000
Health and disability services (MoH contracted revenue)	930,763	884,692
ACC contract revenue	10,517	9,363
Inter-district patient inflows	21,696	21,442
Other revenue	7,686	8,476
Total patient care revenue	**970,662**	**923,973**

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

Breakdown of other revenue

	2018 Actual $000	2017 Actual $000
Gain on sale of property, plant and equipment	8	447
Donations and bequests received	429	422
Rental revenue	2,559	3,187
Other revenue	6,011	5,951
Total other revenue	**9,007**	**10,007**

3. PERSONNEL COSTS

ACCOUNTING POLICY

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

Superannuation schemes

Defined Contribution Plans

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

Breakdown of personnel costs

	2018 Actual $000	2017 Actual $000
Salaries and wages	354,498	349,218
Defined contribution plans employer contributions	8,517	8,100
Increase/(decrease) in employee entitlements	6,613	4,655
Total personnel costs	**369,628**	**361,973**

EMPLOYEE REMUNERATION

There were 681 employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2018 (2017: 656).

Total Remuneration and Other Benefits $000	Number of Employees	
	2018	2017
100 - 110	144	148
110 - 120	93	80
120 - 130	62	52
130 - 140	33	26
140 - 150	30	37
150 - 160	29	33
160 - 170	19	16
170 - 180	24	19
180 - 190	12	18
190 - 200	11	20
200 - 210	22	12
210 - 220	18	14
220 - 230	20	14
230 - 240	16	12
240 - 250	13	18
250 - 260	14	23
260 - 270	10	13
270 - 280	11	10
280 - 290	9	11
290 - 300	15	7
300 - 310	7	10
310 - 320	12	10
320 - 330	9	8
330 - 340	5	6
340 - 350	8	6
350 - 360	6	6
360 - 370	5	3
370 - 380	5	4
380 - 390	1	4
390 - 400	1	5
400 - 410	2	-
410 - 420	6	1
420 - 430	2	3
430 - 440	-	2
440 - 450	-	2
450 - 460	1	-
460 - 470	1	-
470 - 480	1	-
490 - 500	-	-
500 - 510	1	-
520 - 530	1	2
540 - 550	1	-
550 - 560	-	1
710 - 720	1	-
	681	**656**

Each year, as required by the Crown Entities Act, our annual report shows numbers of employees receiving total

remuneration over $100,000 per year, in bands of $10,000.

Of the 681 employees in this category, 457 were medical/dental employees (2017: 438 employees were medical/dental).

The Chief Executive's remuneration and other benefits either paid or accrued, are in the band 520-530.

EMPLOYEE TERMINATION PAYMENTS

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

The total payments were $656,005 (2017: 15 employees totalling $697,961).

BOARD MEMBERS REMUNERATION

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

COMMISSIONER TEAM REMUNERATION

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

	2018 Actual $000	2017 Actual $000
Kathy Grant	170	164
Graham Crombie	55	90
Richard Thomson	43	54
Total Commissioner team remuneration	**268**	**308**

There were payments made to the independent Chairperson of the Finance, Audit and Risk Committee, appointed by the Commissioner since September 2015. Payments totalled $26,400.

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

	2018 Actual $000	2017 Actual $000
Hospital Advisory Committee		
Suzanne Crengle	-	1
Total remuneration	-	1
Community and Public Health Advisory Committee/Disability Support Advisory Committee		
Donna Christine Matahaere-Atariki	1	-
Total remuneration	1	-
Iwi Governance Committee		
Taare Hikurangi Bradshaw	1	1
Justine Camp	2	1
Ann Johnstone	1	1
Donna Matahaere-Atariki	1	1
Odele Stehlin	2	2
Nola Tipa	-	-
Total remuneration	**7**	**6**

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

4. CAPITAL CHARGE

ACCOUNTING POLICY

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

FURTHER INFORMATION ON THE CAPITAL CHARGE

Southern DHB pays capital charge to the Crown twice yearly. This is based on the closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the periods 1 July to 31 December 2017 and 1 January to 30 June 2018 was 6 per cent. The amount charged during the period was $9.1 million (2017: 6 per cent, $5.0 million).

The conversion of $97.4 million of debt to equity in February 2017 resulted in much lower interest costs in the 2017/2018 year compared with the previous year.

5. FINANCE COSTS

ACCOUNTING POLICY

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

Breakdown of finance costs

	2018 Actual $000	2017 Actual $000
Interest on secured loans	10	2,471
Interest on finance leases	125	197
Total finance costs	**135**	**2,668**

6. OTHER EXPENSES

ACCOUNTING POLICY

Breakdown of other expenses

	Note	2018 Actual $000	2017 Actual $000
Impairment of trade receivables		360	943
Bad debts written off		8	310
Loss on disposal of property, plant and equipment		45	56
Audit fees (for the audit of financial statements)		202	197
Fees paid to other auditors for assurance and related services including internal audit		84	95
Commissioners fees	3	268	308
Operating lease expenses		2,401	2,330
Koha		1	2
Total other expenses		**3,369**	**4,241**

Operating Leases

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

The operating lease payments are made up of vehicle leases (54 per cent), premises rental (32 per cent), with the balance being clinical equipment and other equipment rental (15 per cent).

Operating leases as lessee

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

	2018 Actual $000	2017 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	1,296	1,303
Between one and five years	1,399	2,119
More than five years	138	138
Total non-cancellable operating leases	**2,833**	**3,560**

The majority of the non-cancellable operating lease expense relates to 276 fleet car leases. These leases have terms of 3.5 to 6 years, the last ones expiring March 2023.

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

7. CASH AND CASH EQUIVALENTS

ACCOUNTING POLICY

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

Breakdown of cash and cash equivalents and further information

	2018 Actual $000	2017 Actual $000
Cash at bank and on hand	(397)	(133)
Demand funds with New Zealand Health Partnerships Limited	(29,980)	(22,706)
Cash and cash equivalents in the Statement of Cash Flows	**(30,377)**	**(22,839)**

WORKING CAPITAL FACILITY

At 30 June 2018, the Southern DHB held no bank overdraft facilities.

Southern DHB is a party to the 'DHB Treasury Services Agreement' between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to 'sweep' DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of a month's Provider Arm funding plus GST. For Southern DHB, that equates to $48.62m.

8. TRADE AND OTHER RECEIVABLES

ACCOUNTING POLICY

Trade and other receivables are recorded at the amount due less any provisions for uncollectability.

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

Breakdown of receivables and further information

	2018 Actual $000	2017 Actual $000
Receivables (gross)	47,425	45,666
Less: provision for uncollectability	(3,694)	(3,334)
Total receivables	**43,731**	**42,332**
Total receivables comprise:		
Receivables (non-exchange transactions)	25,740	22,479
Other accrued income (exchange transactions)	17,991	19,853
	43,731	**42,332**

Trade receivables are shown net of provision for doubtful debts and impairment amounting to $3.7 million arising from identified debts unlikely to be recovered (2017: $3.3 million).

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

Trade receivables

	2018		2017	
	Gross Receivable $000	Impairment $000	Gross Receivable $000	Impairment $000
Not past due	11	-	767	207
Past due 0-30 days	3,989	1	7,434	470
Past due 31-120 days	2,933	225	1,668	351
Past due 121-360 days	2,004	347	535	258
Past due more than 1 year	3,390	3,121	2,039	2,048
Total	**12,327**	**3,694**	**12,443**	**3,334**

Note: Trade receivables of $12.4 million are included in Receivables (gross) figure, $47.4 million.

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

Trade receivables

	2018 Actual $000	2017 Actual $000
Gross trade receivables	12,327	12,443
Individual impairment	(3,694)	(3,334)
Collective impairment	-	-
Net total trade receivables	**8,633**	**9,109**

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

9. INVENTORIES

ACCOUNTING POLICY

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the year of the write-down.

Breakdown of inventories

	2018 Actual $000	2017 Actual $000
Pharmaceuticals	2,502	2,392
Surgical & medical supplies	2,530	2,530
Total inventories	**5,032**	**4,922**

10. PROPERTY, PLANT AND EQUIPMENT

ACCOUNTING POLICY

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

- land at fair value
- buildings at fair value represented by Depreciated Replacement costs less accumulated depreciation and impairment losses
- plant and equipment at cost less accumulated depreciation and impairment losses
- motor vehicles at cost less accumulated depreciation and impairment losses.

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

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

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

Revaluations

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

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

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

Additions

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

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

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

Disposal of property, plant and equipment

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

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

Subsequent costs

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

Depreciation

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

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

Buildings	1 to 79 years	1.25-6.67%
Plant and equipment	3 to 40 years	6.67-33%
Motor vehicles	5 to 12 years	20%

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

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

Impairment

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

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

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

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

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

Breakdown of property, plant and equipment and further information

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant and equipment	Vehicles	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 2016	27,487	228,242	158,428	2,332	7,737	424,226
Additions	-	-	-	-	22,862	22,862
Transfers from Work in Progress	-	12,577	12,322	20	(24,919)	-
Revaluation increase	-	(20,090)	-	-	-	(20,090)
Disposals	-	(89)	(13,680)	(42)	-	(13,811)
Balance at 30 June 2017	**27,487**	**220,640**	**157,070**	**2,310**	**5,680**	**413,187**
Balance at 1 July 2017	27,487	220,640	157,070	2,310	5,680	413,187
Additions	-	-	-	-	24,913	24,913
Transfers from Work in Progress	-	3,651	7,544	-	(11,195)	-
Revaluation increase	10,510	24,060	-	-	-	34,570
Depreciation writeback on revaluation	-	(33,149)	-	-	-	(33,149)
Disposals	-	-	(1,250)	-	-	(1,250)
Balance at 30 June 2018	**37,997**	**215,202**	**163,364**	**2,310**	**19,398**	**438,271**
Depreciation and impairment losses						
Balance at 1 July 2016	-	16,365	119,582	1,432	-	137,379
Depreciation charge for the year	-	8,364	11,040	275	-	19,679
Disposals	-	(89)	(13,621)	(31)		(13,741)
Elimination on revaluation	-	-	-	-	-	-
Balance at 30 June 2017	**-**	**24,640**	**117,001**	**1,676**	**-**	**143,317**
Balance at 1 July 2017	-	24,640	117,001	1,676	-	143,317
Depreciation charge for the year	-	8,509	10,858	264	-	19,631
Disposals	-	-	(3,492)	(1)		(3,493)
Elimination on revaluation	-	(33,149)	-	-	-	(33,149)
Balance at 30 June 2018	**-**	**-**	**124,367**	**1,939**	**-**	**126,306**
Carrying amounts						
At 1 July 2016	27,487	211,877	38,846	900	7,737	286,847
At 30 June 2017	**27,487**	**196,000**	**40,069**	**634**	**5,680**	**269,870**
At 1 July 2017	27,487	196,000	40,069	634	5,680	269,870
At 30 June 2018	**37,997**	**215,202**	**38,997**	**371**	**19,398**	**311,965**

Capital Commitments

	2018 Actual $000	2017 Actual $000
Buildings	15,474	11,818
Clinical equipment	2,604	1,123
Computer equipment	1,278	222
Non-clinical equipment	224	7
Total capital commitments	**19,580**	**13,170**

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

Revaluation

Current Crown accounting policies require all Crown entities to revalue land and buildings in accordance with PBE IPSAS 17, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with Treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings of Southern DHB was carried out as at 30 June 2018 by Tony Chapman, an independent registered valuer with Colliers International and a member of the New Zealand Institute of Valuers. That valuation conformed to International Valuation Standards and was based on an optimised depreciation replacement cost methodology. The valuer was contracted as an independent valuer.

The revaluation dated 30 June 2018 has been reduced by $20.1 million due to the impairment of land and buildings. This has reduced the carrying amount as at 30 June 2018.

Restriction

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

IMPAIRMENT

Southern DHB impaired Land and Buildings by the value of $20.1 million in the 2016/2017 year due to the impact on fair values of asbestos contamination identified throughout the DHB.

This contamination has been located across a number of buildings.

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

11. INTANGIBLE ASSETS

ACCOUNTING POLICY

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

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

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

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

The following rights are attached to these shares:

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

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

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

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

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

Amortisation

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

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

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

The estimated useful lives are as follows:

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

Breakdown of intangible assets

	FSPC	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
Balance 1 July 2016	4,469	24,658	29,127
Additions	-	358	358
Disposals	-	(464)	(464)
Balance at 30 June 2017	**4,469**	**24,553**	**29,022**
Balance 1 July 2017	4,469	24,553	29,022
Additions	-	215	215
Disposals	-	-	-
Balance at 30 June 2018	**4,469**	**24,768**	**29,237**
Amortisation and impairment losses			-
Balance 1 July 2016	-	15,138	15,138
Amortisation charge for the year	-	1,717	1,717
Disposals	-	(464)	(464)
Balance at 30 June 2017	**-**	**16,391**	**16,391**
Balance 1 July 2017	-	16,391	16,391
Amortisation charge for the year	-	1,962	1,962
Disposals	-	-	-
Balance at 30 June 2018	**-**	**18,353**	**18,353**
Carrying amounts			
At 1 July 2016	4,469	9,520	13,989
At 30 June 2017	**4,469**	**8,162**	**12,631**
At 1 July 2017	4,469	8,162	12,631
At 30 June 2018	**4,469**	**6,415**	**10,884**

The above balance includes $0.8 million of work in progress, the major contributing item being $0.7 million relating to the South Island Patient Management System. (2017: $1.6 million including $0.9 million relating to the E-Prescribing System and $0.7 million relating to the South Island Patient Management System).

12. PAYABLES & DEFERRED REVENUE

ACCOUNTING POLICY

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

Breakdown of payables & deferred revenue

	2018 Actual $000	2017 Actual $000
Trade payables to non-related parties	10,201	11,014
GST payable	5,578	5,415
Revenue in advance relating to contracts with specific performance obligations	158	4,051
Other non-trade payables and accrued expenses	33,992	33,708
Total payables and deferred revenue	**49,929**	**54,188**

	2018 Actual $000	2017 Actual $000
Total payables comprise:		
Exchange transactions	44,192	44,722
Non-exchange transactions	5,737	9,466
	49,929	**54,188**

13. INTEREST-BEARING LOANS & BORROWINGS

ACCOUNTING POLICY

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

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

FINANCE LEASES

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

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

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

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

Breakdown of interest bearing loans & borrowings

	2018 Actual $000	2017 Actual $000
Current		
Current portion of secured loans	600	600
Current portion of unsecured loans	116	116
Current portion of finance lease liabilities	510	672
Total current portion	**1,226**	**1,388**
Non-current		
Secured loans	1,083	1,670
Unsecured loans	51	166
Finance lease liabilities	1,321	1,807
Total non-current portion	**2,455**	**3,643**
Total borrowings	**3,681**	**5,031**

Secured loans

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

Crown Loans

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

SECURITY AND TERMS

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

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

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

Breakdown of Crown loans

	2018 Actual $000	2017 Actual $000
Interest rate summary		
Crown loans - fixed interest	-	-
Repayable as follows:		
Within one year	716	716
One to two years	589	666
Two to three years	548	611
Three to four years	-	559
Four to five years	-	-
Later than five years	-	-
	1,853	**2,552**
Term loan facility limits		
Crown loans	-	-
Term loan facility	-	-

Breakdown of finance leases

	2018 Actual $000	2017 Actual $000
Within one year	509	672
One to two years	269	486
Two to three years	93	269
Three to four years	103	93
Four to five years	112	103
Later than five years	744	856
	1,830	**2,479**

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

14. EMPLOYEE ENTITLEMENTS

ACCOUNTING POLICY

Short-term employee entitlements

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

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

Long-term entitlements

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

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

Presentation of employee entitlements

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

Breakdown of employee entitlements

	2018 Actual $000	2017 Actual $000
Current portion		
Long-service leave	3,616	3,616
Sabbatical leave	179	179
Retirement gratuities	2,889	3,398
Annual leave	43,864	40,636
Sick leave	343	343
Continuing medical education	5,913	6,389
Salary and wages accrual	19,624	13,592
Total current portion	**76,428**	**68,153**
Non-current portion		
Long-service leave	4,016	4,016
Sabbatical leave	1,680	1,680
Retirement gratuities	12,453	12,453
Total non-current portion	**18,149**	**18,149**
Total employee entitlements	**94,577**	**86,302**

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

Since the issues remain under review, the holiday pay provision recognised is estimated based on the best information available at the date of this annual report. Once the issues have been resolved the actual liability may be different.

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

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

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

The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A discount rate of 1.78 per cent (2017: 1.97 per cent) and an inflation factor of 3.40 per cent (2017: 3.37 per cent) were used.

15. PROVISIONS

ACCOUNTING POLICY

General

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

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

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

Restructuring

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

Facilities

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

Breakdown of provisions

	2018 Actual $000	2017 Actual $000
Current portion		
Restructuring	464	2,000
Facility compliance	-	-
Total current portion	**464**	**2,000**
Non-current portion		
Restructuring	-	-
Facility compliance	-	-
Total non-current portion	**-**	**-**
Total provisions	**464**	**2,000**

Restructuring provision

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

Movements in each class of provision are as follows:

	Restructuring $000	Facilities $000	Total
Balance at 1 July 2016	571	1,242	1,813
Additional provisions made	2,000	-	2,000
Amounts used	(571)	(1,242)	(1,813)
Unused amounts reversed	-	-	-
Balance at 30 June / 1 July 2017	**2,000**	**-**	**2,000**
Additional provisions made	-		-
Amounts used	(736)	-	(736)
Unused amounts reversed	(800)	-	(800)
Balance at 30 June 2018	**464**	**-**	**464**

16. CONTINGENCIES

ACCOUNTING POLICY

Contingent Liabilities

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

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

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

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

The DHB is currently subject to two potential litigation issues. One of these relates to a workplace accident and the other a complaint filed with the Human Rights Review tribunal.

There were no other contingent liabilities at year end.

Contingent Assets

Southern DHB has no contingent assets at year end.

17. EQUITY

ACCOUNTING POLICY

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

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

Property revaluation reserve

These reserves relate to the revaluation of property, plant and equipment to fair value. There has been a $34.5 million increase in the reserve this year due to the revaluation of land and buildings at 30 June 2018.

Capital management

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

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

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

Breakdown of equity

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2016	95,107	94,022	(104,468)	84,661
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	20,000	-	-	20,000
Contributed capital - owner transaction	97,400	-	-	97,400
Equity repayment to the Crown	(707)			(707)
Movement in revaluation of land and buildings	-	-	-	-
Transfers from revaluation of land and buildings on impairment	-	(20,090)		(20,090)
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Other movements	-	-	-	-
Deficit for the period	-	-	(21,870)	(21,870)
Balance at 30 June 2017	**211,800**	**73,932**	**(126,338)**	**159,394**
Balance at 1 July 2017	211,800	73,932	(126,338)	159,394
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	-	-	-	-
Contributed capital - owner transaction	20,705	-	-	20,705
Equity repayment to the Crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	34,570	-	34,570
Transfers from revaluation of land and buildings on impairment	-	-	-	-
Transfers from revaluation of land and buildings on disposal	-	-	-	-
Other movements	-	-	-	-
Deficit for the period	-	-	(21,378)	(21,378)
Balance at 30 June 2018	**231,798**	**108,502**	**(147,716)**	**192,584**

Equity is made up of:

	2018 Actual $000	2017 Actual $000
Equity	187,807	154,202
Restricted equity*	4,777	5,192
Total equity	**192,584**	**159,394**

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

18. ASSOCIATED ENTITIES

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

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

The functions of SISSAL are being conducted by South Island DHBs under an agency arrangement.

19. RELATED PARTIES

TRANSACTIONS WITH RELATED PARTIES

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

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

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

Key management team remuneration

The key management remuneration is as follows:

	2018 Actual $000	2017 Actual $000
Commissioner Team		
Remuneration	268	308
Full-time equivalent members	0.9 FTE	1.1 FTE
Total Commissioner team remuneration	**268**	**308**
Total Commissioner team full-time equivalent	**0.9 FTE**	**1.1 FTE**
Executive Management		
Remuneration	2,216	3,197
Termination payments	210	178
Full-time equivalent members	10.2 FTE	10.7 FTE
Total Executive Management remuneration	**2,426**	**3,375**
Total Executive Management full-time equivalent	**10.2 FTE**	**10.7 FTE**
Total remuneration	**2,693**	**3,683**
Total full-time equivalent	**11.1 FTE**	**11.8 FTE**

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

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

20. FINANCIAL INSTRUMENTS

ACCOUNTING POLICY

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

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

CREDIT RISK

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 14.7 per cent of total receivables). It is assessed to be a low risk and high-quality entity due to its nature as the government-funded purchaser of health and disability support services.

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

LIQUIDITY RISK

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

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

	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
2018							
Secured loans	1,683	1,804	300	300	600	604	-
Unsecured loans	167	170	58	58	49	5	-
Finance lease liabilities	1,830	1,830	257	253	269	308	743
Payables and deferred revenue	49,929	49,929	49,929	-	-	-	-
Total	**53,609**	**53,733**	**50,544**	**611**	**918**	**917**	**743**
Inflow	-	-	-	-	-	-	-
Outflow	53,609	53,733	50,544	611	918	917	743
2017							
Secured loans	2,270	2,404	300	300	600	1,204	-
Unsecured loans	282	290	58	58	116	58	-
Finance lease liabilities	2,479	3,152	479	328	615	687	1,043
Payables and deferred revenue	54,188	54,188	54,188	-	-	-	-
Total	**59,219**	**60,034**	**55,025**	**686**	**1,331**	**1,949**	**1,043**
Inflow	-	-	-	-	-	-	-
Outflow	59,219	60,034	55,025	686	1,331	1,949	1,043

INTEREST RATE RISK

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

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

EFFECTIVE INTEREST RATES AND REPRICING ANALYSIS

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

2018

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and cash equivalents	-	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office *	-	1,683	300	300	533	550	-
Finance lease liabilities*	8.78% - 18.34%	1,830	256	253	269	308	744
Unsecured bank loans	-	167	58	58	49	2	-

* These assets/liabilities bear interest at fixed rates

2017

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Cash and cash equivalents	0.00%	-	-	-	-	-	-
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office *	0.00%	2,270	300	300	555	1,115	-
Finance lease liabilities*	5.80% - 18.34%	2,479	406	266	486	465	856
Unsecured bank loans	0.00%	282	58	58	111	55	-

* These assets/liabilities bear interest at fixed rates

Conversion of existing Crown loans to Crown equity

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity.

On the 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

As a consequence of the changes there was a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

The impact on the statements of account for the DHB is as follows:

	Note	2018 Actual $000	2017 Actual $000
Opening balance – Crown loans	13	2,270	100,247
Increase Crown loans		-	-
Repayment of Crown loans		(587)	(577)
Conversion of loans to equity		-	(97,400)
Closing Balance – Crown Loans		**1,683**	**2,270**
Opening balance – contributed capital	17	97,400	-
Capital contribution from/(repayment to) the Crown		-	-
Conversion of Crown loans to Crown equity		-	97,400
Closing Balance – Contributed Capital		**97,400**	**97,400**

FOREIGN CURRENCY RISK

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

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

SENSITIVITY ANALYSIS

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

At 30 June 2018, it is estimated that a general change of one percentage point in interest rates would increase or decrease Southern DHB's operating result by approximately $0.02 million (2017: $0.03 million).

CLASSIFICATION AND FAIR VALUES

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

ESTIMATION OF FAIR VALUES ANALYSIS

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

	Note	Loans and receivables $000	Other amortised costs $000	Carrying amount Actual $000	Fair value Actual $000
2018					
Trade and other receivables	8	43,731	-	43,731	43,731
Cash and cash equivalents	7	(30,377)	-	(30,377)	(30,377)
Secured loans	13	-	1,683	1,683	1,683
Finance lease liabilities	13	-	-	1,830	1,830
Unsecured liabilities	13	-	167	167	167
Trade and other payables	12	-	49,929	49,929	49,929
2017					
Trade and other receivables	8	42,332	-	42,332	42,332
Cash and cash equivalents	7	(22,840)	-	(22,840)	(22,840)
Secured loans	13	-	2,270	2,270	2,270
Finance lease liabilities	13	-	-	2,479	2,479
Unsecured liabilities	13	-	282	282	282
Trade and other payables	12	-	54,188	54,188	54,188

FAIR VALUE HIERARCHY

The only financial instruments measured at fair value in the statement of financial position are Finance Leases. The fair value of finance leases as represented by their carrying amount in the statement of financial position, is determined using a valuation technique that uses observable market inputs (level 2).

FINANCE LEASE LIABILITIES

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

TRADE AND OTHER RECEIVABLES/PAYABLES

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

21. MENTAL HEALTH RING-FENCE

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

During the 2011/12 year there was a change in the ring-fence calculation to include community dispensed anti-psychotic drugs, and primary mental health initiatives. Also, the mental health specific demographic rate is now used in calculating the demographic component of the ring-fence, rather than the district health boards' (DHBs) average demographic rate.

The year ended 30 June 2018 has resulted in a deficit of $1.9 million (2017: $0.9 million) for Mental Health services. Additionally Southern DHB has a brought-forward overspend of $5.9 million; meaning that the carry-forward overspend is $7.8 million (2017: $5.9 million).

22. EVENTS AFTER BALANCE DATE

The Nursing MECA agreement was settled nationally subsequent to balance date. Southern DHB has made an appropriate provision for this settlement.

There were no other significant events after the balance date.

23. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

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

Statement of Comprehensive Revenue and Expense

The favourable variance in total comprehensive revenue and expenses against budget for the year ended 30 June 2018 was $27.2 million. This is substantially impacted by the $34.6 million revaluation of land and buildings included in other comprehensive income.

The total caseweights were 5.4% or 2,818 higher than budgeted, with acute volumes 2.4% or 913 higher than last year.

Revenue

Total Revenue was $5.2 million higher than budget. Patient revenue contributed $6.4 million, of which $4.2 million was due to additional funding for the Bowel Screening and other programmes, Syrian refugees and In-Between travel. Other revenue was $1.2 million less than budget and reflected lower rental income.

Personnel Costs and Outsourcing

Personnel costs were favourable to budget by $5.1 million. Medical costs were $5.0 million favourable because we were unable to fill positions. Offsetting this were Nursing costs at $1.5 million unfavourable, largely as a result of the provision for the MECA negotiations that were settled after balance date.

Also contributing were savings totalling $1.4 million in Support and Management and Administration areas with unfilled positions together with indirect costs reduced by the revaluation of gratuity entitlements.

Outsourced Services (includes outsourced personnel)

Outsourced Clinical Services were $9.2 million over budget, reflecting the outsourcing of services (including outsourced personnel working in our facilities) to meet the demand for delivery of acute and elective services beyond the current capacity within the hospitals. Similarly the services from other DHBs were $1.1 million more than expected.

Clinical Supplies

Clinical supplies were $8.1 million over budget due to a range of factors. These include the increasing use of high cost pharmaceutical products within the hospital environment and the higher than expected demand for blood products, implants and prostheses and ambulance transportation.

Statement of Financial Position

Property, Plant and Equipment

Total Property Plant and Equipment was $7.2 million higher than planned. The Asset Revaluation at 30 June 2018 of $34.6 million and savings in Depreciation of $1.0 million were offset by timing of Capital Expenditure with $28.0 million of the budgeted spend now in the 2018/2019 year.

This includes capital expenditure on the new ICU facility, linear accelerator replacements, various items of clinical and infrastructural equipment and deferred maintenance programmes which have continued into the new financial year.

Trade and Other Receivables

Total Trade and Other Receivables were $5.1 million higher than planned due to additional Crown Funding and higher Pharmacy rebate accruals.

Contributed Capital

Total Contributed Capital is $13.3 million lower than planned. This is a result of the timing of expenditure on the Interim Capital Works Programme.

Employee Entitlements

Total Current Employee Entitlements are $5.9 million higher than planned, which reflects an uplift in provision for MECA settlements.

Statement of Cash Flows

Net Cash Flow from Operating Activities is $8.6 million lower than budget. The Payments to Suppliers were higher in Outsourcing and Clinical Supplies, however this was partially offset by lower Personnel Costs.

Cash Flows from Investing Activities are $27.5 million favourable to Budget due to the timing of capital expenditure.

Net Cash Flow from Financing Activities is $14.0 million lower than planned because the timing of capital expenditure reduced the need for capital contributions.

24. CROWN ENTITIES ACT 2004: STATEMENT OF PERFORMANCE EXPECTATIONS

The Statement of Performance Expectations (SPE) requirements of the Crown Entities Act (CEA) 2004 apply to all DHBs. These requirements are separate to those in the Public Health and Disability (Planning) Regulations 2011 that require each DHB to prepare an Annual Plan and agree that Plan with the Minister of Health. In developing the SPE, the DHB is required to provide the draft SPE to the Minister of Health by 30 April each year and the Minister of Health has 15 working days from receipt to provide comments to the DHB on the SPE. The DHB then considers the comments to the draft SPE and must provide the completed SPE to the Minister of Health before the start of the financial year which is 1 July each year, and publish it on the DHB's website as soon as practicable once it has been provided to the Minister of Health. The SPE is completed when it includes the information required by section 149E of the CEA (such as forecast financial statements and forecast financial information) and is signed and dated by two board members of the DHB. If the SPE is not completed by 1 July each year, this is a breach of section 149C of the CEA.

While Southern DHB met all timelines and expectations of the Ministry of Health, it has made a technical breach of section 149C of the Crown Entities Act 2004 by including the SPE in the 2018 Annual Plan which was not signed off by the Minister of Health until May 2018. In addition, the draft 2019 Annual Plan includes the SPE and was not signed off by the Minister of Health by 1 July 2018.

Information on Ministerial Directions

The following Ministerial Directions have been received by Southern DHB.

WHOLE-OF-GOVERNMENT APPROACH

The Direction to support a whole-of-government approach was issued in April 2014 under s.107 of the Crown Entities Act. The three Directions relating to this cover procurement, ICT and property.

Southern DHB applies the Government Rules of Sourcing for procurement.

Southern DHB works closely with the Government Chief Information Officer to ensure compliance with directions in relationship to ICT.

Southern DHB is exempt from the direction regarding property functional leadership.

REQUIREMENT TO IMPLEMENT NEW ZEALAND BUSINESS NUMBER

The Direction requires Southern DHB to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018. This Direction was issued in May 2016 under s.107 of the Crown Entities Act.

Southern DHB intends to replace or upgrade its key finance and supply chain business system and the replacement or upgraded system will take the NZBN requirements into account. However, as the national finance and supply chain system project has been delayed, Southern DHB will not meet the Direction requirement date.

Work is also ongoing to identify other impacts and to establish the changes that need to be implemented as a result of this Direction.

AUTHENTICATION SERVICES

The Direction on the use of authentication services was issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 Direction.

Southern DHB works closely with the Government Chief Information Officer to ensure that our technology environment is compliant with the expected standards and applicable Directions as provided; this includes authentication services.

ELIGIBILITY DIRECTION

The 2011 Eligibility Direction was issued under s.32 of the NZ Public Health and Disability Act 2000.

Southern DHB strictly and consistently assesses patient eligibility against the Public Health and Disability Act 2000 to ensure that all eligible consumers are recognised as such.

Independent auditor's report

To the readers of Southern District Health Board's financial statements and performance information for the year ended 30 June 2018

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

We have audited:

- the financial statements of the Health Board on pages 75 to 106, that comprise the statement of financial position, statement of contingencies and statement of commitments as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 13 to 25 and 27 to 49.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the Health Board on pages 75 to 106:

- present fairly, in all material respects:
    - its financial position as at 30 June 2018; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards.

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw your attention to the disclosures made in note 1 on page 81 that outline that the Commissioner, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of support received from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, should it be necessary, to maintain viability. We consider these disclosures to be adequate.

Compliance with the Holidays Act 2003

Again without further modifying our opinion, we draw your attention to the fact that District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 14 on page 96 to 97. Our opinion is not modified in respect of this matter.

Our audit of the financial statements and the performance information was completed on 29 October 2018. This is the date at which our opinion is expressed.

Basis for our opinion

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

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

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

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

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

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

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

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

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

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

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information. We were unable to determine whether there are material misstatements in the statement of performance because the scope of our work was limited, as we referred to in our opinion.

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioner.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Commissioner and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial

statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Commissioner is responsible for the other information. The other information comprises the information included on pages 1 to 12, 26 and 50 to 74 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

John Mackey
Audit New Zealand
On behalf of the Auditor-General
Dunedin, New Zealand


Southern District
Health Board
Piki Te Ora


AMBULANCE