Southern District Health Board
Piki Te Ora

Statement of Intent (SOI) incorporating the Statement of Performance Expectations (SPE)

Southern DHB 2019/20 - 2021/22

STATEMENT OF JOINT RESPONSIBILITY

The Southern District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2001. Each DHB is categorised as a Crown Entity under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

This document is our Statement of Intent which has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health.

The Statement of Intent sets out our strategic goals and objectives and describes what we aim to achieve in terms of improving the health of our population and in ensuring the sustainability of our health system. It also contains our Statement of Performance Expectations for the coming year.
The Statement of Performance Expectation is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in the DHB's Annual Report.

In line with the New Zealand Health Strategy, the Southern DHB has made a strong commitment to 'whole of system' service planning. We work in partnership with other service providers and actively engage with individuals, their families and our community, to design and deliver service solutions to meet changing needs.

Clinically-led alliances have been established as vehicles for implementing system change. Our alliance framework means we share a joint vision for the health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our Alliance South, the Southern health system primary care alliance, which was recommissioned in July 2018 and the South Island Regional Alliance with our four partner South Island DHBs.

The Southern DHB recognises its role and responsibility in working towards achieving equitable health outcomes for our population across the Southern health system. Our Iwi Governance Committee is representative of the seven Ngāi Tahu Papatipu Rūnanga from across our district. We will continue to work closely with the Iwi Governance Committee in order to recognise and respect the principles of the Te Tiriti o Waitangi (Treaty of Waitangi), and with a view to improving health outcomes for Māori and enabling Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

In signing this document, we are satisfied that it fairly represents our joint commitment and intentions for the coming year, and is in line with Government expectations for 2019/20.

.....	.....
Kathy Grant	Chris Fleming
Commissioner	Chief Executive
Southern District Health Board	Southern District Health Board
Date: 21 June 2019	Date: 21 June 2019

OUR VALUES

Kind Manaakitanga

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

Open Pono

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

Positive Whaiwhakaaro

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

Community Whanaungatanga

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

OUR VISION

Better health, better lives, whānau ora

OUR MISSION

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

FOREWORD FROM THE COMMISSIONER AND CHIEF EXECUTIVE

The Southern district covers the largest geographic area of all DHBs, across which, over generations, numerous health care structures have been established to enable us to take care of one another. These are wide and varied, from GP and nurse-led practices, to rural hospitals, iwi providers, NGOs, as well as the secondary and tertiary hospitals in Invercargill and Dunedin.

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.

This vision, to develop an equitable and coherent system of care across the Southern district, has been long been articulated, and is fundamental to our Southern Strategic Health Plan adopted in 2015. This was reinforced by Southern Future, an extensive community and staff engagement programme in 2016 that articulated their expectations of a health care system. They asked us to ensure care was better coordinated across providers, with less wasted time and delivered closer to home; that communication made sense and was respectful; that they would have a calm, compassionate and dignified experience and that health services are high quality and equitable.

Over the past years, our focus has been on developing a comprehensive roadmap that would take us from our current state to a truly integrated, equitable health system that sets us up for the future, contributes to the vision of a strong public health sector and aligns with national health priorities. For Southern DHB this includes:

- **Creating an environment for good health** – building an environment and society that supports health and well-being
- **Primary and Community Care Strategy and Action Plan** – creating a health system that is more equitable, coordinated, accessible and delivered closer to home where possible.
- **Valuing Patients' Time** – focusing on patient flow through our hospital system to remove steps that add time with no value to our patients.
- **Enabling people and systems –** so that people have the skills, support and systems to deliver the care our communities have asked for. This is underpinned by digital and workforce strategies.
- **Facilities for the future –** Including ongoing planning for the new Dunedin Hospital, continuing redevelopment work at Lakes District Hospital, and progressing Community Health Hubs to accommodate and adapt to new models of care.

This 2019/20 Annual Plan centres on taking steps towards implementing these priority areas. These consolidate and continue to build on the wider priorities of recent years, to ensure a transformed health system is built on a solid foundation.

These include developing a whole-of-system culture based on shared values, collaboration and innovation. We continue to invest in organisational capability and leadership, business and IT systems, quality improvement processes and communications with our communities.

They also see dedicated focus on creating sustainable pathways in key identified areas, to ensure we are optimising new opportunities and making the most effective use of our resources. Five critical programmes of improvement have been commenced in the 2018/19 year and are expected to bear significant results in the next one to two years, and a further tranche are being refined for inclusion in the 2019/20 year, which will provide longer term opportunities.

Collectively, these efforts enable no less than an overarching reshaping of the health care system for our district. Indeed, 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.

This means we can begin to enjoy the benefits of a redesigned health system long before the opening of the new hospital.

In all this work, we value our partnerships with WellSouth Primary Health Network, 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.

HE MIHI

Tērā ia te pure rangi
Haehae ana kei Hananui
Aro-paki mai ki te Rua-o-te-Moko
Aro atu rā ki te Puna Hauaitu
Tārere Waitaki ki te Umu o Te Rakitauneke
Rere atu ra te Tai o Araiteuru
Ki te Rae o Tupa
Ki Tarahaukapiti ē.

Kei reira ra te waka o Tākitimu e takoto ana
Ko tēnei uri o Aotea, o Ngatokimatawhaorua
E mihi atu nei.

E ngā mate huhua kua ninihi rā ki Tua-o-Paerau
Haere ake koutou ki te Huinga o ngā Mano
Ki te Okiokinga o ngā Tūpuna
Waiho koutou ki te Ao Wairua
Hoki mai ki a tātou anō.

Tēnā rā koutou katoa e te iwi ē
Ngāi Tahu, Ngāti Māmoe, Waitaha
Tēnā koutou nōhou te mana o te whenua
Tēnā hoki tātou ngā heke o ngā waka Māori e maha
E noho pīwawa nei ki tēnei takiwā
Tahuri mai ki tēnei waha e mea ake nei
Me whai tātou i te oranga tonutanga o te tangata.

Translation

Light breaks upon the peak of Hananui (Mount Anglem, Rakiura)
Turn then to Orepuke and Fiordland
Then to the Inland Lakes
Waitaki flows to the Oven of Te Rakitauneke (Mouth of the Waitaki)
Flowing down the Eastern coast
To the Otago Heads
And back to Western Dome (in Central Southland).

There lies the canoe Tākitimu
Whilst this descendant of Aotea and Ngatokimatawhaorua
Sends greetings.

To the many dead passed on to Paerau
Go to the gathering place of the multitudes
To the resting place of ancestors
To you consigned to the Spirit World
We return to our world.

Greetings Ngāi Tahu, Ngāti Māmoe, Waitaha
You who maintain the mana of the land
And also to us who are the descendants of all the ancestral canoes
Now living scattered about this region
Turn your ears and listen to my important thoughts
We must pursue that which delivers those most lifegiving outcomes for us all.

Greetings all

EQUITY OF HEALTH CARE FOR MĀORI

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage, require different approaches and resources to get equitable health outcomes. Achieving equity is not a series of discrete deliverables and milestones, instead it is recognising and taking opportunities to embed equity within the operation of the health and disability system at all levels. The Southern DHB holds the view that these differences are not random and exist because of multiple reasons. Achieving equity for Māori must be a priority, as the health gaps across the life-course are more significant.

The right to the highest attainable standard of health, implies a clear set of legal obligations to ensure appropriate conditions for the enjoyment of health for all people without discrimination. Equity in health is based on the WHO definition, the absence of avoidable or remediable difference among groups of people. The concept acknowledges that these differences in health status are unfair and unjust, but are also the result of differential access to the resources necessary for people to lead healthy lives.

The SDHB 2019/20 Annual Plan has a focus on working towards achieving equitable health outcomes for its population across the Southern health system. Our System Level Measures Improvement Plan will focus on Māori: ambulatory sensitive (avoidable) hospital admissions 0-4 and 45-64 years; acute admissions and readmissions to hospital; amenable mortality; acute bed days; and self-harm hospitalisation admissions. We will also focus on cervical screening 25-69, cancer treatment services and child respiratory inpatient admissions. This will include the development of robust data sets, the establishment of a clinical Māori strategy group, and a work plan that targets activities to reduce disparity. This will include the realignment of our Māori secondary health services across both the general hospitals and mental health services, stronger linkages with Wellsouth Primary Health Network and our Kaupapa Māori health providers. Strengthening Māori workforce is critical as we move forward and our equity plan will include the development of a Māori workforce strategy. This work will be developed with oversight of the Iwi Governance Group and the Alliance Leadership Team.

Activity needs to aim at reducing health equity gaps, not only for Māori, but for Pacifica and other high needs populations. Much of our population reside in rural areas that are widely dispersed across our district. We all have a responsibility to address the disparities and inequities within our communities. As our ethnicity data improves we will work towards placing the spotlight on these groups and alight actions appropriate over time.

In New Zealand, disparities between Māori and non-Māori are the most consistent and compelling inequities in health. The Treaty of Waitangi was signed to protect the interests of Māori and it is not in the interest of Māori to be disadvantaged in any measure of health, social or economic wellbeing. Effective, responsive, patient-centred services, supported by targeted interventions, will be required to achieve health equity.

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1. OVERVIEW OF STRATEGIC DIRECTION

1.1 Strategic Intentions And Priorities

Strategic Context

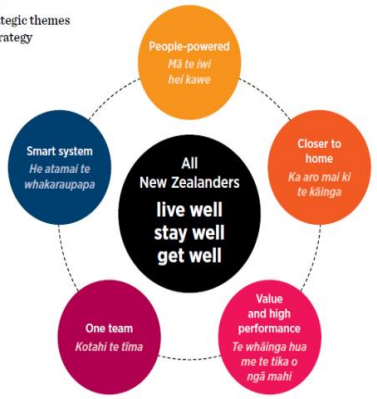
This Annual Plan for 2019/20 articulates Southern DHB's (SDHB) commitment to meeting the expectations of the Minister of Health. The Plan will deliver against national and regional priorities and illustrate our continued commitment to the goals of supporting everyone across our district to live well and access the right care when they need it. We will work as part of a wider Southern health system to deliver high quality, patient-centred and equitable health services to our diverse communities.

National Direction

The long-term vision for New Zealand's health service is articulated through the New Zealand Health Strategy. The overarching intent is to support all New Zealanders to 'live well, stay well, and get well'.[1] The Strategy identifies five key themes to give the health sector a focus for change:

- People powered
- Closer to home
- High value and performance
- One team
- Smart system

Figure 1:
Five strategic themes of the Strategy



Southern DHB's direction is further guided by a range of population or condition-specific strategies. These include: *He Korowai Oranga*[2], *Ala Mo'ui*: Pathways to Pacific Health and Wellbeing[3], *Healthy Ageing Strategy*[4], *Rising to the Challenge*: Mental Health & Addiction Service Development Plan[5], *Disability Strategy*[6] and the UN Convention on the Rights of Persons with Disabilities.

The Minister's letter of expectations signals annual expectations and priorities for DHBs. The Government has signalled an increased priority for bowel screening, planned care, disability, rural health, primary care, mental health and addiction care child wellbeing, Smokefree 2025 goal, non-communicable disease, public health and the environment, maternity care and midwifery and a strong focus on improving equity in health outcomes.

Southern DHB aligns health and disability services with *He Korowai Oranga*, the New Zealand Māori Health Strategy and is committed to a special relationship between Iwi and the Crown under the Treaty of Waitangi. A *Principles of Relationship*[7] - *Te Hauroa o Murihiku me Araiteuru* is in place between Murihiku and Araiteuru Rūnaka and the Southern DHB and is currently being revised The purpose of *Te Hauora o Murihiku me Araiteuru* is to improve Māori health and wellbeing outcomes in the Southern district.

DHBs are expected to work closely with and support their local public health units and health promotion providers; continue to focus on capital planning; demonstrate leadership in the collaboration between and integration of health and social services, especially housing; continue to co-design and deliver initiatives to achieve progress on System Level Measures with Primary Health Organisations (PHOs) and other key stakeholders; establish clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings and to support workforce training opportunities; and to live within their means.

DHBs are also expected to contribute to the Government's priority outcome of environmental sustainability, support healthy eating and health weight and support changes to drinking water regulations. This Annual Plan outlines how the Southern DHB will meet those expectations in 2019/20.

[1] Minister of Health. 2016. New Zealand Health Strategy. Wellington: Ministry of Health www.moh.health.nz
[2] Ministry of Health – *He Korowai Oranga* – Māori Health Strategy (2013/14) http://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga
[3] Ministry of Health - 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing (2014–18) http://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018
[4] Ministry of Health – Healthy Ageing Strategy (2016) http://www.health.govt.nz/publication/healthy-ageing-strategy
[5] Ministry of Health – Rising to the Challenge (2012-17) http://www.health.govt.nz/our-work/mental-health-and-addictions/rising-challenge
[6] Office of Disability Issues – Disability Strategy (2016-26) http://www.odi.govt.nz/nz-disability-strategy/
[7] Principles of Relationship – Te Hauroa o Murihiku me Araiteuru http://www.southerndhb.govt.nz/files/15686_2015051993319-1431984799.pdf

Regional Direction

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23.2%) of the total New Zealand population. While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Alliance to better address our shared challenges and technology and demographics. Our jointly-developed South Island Health Services Plan outlines the agreed regional activity 2017-2020. The Regional vision is a sustainable South Island health system, focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services as close to people's homes as possible. Southern DHB has made a strong regional commitment and staff take the clinical or executive lead in a number of priority areas such as child health services and mental health and addiction services.

Southern DHB Direction

Southern DHB is committed to a quality and patient-focused health system while achieving clinical and financial sustainability. Health systems are complex and this requires an approach that addresses not only services and performance but how we engage with our people and the way we work together.

Other initiatives will need to be fully scoped, approved and planned but these include a range of activity to ensure that we are able to deliver on the national, regional and local priorities as described in more detail within the plan. These inter-related areas build on local priorities agreed with the Ministry in 2018/19 and align with the national direction and the strategic themes identified by our Commissioners; these will continue in 2019/20.

1. **Positioning public health services for the future.** Public health is the part of our health system that works to keep our people well. The public health goal is to improve, promote and protect the health and wellbeing of populations and to reduce inequities. Key strategies are:

    - Information: sharing evidence about our people's health and wellbeing (and how to improve it)
    - Capacity-building: helping agencies to work together for health
    - Health promotion: working with communities to make healthy choices easier
    - Health protection: organising to protect people's health, including via use of legislation
    - Supporting preventive care: supporting our health system to provide preventive care to everyone who needs it (for example immunisation, stop smoking)

    The principles of public health work are: focusing on the health of **communities** rather than individuals; influencing **health determinants**; prioritising improvements in **Māori health**; reducing **health disparities**; basing practice on the best available **evidence**; building effective **partnerships** across the health sector and other sectors; and remaining **responsive** to new and emerging health threats.

2. **Primary and community services, investing in change:** Developed in partnership with WellSouth PHO, the Primary and Community Care Strategy has been developed as a framework for primary, community and secondary areas and also acts as an enabler for the delivery system to be reframed. It forms the first of the two key planks to create system change alongside Valuing Patients' Time. We have articulated at a conceptual level a change programme focussed on redesigning services across the Southern health system to achieve our commitment to integrated, patient focussed care and many of these initiatives are already underway, including Health Care Homes (HCH) and planning for Community Hubs.

    The development of the Primary and Community Care Strategy and Action Plan has provided a much needed roadmap not only for Primary Care but also the broader system and 2018/19 saw a significant emphasis supported by sizable investment on the realisation of the year one goals outlined in the Plan. These include the development of the first tranche of Health Care Homes alongside the establishment of a network of Community Hubs , which collectively will provide the relevant infrastructure to begin integrating key services across traditional domains of primary and secondary care.

    The HCH model reinforces the role of the general practice as the main provider of primary care and enhances capacity and capability through new roles, skills and ways of working[8]. HCHs are being rolled out across the district in accordance with national model of care requirements which will see traditional general practices transition into modern, fit for purpose business units. Sixteen General Practices were designated as Southern Health Care Home Practices in 2018/19 and a further five practices will

[8] Southern Primary and Community Care Action Plan, (2018) Southern DHB and WellSouth Primary Health Network

begin the programme in mid-2019. All practices in the district are eligible to apply to become a Health Care Home. The full process of implementing changes and becoming a Health Care Home can take up to three years, depending on how ready a practice is to implement change.

3. **Valuing Patients' Time** is a critical programme which Southern DHB is partnering with Francis Health to deliver. The approach is based on the principles of Agile, so that high staff engagement translates to swift change with a balanced approach to traditional project management processes. Critical to this work will be the mentoring, support and engagement of clinicians, to lead a transformational change process in patient care, resulting in initiatives across primary and community and acute hospital based on shaping or reducing demand, matching capacity and demand, and redesigning the system. The pace of Valuing Patient Time will be enhanced and accelerated in 2019/20 by improving workflow, outcomes, work place, patient experience, and by saving resources.

4. **Enabling people and systems.** We continue to strengthen the foundations of our organisation through a focus on our workforce, and on the underlying infrastructure and business processes that support the health system.

   Within this, and in addition to the transformation that is required to support a new delivery system, we are also focusing on creating new and sustainable pathways in specific areas. Four specific critical areas for improvement have been identified as opportunities to optimise new opportunities, maximise efficiencies and help return the system to financial good health.. These areas are:

   - Efficient Utilisation of Pharmaceuticals
   - SMO Remuneration Review Programme
   - Maximisation of Procurement Opportunities
   - Optimisation of the Nursing Workforce

   This year will see the beginning of the roll out of the Workforce and Digital Strategy, that anticipates the requirements of the new Dunedin Hospital and reconfigured health system of the future.

5. **Facilities and the Dunedin Rebuild Transition Programme:** This focuses on work required to ensure safety and sustainability of services for the next 10 years until the opening of the new hospital. This includes maintenance, creating physical capacity with alterations and capacity through outsourcing elective volumes and day case procedures. A key part of this activity will be the development of an Ambulatory services centre, which will open in advance of the new Dunedin Hospital, and will focus on delivering day surgery and outpatient clinics, as well as other secondary services that are not required to be delivered from the Acute services block. This is a critical first step in moving to new strategic models of care which includes altering behaviours across clinician groups as well as patients to think and use both acute hospital, community and primary care services differently.

At a Glance ***Southern Population***

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

Approximately 336,000 people live in the Southern district. Approximately 45% live in rural areas that are widely dispersed across the district. The other 55% of the population live in the two main centres of Dunedin and Invercargill.

Ethnically the Southern district is predominantly European, at 79.8%, 10.1% are Māori, 8.0% Asian and 2.1% Pacific

Our population is slightly older (17.3% aged >65) compared to the national average, with 15.7% aged >65.

Which services go where, both at a district and regional level

A critical part of the planning for the new Dunedin hospital is the appropriate planning for what can be provided across the district , and what is required to enable this. Southern DHB is undertaking upgrade work to Lakes Hospital to ensure that services can be delivered for the next seven to eight years whilst further work is undertaken to look at the needs of the broader Lakes/Dunstan area, taking into consideration the projected population growth and where services are best placed. This includes an examination of primary maternity needs, including long term positioning of primary birthing units across the district given the change in population, along with plans to develop, implement and evaluate a midwifery workforce plan. This will be done in conjunction with the recently reformed Central Lakes Locality Network.

Shift services into the community where appropriate

As part of the Primary and Community Care Action Plan, the DHB is in discussions with WellSouth on the development of the community hubs, in terms of the number, location and the range of services that will be provided from them. This work links in with the further work underway on revising the schedule of accommodation with regard to services that could be shifted from the hospital to the community in conjunction with the plans for the Dunedin rebuild.

The Community Hub models will provide expanded HCH services, to include colocation of community health services, both mobile and in-clinic services [for example rehabilitation], hospital specialist care, on-site pharmacy and diagnostics, enhanced urgent care and minor procedures.

The DHB has identified a range of services that could appropriately be repurposed to operate from an ambulatory care centre, but before this can be ultimately confirmed important current conversations need to be concluded to ensure that the opportunity for integrated care responses delivered out of Community Hubs are maximised and leveraged. To support the discussion, a closer examination of current patient pathways through the inpatient journey are being undertaken, firstly to ensure that as an organisation we truly are valuing patient time, but also to ensure that we are committed to shifting as much activity to the community to be delivered in a primary/secondary partnership model as is clinically appropriate. In turn, opportunities to execute a more generalist medical workforce and to employ the Calderdale Framework for Allied Health, are also being explored.

Working with communities to shape our health system

This journey of transformation requires advice, input and support from across the health system and wider community. Its success will be defined by the extent to which it meets the needs of our people, and delivers on the priorities they told us were important. To support this, the following bodies have been established or reshaped in the past year, and continuing to support their work, and draw upon their insights, remain a critical priority for building the Southern health system we need.

Alliance South

Alliance South, the Southern health system primary care alliance, was recommissioned in July 2018. The main body of work for the new Alliance is to provide governance for the implementation of the Primary and Community Care Strategy while also monitoring progress with the suite of System Level Measures (SLMs).

Community Health Council

The Community Health Council (CHC) is an advisory council for the Southern District Health Board (DHB) and WellSouth Primary Health Network (hospital and community health services including GPs) and has enabled a stronger patient and whānau voice to be heard across the Southern district. The CHC was established in February 2017 and includes community representatives from across the Southern district. For the 2019/20 year the CHC will continue to progress a programme of work to engage communities, whānau and patients in decision-making across the health system. As of January 2019, the CHC has 34 CHC advisors involved in 22 projects across our health system, and there is a growing number of people who have expressed an interest in becoming CHC advisors. There will be a focus on obtaining feedback from the CHC advisors and staff, already engaged in projects, in relation to what has worked and what needs to be focussed on in order to make future improvements to this process. The CHC plan to host a symposium to bring together staff and CHC advisors to share experiences over the last year.

The CHC will also be involved with providing recommendations to improving the feedback process at Southern DHB. Another key challenge this year will be to provide updated communication to our communities and staff about the role and purpose of the CHC and activities that are occurring.

Clinical Council

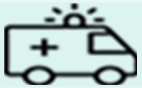
The Southern Clinical Council (CC) is the principal clinical governance, leadership and multi-disciplinary advisory group for the Southern DHB. The purpose of the Clinical Council is to give balanced, clinically-informed advice to the Commissioners/Board and the Executive Leadership Team as to clinical governance at Southern DHB.

For the 2019/20 year the CC will focus on moving the Council to align more with the HQSC Clinical Governance Framework, will establish a Mortality Review Committee and a Clinical Practice Committee which will both report through to the Council.

Given the strong foundation of organisational and culture change that has been laid down in recent years, the DHB is well placed to continue in 2019/20 on this journey of change. A platform has been established which outlines the pathway we will take to organisational stability and an eventual breakeven position.

Our Health and Wellbeing

People living in the Southern district have relatively good health status[12] compared with the rest of New Zealand. However, there are a number of areas still requiring improvement to reduce inequalities.



Emergency Department attendances for Southern residents have been rising faster than population growth, suggesting potential barriers in accessing primary care.

16.9% of our adult population are current smokers, with smoking rates for Māori (33.5%) populations significantly higher.

12.4% of our adult population were told by a doctor that they had asthma and were taking regular treatments for asthma. Rates were significantly higher for Māori (21%).

30.6% of our adult population are classified as obese and rates amongst our Māori (43.2%) and Pacific (70.2%) are signifantly higher.

Source for smoking, asthma and obesity data: Regional Results 2014-2017: New Zealand Health Survey

1.2 STRATEGIC OUTCOMES

People are healthier and enabled to take greater responsibility for their own health

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions. Cancers, heart disease, musculoskeletal conditions, respiratory disease, diabetes and mental illness are major drivers of poor health and premature mortality and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates that long-term conditions make up 87.3% of all health loss in New Zealand up from 82.5% in 1990.

Tobacco smoking, inactivity, poor nutrition and hazardous drinking and substance abuse are major risk factors for a number of the most common long-term conditions. These are modifiable risk factors and can be reduced through supportive environments and improved awareness, which enable people to take personal responsibility for health and wellbeing. Public health, promotion and education services, by supporting people to make healthier lifestyle choices, will improve health outcomes for our population. Because these major risk factors also have strong socio-economic gradients, a change in behaviours will contribute to reducing inequities in health outcomes between population groups.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN SMOKING RATES

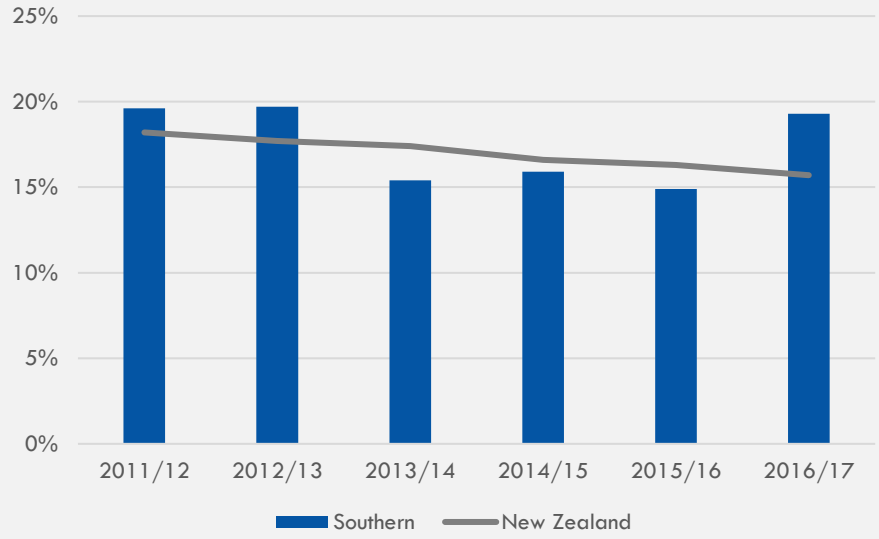
Smoking and exposure to second-hand smoke causes an estimated 4,627 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

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, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequalities in health status between population groups.

Data Source: Ministry of Health NZ Health Survey [9]

Measure: Proportion of the population (15+) who smoke



[9] *The New Zealand Health Survey is commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. Every year about 14,000 households take part in the survey with total population results presented annually and ethnicity breakdowns over combined time periods (due to small population numbers).*

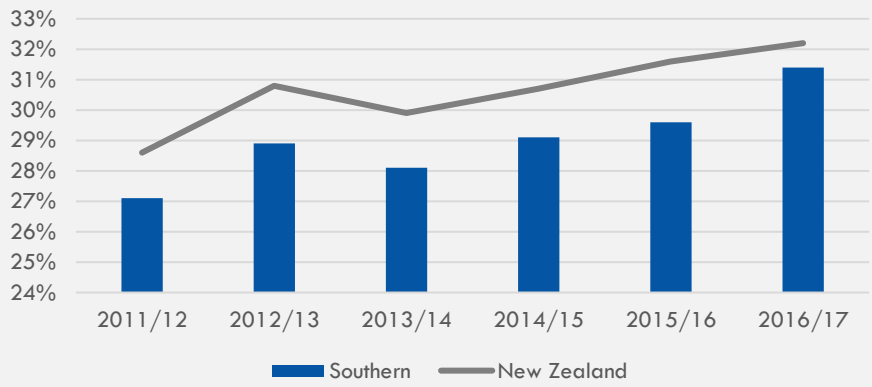
A REDUCTION IN OBESITY RATES

There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicities. Obesity is set to overtake tobacco as the leading risk to health and the most recent NZ Health Survey found 32% of all adults and 12% of children were obese.

Supporting people to achieve a healthier body weight is fundamental to improving people's wellbeing and to preventing poor health and disability at all ages.

Data Source: Ministry of Health NZ Health Survey [10]

Measure: Proportion of the population (15+) who have obesity



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

FEWER AVOIDABLE HOSPITAL ADMISSIONS

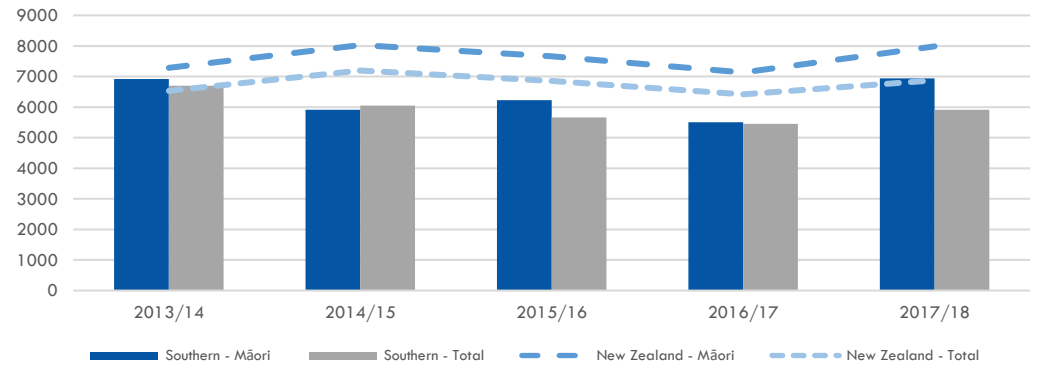
A number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, a reduction in risk factors and earlier intervention by primary and community services.

Ensuring children have the best start to life is a crucial component in the long-term health and wellbeing of our population and keeping children out of hospital is a priority. A reduction in preventable admissions will also free up hospital and specialist resources and reduce pressure on our health system.

This measure is seen as an indicator of the accessibility and effectiveness of health care and a marker of increased integration between health and social services and a reduction in the burden of disease for young children.

Data Source: Ministry of Health DHB Performance Reporting [11]

Measure: Rate of ambulatory sensitive hospital admission for children (0-4)	Base	Target			
	17/18	19/20	20/21	21/22	22/23
	5,912	<5,678	<5,678	<5,678	<5,678



[10] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people. Rates are available by ethnicity over the combined period 2014-2017 – 35.2% of the total population were obese, compared to 55.5% of the Māori population.*

[11] *This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a non-standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2018..*

CHILDREN HAVE IMPROVED ORAL HEALTH

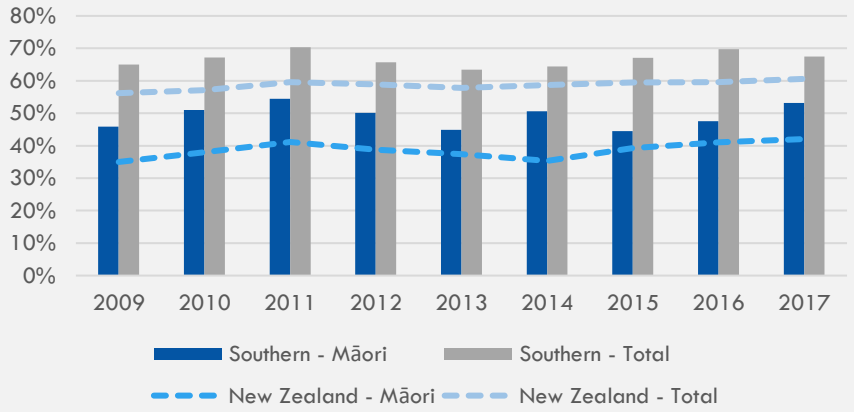
Poor oral health is a marker for a range of poor health outcomes in childhood and later in life. There is a direct link between good nutrition and good oral health, and good nutrition is also an important factors in supporting a healthy weight and reducing obesity.

Improvements in the proportion of children caries-free at age five is seen as a proxy indicator of the effectiveness of mainstream services in reaching those most at risk. It is also an indicator of improved nutrition and wellbeing.

Data Source: School & Community Oral Health Services and Statistics NZ Population Projections [12]

Measure: children caries-free at age five

Base	Target			
2018	2019	2020	2021	2022
67%	>70%	>70%	>70%	>70%



FEWER YOUNG PEOPLE TAKE UP SMOKING

The highest prevalence of smoking is amongst younger people, and preventing young people from taking up smoking is a key contributor to reducing smoking rates across our total population.

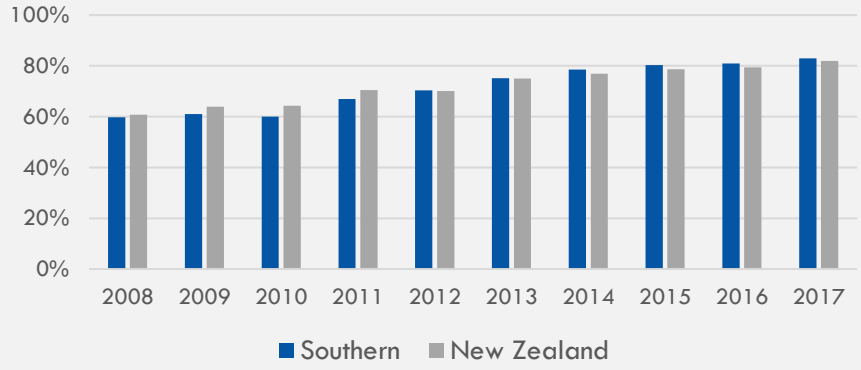
Because Māori and Pacific people have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups and reduce inequalities.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles.

Data Source: National ASH Year 10 Survey [13]

Measure: 'never smokers' amongst Year 10 students

Base	Target			
2018	2019	2020	2021	2022
82.6%	>82.6%	>82.6%	>82.6%	>82.6%



[12] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.*

[13] *The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. Run by Action on Smoking & Health, the survey has been used to monitor student smoking since 1999 and provides valuable insights into tobacco use trends amongst young people. For more detail see www.ash.org.nz.*

People stay well, in their own homes and communities

WHY IS THIS A PRIORITY?

When people are supported to stay well, and can access the care they need closer to home, in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital admission, residential care or premature mortality (death). This is not only better in terms of people's health outcomes and quality of life, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital level response.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

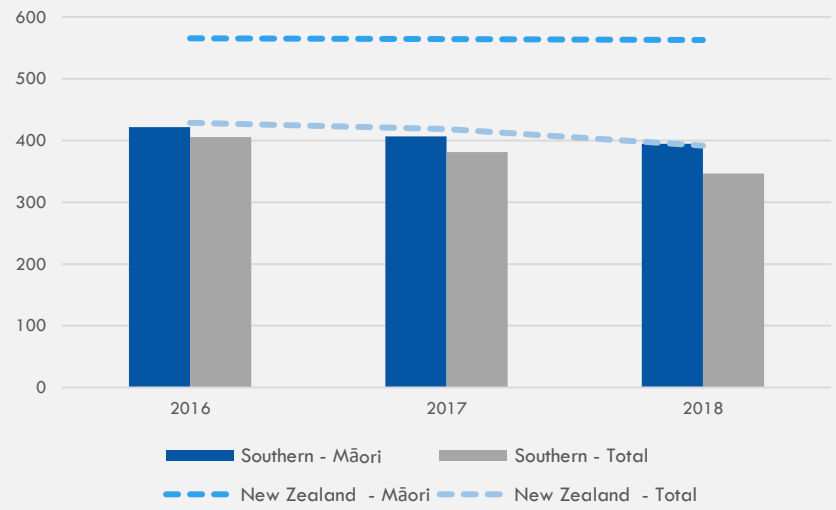
Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand.

Acute hospital bed-days are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatments that reduce crisis and deterioration. The measure also reflects the quality and effectiveness of discharge planning.

Reducing acute hospital admissions and the length of time people spend in our hospitals has a positive effect on people's health. It also enables more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care, allowing the DHB to provide more planned care.

Data Source: National Minimum Data Set[14]

Measure: rate of acute hospital bed-days (age standardised, per 1000 people)



[14] *Data is provided by the Ministry of Health via the national minimum data set. This is a newly introduced measure with only a three year time period currently available for comparison, a longer-term view will build over time.*

MORE PEOPLE LIVING LONGER IN THEIR OWN HOME

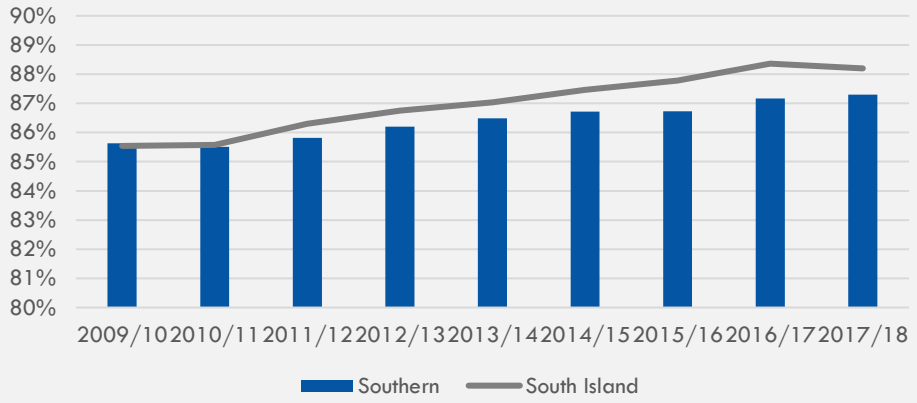
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes when people remain in their own homes and are positively connected to their local communities.

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

An increase in the proportion of older people living in their own homes is seen as a proxy indicator of how well the health system is enabling people's wishes to remain in their own homes, managing age-related and long-term conditions and responding to the needs of our older population groups.

Data Source: SIAPO Client Claims Payment System

Measure: proportion of the population (75+) living in their own home



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

PEOPLE'S CONDITIONS ARE DIAGNOSED EARLIER

People want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

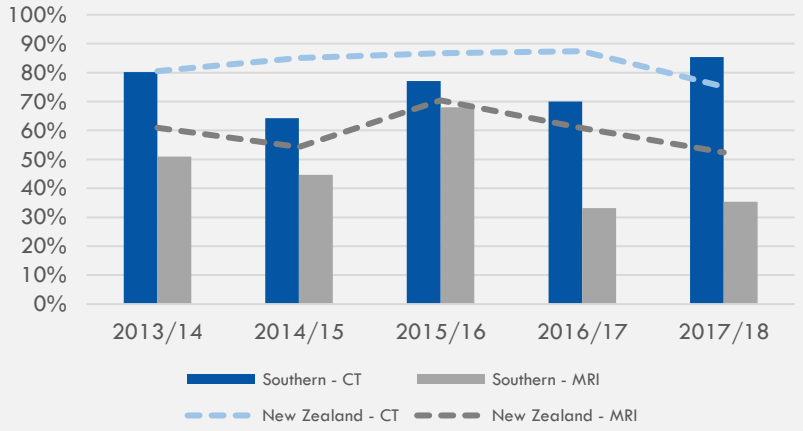
Timely access to diagnostics, by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes.

Wait times for diagnostics therefore can be seen as a proxy indicator of the responsiveness of our health system and our ability to match capacity with demand, particularly when we are seeking to minimise wait times and operating within a constrained environment.

Data Source: DHB Patient Management System[15]

Measure: people receiving non-urgent MRI or CT scan within six weeks

Base	Target			
17/18	19/20	20/21	21/22	22/23
MRI 32%	>67%	>75%	>90%	>90%
CT 81%	>85%	>95%	>95%	>95%



[15] *These measures are national DHB performance indicator (PP29) Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final month of each year (June).*

FEWER AVOIDABLE HOSPITAL ADMISSIONS

An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, risk factor reduction, earlier intervention and the effective management of long-term conditions.

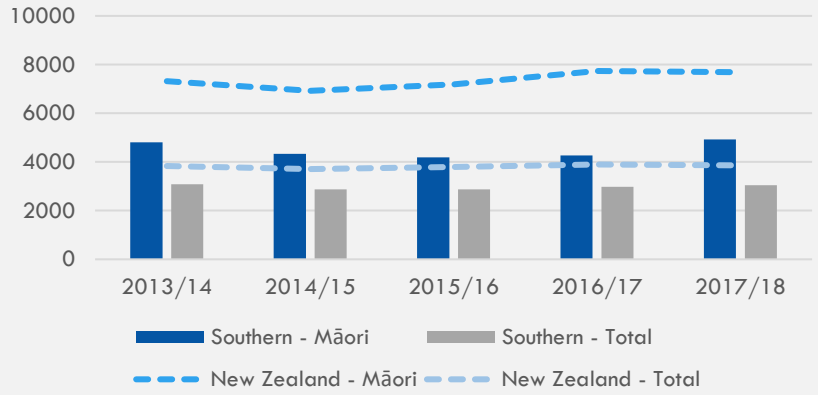
With the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness or hospital admission. A reduction in avoidable admissions will also reduce pressure on hospital and specialist service resources.

A key factor in reducing avoidable hospital admissions is improved coordination between primary and secondary services. As such, this measure is seen as an indicator of the accessibility and effectiveness of primary care and a marker of a more integrated health system.

Data Source: Ministry of Health Performance Reporting [16]

Measure: Rate of ambulatory sensitive hospital admission for adults (45-64)

Base	Target			
17/18	19/20	20/21	21/22	22/23
3,047	2,865	2,865	2,865	2,865



FEWER FALLS-RELATED HOSPITAL ADMISSIONS

Compared to older people who do not fall, those who fall experience prolonged hospital stays, loss of confidence and independence and an increased risk of institutional care.

With an ageing population, our focus on reducing harm from falls will help people to stay well and independent and reduce the demand for hospital and residential services.

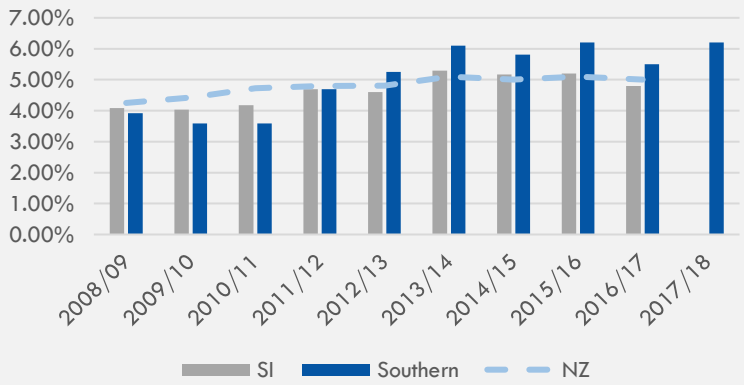
Solutions to preventing falls include appropriate medications use, improved physical activity and nutrition, access to restorative support and rehabilitation and a reduction in personal and environmental hazards.

This measure is seen as an indicator of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the services being provided.

Data Source: National Minimum Data Set[17]

Measure: population (75+) admitted to hospital as a result of a fall

Base	Target			
17/18	19/20	20/21	21/22	22/23
6.2%	<5.0%	<5.0%	<5.0%	<5.0%



[16] *This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2018.*

People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it.

This goal also considers the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population, people's experience of care and their confidence in the health system. Ineffective or poor-quality treatment and long waits for treatment also waste resources and add unnecessary cost.

We are in the midst of a significant facilities redevelopment and repair programme and we are transforming the way we deliver services to increase capacity with the resources we have available. We are focusing on improving the flow of patients across our system and reducing duplication of effort to maintain service access while reducing waiting times for treatment. We also aim to increase the value from our investment in technology to support clinical decision making and improve the quality of the care we provide.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN AMENABLE MORTALITY

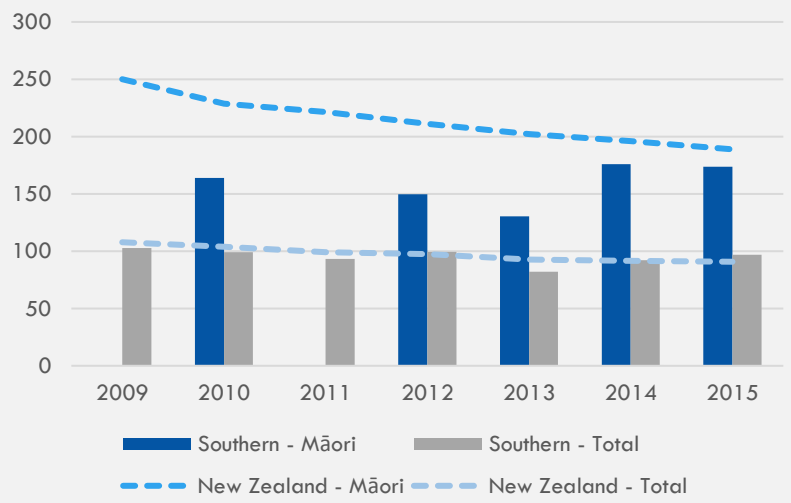
Amenable mortality is defined as premature death (before age 75) from conditions that could have been avoided through lifestyle change, earlier intervention, and the effective and timely management of long-term conditions.

There are many economic, environmental and behavioral factors that have an influence on people's life expectancy. However, timely diagnosis, improved management of long-term conditions and access to safe and effective treatment are crucial factors in improving survival rates for complex illnesses such as cancer and heart disease.

A reduction in the rate of amenable mortality can be used to reflect the responsiveness of the health system to the needs of people with complex illness, and as an indicator of access to timely and effective care.

Data Source: National Mortality Collection[18]

Measure: rate of amenable mortality for people aged under 75 (age standardised, per 100,000 people)



[18] *The performance data for this measure is sourced from the national mortality collection which classifies the underlying cause of all deaths registered in New Zealand. Data is released three years in arrears and the 2015 results are provisional. Amenable mortality rates are excluded where there are fewer than 30 deaths recorded. This affects small DHBs as well as ethnicity reporting.*

A REDUCTION IN ACUTE READMISSIONS

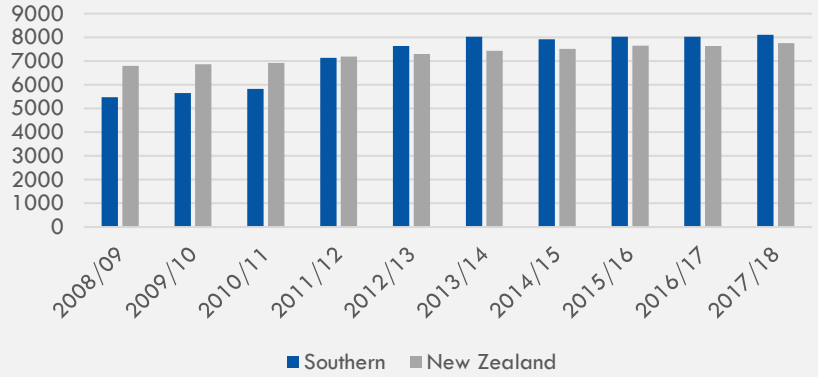
As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

Key factors in reducing acute readmissions include patient safety and quality standards, discharge planning and care coordination at the interface between services. Ensuring people receive effective treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided, and the integration between service providers. These rates are also a good balancing-measure to productivity measures such as reductions in lengths of stay.

Data Source: Ministry of Health Performance Reporting [19]

Measure: rate of acute readmissions to hospital within 28 days of discharge (standardised) per 100,000 people



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

SHORTER WAITS FOR URGENT CARE

Emergency Departments (EDs) are often seen as a barometer of the effectiveness, efficiency and responsiveness of the hospital and wider health system.

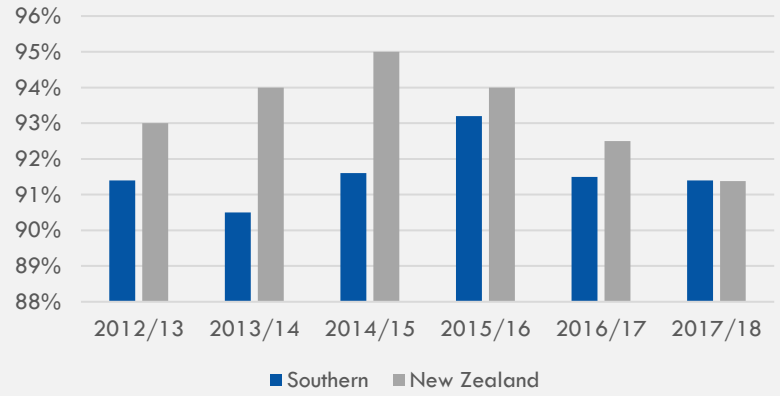
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improved patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our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

Solutions to reducing ED wait times address the underlying causes of delay and span not only hospital services but the wider health system, ensuring that only those who require emergency services present to ED. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Data Source: DHB Patient Management System [20]

Measure: people admitted, discharged or transferred from ED within 6 hours

Base	Target			
17/18	19/20	20/21	21/22	22/23
91%	95%	95%	95%	95%



[19] *This measure is a national DHB performance indicator (OS8) providing data three months in arrears, with results being the year to March 2018. This is a newly introduced measure, a longer-term view will build over time*

[20] *This measure is a national performance measure (Shorter Stays in ED). Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final quarter of each year (April – June).*

SHORTER WAITS FOR PLANNED CARE

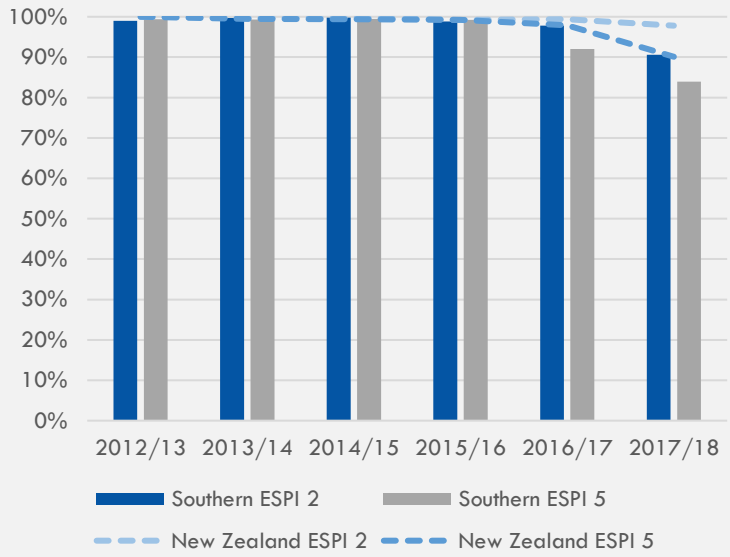
Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort, slowing the progression of disease and helping to restore independence and wellbeing.

Improved performance against these measures requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our system, a proxy for how well we are managing the flow of patients across our services.

Data Source: Ministry of Health Elective Services Website [21]

Measure: people receiving specialist assessment and treatment within set time frames	Base	Target			
	17/18	19/20	20/21	21/22	22/23
	ESPI2 91%	100%	100%	100%	100%
	ESPI5 84%	100%	100%	100%	100%



[21] *These measures are part of the national Elective Services Patient Flow Indicators (ESPIs) set and are a measure of whether DHBs are meeting expectations at key point in a patient's journey. ESPI 2 refers to the wait from referral to a person's first specialist assessment. ESPI 5 refers to the wait from the point from when treatment was agreed until treatment is delivered. Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final month of each year (June).*

2. MANAGING OUR BUSINESS

2.1 GOVERNANCE

Southern DHB has been governed by a Commissioner, supported by Deputy Commissioners, since June 2015. We are now undertaking the work required to transition to a full Board in December 2019.

2.2 ORGANISATIONAL PERFORMANCE MANAGEMENT

Southern DHB's performance is assessed on both financial and non-financial measures, which reported at governance and management levels within the organisation.

2.3 FUNDING AND FINANCIAL MANAGEMENT

Southern DHB's key financial performance is reported to the Finance Audit and Risk Committee (FARC) and Commissioner team every month. Further information about Southern DHB's planned financial position for 2019/20 and out years is contained in the Financial Performance Summary section of this document on page 32.

2.4 INVESTMENT AND ASSET MANAGEMENT

The Treasury is committed to robust and transparent stewardship of public funds. Owning the right assets, managing them well, funding them sustainably and managing risks to the Crown balance sheet are all critical to public services being cost effective and high quality.

The Investor Confidence Rating (ICR) three yearly assessment is Treasury's process to assess the performance of investment-intensive agencies in managing investments and assets that are critical to the delivery of NZ Government services. The ICR provides an indication of the level of confidence that investors (such as Cabinet and Ministers) can have in an agency's ability to realise a promised investment result if funding was committed. The assessment of Southern DHB was undertaken in November and December 2017 resulting in a D rating. The next ICR audit is scheduled to be undertaken during 2020. Currently significant work is underway to revise the Asset Management Plan and the Long Term Investment Plan to support achievement of an improved assessment.

2.5 SHARED SERVICE ARRANGEMENTS AND OWNERSHIP INTERESTS

Southern DHB does not hold any controlling interests in a subsidiary company. The DHB does not intend to acquire shares or interest in other companies, trusts or partnerships at this time.

2.6 RISK MANAGEMENT

Southern DHB has a formal risk management and reporting system, which entails monthly reporting to the Executive Leadership Team and FARC. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

2.7 QUALITY ASSURANCE AND IMPROVEMENT

Southern DHB is developing a quality framework that aligns to the IHIs triple aim adopted within healthcare in New Zealand. The framework will reach across primary, community, secondary and tertiary care delivery within Southern DHB. We expect the same standard of care to be delivered in any (*Southern DHB funded*) healthcare setting to ensure our patients experience and healthcare outcomes continuously improve. Alongside the quality framework will sit a clear clinical governance framework. It will articulate responsibilities and accountabilities to our population and to the Board. Clinical governance will act as the internal watch dog for the quality frameworks success and ensure continuous improvement.

3. STATEMENT OF PERFORMANCE EXPECTATIONS

This Statement of Performance Expectations sets out the four Output Classes that the Southern DHB will deliver in the 2019/20 financial year.

Crown Entity (established under *New Zealand Public Health & Disability Act 2000*)

Purpose:

- Improve, promote and protect the health of our population
- Promote the integration of health services across primary and secondary care services
- Seek the optimal arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs
- Reduce health disparities by improving health outcome for Māori and other population groups
- Manage national strategies and implementation plans
- Develop and implement strategies for the specific health needs of the local population

Vision: *Better Health, Better Lives, Whānau Ora*

Values:

Kind- Manaakitanga
Open –Pono
Positive – Whaiwhakaaro
Community - Whanaungatanga

Governance: DHB Commissioner: Mrs Kathy Grant
Deputy Commissioners: Mr Richard Thomson
Mr David Perez
Ms Jean O'Callaghan

Population: Approximately 336,000 people live within Southern DHB boundaries.

Staff: Southern DHB employs over 4,500 people.

Southern DHB's Statement of Intent (SOI)[22] provides the basis for our Statement of Performance Expectations (SPE), outlining the strategic directions for the DHB for the next four years, and defining the performance framework and outcomes that we are aiming to achieve.

How Will We Demonstrate Success?

The SPE 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).

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver in the coming year and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report[23].

[22]Southern DHB's Statement of Intent (SOI) is available on the DHB's website http://www.southerndhb.govt.nz
[23]The Annual Report is tabled in Parliament and will be available on the DHB's website.

Choosing Measures of Performance

To make all this happen we have to balance our investment so we can deliver services now and into the future. In 2019/20, the Southern DHB plans to spend approximately $989 million in delivering the following four Outputs funded through Vote Health:

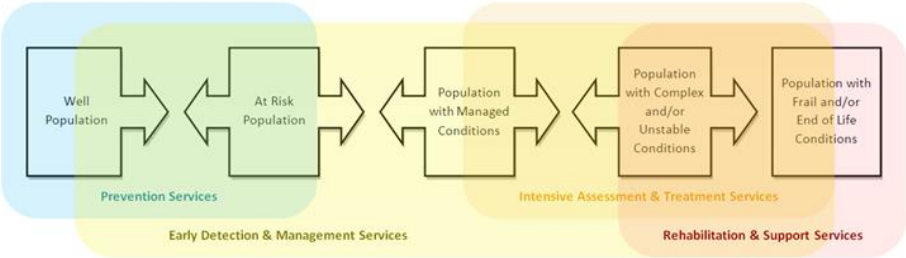
Output 1: Prevention Services;

Output 2: Early Detection and Management Services;

Output 3: Intensive Assessment & Treatment Services; and

Output 4: Rehabilitation & Support Services.

Figure 1: Scope of DHB operations - output classes against the continuum of care



Identifying a set of appropriate measures for each output class can be difficult. We cannot simply measure 'volumes' of service delivered. 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'. In order to best demonstrate this, we have chosen to present our statement of performance expectations using a mix of measures of Timeliness (T), Volume (V), Coverage (C) and Quality (Q).

Wherever possible, past years' baseline and national results are included to give context in terms of what we are trying to achieve and to support evaluation of our performance over time. Services have also been grouped into one of the four 'output classes' that are a logical fit with the continuum care and are applicable to all DHBs.

Setting Standards

In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care. Our targets also reflect our commitment to reducing inequities between population groups, and hence some measures appropriately reflect a specific focus on high need groups. Measures that relate to new services have no baseline data.

Where Does the Money Go?

The 2019/20 budget and out-year projections included in this document continue to be based on the approved 2018/19 Annual Plan. The 2019/20 budget and out-year projections will be updated when the 2019/20 Annual Plan is approved by the Minister of Health.

Table 3 (page 26) presents a summary of the budgeted financial expectations for 2019/20, by output class.

Table 2: Revenue and expenditure by Output Class (page 26) presents a summary of budgeted financial expectations through until 2022/23. Over time, we anticipate it will be possible to use this framework to demonstrate changes in the allocation of resources and funding from one end of the continuum of care to the other. The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year and therefore reflect a picture of activity across the Southern health system.

Table 1: Revenue and expenditure by Output Class 2019/20

REVENUE	Total $'000
Prevention	5,164
Early Detection and Management	206,382
Intensive Assessment & Treatment	685,718
Rehabilitation & Support	149,217
Total Revenue	**1,046,482**
EXPENDITURE	**Total $'000**
Prevention	5,164
Early Detection and Management	211,488
Intensive Assessment & Treatment	689,421
Rehabilitation & Support	155,148
Total Expenditure	**1,061,222**
Net Surplus / (Deficit) – $' 000	**(14,740)**

Table 2: Revenue and expenditure by Output Class 2017/18 – 2022/23

Revenue & Expenditure by Output Class	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Prevention Services						
Revenue	8,677	9,468	5,164	5,339	5,521	9,778
Expenditure	(8,677)	(9,468)	(5,164)	(5,339)	(5,521)	(9,778)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	194,932	204,299	206,382	214,821	225,710	234,749
Expenditure	(197,454)	(202,757)	(211,488)	(218,233)	(227,401)	(234,761)
Net Result	(2,522)	1,542	(5,106)	(3,412)	(1,691)	(12)
Intensive Assessment and Treatment						
Revenue	630,269	649,136	685,718	707,727	728,519	775,178
Expenditure	(646,194)	(697,438)	(689,421)	(710,202)	(729,746)	(781,168)
Net Result	(15,925)	(48,302)	(3,703)	(2,475)	(1,227)	(5,990)
Rehabilitation and Support						
Revenue	146,111	158,342	149,217	156,951	164,938	170,130
Expenditure	(149,041)	(156,551)	(155,148)	(160,915)	(166,903)	(170,143)
Net Result	(2,930)	1,791	(5,931)	(3,964)	(1,965)	(13)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	979,988	1,021,245	1,046,481	1,084,839	1,124,688	1,189,835
Total Expenditure per DHB Consolidated Financials	(1,001,366)	(1,066,215)	(1,061,221)	(1,094,689)	(1,129,571)	(1,195,850)
Net Surplus / (Deficit)	**(21,378)**	**(44,970)**	**(14,740)**	**(9,850)**	**(4,883)**	**(6,015)**

NOTE:

Rather than repeating footnotes, the following symbols have been used in the performance tables:

E Some services are demand driven and it is not appropriate to set targets: instead estimated volumes are provided to give context as to the use of resource across our system.

Δ Performance data provided by external parties can be affected by a delay in invoicing and results are subject to change.

❖ Performance data for some programmes relate to the calendar rather than financial year.

† National Health Targets are set for DHBs to achieve by the final quarter of the year. Performance data therefore refers to the fourth quarter result for any given year.

☩ System Level Measure

3.1 Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.

Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

On a continuum of care these services are public wide preventative services.

Why is this Output Class Significant for the DHB?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes, cancer, cardiovascular disease and respiratory disease, which account for a significant number of presentations in primary care and admissions to hospital and specialist services. These diseases are largely preventable.

By improving environments and raising awareness, preventative services support people to make healthier choices – reducing major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. High-needs and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices.

Prevention services are our best opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes.

How we will measure performance of our prevention services

Output Class: Prevention Services

Sub Output Class	Measure	Notes		Actual 2017/18	Target 2018/19	Target 2019/20
Immunisation Services These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care & allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	Percentage of children fully immunised at age 8 months	C†	Total	94%	>95%	>95%
			Māori	94%		
	Percentage of children fully immunised at age 2 years	C	Total	94%	>95%	>95%
			Māori	92%		
	Percentage of eligible boys and girls fully immunised with HPV vaccine	C	Total	68%	>75%	>75%
			Māori	71%		
	Percentage of people (≥ 65 years) having received a flu vaccination	C	Total	52 %	>75%	>75%
			Māori	44%		
Health Promotion & Education Services These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.	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	C†	Total	91%	>90%	>90%
			Māori	90%		
	Infants exclusively or fully breastfeeding at 3 months	Q Δ	Total	60%	>60%	>60%
			Māori	52%		
Population Based Screening These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Percentage of 4 year old children receiving a B4 School Check	C	Total	91%	>90%	>90%
			Quintile 5	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	Q†	Total	94%	95%	>95%
	Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	C	Total	74%	>70%	>70%
			Māori	67%		
	Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	C	Total	77%	80%	>80%
			Māori	68%		

3.2 Early Detection And Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Why is this Output Class Significant for the DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age.

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

Our vision to better integrate services presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home. Providing flexible and responsive services in the community, without the need for a hospital appointment, better supports people to stay well and manage their condition.

How we will measure performance of our Early Detection and Management Services

Output Class: Early Detection and Management

Sub Output Class	Measure	Notes		Actual 2017/18	Target 2018/19	Target 2019/20
Oral Health These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination & treatment indicates successful preventative treatment and education.	Percentage of 0-4 enrolled in community oral health services	C ❖	Total	79%	95%	>95%
			Māori	68%		
	Percentage of children caries-free at five years of age	Q ❖	Total	67%	70%	>70%
			Māori	53%		
Primary Health Care Services These services are offered in local community settings by general practice teams and other primary health care professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake of services are indicative of engagement, accessibility & responsiveness of primary care services.	Avoidable Hospital Admissions[24] rates for children (0-4 years)	Q ✞	Total	5,756	<5,190	<5,370
			Māori	6,323	<5,190	<5,370
	Number of people receiving a brief intervention from the primary mental health service	V	Total	6,882	>6,000	>6,000
	Percentage of the eligible population who have had a CVD Risk Assessment[25] in the last 5 years	C	Total	84%	>90%	>90%
			Māori	83%		
	Percentage of the population identified with diabetes having good or acceptable glycaemic control[26]	C	Total	48%	>58%	>60%
			Māori	41%		
Community Referred Testing & Diagnostics These are services which a health professional may use to help diagnose a health condition, or as part of treatment. While services are largely demand driven; faster & more direct access aids clinical decision-making, improves referral processes & reduces the wait for treatment.	Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	T	Total	81%	>85%	>85%
	Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	T	Total	32%	>67%	>67%
	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 2 weeks	T †	Total	85%	>90%	>90%

[24] Avoidable Hospital Admissions are admissions to hospital seen as preventable through appropriate early intervention and therefore provide an indication of access to and effectiveness of primary care, the interface between primary and secondary services. The measure is a national DHB performance indicator (SI1), and is defined as the standardised rate per 100,000. The definition for this measure is being revised nationally and was not available at the time of printing – targets will be confirmed once the definition is set.

[25] This refers to CVD risk assessments undertaken in primary care in line with the national 'More heart and diabetes checks' Health Target is for those who are aged 45-79 years.

[26] An annual HbA1c test of patient's blood glucose levels is seen as a good means of assessing the management of their condition - HbA1c <64mmol/mol reflects an acceptable blood glucose level.

3.3 Intensive Assessment And Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.

Intensive assessment and treatment services include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Why is this Output Class Significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or through corrective action. Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner of these services, Southern DHB is also committed to providing high quality services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and improve health outcomes.

How we will measure performance of our intensive assessment and treatment Services

Output Class: Intensive Assessment and Treatment

Sub Output Class	Measure	Notes		Actual 2017/18	Target 2018/19	Target 2019/20
Specialist Mental Health 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 and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Percentage of young people (0-19 years) accessing specialist mental health services	C Δ	Total	430%	>3.75%	>3.75%
			Māori	4.90%		
	Percentage of adults (20-64 years) accessing specialist mental health services	C Δ	Total	3.80%	>3.75%	>3.75%
			Māori	7.70%	>5.22%	>5.22%
	Percentage of people who have a transition (discharge) plan	Q	Total	30%	>95%	>95%
	Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	T	< 3 weeks	67%	>80%	>80%
			< 8 weeks	84%	>95%	>95%
Acute Services These are services for illnesses that may have a quick onset, are often of short duration and progress rapidly, for which the need for care is urgent. Hospital-based services include EDs, short-stay acute assessments and intensive care services.	People are assessed, treated or discharged from ED in under 6 hours	T†	Total	90%	>95%	>95%
	Number of people presenting at ED	V	Total	84,110	< 80,000	< 88,000
Elective Services (Inpatient & Outpatient) These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also nonsurgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).	Number of elective surgical service discharges [27]	V†	Total	13,219	13,502	TBC
	Percentage of elective and arranged surgery undertaken on a day case basis[28]	Q	Total	67%	>60%	>60%
	Percentage of people receiving their elective and arranged surgery on day of admission	Q	Total	83%	>95%	>95%
	Number of elective surgical services (CWDs) delivered (elective initiative)	V	Total	15,863	18,311	18,311

[27] This measure is a national performance measures (the electives health target). The measure was redefined in 2015/16 and now includes inpatient surgical discharges, regardless of whether the discharge is from a surgical or non-surgical speciality and both 'elective' and 'arranged' admissions. Previous year's baselines were provided by the Ministry of Health.

[28] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own home and it frees up hospital resources.

Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

Output Class: Intensive Assessment and Treatment						
Sub Output Class	Measure	Notes		Actual 2017/18	Target 2018/19	Target 2019/20
Maternity Services These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided by a range of health professionals, including midwives, GPs and obstetricians. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Number of maternity deliveries in Southern DHB facilities[29]	V E	Total	3,420	<3,277	3,400
			Māori	559	>542	560
	Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Q	Total	77.9%	80%	>80%
Assessment Treatment & Rehabilitation (AT&R) These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units and outpatient clinics. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.	Average length of stay (days) for inpatient AT&R services	T	<65 years	21.8	<28.3	<21.8
			≥65 years	20.2	<18.5	<18.5
	Patients have improved physical functionality on discharge	Q ❖	<65 years	26.1	>24.2	>26.1
			≥65 years	18.3	>16.9	>18.3

[29] Some services are demand driven and it is not appropriate to set targets, instead estimated volumes are provided to give context as to the use of resource across our system.

3.4 Rehabilitation & Support

Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services.

On a continuum of care these services will provide support for individuals.

Why is this Output Class Significant for the DHB?

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 re-admission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

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

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.

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How we will measure performance of our rehabilitation and support services

Output Class: Rehabilitation and Support					
Sub Output Class	Measure	Notes	Actual 2017/18	Target 2018/19	Target 2019/20
Needs Assessment & Services Coordination Services These are services that determine a person's eligibility and need for publicly funded support services and then assist the person to determine the best mix of supports based on their strengths, resources and goals.	Percentage of aged care residents who have had an InterRAI[30] assessment within 6 months admission	Q Δ	97%	>95%	>95%
	Percentage of people ≥65 years receiving long-term home support who have a Comprehensive Clinical Assessment & an Individual Care Plan	Q	99%	>95%	>95%
Home and Community Support Services (HCSS) These are services designed to support people to continue living in their own homes and to restore functional independence. An increase in the number of people being supported is indicative of the capacity in the system, and success is measured against delayed entry into residential or hospital services with more people supported to live longer in their own homes.	Total number of eligible people aged over 65 years supported by home and community support services	E	4,464	4,400	4,400
	Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Q Δ	76%	>80%	>80%
Rehabilitation These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupational therapy, treatment of pain or inflammation and retraining to compensate for lost functions.	Number of people assessed by the GP (primary care provider) for fracture risk using the portal	Q Δ	849	100	1,050
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.	Number of Rest Home Bed Days per capita of the population aged over 65 years	V	6.7	<7.0	<6.8

[30] InterRAI is an evidence-based geriatric assessment tool the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care.

4. FINANCIAL PERFORMANCE

The 2019/20 budget and out-year projections included in this document continue to be based on the approved 2018/19 Annual Plan. The 2019/20 budget and out-year projections will be updated when the 2019/20 Annual Plan is approved by the Minister of Health.

4.1 FORECAST FINANCIAL STATEMENTS

The draft projected DHB deficit for 2019/20 is $14.7million. This is draft as work continues to assess the impact of changes to operating models on the current year and the three out-years.

The Commissioner team is embedded into Southern DHB and consults with the community, health service providers and staff. The Commissioners actively support the improvement in culture at Southern DHB and encourage staff to identify and implement changes to processes to achieve efficiencies.

It has been highlighted over the past few years that the DHB must invest in services and facilities to continue to meet the health demands from the population groups it serves. The investment in bringing to life the Primary & Community Strategy is a key component of the fundamental shift in service delivery for Southern DHB.

Table 3: DHB Consolidated Prospective Net Results

DHB Consolidated Prospective Net Results	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Governance	576	122	(272)	(156)	(101)	(0)
Funds	(7,858)	4,329	5,448	7,983	8,471	(0)
Provider	(14,096)	(49,420)	(19,917)	(17,677)	(13,253)	(6,015)
Net Surplus / (Deficit)	**(21,378)**	**(44,969)**	**(14,741)**	**(9,850)**	**(4,883)**	**(6,015)**

The focus is on valuing patient time as a key driver for change in the DHB. By rethinking the models of care, investing and coordinating the process change across the DHB to drive the pace of change required to take the DHB forward. The budget for 2019/20 continues to reflect the investments on the pathway to a sustainable future across all areas of the DHB.

KEY ASSUMPTIONS

Key assumptions include:

- Successful delivery of the programme of change through service alignment initiatives.
- The improvement of information delivery primarily due to investment in IT systems.
- Achieving elective surgery targets to ensure receipt of the associated revenue.
- Managing personnel cost growth and the impacts from national collective agreements and workforce retention / recruitment issues.
- Managing service growth demand and Full Time Equivalent (FTE) staff growth within the context of the limited increase in demographic funding.
- Continuing the focus on management of expenditure through regional alignment, national procurement and shared services activity.
- Effective capital expenditure to enhance service delivery and contnue on the pathway to a robust Asset Management Plan.
- Managing the working capital and cash position to minimise the cost of capital.

SIGNIFICANT ASSUMPTIONS

The DHBs key assumptions relating to the 2019/20 budgeted financial statements are summarised below:

- Funding is based on the Government Allocations under Population Based Funding (PBF). Southern DHB's share of the pool is projected to decrease marginally year on year as shown below.

Table 4: Southern DHB PBF projections

DHB	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Southern	6.79%	6.77%	6.75%	6.73%	6.70%	6.67%

- Despite the decreasing share of PBF revenue, Government allocated revenue is forecast to increase.
- The investments include outsourcing to meet capacity constraints, implementing the primary & community strategy action plan, increasing ICU capacity, progressively reducing the vacancy factor, resourcing for growth in Queenstown Lakes region and implementing change management processes with the focus on valuing patient time.
- Demographic driven service growth continues to be projected as follows;

Table 5: Southern DHB demographic driven service growth

DHB	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Southern	2.30%	2.22%	1.99%	1.85%	1.64%	1.55%

- Incremental savings and efficiency targets have been built into baseline budgets.
- Costs associated with the activities of New Zealand Health Partnership Ltd (NZHPL) excluding adoption of Finance, Procurement and Information Management (FPIM) and impairments.
- Acute demand continues to increase, however the DHB plans to meet the elective targets set.

Capital Expenditure and Capital Funding

Southern DHB has an on-going need for capital expenditure. Capital Expenditure is shown in Table 6.

Table 6: Planned Capital Expenditure

Planned Capital Expenditure	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Clinical Capital	(10,808)	(19,006)	(11,569)	(11,120)	(6,854)	(11,250)
Building Capital	(1,506)	(17,737)	(83,496)	(18,850)	(5,949)	(11,638)
Dunedin Master Site Redevelopment	(12,118)	(7,117)	(244)	0	0	(2,900)
Local Information System requirement	(2,983)	(3,130)	(23,240)	(13,397)	(12,919)	(9,256)
Total capital expenditure budget	**(27,415)**	**(46,990)**	**(118,549)**	**(43,367)**	**(25,722)**	**(35,044)**

The capital investment needs are spread across the DHB with services (demographics), technology, productivity, and quality requirements all driving demand for capital expenditure. The development and refinement of the Asset Management Plan currently in progress is critical for effective assessment of expenditure especially for the Interim Works on the Dunedin Hospital site.

Interim Works

The ICU redevelopment will be completed and fully operational in the 2019/2020 year. There are ongoing deferred maintenance projects required to sustain the operational capability of Dunedin Hospital from 2019/2020 through to the new Dunedin Hospital.

Queenstown Lakes Hospital Redevelopment

The Queenstown Lakes Hospital Redevelopment is progressing to plan and equity injections are being sought as the project progresses. The budget for the project is $9.8m.

Baseline Clinical Capital

Capital investment includes a commitment from the Commissioners for capital to assist Southern DHB meet its clinical goals with $2.0m allocated to the 2019/20 year.

A Contingency fund is included within the baseline investment level to ensure the Southern DHB has the ability to meet expenditure that has arisen through items such as unexpected failures and changes in legislation.

Capital Financing and Debt Facilities

Financing for capital expenditure and the cash requirements for the DHB are shown in Table 9. The key component of financing highlighted is as follows;

- Deficit support, which will continue to be a requirement until the DHB is in a better financial position. Once a sound base it achieved, the level of deficit support will be dependent on maintaining that position, particularly when undergoing a significant rebuild that will incur a capital charge on the funding.

Table 9: Planned Capital Financing

Planned Capital Financing	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Deficit Support	15,000	40,300	53,546	20,857	0	0
Equity for Capital Projects	5,706	23,694	80,000	0	0	0
Equity repaid	(707)	(707)	(707)	(707)	(707)	(707)
Cash Balance	(30,377)	(33,895)	(27,749)	(27,838)	(18,590)	(16,687)

The DHB has the following financing arrangements in place:

Table 10: DHB Financing Arrangements

Facility / Lender	Facility $'000	Amount Drawn	Due Date	Rate
Crown Debt	1,670	1,670	Qrtly Instalment	0.00%
EECA Loans	166	166	Qrtly Instalment	0.00%
Finance Leases	1,830	1,830	Mthly & Qtrly Instalment	3.76%-8.56%
	3,666	3,666		

Asset Valuations and Disposals

Land and buildings are revalued to fair value as determined by an independent registered valuer. The revaluation is undertaken with sufficient regularity to ensure the carrying amount is not materially different to fair value. This determination is made each year. The last revaluation was undertaken as at 30 June 2018.

Buildings with known asbestos issues were impaired by $20 million as at 30 June 2017 in accordance with PBE IPSAS 21 – Impairment of Non-Cash Generating Assets. This resulted in a decrease in the carrying cost of the assets as well as a corresponding reduction in the revaluation reserve. As remedial work is undertaken on the buildings, the DHB increases the carrying cost of the asset by the value of the remediation work.

Future valuations of Land and Buildings will be adjusted to include the essential capital maintenance at the Dunedin Hospital site to ensure the buildings are maintained to a minimum standard until the new Dunedin Hospital is operational.

The DHB will ensure that disposal of land or buildings transferred to, or vested in it pursuant to the Health Sector (Transfers) Act (1993) will be subject to approval by Cabinet. The DHB will ensure that the relevant protection mechanisms that address the Crown's obligations under the Treaty of Waitangi and any processes relating to the Crown's good governance obligations in relation to Māori sites of significance and that the requirements of section 40 of the Public Works Act and Ngai Tahu Settlements Act are addressed. Any such disposals are planned in accordance with s42(2) of the NZPHD Act 2000.

Valuation of Land and Buildings at 30 June 2018

Tony Chapman of Colliers Otago undertook a valuation of the Southern DHB land and buildings portfolio at 30 June 2018. As a result a revaluation of $34,570,000 was made to land and buildings at 30 June 2018 based on the existing useful lives. The Minister of Health has announced an intention to build a new Dunedin Public Hospital and the Ministry of Health has commenced work on the project. However, at 30 June 2019 the concept design for the new Dunedin Public Hospital had not been developed. Therefore, the Southern DHB finance team have been unable to assess the remaining useful life of the existing Dunedin Public Hospital or the potential for repurposing and/or sale of the land and buildings. For this reason the depreciation charge in the 2020 Annual Plan was calculated based on the revaluation of property at 30 June 2018. Once the concept design is available there is potential for the depreciation charge to alter to reflect the reassessment of the remaining useful life of the existing buildings at Dunedin Hospital.

4.2 Prospective Financial Statements

In accordance with the new Accounting Standards Framework the District Health Board is classified as a Tier 1 Public Sector Public Benefit Entity (PBE).

Table 11: DHB Consolidated Statement of Prospective Financial Performance

DHB Consolidated Statement of Prospective Financial Performance	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Revenue						
PBF Funding Package	852,077	894,980	916,725	950,799	986,182	1,034,389
Inter District Revenue	21,777	21,519	23,207	24,071	24,968	25,026
Funder Side Contracts	57,646	68,151	57,310	59,440	61,652	79,478
Provider Misc Revenues	48,488	47,844	49,239	50,529	51,887	51,001
Total Revenues	979,988	1,032,494	1,046,481	1,084,839	1,124,689	1,189,894
less Personnel Expenses						
Medical Personnel	(125,879)	(140,158)	(124,680)	(128,058)	(132,502)	(160,606)
Nursing Personnel	(142,782)	(156,543)	(156,492)	(159,331)	(163,812)	(170,778)
Allied Health Personnel	(50,560)	(54,261)	(53,070)	(54,890)	(57,048)	(62,442)
Support Services Personnel	(5,696)	(5,732)	(6,305)	(6,393)	(6,535)	(6,483)
Management/Admin Personnel	(44,711)	(49,259)	(51,099)	(51,694)	(52,719)	(56,807)
Personnel Costs Total	(369,628)	(405,953)	(391,646)	(400,366)	(412,616)	(457,116)
less Non Personnel Expenditure						
Outsourced Services Expenses	(45,237)	(47,461)	(41,100)	(42,160)	(43,552)	(49,796)
Clinical Supplies Expenses	(93,481)	(103,455)	(93,792)	(96,690)	(97,892)	(113,671)
Infrastructure & Non Clinical Supplies Expenses	(73,463)	(80,111)	(87,753)	(94,262)	(97,329)	(90,893)
Total Non-Personnel Expenditure	(212,181)	(231,027)	(222,645)	(233,112)	(238,773)	(254,360)
less Provider Payments						
Personal Health Expenses	(249,644)	(261,422)	(265,980)	(273,533)	(283,521)	(289,455)
Mental Health Expenses	(24,673)	(26,034)	(26,379)	(27,359)	(28,377)	(29,280)
Disability Support Expenses	(143,740)	(151,165)	(152,539)	(158,210)	(164,099)	(163,778)
Public Health Expenses	(601)	(648)	(756)	(784)	(813)	(618)
Maori Health Expenses	(900)	(1,215)	(1,276)	(1,323)	(1,373)	(1,302)
Total Provider Payments	(419,558)	(440,484)	(446,930)	(461,210)	(478,183)	(484,433)
Total Expenses	(1,001,366)	(1,077,464)	(1,061,221)	(1,094,689)	(1,129,572)	(1,195,909)
Net Surplus / (Deficit)	**(21,378)**	**(44,970)**	**(14,740)**	**(9,850)**	**(4,883)**	**(6,015)**
Supplemental Information						
Depreciation Charges	(21,593)	(24,718)	(28,012)	(32,116)	(34,240)	(40,768)
Interest Costs	(10)	(12)	0	0	0	0
Capital Charge	(9,122)	(11,015)	(14,208)	(18,701)	(18,970)	(13,661)
Total IDCC Costs	(30,725)	(35,745)	(42,220)	(50,817)	(53,210)	(54,429)
Medical FTE	542	578	526	534	542	542
Nursing FTE	1,691	1,757	1,785	1,799	1,816	1,816
Allied FTE	661	678	684	694	701	701
Support FTE	100	95	103	103	103	103
Management/Admin FTE	676	700	714	715	717	717
Total FTE	3,670	3,808	3,812	3,845	3,879	3,879

Table 12: DHB Consolidated Prospective Balance Sheet

DHB Consolidated Prospective Balance Sheet	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Current Assets:						
Cash & Bank Accounts	8	8	8	8	8	8
Prepayments	3,258	3,258	3,317	3,380	3,447	3,447
Inventory	5,032	5,032	5,122	5,220	5,325	5,032
Accounts Receivable	40,473	40,473	41,201	41,984	42,824	42,196
Assets held for resale						
Total Current Assets	48,771	48,771	49,648	50,592	51,604	50,683
Current Liabilities:						
Bank overdraft and current debt	(31,610)	(35,129)	(29,226)	(29,026)	(19,826)	(18,645)
Creditors provisions and payables	(126,820)	(130,257)	(133,492)	(134,751)	(141,141)	(145,378)
Total Current Liabilities	(158,430)	(165,386)	(162,718)	(163,777)	(160,967)	(164,023)
Net Working Capital	(109,659)	(116,615)	(113,070)	(113,185)	(109,363)	(113,340)
Non Current Assets:						
Land, Buildings, Plant and Equipment	318,380	343,139	459,677	470,928	462,409	454,359
Long Term Investments	4,469	5,127	4,469	4,469	4,469	5,127
Total Non Current Assets	322,849	348,266	464,146	475,397	466,878	459,486
Non Current Liabilities:						
Long Term Debt	(2,455)	(1,976)	(2,455)	(2,455)	(2,455)	(1,010)
Other Liabilities	(18,149)	(18,774)	(19,622)	(20,459)	(21,352)	(18,150)
Net Equity	**192,585**	**210,901**	**328,999**	**339,298**	**333,708**	**326,986**

Table 13: DHB Consolidated Statement of Prospective Changes in Equity

DHB Consolidated Statement of Prospective Changes in Equity	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Total Equity at beginning of period	159,394	192,585	210,901	328,999	339,298	333,708
Net Result for the period - Governance	576	122	(272)	(156)	(101)	0
Net Result for the period - Funds	(7,858)	4,329	5,448	7,983	8,471	0
Net Result for the period - Provider	(14,096)	(49,420)	(19,917)	(17,677)	(13,253)	(6,015)
Revaluation of Fixed Assets	34,570	0	0	0	0	0
Other movement	0	0	0	0	0	0
Equity Repaid (Revaluation funding)	(707)	(707)	(707)	(707)	(707)	(707)
Equity Injections for Capital	5,706	23,694	80,000	0	0	0
Equity Injections for Deficit	15,000	40,300	53,546	20,856	0	0
Total Equity at end of Period	**192,585**	**210,901**	**328,999**	**339,298**	**333,708**	**326,986**

Table 14: DHB Consolidated Statement of Prospective Cash Flows

DHB Consolidated Statement of Prospective Cash Flows	2017/18 Actual $' 000	2018/19 Forecast $' 000	2019/20 Budget $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000	2022/23 Projection $' 000
Operating Cashflows						
Cash inflows from operating activities	971,515	1,012,615	1,045,570	1,083,869	1,123,658	1,189,531
Cash outflows from operating activities	(970,584)	(1,027,598)	(1,031,311)	(1,060,930)	(1,088,175)	(1,151,792)
Net cash inflows(outflows) from operating activities	929	(14,983)	14,259	22,939	35,483	37,739
Investing Cashflows						
Cash inflows from investing activities	325	183	187	190	194	193
Cash outflows from investing activities	(27,415)	(51,995)	(118,549)	(43,367)	(25,722)	(35,045)
Net cash flows from investing activities	(27,090)	(51,812)	(118,362)	(43,177)	(25,528)	(34,852)
Financing Cashflows						
Cash inflows from financing activities	20,706	63,994	110,966	20,856	0	0
Cash outflows from financing activities	(2,082)	(717)	(707)	(707)	(707)	(984)
Net cashflows from financing activities	18,624	63,277	110,259	20,159	(707)	(984)
Net increase/(decrease) in cash held	(7,537)	(3,518)	6,146	(89)	9,248	1,903
Add opening balance	(22,840)	(30,377)	(33,895)	(27,749)	(27,838)	(18,590)
Closing cash balance	**(30,377)**	**(33,895)**	**(27,749)**	**(27,838)**	**(18,590)**	**(16,687)**

4.3 Statement of Accounting Policies

4.3.1 Reporting Entity

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

Southern DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 2013, the Public Finance Act 1989 and the Crown Entities Act 2004.

Southern DHB designated itself as a public benefit entity (PBE) for financial reporting purposes.

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

4.3.2 Basis of Preparation

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

Statement of Compliance

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

The financial statements comply with Public Sector PBE accounting standards including PBE FRS 42.

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

Going Concern

The Southern DHB's Commissioner has received a letter of support from the Ministers of Health and Finance in the New Zealand Government. The Ministers' acknowledge that equity support may be required and the Crown will provide such support should it be necessary. The letter of support is fundamental to the going concern assumption underlying the preparation of the financial statements as the 2019/20 Annual Plan has yet to be sumitted to the Ministry of Health for approval.

Functional and Presentation Currency

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand dollars ($000).

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 starting value as the Southern District Health Board continues to deliver the services of the Otago and Southland District Health Boards with no significant curtailment or restructure of activities. The value on recognition of those assets and liabilities has been treated as capital contribution from the Crown.

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

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

Standards, Amendments, and Interpretations Issued That Are Not Yet Effective and Have Not Yet Been Early Adopted

In 2017, the External Reporting Board issued the following amendments for future adoption:

- PBE IPSAS 39, Employee benefits. This amendment is effective for annual financial statements beginning on or after 1 January 2019.
- PBE IPSAS 9 Reclassification and measurement of financial assets that replaces most of the requirements of PBE ISAS 29. This becomes mandatory for annual periods beginning on or after 1 January 2021 and looks to improve and simplify the approach for classification and measurement of financial assets.

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

PBE IPSAS 21 Impairment of Non-Cash-Generating Assets - Amendment.

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.

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

Critical Accounting Estimates and Assumptions

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

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

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

- Impairment due to reduction of service potential caused by asbestos,
- Fixed assets revaluations, and
- Employee entitlements.

4.3.3 Significant Accounting Policies

Revenue

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

MOH Revenue

The DHB is primarily funded through revenue received from the Ministry of Health. 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 Ministry of Health is recognised as revenue at the point of entitlement if there are conditions attached in the funding.

The fair value of revenue from the Ministry of Health 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 Ministry of Health credits Southern DHB with a monthly amount based on estimated patient treatment for non-Southern residents within Southern. An annual wash-up occurs at year end to reflect the actual number of non-Southern patients treated at Southern DHB.

Interest Income

Interest income is recognised using the effective interest method.

Rental Income

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

Provision of Services

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

Donations and Bequests

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

Revenue from Grants

Revenue from grants includes grants given by other charitable organisations, government organisations or their affiliates. Revenue from grants is recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset. Grants are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as revenue received in advance and recognised as revenue when conditions of the grant are satisfied.

Research Revenue

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

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

Leases

Finance Leases

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

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

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

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

Operating Leases

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

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Foreign Currency Transactions

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

Cash and Cash Equivalents

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

Trade and Other Receivables

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

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

Investments

Bank Deposits

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

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

Inventories

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

Inventories Held for Distribution

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

Non-Current Assets Held For Sale

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

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

Impairment losses are recognised in the surplus and deficit.

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

Property, Plant and Equipment

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

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

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

The 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, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located and an appropriate proportion of direct overheads.

Revaluations

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

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

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

Disposal of Property, Plant and Equipment

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

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

Additions

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

Capital work in progress is recognised at cost less impairment.

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

Subsequent Costs

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

Depreciation

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

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

Buildings	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 completion and then depreciated.

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

Intangible Assets

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

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

The National Oracle System Project (NOS) (previously part of the Finance, Procurement and Supply Chain programme now renamed Health Finance, Procurement and Information Management (FPIM)) rights represent the DHB's right to access, under a service level agreement, shared NOS 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 the National Oracle System Project.

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

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

Amortisation

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

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

The estimated useful lives are as follows:

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

Impairment

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

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

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

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

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

Trade and other payables

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

Borrowings

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

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

Employee Benefits

Employee Entitlements

Short-term Employee Entitlements

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

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

Long-term Entitlements

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

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

Presentation of Employee Entitlements

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

Superannuation Schemes

Defined Contribution Plans

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

Provisions

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

Restructuring

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

Onerous Contracts

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

ACC Partnership Programme

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

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

The value of the liability is measured at the present value of the future payments for which Southern DHB has responsibility using a risk free discount rate. The value of the liability

includes a risk margin that represents the inherent uncertainty of the present value of the expected future payments.

Income tax

Southern DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

Budget Figures

The draft budget figures are derived from the Statement of Intent as approved by the Commissioner at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Commissioner in preparing these financial statements. They comply with PBE IPSAS and other applicable Financial Reporting Standards as appropriate for public benefit entities.

Goods and Services Tax

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

Custodial/Trust and Bequest Funds

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

Financial Instruments

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

Cost of Service Statements

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

Cost Allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

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

Comparative Data

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