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Southern District Health Board

Piki Te Ora

Statement of Performance Expectations 2018/19

Presented to the House of Representatives pursuant to section 149 (L) of the Crown Entities Act 2004

OUR VALUES

Kind Manaakitanga

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

Open Pono

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

Positive Whaiwhakaaro

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

Community Whanaungatanga

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

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.

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1.0 Signatories

This Statement of Performance Expectations (SPE) contains the service and financial performance expectations for the coming year to 30 June 2019.

This SPE 2018/19 has been developed as part of the Southern DHB planning process in 2018 to meet the legislative requirements in providing accountability to Parliament and the public in Section 149 149(L) of the Crown Entities Act 2004.

Accordingly, this SPE has been developed in conjunction with government expectations, local priorities, legislative compliance and public sector accountability.

…… ……

Kathy Grant
Commissioner
Southern District Health Board
Date: …..09 / …11/ 2018

Chris Fleming
Chief Executive
Southern District Health Board
Date: 09….. / …11 / 2018

2.0 Performance expectations

Key Facts about Southern DHB

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 Graham Crombie
Mr Richard Thomson

Population: Approximately 324, 090 people live within Southern DHB boundaries.

Staff: Southern DHB employs over 4,500 people.

Southern DHB's Statement of Intent (SOI)[1] 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[2].

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 2018/19, the Southern DHB plans to spend approximately $989 million in delivering the following four Outputs funded through Vote Health:

Output 1: Prevention Services;

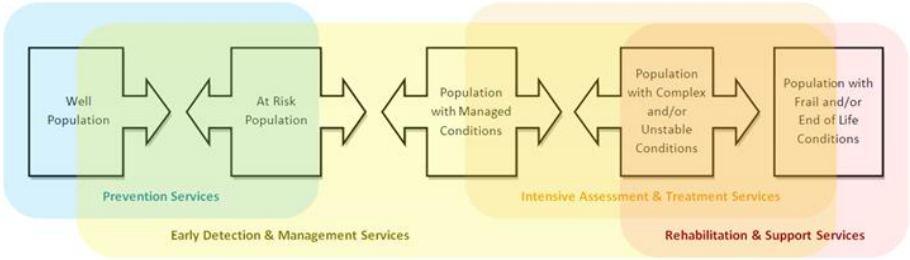
Output 2: Early Detection and Management Services;

Output 3: Intensive Assessment & Treatment Services; and

Output 4: Rehabilitation & Support Services.

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

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?

Table 1 (page 6) presents a summary of the budgeted financial expectations for 2018/19, by output class.

Table 2: Revenue and expenditure by Output Class (page 6) presents a summary of budgeted financial expectations through until 2021/22. 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 2018/19

REVENUE	Total $'000
Prevention	4,995
Early Detection and Management	194,170
Intensive Assessment & Treatment	670,828
Rehabilitation & Support	143,889
Total Revenue	**1,013,882**

EXPENDITURE	Total $'000
Prevention	4,995
Early Detection and Management	201,926
Intensive Assessment & Treatment	676,453
Rehabilitation & Support	152,898
Total Expenditure	**1,036,272**
Net Surplus / (Deficit) – $' 000	**(22,390)**

Table 2: Revenue and expenditure by Output Class 2018/19 – 2021/22

Revenue & Expenditure by Output Class	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Prevention Services						
Revenue	8,144	4,834	4,995	5,164	5,339	5,521
Expenditure	(8,144)	(4,834)	(4,995)	(5,164)	(5,339)	(5,521)
Net Result	0	0	0	0	0	0
Early Detection and Management Services						
Revenue	180,267	186,855	194,170	206,382	214,821	225,710
Expenditure	(187,843)	(194,261)	(201,926)	(211,488)	(218,233)	(227,401)
Net Result	(7,576)	(7,406)	(7,756)	(5,106)	(3,412)	(1,691)
Intensive Assessment and Treatment						
Revenue	628,954	650,843	670,828	685,718	707,727	728,519
Expenditure	(634,448)	(656,214)	(676,453)	(689,421)	(710,202)	(729,746)
Net Result	(5,494)	(5,371)	(5,625)	(3,703)	(2,475)	(1,227)
Rehabilitation and Support						
Revenue	116,910	137,456	143,889	149,217	156,951	164,938
Expenditure	(125,710)	(146,058)	(152,898)	(155,148)	(160,915)	(166,903)
Net Result	(8,800)	(8,602)	(9,009)	(5,931)	(3,964)	(1,965)
Share of Loss in associates	0	0	0	0	0	0
Total Revenue per DHB Consolidated Financials	934,275	979,987	1,013,882	1,046,482	1,084,839	1,124,688
Total Expenditure per DHB Consolidated Financials	(956,145)	(1,001,366)	(1,036,272)	(1,061,222)	(1,094,689)	(1,129,571)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**

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

2.1 PREVENTION SERVICES

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

Preventative services include health promotion and education programmes which promote healthy choices and work to create environments where we live, learn, work and play to support wellness; statutory mandated health protection services to protect the public from environmental risks and communicable diseases; and population health prevention services such as immunisation and screening services that support early intervention and good health.

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 2016/17	Target 2017/18	Target 2018/19
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	92%		
	Percentage of children fully immunised at age 2 years	C	Total	95%	95%	>95%
			Māori	95%		
	Percentage of eligible girls fully immunised with HPV vaccine	C	Total	67%	75%	>75%
			Māori	72%		
	Percentage of people (≥ 65 years) having received a flu vaccination	C	Total	-	75%	>75%
			Māori	-		
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	85%	90%	>90%
			Māori	89%		
	Infants exclusively or fully breastfeeding at 3 months	Q Δ	Total	-	60%	>60%
			Māori	-		
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	95%		
	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	N/A	95%	>95%
	Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	C	Total	75%	70%	>70%
			Māori	67%		
	Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	C	Total	79%	80%	>80%
			Māori	63%		

2.2 EARLY DETECTION AND MANAGEMENT

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

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

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 2016/17	Target 2017/18	Target 2018/19
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 a well-functioning, efficient service.	Percentage of eligible preschoolers enrolled in community oral health services	C ❖	Total	81%	95%	>95%
			Māori	65%		
	Percentage of children caries-free at five years of age	Q ❖	Total	69%	70%	>70%
			Māori	58%		
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[3] rates for children (0-4 years)	Q ✞	Total	5,465	<5,190	<5,370
			Māori	5,331	<5,190	<5,370
	Number of people receiving a brief intervention from the primary mental health service	V	Total	7,418	6,000	>6,000
	Percentage of the eligible population who have had a CVD Risk Assessment[4] in the last 5 years	C	Total	86%	90%	>90%
			Māori	82%		
	Percentage of the population identified with diabetes having good or acceptable glycaemic control[5]	C	Total	37%	79%	>58%
			Māori	36%		
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	74%	95%	>85%
	Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	T	Total	48%	85%	>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	79%	90%	>90%

[3] 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.

[4] 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.

[5] 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.

2.3 INTENSIVE ASSESSMENT AND TREATMENT

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

A proportion of these services are in response to an acute event and others are planned where access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements. Services include: Ambulatory services, Inpatient services and Emergency Department services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered.

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 2016/17	Target 2017/18	Target 2018/19
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	3.85%	3.75%	>3.75%
			Māori	3.96%		
	Percentage of adults (20-64 years) accessing specialist mental health services	C Δ	Total	3.60%	3.75%	>3.75%
			Māori	6.93%	5.22%	>5.22%
	Percentage of people who have a transition (discharge) plan	Q	Total	TBC	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	74%	80%	>80%
			< 8 weeks	88%	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	81,124	< 80,000	< 80,000
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 [6]	V†	Total	12,756	13,190	13,502
	Percentage of elective and arranged surgery undertaken on a day case basis[7]	Q	Total	N/A	60%	>60%
	Percentage of people receiving their elective and arranged surgery on day of admission	Q	Total	N/A	95%	>95%
	Number of elective surgical services (CWDs) delivered (elective initiative)	V	Total	15,279	16,090	18,311

[6] 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.

[7] 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 2016/17	Target 2017/18	Target 2018/19
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[8]	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	TBC	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	27.1	28.3	<28.3
			≥65 years	17.0	18.5	<18.5
	Patients have improved physical functionality on discharge	Q ❖	<65 years	25.2	24.2	>24.2
			≥65 years	18.8	16.9	>16.9

[8] 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.

2.4 REHABILITATION & SUPPORT

Rehabilitation and support services provide people with the assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives.

These services are delivered after a clinical 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) services and include: domestic support, personal care, community nursing, respite and residential care. Services are mostly for older people, mental health clients and people with complex conditions.

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 2016/17	Target 2017/18	Target 2018/19
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[9] assessment within 6 months admission	Q Δ	100%	90%	>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	4,287	4,200	4,400
	Percentage of clients receiving home support who are classified as complex	Q Δ	52%	55%	>55%
	Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Q Δ	80%	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	170	100	300
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	6.94	7.5	<7.0

[9] 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.

3.0 Financial Performance

3.1 FORECAST FINANCIAL STATEMENTS

The projected DHB deficit for 2018/19 is $20.1 million. The projected deficits in the three out-years progressively track downwards with a deficit of $4.9 million planned in 2021/22.

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	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Governance	1,616	576	681	(272)	(156)	(101)
Funds	(2,412)	(7,858)	6,090	5,448	7,983	8,471
Provider	(21,075)	(14,096)	(29,160)	(19,917)	(17,677)	(13,253)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**

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 2018/19 reflects 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 continue on the pathway to 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 2018/19 budgeted financial statements are listed below:

- The 2018/19 budget includes the impact of the one off payment and 2% increase for the NZNO settlement recognised at 30 June 2018. Any settlement higher than this is assumed to be offset by an increase in revenue from MoH.
- 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	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Southern	6.81%	6.76%	6.75%	6.72%	6.66%	6.63%

- Despite the decreasing share of PBF revenue, Government allocated revenue is forecast to increase by 2.9% both in 2018/19 and the out years.
- 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 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	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Southern	2.10%	1.85%	1.80%	1.75%	1.65%	1.62%

- Incremental savings and efficiency targets have been built into baseline budgets. The detail programmes that contribute to the savings in the out years are still being defined.
- Costs associated with the activities of New Zealand Health Partnership Ltd (NZHPL) have been factored in together with the significant benefits proposed to be delivered from procurement.
- Elective targets have been increased by 229 discharges over levels planned in 2017/18 with associated additional revenue.
- Acute demand continues to increase, however the DHB plans to meet the elective targets set.

3.2 CAPITAL EXPENDITURE AND CAPITAL FUNDING

Southern DHB faces on-going difficulties in funding capital expenditure. Capital Expenditure is shown in Table .

Table 6: Planned Capital Expenditure

Planned Capital Expenditure	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Clinical Capital	(2,420)	(11,228)	(28,999)	(11,569)	(11,120)	(6,854)
Building Capital	(9,349)	(1,507)	(19,737)	(83,496)	(18,850)	(5,950)
Dunedin Master Site Redevelopment	(4,624)	(12,118)	(15,117)	(244)	0	0
Local Informatiom System requirement	(904)	(2,563)	(13,477)	(23,240)	(13,397)	(12,919)
Total capital expenditure budget	**(17,297)**	**(27,415)**	**(77,330)**	**(198,549)**	**(43,367)**	**(25,722)**

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 Programme on the Dunedin Hospital site.

INTERIM WORKS PROGRAMME

During 2019 the ICU redevelopment will be completed and is expected to be fully operational at the commencement of the 2019/2020 year. There are ongoing deferred maintenance projects required to sustain the operational capability of Dunedin Hospital through to the new Dunedin Hospital.

LAKES HOSPITAL REDEVELOPMENT

Equity injections will be sought to fund the Lakes Redevelopment Project that has a budget of $9.8m in 2018/19.

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 2018/19 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 be a requirement until 2020/21 when the DHB is in a better position. After this the level of deficit support will be dependent on maintaining this position, particularly when undergoing a significant rebuild that will attract a capital charge on the funding.

Table 7: Planned Capital Financing

Planned Capital Financing	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Deficit Support	(20,000)	(15,000)	(40,300)	(30,966)	(20,857)	0
Equity for conversion of Crown Loans	0	(97,400)	0	0	0	0
Equity for Capital Projects	(97,400)	91,694	(23,694)	(80,000)	0	0
NZHPL Investment (Capital component)	0	0	0	0	0	0
Equity repaid	(707)	(707)	(707)	(707)	(707)	(707)
Cash Balance	(22,840)	(30,377)	(36,178)	(27,749)	(27,838)	(18,590)

The DHB has the following financing arrangements in place:

Table 8: 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, and at least every five years. This determination is made each year. The last revaluation was undertaken as at 30 June 2014.

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 2018 the master site plan 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 2019 Annual Plan was calculated using the building base before the revaluation. As such the budget deprecation charge is understated by $2,245,197 arising from the revaluation of buildings at 30 June 2018 and there is no way to mitigate the impact on the 2019 financial performance. In addition, once the master site plan is available there is potential for the depreciation charge to further increase to reflect the reassessment of the remaining useful life of the existing buildings used by Dunedin Public Hospital.

3.3 PROSPECTIVE FINANCIAL STATEMENTS

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

Table 9: DHB Consolidated Statement of Prospective Financial Performance

DHB Consolidated Statement of Prospective Financial Performance	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Revenue						
PBF Funding Package	823,201	852,077	883,906	916,725	950,799	986,182
Inter District Revenue	21,894	21,778	22,377	23,207	24,071	24,968
Funder Side Contracts	42,960	57,645	59,587	57,310	59,440	61,652
Provider Misc Revenues	46,220	48,487	48,012	49,238	50,528	51,888
Total Revenues	934,275	979,987	1,013,882	1,046,481	1,084,839	1,124,689
less Personnel Expenses						
Medical Personnel	(122,538)	(125,880)	(131,858)	(124,681)	(128,058)	(132,502)
Nursing Personnel	(137,529)	(142,782)	(145,389)	(156,492)	(159,331)	(163,812)
Allied Health Personnel	(50,376)	(50,560)	(53,957)	(53,070)	(54,890)	(57,048)
Support Services Personnel	(5,833)	(5,696)	(6,294)	(6,305)	(6,393)	(6,535)
Management/Admin Personnel	(45,695)	(44,711)	(49,156)	(51,099)	(51,694)	(52,719)
Personnel Costs Total	(361,973)	(369,628)	(386,655)	(391,647)	(400,367)	(412,616)
less Non Personnel Expenditure						
Outsourced Services Expenses	(42,785)	(45,237)	(42,404)	(41,100)	(42,160)	(43,552)
Clinical Supplies Expenses	(89,109)	(93,481)	(94,386)	(93,792)	(96,690)	(97,892)
Infrastructure & Non Clinical Supplies Expenses	(69,754)	(73,463)	(79,430)	(87,753)	(94,262)	(97,329)
Total Non-Personnel Expenditure	(201,649)	(212,180)	(216,220)	(222,645)	(233,113)	(238,773)
less Provider Payments						
Personal Health Expenses	(242,673)	(249,643)	(255,620)	(265,980)	(273,533)	(283,521)
Mental Health Expenses	(24,412)	(24,673)	(25,434)	(26,379)	(27,359)	(28,377)
Disability Support Expenses	(123,762)	(143,740)	(150,384)	(152,540)	(158,210)	(164,098)
Public Health Expenses	(702)	(601)	(729)	(756)	(784)	(813)
Maori Health Expenses	(975)	(900)	(1,230)	(1,276)	(1,323)	(1,373)
Total Provider Payments	(392,524)	(419,557)	(433,397)	(446,930)	(461,210)	(478,182)
Total Expenses	(956,145)	(1,001,366)	(1,036,272)	(1,061,221)	(1,094,689)	(1,129,572)
Net Surplus / (Deficit)	**(21,870)**	**(21,378)**	**(22,390)**	**(14,740)**	**(9,851)**	**(4,883)**
Supplemental Information						
Depreciation Charges	(21,396)	(21,590)	(26,570)	(28,012)	(32,116)	(34,240)
Interest Costs	(2,471)	(10)	0	0	0	0
Capital Charge	(5,042)	(9,120)	(9,850)	(14,208)	(18,701)	(18,970)
Total IDCC Costs	(28,909)	(30,720)	(36,419)	(42,220)	(50,817)	(53,211)
Medical FTE	528	546	579	526	534	542
Nursing FTE	1,663	1,687	1,716	1,785	1,799	1,816
Allied FTE	668	668	687	684	693	701
Support FTE	102	101	103	103	103	103
Management/Admin FTE	675	675	702	714	715	717
Total FTE	3,636	3,676	3,788	3,812	3,845	3,879

Table 10: DHB Consolidated Prospective Balance Sheet

DHB Consolidated Prospective Balance Sheet	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Current Assets:						
Cash & Bank Accounts	8	8	8	8	8	8
Prepayments	6,113	3,258	3,258	3,317	3,380	3,447
Inventory	4,922	5,032	5,032	5,122	5,220	5,324
Accounts Receivable	36,219	40,473	40,473	41,201	41,984	42,824
Assets held for resale	0					
Total Current Assets	47,262	48,771	48,771	49,648	50,592	51,604
Current Liabilities:						
Bank overdraft and current debt	(1,530)	(1,631)	(1,226)	(1,226)	(1,226)	(1,226)
Creditors provisions and payables	(147,048)	(156,800)	(166,443)	(161,493)	(162,552)	(159,742)
Total Current Liabilities	(148,577)	(158,431)	(167,669)	(162,718)	(163,777)	(160,967)
Net Working Capital	(101,315)	(109,660)	(118,898)	(113,070)	(113,186)	(109,364)
Non Current Assets:						
Land , Buildings, Plant and Equipment	278,032	318,380	369,139	459,677	470,928	462,409
Long Term Investments	4,469	4,469	4,469	4,469	4,469	4,469
Total Non Current Assets	282,501	322,849	373,608	464,146	475,397	466,878
Non Current Liabilities:						
Long Term Debt	(3,643)	(2,455)	(2,455)	(2,455)	(2,455)	(2,455)
Other Liabilities	(18,149)	(18,149)	(18,774)	(19,622)	(20,458)	(21,352)
Net Equity	**159,394**	**192,585**	**233,480**	**328,999**	**339,298**	**333,708**

Table 11: DHB Consolidated Statement of Prospective Changes in Equity

DHB Consolidated Statement of Prospective Changes in Equity	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Total Equity at beginning of period	84,662	159,394	192,585	233,481	328,999	339,298
Net Result for the period - Governance	1,616	576	681	(272)	(156)	(101)
Net Result for the period - Funds	(2,412)	(7,858)	6,090	5,448	7,983	8,471
Net Result for the period - Provider	(21,075)	(14,096)	(29,160)	(19,917)	(17,677)	(13,253)
Revaluation of Fixed Assets	(20,090)	34,570	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	97,400	5,706	23,694	80,000	0	0
Equity Injections for Deficit	20,000	15,000	40,300	30,966	20,857	0
Total Equity at end of Period	**159,394**	**192,585**	**233,481**	**328,999**	**339,298**	**333,708**

Table 12: DHB Consolidated Statement of Prospective Cash Flows

DHB Consolidated Statement of Prospective Cash Flows	2016/17 Actual $' 000	2017/18 Actual $' 000	2018/19 Budget $' 000	2019/20 Projection $' 000	2020/21 Projection $' 000	2021/22 Projection $' 000
Operating Cashflows						
Cash inflows from operating activities	931,178	971,515	1,005,252	1,045,570	1,083,869	1,123,658
Cash outflows from operating activities	(935,902)	(970,585)	(997,184)	(1,029,037)	(1,060,930)	(1,088,175)
Net cash inflows(outflows) from operating activities	(4,724)	929	8,068	16,533	22,939	35,483
Investing Cashflows						
Cash inflows from investing activities	295	319	183	187	190	194
Cash outflows from investing activities	(23,061)	(27,409)	(77,329)	(118,549)	(43,367)	(25,722)
Net cash flows from investing activities	(22,766)	(27,090)	(77,146)	(118,363)	(43,177)	(25,528)
Financing Cashflows						
Cash inflows from financing activities	20,000	20,706	63,994	110,966	20,857	0
Cash outflows from financing activities	(5,498)	(2,082)	(717)	(707)	(707)	(707)
Net cashflows from financing activities	14,502	18,624	63,277	110,258	20,150	(707)
Net increase/(decrease) in cash held	(12,989)	(7,537)	(5,801)	8,429	(88)	9,248
Add opening balance	(9,850)	(22,840)	(30,377)	(36,178)	(27,749)	(27,838)
Closing cash balance	**(22,840)**	**(30,377)**	**(36,178)**	**(27,749)**	**(27,838)**	**(18,590)**