Southern District Health Board
Piki Te Ora

Southern Health
He hauora, he kuru pounamu

Annual Report

Quality and Performance Account

2018/19

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This Southern District Health Board Annual Report 2018/19 is presented to the House of Representatives pursuant to section 150(3) of the Crown Entities Act 2004.

Contents

Foreword from the Commissioner & Chief Executive

Kathy Grant
Commissioner

Chris Fleming
Chief Executive Officer

Reflecting on the achievements and challenges in our annual report has an added significance this year, as it represents the conclusion of the term of the Commissioner team that has governed Southern DHB since 2015.

As well as considering the priorities and progress of 2018/19, therefore, this foreword is a timely opportunity to take a broader view, and put this year's steps in the context of a longer journey.

When the Commissioner team was appointed in 2015 to oversee the delivery of all-important health care to the people in the Southern district, much was made of the budgeted deficit at the time, far exceeding that posted by other DHBs. While this may have been the most visible concern, it was symptomatic of an organisation under great pressure, and a growing responsibility to meet continually increasing demands for services.

Our focus in the past years has been to put in place the architecture to ensure a more sustainable pathway forward for Southern DHB, to continue to serve the health needs of the community into the future.

We are often reminded that the Southern district covers the largest geographic area of all DHBs, and has a history of services that have developed in response to opportunities, community need and political decisions, and at times reacting to crisis as opposed to strategically moving forward. What has been needed is a coherent approach to pulling these resources together in order 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.

In 2016, we undertook a comprehensive community engagement programme, Southern Future. Our communities 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. What we heard remains at the heart of our work. To achieve this, we are focusing on programmes in the following areas that collectively enable us to build the health system our community has asked for. This has provided the basis for our reporting in recent years, and in 2018/19 we continued to make progress on this journey.

- 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 and we make the most effective use of our resources.
- Facilities for the future – Including ongoing planning for the new Dunedin Hospital, redevelopment work at Lakes District Hospital, and progressing Community Health Hubs to accommodate and adapt to new models of care.

Creating a coherent system of care was a driving principle behind the development of the Primary and Community Care Strategy and Action Plan, co-sponsored by Southern DHB and WellSouth Primary Health Network, launched in early 2018.

Behind this is the fundamental principle that improving health care requires the whole system working together. It is not something the DHB can or should be contemplating by itself. It depends on the integrated efforts of partners in primary care, iwi, NGOs, education partners such as the University of Otago, and our regional polytechnic and Institute of Technology.

The progress with the Primary and Community Care Strategy and Action Plan has been exceptional. We were oversubscribed with general practices wanting to make the journey to becoming Health Care Homes, offering a more flexible and accessible approach to primary care. Initiatives to improve pathways for those with long term conditions, and the frail elderly, have developed considerable momentum. We have started the process for developing the infrastructure of Community Health Hubs, enabling greater integration between traditionally 'primary' and 'secondary' services in ways that make sense for patients. We made progress in the 2018/19 year in building locality networks, calling for expressions of interest for those wanting to contribute to this advisory group in the Central Lakes area; this team has since been appointed.

We have also taken steps towards fulfilling the vision of the Southern health system operating under a unified identity, with the launch of the Southern Health website and logo. Developed in partnership by Southern DHB, WellSouth and the Community Health Council, its aim is to make it easier for people to understand our health system, and find the health services they need. It brings together information from over 500 health services across the district, and provides a way for health care providers in the Southern district to present themselves as part of the same team and wider health system.

This momentum in reshaping primary and community services has been supported by the progress in the planning for the new Dunedin Hospital. This has provided an unprecedented opportunity to open up a wider conversation about how we envisage health care being delivered in the future. A secondary/tertiary base hospital is just one part of this; equally, or arguably more importantly, are the services that are available and distributed across our district.

We are determined to enable equity in outcomes across the district, and this year appointed in conjunction with WellSouth PHN a new role, Chief Māori Health Strategy and Improvement Officer, along with two new Associate Directors for Māori Health focusing on primary and secondary care respectively. This team is positioned to lead the changes that are needed for our Māori communities across the district and health system.

Part of working towards a more coherent approach to health services, however, has involved some difficult decisions, and we have experienced this while implementing our Integrated Primary Maternity System of Care.

Maternity services had long been recognised as needing reform, with services unequally distributed across the district, and serious pressure points developing, particularly in relation to the sustainability of the critical LMC workforce, and especially in the Wanaka area. Following extensive review and consultation to develop the principles for a more equitable system of care, the decision was made to invest resources into providing additional payments for LMC midwives, and establishing a new layer of support in the form of maternal and child hubs. These are non-birthing facilities (except in emergencies) that provide office space, resources and emergency equipment to LMS midwives in remote areas. Importantly, they enabled services to be extended into parts of the district with no formal maternity infrastructure despite being significant population centres, namely Wanaka and Te Anau. In this process the Lumsden Maternity Centre also became a maternal and child hub rather than a fully staffed primary birthing unit, due to the very low number of births at the facility and its proximity to other birthing centres in Winton and Gore. This however was vigorously opposed by the community and reflects the genuine challenges involved in adapting services in terms of wider planning, when the impacts may be experienced by specific communities. We have also learned some valuable lessons through reflecting on how we as a DHB approached the implementation of the strategy. This is a reminder of the need to have robust project management and governance structures when embarking on significant changes. We are modifying our approach moving forward to minimise the risk of similar challenges materialising in future changes.

This experience points to a broader challenge to confront, around how we address genuine conflicts we face. We know we will continue to have challenges, and that there will inevitably be differences of views, sometimes strongly held, by individuals working within constrained resources but with the shared goal of doing their best for our patients and community. We must acknowledge and prioritise the reality of this difficult aspect of roles, and build constructive processes for handling the challenging situations this inevitably brings.

This is as important when working across organisations and sectors as it is within any individual organisation or team. We were faced with this again following the review of colonoscopy cases at Southern DHB. While the discussions around referral criteria and decision-making processes are important, they can only be progressed in a spirit of cooperation. An outcome of the review was to invest in external expertise to assist the teams involved, and we owe it to our patients to do make the improvements that are needed.

This situation also underscores why we have continued to invest in building a strong culture within Southern DHB. In 2019 we undertook our second staff engagement survey, and were heartened by the improvements across all priority areas, signalling that as a place to work, we are moving in the right direction. Our inaugural staff excellence awards in September 2018 were a highlight of the year.

It's also important to recognise that the efforts of our colonoscopy team and others have also been central to a great success story for Southern DHB this year, with the outstanding achievements relating to the roll-out of the National Bowel Screening Programme. We are proud to have the highest participation rate not only nationally for the programme, but also for Māori, with participation rates some 16 per cent ahead of the national average for this community. We also note that over the past 18 months colonoscopy rates have increased by more than 75 per cent. A significant amount of this is attributable to the bowel screening programme however symptomatic screening has increased by more than 25 per cent.

And there has been much else to celebrate. Our Valuing Patients' Time programme of work, aimed at reducing unnecessary wasted time for patients in our hospital system, has made a significant difference

across several areas, particularly in our pathways for older people who are now better supported to return home earlier.

We celebrated the opening Stage One of Te Puna Wai Ora Critical Care Unit, bringing together ICU and HDU care in a vastly improved space. We completed the upgrade of the Emergency Department

at Lakes District Hospital in Queenstown and installed a long-called for CT scanner, thanks to the generous support of the Lakes Hospital Foundation and the Central Lakes Trust. Our dedicated focus on ensuring patients received the surgery they needed in a timely way saw us achieve our target for elective surgery this year, despite the pressures of five junior doctors' strikes. We thank all of our teams involved for their tremendous efforts in making these gains possible.

These achievements, and more, give us confidence that Southern DHB is not only moving in the right direction, but is building the underlying systems and structures to do so sustainably.

The Commissioner team was appointed following the previous board estimating a budgeted deficit of around $40 million. The fact that that Commissioner's term is finishing while reporting a similar financial positon (excluding the additional Holidays Act liability, which has increased the deficit further) is not lost on us. But our goal was never just to remove the deficit; we could have done that easily by simply cutting services. It was to manage it downward, while making the investments needed to address critical areas, and lead a transformation of the overall system.

While initially we were able to deliver reductions to the deficit, the past year has challenged this trajectory, with higher than budgeted staffing costs as a result of industrial action, pharmaceutical costs, and other cost pressures.

So no, we have not eradicated the deficit, but we have made progress in other areas, and at a time when all DHBs are experiencing cost pressures and we are no longer such outliers in terms of the challenges we face.

Certainly we have faced challenges, and the pathway to a more robust health system for the South has not been smooth.

But the Commissioner team moves on from this role leaving we believe a more stable, better oriented organisation, with a vision and pathway for enhanced primary and community care services; stronger clinical leadership; improving quality and business systems and workplace culture; enhanced facilities in critical areas; and a new hospital to look forward to.

We trust that the new board will take the next steps on this journey with confidence that important foundations have been put in place.

We await with interest the proposals arising from the Health and Disability System review, and are confident the leadership and staff at the DHB will adapt to further changes in an ever-evolving, and critically important sector.

Reflecting on our journey will always be tinged with sadness, as we recognise the contribution and feel the loss of deputy commissioner Graham Crombie, who passed away earlier this year. Graham was a passionate believer in people, and their ability to learn, grow and create change. He is remembered as a man of humour, heart and integrity, and a towering source of optimism that stood us in great stead in even the toughest times.

Following Graham's passing, we welcomed two new deputy commissioners, Dr David Perez and Jean O'Callaghan, who were able to support us to complete our term, and we thank them for their contributions.

Finally, we extend our enormous thanks to all of our partners in WellSouth Primary Health Network, the rural hospital trusts, primary and community care providers across the district, and iwi and education, and our exceptionally capable 4,600 staff whose efforts every day provide outstanding care to the people in our community. It is, as always, greatly appreciated.

Kathy Grant, Commissioner
Chris Fleming, Chief Executive Officer

Statement of Responsibility

For the 12 months ended 30 June 2019

The Commissioner team and the management of the Southern DHB accept responsibility for the preparation of the financial statements, the statement of service performance, including the performance information for an appropriation required under section 19A of the Public Finance Act 1989, and for the judgements made in them.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, except for the substantial uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003 as described in note 14 on page 102, these financial statements and the performance information fairly reflect the financial position and operations of Southern DHB for the year ended 30 June 2019.

Chris Fleming
Chief Executive Officer
23 October 2019

Kathy Grant
Commissioner
23 October 2019

Our Purpose

Better Health, Better Lives, Whānau Ora

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

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

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

This is achieved through:

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

Our Governance

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

Elections resume this year and the Commissioner's term will continue until the board that is elected takes office in December 2019.

Partnership with Iwi

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

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

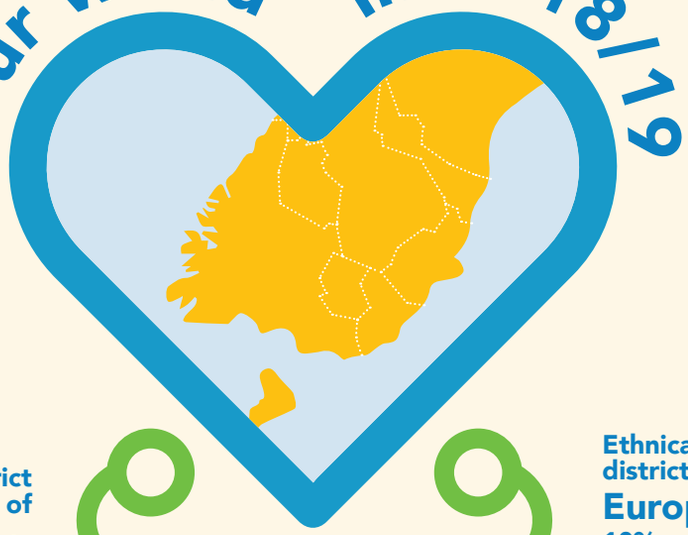
Kā Rūnaka is made up of a representative from each of the seven Rūnaka whose takiwā is in the Southern DHB:

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

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

Mauri ora ki a tātou katoa.

Our world in 2018/19



The Southern district has a population of **332,020** residents

62,356 km²
We are the DHB with the largest geographical area

Ethnically, the Southern district is predominantly **European at 80%.**
10% are Māori, 8% Asian and 2% Pacific.

6,504 acute surgical operations

13,452 elective operations or procedures

3,119 babies born in DHB facilities in 2018

82,467 presentations to the Emergency Departments

4,879 staff employed by the DHB

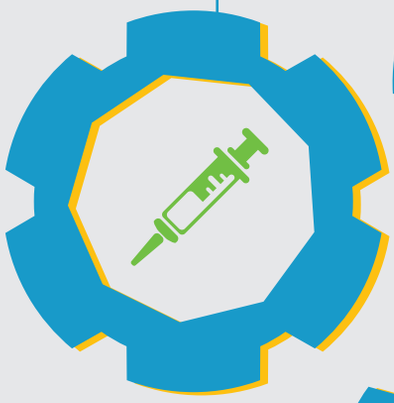
Our population is slightly older when compared to the national average.
56,450 are aged **65 and over**

130,373 outpatient appointments (first specialist appointments and follow up appointments)

Key highlights

Achieved highest rate for **Māori participation** in the National Bowel Screening Programme, **72%**

More elective surgery delivered, achieving **99.6%** of our target, with **13,452** surgeries and procedures



More older people are supported at home – more are receiving **home-based support**, and the length of stay on the older person's **rehabilitation ward** has decreased by **8 days (37%)** compared to the same period last year

9 practices began implementing the Health Care Home programme, reaching total of around **64,000** patients in the district.

New **Emergency Department** and **CT scanner** opened at Lakes District Hospital

Whole of health system website and identity developed – **www.southernhealth.nz** – making it easier for people to find the care they need

Our pathway towards enabling

Better health, better lives,

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

What have our people asked for?*

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

* Southern Future listening sessions, 2016

How will we get there?

THE SOUTHERN STRATEGIC HEALTH PLAN:

IMPROVING EXPERIENCE & OUTCOMES

Creating an environment for health

The environment and society we live in supports health and wellbeing.

Primary & Community Care

Care is more accessible, coordinated and closer to home.

Clinical service design

Patients experience high quality, efficient services that respect their time.

ENABLING SUCCESS

Enabling people & systems

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

Facilities for the future

Including Dunedin Hospital, Lakes District Hospital redevelopment and community health hubs to accommodate and adapt to new models of care.

Whānau Ora

Southern Health
He hauora, he kuru pounamu

By 2026: We work in partnership to build:

A health enabling society within which we deliver:

Sustainability

Experience

Quality

Adaptability

More accessible, extensive primary and community care

Quality coordinated care

The right secondary and tertiary care when it's needed

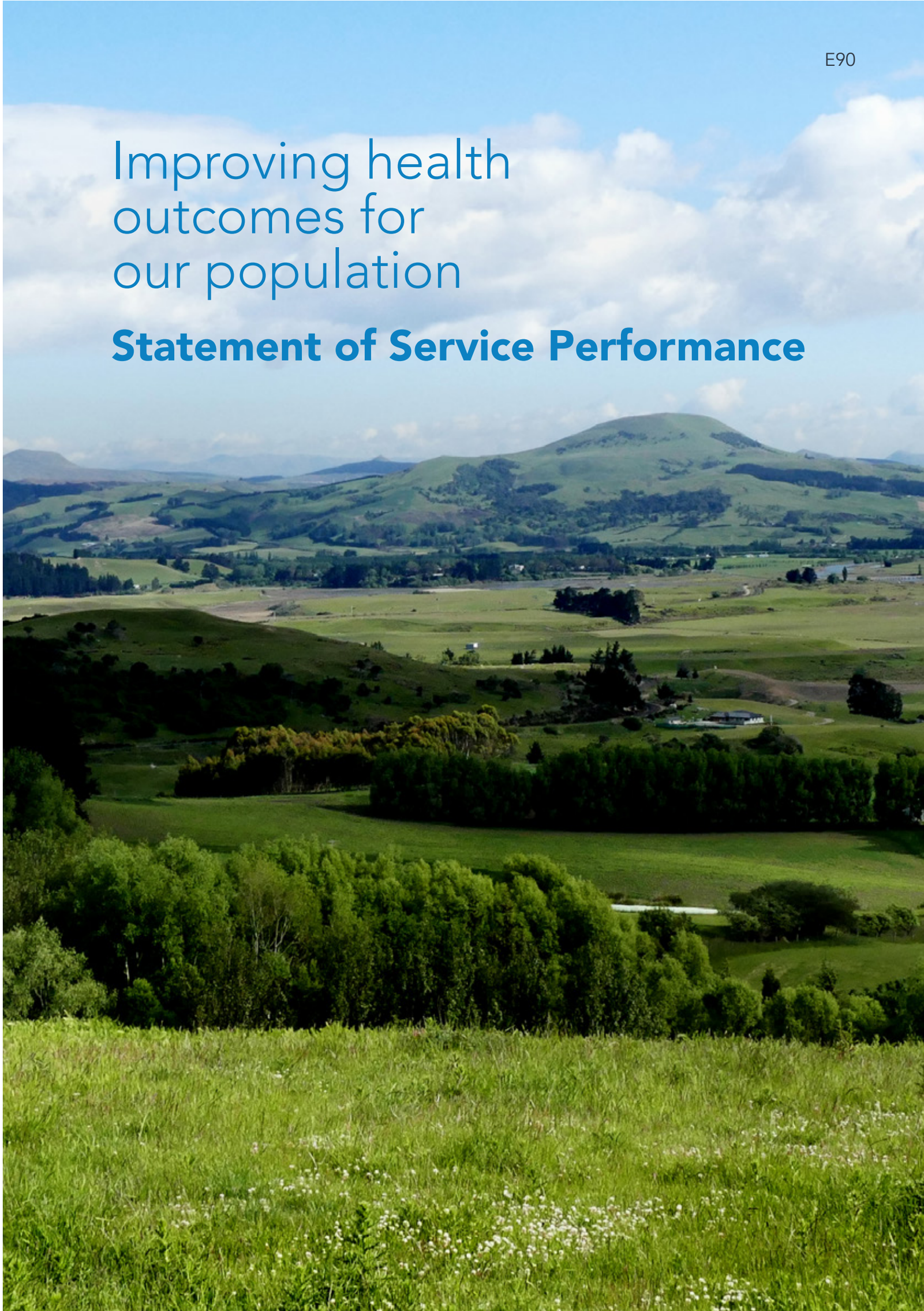
Including New Dunedin Hospital
PIKI TE ORA

So that our people:

- are healthier and take greater responsibility for their own health (p17)
- stay well in their own homes and communities (p21)
- with complex illness have improved health outcomes (p25)

Improving health outcomes for our population

Statement of Service Performance



Statement of Service Performance

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

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

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

Improving Health Outcomes for Our Population

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

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

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

The three strategic outcomes outlined in the 2018/19 Annual Plan with associated outcome and impact measures are shown below.

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

Outcome 1

People are healthier and take greater responsibility for their own health

Why is this important?

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

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

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

How have we measured our success?

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

- Reducing the number of people smoking in our population
- Reducing obesity rates

The impact measures that contribute to these outcomes are:

- More babies being breastfed
- More children are caries free (no holes or fillings)
- Fewer young people taking up smoking

How did we perform?

To date we have seen varied performance in the measured areas. Uptake of smoking by youth (as measured by the year 10 ASH survey) continues to reduce (exceeding the target for reduction), and the caries free rate for 5-year olds has also improved. Breastfeeding rates also continue to improve for the total population, however an inequity remains for Māori. A range of different initiatives are being pursued to improve performance across these areas, as explained in the following sections.

Outcome: Smoking

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

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

Southern's smoking rate data is acquired from the NZ Health Survey; unfortunately due to the timing of publications, the 18/19 data is not yet available and we generally remain 12 months behind in our reporting for these measures.

17/18 data saw a large drop in reported number of smokers. While this is a positive improvement and is partially understood to reflect the investment of programmes established, it should also be noted that the New Zealand Health Survey is mainly designed to get robust national figures, and not single-year DHB results. The implication of this is that there could be a lot of variation for individual DHB values, and DHB yearly results should also be considered alongside the three year "pooled" results that are produced and are available online.

We have continued to focus on assisting people to quit smoking including incentivising commitment to quit, and increasing access by improving referral pathways to smoking cessation services. Over the past year, 86 per cent of smokers in primary care were provided with brief advice and offered cessation support.

Percentage of the population 15+ who smoke

	2015/16	2016/17	2017/18	2018/19
Southern DHB	14.9%	19.3%	13.5%	Not available
New Zealand	16.3%	15.7%	14.9%	Not available

Data sourced from national NZ Health Survey

Outcome: Obesity

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

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

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

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

Southern also continues to perform well in the Raising Healthy Kids target. While this target strictly measures referrals for children, the family-based nutrition, activity and lifestyle interventions support multiple age groups as well as the children.

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

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

Percentage of the population 15+ who are obese

	2015/16	2016/17	2017/18	2018/19
Southern DHB	29.6%	31.4%	29.4%	Not available
New Zealand	31.6%	32.2%	32.2%	Not available

Data sourced from national NZ Health Survey

Impact Indicator: Breastfeeding

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

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

While overall our performance exceeds both target, and national performance rates, an inequity remains between Māori and non-Māori. To reduce this inequity, 18/19 saw an emphasis in WellSouth's Breastfeeding Peer Support Programme on developing Māori and Pacific support groups, and pregnancy and parenting sessions being delivered from new settings to support engagement of Māori and Pacific women and whānau.

One-on-one pregnancy and parenting sessions have also been introduced to support women who cannot engage in group sessions – ensuring they have access to the same information and support.

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

Percentage of babies fully/exclusively breastfed at 6 weeks

	2016/17	2017/18	2018/19	
	Actual	Actual	Target	Actual
Southern DHB	73%	73%	>70%	74%
Southern DHB Māori	73%	67%	>70%	64%
New Zealand	73%	72%	>70%	72%

Data sourced from WellChild / Tamariki Ora Quality Improvement Framework

Impact Indicator: Oral Health

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

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

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

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

Southern DHB continues to offer family appointment bookings, as well as providing services over the school holidays. 18/19 saw an additional emphasis on supporting higher deprivation populations, and to support Māori health outcomes, oral health education was provided for Kaumatua in Southland to enable them to support their mokopuna and wider whānau.

Percentage of 5-year-olds who are caries free

	2016	2017	2018	
	Actual	Actual	Target	Actual
Southern DHB	69%	67%	>70%	70%
Southern DHB Māori	58%	53%	>70%	55%
New Zealand	60%	61%	>70%	Not available

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

Medium Term Indicator: Reduced Smoking

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

The number of Year 10 students who have 'never smoked' continues to exceed target.

A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Percentage of Year 10 students who have 'never smoked'

	2016	2017	2018	
	Actual	Actual	Target	Actual
Southern DHB	81%	83%	>70%	81%
New Zealand	79%	82%	>70%	81%

Data Source: ASH Year 10 Survey

Outcome 2

People stay well in their own homes and communities.

Why is this important?

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

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

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

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

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

How did we perform?

We are supporting more people to stay in their own homes for longer. In 18/19 the number of people aged 75 and over living in their own home increased further to 88 per cent. This is in the additional context of the number of people being supported at home by community support services aged over 65 also continuing to increase. These results indicate that the investments and changes to primary and community services are having the desired effects – enabling people to live longer in their own homes.

There are still opportunities for improvement however, indicated by the decrease in target performance for CT access, and while MRI access improved by 15 per cent, more can be done here also.

Outcome: Acute Medical Admissions

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

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

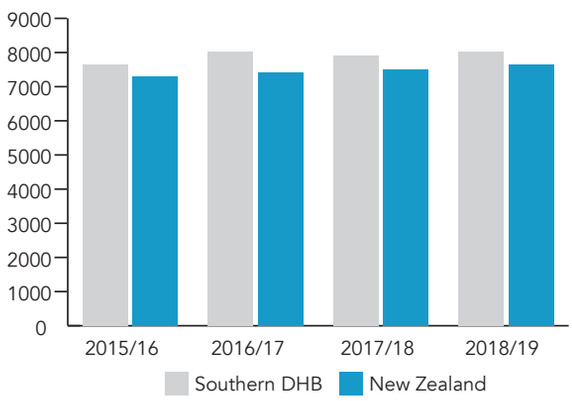
To support this, 18/19 saw the rollout of the first tranche of General Practices adopting the Health Care Home model of care. This model includes GP triage, acute daily appointment capacity and extended hours – all factors expected to increase patient access to care.

The Primary Options for Acute Care (POAC) programme also enables General Practices to deliver acute care closer to home. This work is a sustainable method of increasing volumes in primary care, while also reducing the number of Emergency Department presentations.

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

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

	2015/16	2016/17	2017/18	2018/19
Southern DHB	8,028	8,023	8,109	8,414
New Zealand	7,644	7,638	7,759	7,945



Data sourced from National Minimum Data Set.

Outcome: People Living at Home

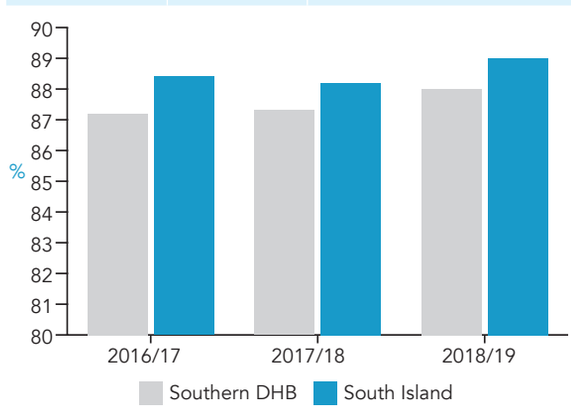
Studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and are positively connected to their communities.

We have been seeing a gradual increase in the percentage of older people supported in their own homes (trend continued in to 18/19). This can be used as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

In the coming years we are expecting to see more people enter hospital and dementia level care services, as they live longer in their own homes, and enter aged-residential care services older in age.

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

	2016/17	2017/18	2018/19
Southern DHB	87.2%	87.3%	88.0%
South Island	88.4%	88.2%	89.0%



Data source: National Minimum Data Set

Medium Term Indicator: Earlier Diagnosis

Diagnostics are an important part of the health-care system and timely access by improving clinical decision-making, early and appropriate intervention, improving quality of care and outcomes for our population.

The radiology service continues to experience increasing levels of urgent acute demand which is negatively impacting on timeliness.

CT waiting time performance across the DHB has reduced, primarily due to capacity constraints at Dunedin Hospital. Performance at Dunedin Hospital has dropped to around 50 per cent scanned and reported within 42 days whereas in Southland it has remained consistently over 90 per cent. We have improved the utilisation of CT resource across the whole of Southern DHB including rural hospitals but this has not addressed the Dunedin capacity issue. A trial has been completed which increased planned CTs performed during weekday evenings. This was successful in matching capacity to demand. Plans are underway to permanently increase this capacity, which should support an improvement in CT performance.

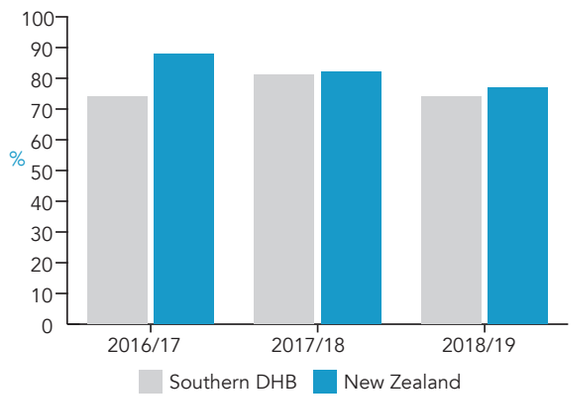
Percentage of people waiting no more than 6 weeks for their CT scan

	2016/17	2017/18	2018/19	
	Actual	Actual	Target	Actual
Southern DHB	74%	81%	85%	74%
New Zealand	88%	82%	95%	77%

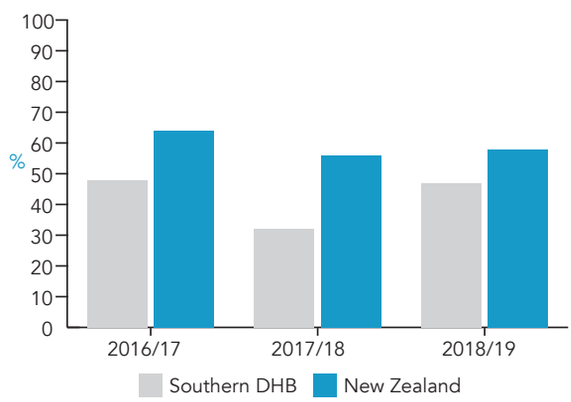
Percentage of people waiting no more than 6 weeks for their MRI scan

	2016/17	2017/18	2018/19	
	Actual	Actual	Target	Actual
Southern DHB	48%	32%	67%	47%
New Zealand	64%	56%	95%	58%

Percentage of CT scans within 6 weeks



Percentage of MRI scans within 6 weeks



Data sourced from Ministry of Health.

Medium Term Indicator: Avoidable Hospital Admissions

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

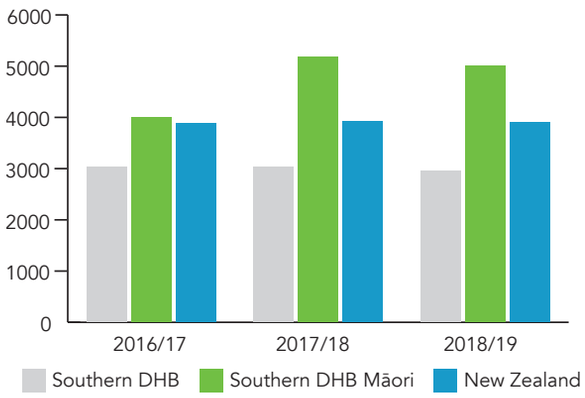
Lower avoidable hospital admission rates, measured as Ambulatory Sensitive Hospitalisation (ASH) rates, are seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

ASH rates have stabilised in Southern over 18/19, as they have across New Zealand, and decreased for Māori. Some of this local performance improvement is expected to be attributable to changes in Primary Care availability (such as the Health Care Home model allocating daily acute GP appointment slots), embedding of primary options for acute care (POAC) and advances in Client Lead Integrated Care (CLIC) that supports the management of long-term conditions.

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

	2016/17	2017/18	2018/19	
	Actual	Actual	Target	Actual
Southern DHB	3,028	3,036	<2,844	2,957
Southern DHB Māori	4,003	5,180	<2,844	5,004
New Zealand	3,881	3,920	N/A	3,905

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



This indicator is based on the national performance indicator SI1 and covers hospitalisations for a range of conditions which are considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis.

Medium Term Indicator: Falls Prevention

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

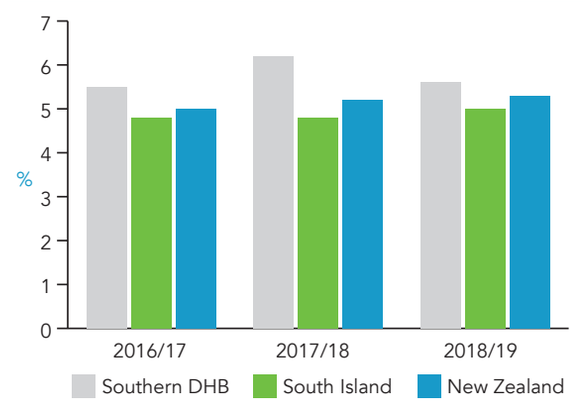
Lower falls rates can therefore be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided.

For 18/19, our performance for this metric has improved on the year prior.

Our well-established multi-agency Southern Falls and Fracture Prevention Steering Group continues to take a sector-wide approach to falls and fracture prevention. The group monitors our ACC/DHB investment in an integrated approach led by WellSouth (who provide Lead Agency, Fracture Liaison and In Home Strength and Balance), and continuously looks for opportunities to make a difference in the falls and fracture prevention arena.

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

	2016/17	2017/18	2018/19	
	Actual	Actual	Target	Actual
Southern DHB	5.5%	6.2%	5.0%	5.6%
South Island	4.8%	4.8%	5.0%	5.0%
New Zealand	5.0%	5.2%	-	5.3%



Data source: National Minimum Data Set

Outcome 3

People with complex illness have improved health outcomes.

Why is this important?

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

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

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

How have we measured our success?

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

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

The impact measures that contribute to these outcomes are:

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

How did we perform?

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

Timeliness to access some services such as the Emergency Department and elective surgery is an ongoing challenge; a range of initiatives have been implemented to improve performance in these areas.

Outcome: Acute Readmissions

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

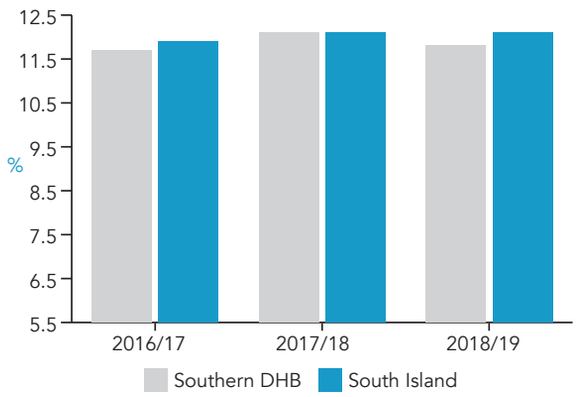
The key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge. Therefore, they are a useful marker of the quality of care being provided and the level of integration between services.

Southern readmission rates have improved in the last year, and now sit below the national average.

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

	2016/17	2017/18	2018/19
Southern DHB	11.7%	12.1%	11.8%
New Zealand	11.9%	12.1%	12.1%

Data source: Ministry of Health Performance Reporting OS8.



These results differ to those published in 16/17 following a further reset of the definition by the Ministry of Health in 2017/18.

Outcome: Mortality Rates

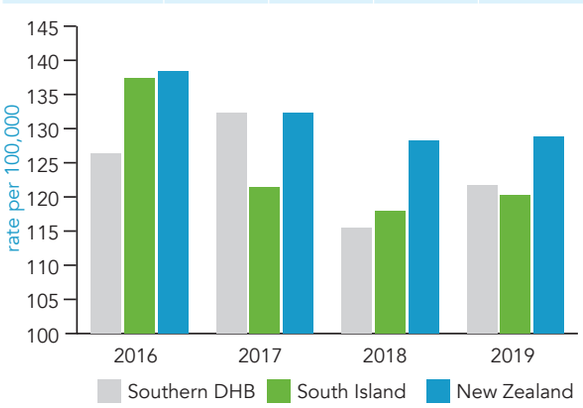
Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

While the data presented here shows 2016 onwards, it should be noted that Southern has seen an overall reduction in preventable mortality since 2011. Rates climbed slightly in 2014 and 2015, indicated to be due to increases in rectal and prostate cancer. The drop in 2016 is counter to the previous two years but in line with the overall trend. We are awaiting further data to assist us to understand this better.

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

	2016	2017	2018	2019
Southern DHB	115	122	137	112
South Island	118	120	120	112
New Zealand	128	129	126	125



Note: There is a delay in mortality data as the cause of death has to be established for all reported deaths. Data is currently only available to 2016.

Medium Term Indicator: Waits for Urgent Care

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

Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance improves patient outcomes by providing early intervention and treatment as well as public confidence and trust in health services.

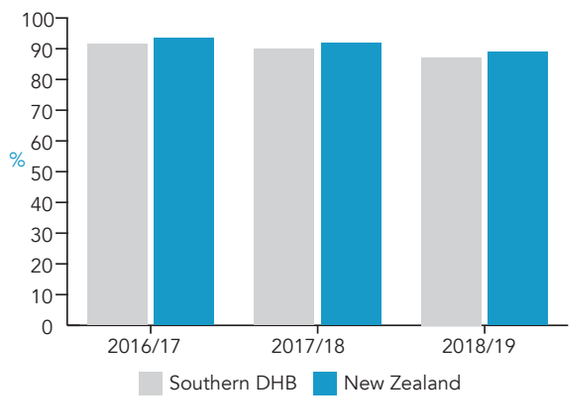
Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Work to increase performance has involved looking at ED assessment times (through a trial of Early Specialist Assessment), and admissions through the establishment of an Older Person's Assessment Liaison service. Despite this, increasing numbers of people attending EDs in the Southern district continue to place pressures on the system.

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

	2016/17	2017/18	2018/19	
	Actual	Actual	Target	Actual
Southern DHB	91.5%	89.9%	95.0%	87.2%
New Zealand	93.5%	91.8%	95.0%	89.0%

Data source: Ministry of Health Quarterly Reporting.



Medium Term Indicator: Adverse Events

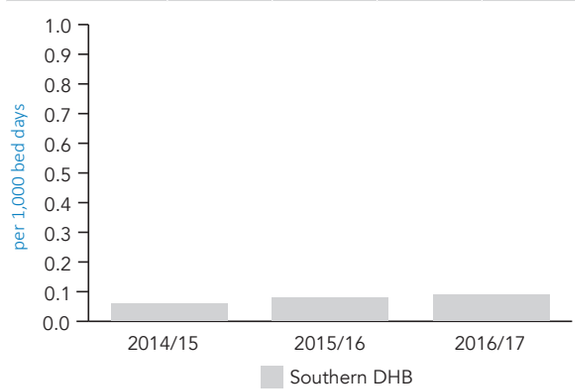
The rate of adverse events are a key indicator of care quality. Events such as pressure injuries, hospital acquired infections, and falls are all examples of adverse events. The number of adverse events remains very low but the ultimate goal is no adverse events and zero patient harm.

Preventing falls is important, as patients who experience a fall while in hospital are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence and increased risk of institutional care.

Our rate of serious falls has risen in the last two years. It is known that our hospital patients are generally increasing in their acuity and therefore their vulnerability to falls. Due to the complex needs of the patients in our care we are working on preventative analyses and actions – for example identifying the high risk patients early, as well as assessing trends in time of day and associated activities when falls occur. Findings from these analyses have led to changes – for example the piloting of additional resource to undertake intentional ward rounds to support patients who may be awake and disoriented in the early hours of the morning.

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

	2016/17	2017/18	2018/19	
	Actual	Actual	Target	Actual
Southern DHB	0.06%	0.08%	0.05%	0.09%



Data source: Internal quality system data reporting.

Medium Term Indicator: Access to Planned Care

Planned services (including specialist assessment and elective surgery) are an important part of the health-care system and improve people's quality of life by reducing pain or discomfort and improving independence and well-being. Timely access to assessment and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

Delivering timely access to some treatments has been challenging for all DHBs in 2018/19, particularly for Southern DHB and especially for elective surgery. The solutions to these issues are not easy. Some steps have been made to address capacity issues, such as optimising theatre usage, extending hours, increasing outsourcing and increasing staffing levels

People receiving their specialist assessment/ treatment within four months shows how responsive the system is to the needs of our population. Patients have a much better chance of recovering and getting on with their lives where they are diagnosed, treated, and return home in a timely manner.

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

	2016/17	2017/18	2018/19	
ESPI 2	**Actual**	**Actual**	**Target**	**Actual**
Southern DHB	97.8%	90.6%	100.0%	85.7%
New Zealand	99.4%	97.8%	100.0%	89.8%

	2016/17	2017/18	2018/19	
ESPI 5	**Actual**	**Actual**	**Target**	**Actual**
Southern DHB	92.0%	83.9%	100.0%	82.7%
New Zealand	97.9%	90.1%	100.0%	84.3%

Data source: Ministry of Health Data Warehouse.

National Health Targets

During the 2018/19 year Southern DHB saw variable performance across the health targets. Some of these targets involve work being undertaken in primary care with our health partners.

Shorter stays in Emergency Departments

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

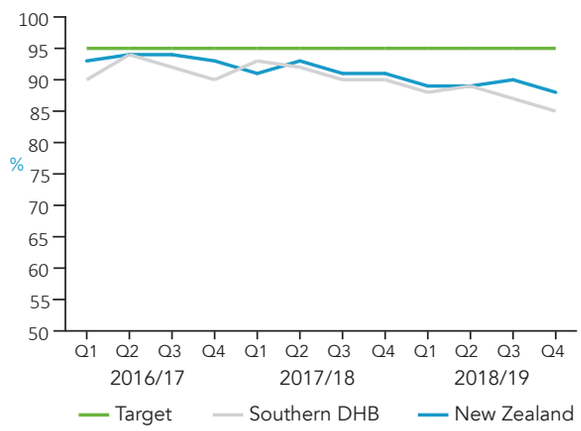
The number of people accessing the Emergency Departments continues to increase. This is putting increased pressure on existing staff and resources to consistently manage patients in a timely way.

To reduce the number of people turning up at the Emergency Department, a number of initiatives have been implemented such as Primary Options for Acute Care.

18/19 also saw work undertaken to increase the speed of ED decision making (through a trial of Early Specialist Assessments), and the establishment of an Older Person's Assessment Liaison service to support timely admission of those aged over 75 years.

Despite these efforts, ED performance has deteriorated compared to past years – a trend also experienced nationally.

	2018/19			
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
Southern DHB	88%	89%	87%	85%
NZ	89%	89%	90%	88%



Data source: Ministry of Health

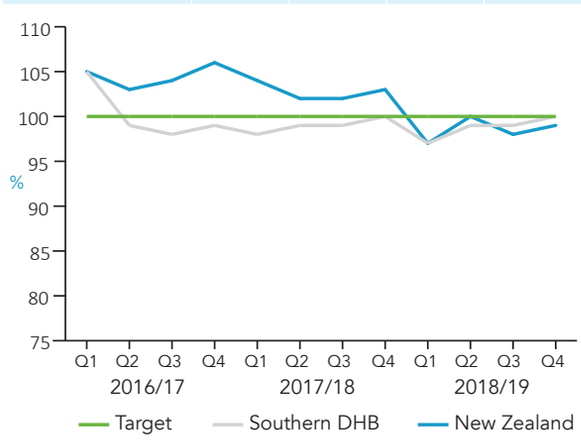
Improved Access to Elective Surgery

Nationally, DHBs will deliver an increase in the volume of elective surgery by an average of 4,000 per year. Southern will deliver at least 13,502 elective procedures in 2018/19.

A total of 13,452 elective procedures were completed in 2018/19. This is against a target of 13,502 (99.63%).

Changes implemented in 2018/19 to support capacity and timely provision of services included advancing production planning process to allow more accurate planning and phasing of services; optimising operating theatre utilisation and increasing utilisation; outsourcing where appropriate; and increasing resourcing to facilitate these actions.

	2018/19			
	Q1	Q2	Q3	Q4
Target	100%	100%	100%	100%
Southern DHB	97%	99%	99%	100%
NZ	97%	100%	98%	99%



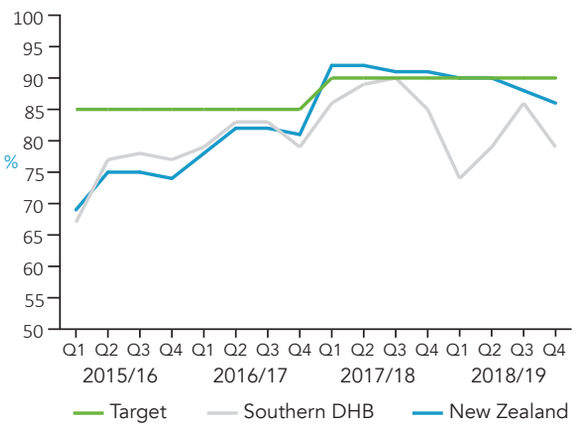
Data source: Ministry of Health

Faster Cancer Treatment

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

Southern DHB did not meet the 62 day target in any of the quarters and had a poor result in the last quarter. A component of this was due to surgical access, while the last quarter result was due to data issues which have been shown to be more serious than first thought. A refreshed data capture process is planned for 2019/20, as are improvements in theatre access.

	2018/19			
	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
Southern DHB	74%	79%	86%	79%
NZ	90%	90%	88%	86%



Data source: Ministry of Health

Increased Immunisation

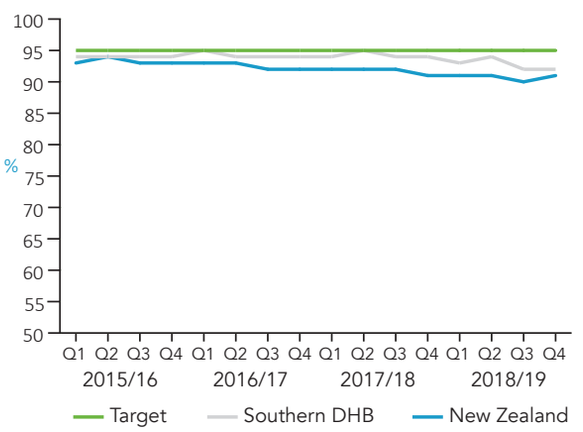
95 per cent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

2018/19 saw variable performance for immunisation rates. Performance continues to exceed national average, however has dropped compared to past years.

While eight-month-old performance has decreased, two-year-old performance has improved for Māori, and remained static for the total DHB.

Southern DHB continues work to track the immunisation status of every child, and works with key stakeholders such as midwives to promote vaccination in pregnancy and responsive baby vaccine schedules.

	2018/19			
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
Southern DHB	93%	94%	92%	92%
NZ	91%	91%	90%	91%



Data source: Ministry of Health

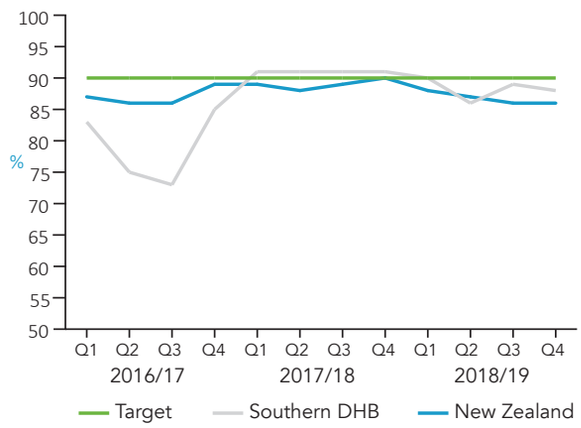
Better Help for Smokers to Quit – Primary

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

Although Southern's average performance for this target remains higher than the national average, and the target was achieved in Q1, we did not meet the target for the remaining three quarters.

Despite this, Southern DHB remains committed to this target and supporting smokers to quit. Efforts are three-fold: supporting different professional groups through training and education of best-practice (to then support patients); delivery of live reporting, audit and analysis for GP practices; and delivery of health promotion initiatives to support patients – such as the "12 smoke-free days of Christmas" promotion, offering interactive free carbon monoxide testing to smokers and non-smokers alike, and our incentive programme.

	2018/19			
	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
Southern DHB	90%	86%	89%	88%
NZ	88%	87%	86%	86%



Data source: Ministry of Health.

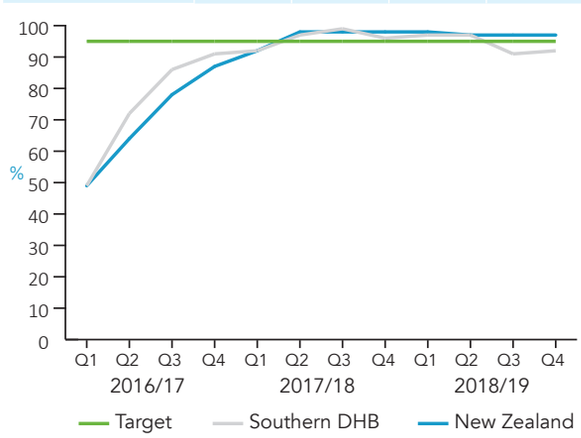
Raising Healthy Kids

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

Raising Healthy Kids was a new health target that was introduced in 16/17. Southern DHB has shown significantly improved progress against this target since inception and, as reported last year, reached the target for the first time in Q2 17/18.

Performance dipped slightly towards the end of 2018/19, but with pathways established and systems in place it is expected that this will improve in 2019/20.

	2018/19			
	Q1	Q2	Q3	Q4
Target	95%	95%	95%	95%
Southern DHB	97%	97%	91%	92%
NZ	98%	97%	97%	97%



Outputs – Short-term Performance Measures

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

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

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

We use this grading system for the 2018/19 Statement of Service Performance to assess performance against each indicator in the Output Measures section.

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

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

Cost of Service Statement

	2018/19 Actual $000	2018/19 Budget $000	2018/19 Variance $000
Income			
Prevention Services	5,378	4,995	383
Early Detection and Management Services	176,223	194,170	(17,947)
Intensive Assessment and Treatment	733,854	670,828	63,026
Rehabilitation and Support	116,585	143,889	(27,304)
Total Income	**1,032,040**	**1,013,882**	**18,158**
Expenditure			
Prevention Services	5,378	4,995	(383)
Early Detection and Management Services	207,172	201,926	(5,246)
Intensive Assessment and Treatment	756,300	676,453	(79,847)
Rehabilitation and Support	152,535	152,898	363
Total Expenditure	**1,121,385**	**1,036,272**	**(85,113)**
Surplus/(Deficit) for the year	**(89,345)**	**(22,390)**	**(66,955)**

Appropriations

Under the Public Finance Act, the DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by the DHB for the financial year 2018/19 is $875.3 million which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 15 to 47.

Output Class: Prevention

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

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

As well as working to continue to improve these services in 19/20, Southern will also advance a "Health in All Policies" approach to engaging across sectors to improve the determinants of health (for example in housing, alcohol harm minimisation, community resilience, nutrition and physical activity).

Immunisation Services

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

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

How did we perform?

In 2018/19, we saw variable performance for immunisation rates. Coverage has been reported from the National Immunisation Register (NIR), capturing PHO and community pharmacist data.

While rates dropped off for Māori at 8 months, they also saw a three per cent increase in the two-year cohort, and were the only group to meet the child targets. Key programmes of work in the year included a focus on bringing active delayers back on schedule (active delayers being those who have needed to delay an immunisation for medical reasons) which benefited the two-year performance, and a focus on capturing the immunisation status of all children across the district for better monitoring.

Immunisation Coordinators also continued their ongoing commitment to working with the midwifery sector promoting vaccination in pregnancy and responsive baby schedule vaccines.

Flu vaccinations for older people remains a priority. 2018 saw a slight improvement on the year prior, however performance remains below target. One particular challenge is data quality – our performance is thought to be under-reported by about 10 per cent and there has been a concerted effort to audit and understand data capture anomalies. Another challenge is ensuring accurate messaging and perceptions about the vaccines. Our Immunisation Coordinators continue to provide proactive training for pharmacies and GP practices ahead of each flu season.

Finally, HPV vaccination rates for girls unfortunately dropped off this year, which is understood to be largely attributable to the shortages in vaccine supply experienced at a national level, as well as the continued uptake of the vaccination for boys.

2018/19 Performance Results for Immunisation Services

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Percentage of children fully immunised at 8 months (Health Target)	Total	94%	94%	>95%	92%	🟡
	Māori	94%	94%	>95%	85%	🟠
Percentage of children fully immunised at 2 years	Total	95%	94%	>95%	94%	🟡
	Māori	96%	92%	>95%	95%	🟢
Percentage of eligible girls fully immunised with 3 doses of HPV Vaccine	Total	68%	68%	>75%	55%	🔴
	Māori	72%	71%	>75%	49%	🔴
Percentage of people aged over 65 having received a flu vaccination (PP21)[1]	Total	Not available	52%	>75%	56%	🔴
	Māori	Not available	44%	>75%	45%	🔴

[1]The results reported are for the period 01 March 2018 - 30 September 2018, which is in line with PP21 and takes account the winter flu season.

Health Promotion and Education Services

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

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

How did we perform?

Southern DHB did not meet the target in 2018/19 for the percentage of enrolled patients who smoke who are seen by a health practitioner in primary care being offered brief advice and support to quit smoking. WellSouth PHO continues to work with practices and developed a dashboard reporting tool to simplify the process for General Practices when delivering their brief advice.

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

The Southern Stop Smoking Service was established by Nga Kete Matauranga Pounamu to receive referrals from multiple providers. The voucher system to support commitment to cessation has been reviewed. The impact of the voucher scheme has been reviewed and as a resulted their value increased. This has resulted in an increase in pregnant women remaining in their programme at the four and eight week points.

New referral pathways to the Southern Stop Smoking Service were also developed, including working with St John to create a new pathway. While the referral pathways cover all groups there is an equity focus on supporting Māori and Pasifika, and reducing the rate of smoking in pregnancy.

Overall, breastfeeding rates are gradually improving however an inequity still exists between Māori and non-Māori.

To address this gap, advancement of WellSouth's Breastfeeding Peer Support Programme continued through 18/19, including a deliberate engagement with Māori and Pacific peer supporters. Additionally, pregnancy and parenting sessions are now being delivered from new settings to support engagement of Māori and Pacific women and whānau.

One-on-one pregnancy and parenting sessions have also been introduced to support women who cannot engage in group sessions – ensuring they have access to the same information and support. In the last year, Southern also participated in the South Island Alliance project to understand Māori and Pasifika women's experiences of breastfeeding (in order to identify opportunities for improvement and support). Recommendations from this project are expected to flow in to 19/20 service planning.

2018/19 Performance Results for Health Promotion and Education Service

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	Total	85%	91%	>90%	88%	🟡
	Māori	89%	90%	>90%	87%	🟡
Infants exclusively or fully breastfed at 3 months	Total	58%	60%	>60%	63%	🟢
	Māori	50%	52%	>60%	49%	🔴

Population-Based Screening

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

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

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

How did we perform?

Southern DHB has remained relatively stable with coverage for these measures. The breast screening rate for Māori women slightly improved, and DHB total performance exceeds target.

Programmes enabling this work include proactive Cervical Screening Status reporting that supports primary health care providers with managing advanced reminders for patients. Additionally, the recently-introduced 'One Stop' appointments support women to undertake both breast and cervical screening in one appointment session, rather than needing to spend time attending multiple appointments.

Community Screening Coordinators also work to promote breast screening within the Pacific community, and work with practices to identify, invite and support women with screening.

The percentage of children receiving their B4 School Check continues to exceed target. The B4 School Check is a free health and development check for all four-year-olds, and is undertaken by DHB public health nurses. The DHB continues to maintain staff education and awareness of referral pathways in order to support these results.

2018/19 Performance Results for Population-Based Screening

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Percentage of eligible women (50-69 years) who have had a BSA mammogram breast screen examination in the past 2 years (MHP).	Total	75%	74%	>70%	75%	●
	Māori	67%	67%	>70%	69%	●
Percentage of eligible women (25-69 years) who have had a cervical screening event in the past 36 months (MHP).	Total	78%	77%	>80%	75%	●
	Māori	63%	68%	>80%	69%	●
The percentage of 4 year old children receiving a Before School Check (B4SC).	Total	91%[2]	91%	>90%	91%	●
	Quintile 5[3]	94%	90%	>90%	91%	●
Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	87%	94%	>95%	92%	●

[2] The 16/17 result for children receiving a B4SC differs from that previously reported due to a reporting error.
[3] Quintile 5 relates to most deprived (20%) in our population based on the Deprivation Index

Output Class: Early Detection and Management

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

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

Oral Health

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

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

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

How did we perform?

The Southern DHB District Oral Health model of care has continued to show benefits to the children of the service. The principle of working in partnership with children's whānau/parents/caregivers to achieve improved oral health outcomes has been firmly embedded and as previously indicated, the longer term strategy is yielding positive results.

Performance has been improving in line with this expectation, and in 2018 the overall target of 70 per cent of five-year-olds being caries-free was met. While the target wasn't achieved for Māori, there was a two per cent improvement from the previous year.

2018/19 initiatives to further support performance include:

- Working with higher deprivation populations providing fluoride varnish programmes bi-annually in preschools and Kohanga Reo.
- Continuation of school-based tooth-brushing and education programmes
- Providing oral health education in Southland for kaumatua to enable them to support their mokopuna and wider whānau in understanding the need for good oral health for life. This has been offered as ongoing if required.

While progress continues to be made in these areas, Southern DHB did not meet its oral health targets surrounding enrolments. A key factor contributing to this result remains the number of dental therapist vacancies during the year. Recruitment is ongoing for vacancies.

It is pleasing to report that despite the vacancies, the staff continue to provide an excellent service to the children of the district.

2018/19 Performance Results for Oral Health

Measure		2016	2017	2018		
		Actual	Actual	Target	Actual	
The percentage of eligible preschool children enrolled in school and community oral health services (PP13a & MHP)	Total	81%	79%	>95%	93%	●
	Māori	65%	68%	>95%	71%	●
The percentage of children caries-free at five years of age (PP11)	Total	69%	67%	>70%	70%	●
	Māori	58%	53%	>70%	55%	●

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

Long-term Conditions Management

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

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

How did we perform?

WellSouth continues to prioritise CVDRA for Māori men aged 35 to 44 years but Southern DHB is yet to reach the 90 per cent target for CVD checks. There are a range of new initiatives to address long-term outcomes and targets.

The 'Do the Right Thing' programme led by the Long Term Conditions Network has evolved as CLIC (Client-Led Integrated Care). This programme puts the enrolled patient population through a Risk Prediction algorithm, and utilises a range of assessment tools to help determine the types of support patients may require to best support their long-term conditions. District-wide completion of the rollout of CLIC is expected to be complete by Q2 2020-21.

WellSouth PHO will also launch the new CVD Risk Assessment algorithm by Q2 2019-20. Aligned to this new risk assessment tool will be a new approach to the CVD incentive programme.

The DHB is yet to meet the target of 58 per cent of the population identified with diabetes having good or acceptable glycaemic control. WellSouth continues to offer the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) programme for patients with Type 2 Diabetes, while the preventative-focussed 'Walking Away' from diabetes programme is for patients identified with pre-diabetes. Looking forward, the intent is to advance diabetes care through greater integration with the CLIC programme.

A new local diabetes team has been re-established to focus on improved outcomes for people with diabetes. This work will continue to progress through 2019-20, with an initial focus on the diseased diabetic foot. Initially activity will involve analysis of community podiatry, multidisciplinary foot clinics, integration between primary and secondary services, health pathways and risk stratification into the appropriate service.

2018/19 Performance Results for Long-Term Conditions Management

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Percentage of the eligible population who have had a CVD Risk Assessment in the last 5 years (PP20)	Total	86%	84%	>90%	81%	●
	Māori	82%	83%	>90%	80%	●
Percentage of the population identified with diabetes having good or acceptable glycaemic control (PP20)	Total	37%	48%	>58%	45%	●
		36%	41%	>58%	38%	●

Community-Referred Testing and Diagnostics

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

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

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

How did we perform?

With regard to the Faster Cancer Treatment target, Southern DHB did not meet the 62 day target in any of the quarters and had a particularly poor result in the last quarter. The last quarter result was due to data issues which, when investigated, were shown to be present in the first three quarters also. We estimate that this data issue has deteriorated our performance by five to ten per cent. A refreshed data capture process is planned for 2019/20. This will involve detailed tracking of patients to ensure they are in the correct pathway, ensuring consistency in data collection, weekly tracking of results and the development of audit protocols with the aim to provide early indications of drift in data integrity and/or timeliness of diagnostics and treatments.

A number of other factors have affected our performance in delivering timely diagnosis and treatment including delays in recruiting suitable specialists, constraints in surgical, radiation and chemotherapy capacity and high levels of cancers found in the successfully implemented bowel screening programme. In the last year access to surgical treatment has fluctuated between 59 per cent and 72 per cent compliance. Radiation oncology treatment 71 per cent to 95 per cent and chemotherapy 70 per cent to 100 per cent compliance. Because the largest group of patients have surgery for their first treatment, this drives the low results we are seeing for treatment. In the coming year we are have increased the number of theatres for General Surgery which will reduce the waiting times for treatment particularly for lower gastrointestinal cancers (from the diagnostic pathways and the bowel screening programme). There has also been good recruitment recently into specialist roles which will also reduce waiting times.

The high tech imaging radiology service continues to experience increasing levels of planned demand (due to increasing demand for cancer pathways and targeted therapies which required monitoring).

CT waiting time performance across the DHB has reduced, primarily due to capacity constraints at Dunedin Hospital. Performance at Dunedin Hospital has dropped to around 50 per cent scanned and reported within 42 days whereas in Southland it has remained consistently over 90 per cent. We have improved the utilisation of CT resource across the whole of Southern DHB including rural hospitals but this has not addressed the Dunedin capacity issue. A trial has been completed which increased planned CTs performed during weekday evenings. This was successful in matching demand to capacity. Plans are underway to permanently increase this capacity, which should support an improvement in CT performance. We have also had approval to outsource CTs, which will go some way to addressing the backlog issue in Dunedin and contribute improved performance.

There have been significant gains in MRI scanning within 42 days due to implementation of weekend scanning (and increased staffing). MRI in Southland rose from 30 per cent in July 2018 to 60 per cent June 2019. MRI in Dunedin rose 10 per cent to 48 per cent. Continued work will be required to further increase this performance.

2018/19 Performance Results for Community-Referred Tests

Measure	2016/17	2017/18	2018/19		
	Actual	Actual	Target	Actual	
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	79%	85%	>90%	79%	●
The percentage of accepted referrals for CT scans receiving procedure within 42 days	74%	81%	>85%	74%	●
The percentage of accepted referrals for MRI scans receiving procedure within 42 days	48%	32%	>67%	47%	●

Primary Health Care Services

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

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

How did we perform?

A lower level of Ambulatory Sensitive Hospital (ASH) admissions indicates the primary sector is performing well and successfully keeping people well in the community. Meeting our ASH rate targets is challenging, however a range of initiatives have been developed and will roll out through 19/20 to improve performance in this area.

Key to addressing the equity disparity in our ASH rates is the formation of a new Clinical Māori Strategy Group that will lead the planning and implementation of actions for Southern DHB in this space. We know already that respiratory conditions, asthma and dental problems comprise the main reasons behind ASH 0-4 admissions, especially for Māori.

19/20 actions to address these include the establishing of a partnership between WellSouth, Southern DHB, Community NGO Providers such as Cosy Homes, the University of Otago and others to provide support to families with unmet needs and high levels of hospital admissions. 18/19 also saw a trial in Southland of following up and providing support to families that were missing their oral health appointments. Following the successes of this trial, the programme will be rolled out in Otago in 19/20.

Supporting ASH rates also involves the continued investment by Southern DHB and WellSouth PHO in the Health Care Home model of care. The first tranche was rolled out in 18/19, and 19/20 will see delivery of a second tranche of GP practices from across the district. This is a primary-oriented model, which seeks to meet the objectives of the primary care strategy. Specific initiatives to increase access include GP phone triage, retained daily acute capacity appointments and extended hours – all factors expected to favourably influence ASH rates.

Additionally, Southern DHB and WellSouth PHO have implemented the first locality network in the district. These networks align with our strategic aims of better access, care closer to home, integrated services and technologically supported care delivery (such as telehealth and GP telephone triage).

The formation of Community Health Hubs is another key plank of the Primary and Community Care Strategy. A market engagement exercise was undertaken late 18/19 to further understand who may partner with us to develop these hubs and in what capacities.

Finally, our Primary Options for Acute Care (POAC) programme is underway. General Practices, through this service can deliver acute care closer to home and in a timelier way to their populations. This work is a sustainable method of increasing volumes in primary care, and reducing the number of ED presentations.

Youth primary mental health services transitioned to a community provider in early 2018 and 18/19 performance exceeded target across both DHB and community services providers. Recruitment to vacancies, particularly in rural areas, remains a challenge for brief intervention services.

2018/19 Performance Results for Primary Health Care Services

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Ambulatory Sensitive Hospital (ASH) admission rates (per 100,000) for children aged 0-4 years[5]	Total	5,471	5,762	<5,370	5,869	●
	Māori	5,521	6,379	<5,370	7,611	●
The number of people receiving a brief intervention from the primary mental health service	Total	7,418	6,882	>6,000	6,606	●

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

Output Class: Intensive Assessment and Management

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

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

Elective Services

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

How did we perform?

Southern DHB achieved slightly under (by 50 discharges) the target for the total number of elective surgical discharges achieving 13,452 discharges against a target of 13,502. However the elective surgical case-weight delivery was above target at 18,539 case-weights against a target of 18,311.

The solutions to delivering the increasing number of required electives were not easy. Some steps were made to address capacity and equity issues, such as by extending the hours for our operating theatres and supporting projects to further optimise theatre time. We also increased the number of cardiothoracic and neurosurgery surgery cases, leading to a lower discharge rate but higher case-weight reflecting the slight adjustment in the case-mix of surgery delivered. In all, these measures contributed towards an effort to reduce the time some patients need to wait for surgery.

Changes implemented in 2018/19 included:

- Implementing production planning processes which allowed for more accurate planning and phasing of elective surgical activity during the course of 2018/19
- Increasing theatre utilisation through greater monitoring of list planning and optimisation of theatre capacity (for example intense management and reallocation of dropped lists)
- Continuing to utilise local private facilities using DHB staff (outplacing) and through targeted outsourcing.
- Increasing staffing resources to facilitate these actions.

2018/19 Performance Results for Elective Services

Measure	2016/17	2017/18	2018/19		
	Actual	Actual	Target	Actual	
Percentage of elective and arranged surgery undertaken on a day case basis	New Measure	67%	>60%	63%	●
Percentage of people receiving their elective and arranged surgery on day of admission	New Measure	83%	>95%	88%	●
The number of elective surgical services discharges	12,756	13,219	>13,502	13,452	●
The number of elective surgical services case-weights (CWDs) delivered[6]	15,197	15,863	>18,311	18,539	●

[6] The measure and target for 2018/19 was updated by the Ministry of Health to additionally include arranged admissions.

Acute Services

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

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

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

How did we perform?

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

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

The Fit2Sit work seeks to support suitable patients maintain their mobility in the Dunedin Emergency Department. The trial with two chairs was successful and a proposal scaled for eight chairs has been costed and approved for implementation in 2019.

Concurrently a trial of Early Specialist Assessment continues three times a week. This programme seeks to improve clinical safety, facilitate earlier initiation of planning and treatment, improve patient experience and improve flow through the ED.

Improving clinical safety, patient experience and ED flow is supported through the Dunedin Hospital Medical Assessment Unit. This unit has enabled short stay medical patient to be transferred for recovery supporting right-time/right-place care for patients.

Work continues across the district to address the delays to transfer patients from ED to the inpatient wards. There are a number of initiatives to facilitate timely discharges and avoidance of readmissions.

In 2019 a trial was set up for the implementation of an Older Person's Assessment Liaison service for over 75 year-olds, with four beds on ward 6ATR and a maximum stay of 48 hours. This service is now permanent.

2018/19 Performance Results for Acute Services

Measure	2016/17	2017/18	2018/19		
	Actual	Actual	Target	Actual	
People are assessed, treated or discharged from the emergency department (ED) in under six hours[7]	90%	90%	>95%	85%	●
Number of people presenting at ED	80,903	82,403[8]	<80,000	82,467	●

Maternity Services

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

How did we perform?

The number of births in the district continues to be relatively constant with minor variation from year to year. There was a slight decrease in the number of births in DHB facilities in 2018 which may indicate greater uptake of primary birthing options or home births. Breastfeeding rates are also a priority focus and are gradually improving (discussed on Page 23).

Important developments in 2018/19 included commencing implementation of the Southern Primary Maternity System of Care. This rollout saw expansion of the service network to include new primary maternal and child hubs in Wanaka and Te Anau, where previously facilities were not available. The rollout also involved changing the service scope of the Lumsden Maternity Unit to operate as a maternal and child hub, alongside the Wanaka and Te Anau facilities. This programme of work seeks to improve the network of Southern maternity facilities and services for the whole Southern population.

Nationally there are a variety of maternity workforce challenges that are also being experienced in Southern. Workforce availability is one of these; a challenge which is experienced more acutely in rural areas. 18/19 saw the implementation of a Southern

[7] Actuals reflect Q4 performance

[8] Note a reporting error occurred in 2017/18 for the measure "number of people presenting at ED". The updated figure this year is less than previously reported.

rural midwifery sustainability package to help alleviate some of these pressures.

18/19 developments also included the continued implementation of the perineal harm reduction strategy, and partnering with community stakeholders to improve linkages to midwifery services. This included the development of resources to communicate to women and their whānau about the importance of early booking with midwives; performance is incrementally improving in this area.

Finally, improving rural access to specialist services for mothers continues to be a priority and has advanced through the implementation of regular telemedicine clinics in Wanaka and Queenstown. These clinics connect women and whānau with specialist obstetric services. 19/20 sees plans to extend these services in to Central Otago.

2018/19 Performance Results for Maternity Services

Measure		2016	2017	2018		
		Actual	Actual	Target	Actual	
The number of births in the DHB region	Total	3,216	3,312	3,400	3,119	
	Māori	514	517	560	481	
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Total	New Measure	78.1%	>80%	78.9%	●

Reporting for these measures has moved to a calendar year basis for consistency with other maternity reports (in previous years, these measures were reported on a financial-year basis).

Assessment, Treatment and Rehabilitation Services (AT&R)

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

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

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

How did we perform?

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

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

Staffing vacancies for specialised rehab roles did have an impact on patients' length of stay through 2018. These roles have now been successfully recruited to and, although performance has not reached 2017/18 levels, length of stay has been improving in 2019.

The biggest challenge through 2018 was the impact of having to shift the AT&R unit at short notice due to noise from adjacent construction. This resulted in fewer beds which initially negatively impacted on patient flow. When it became apparent the relocation was going to be at least a further 15 months, the team commenced work on redesigning the service. The AT&R unit now operates very successfully with 24 beds, which is eight fewer beds. We are currently embedding these changes which are showing significant improvement in patient outcomes and admission rates to aged residential care.

2018/19 Performance Results for Assessment, Treatment and Rehabilitation Services (AT&R)

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Average length of stay for inpatient AT&R services	<65 years	27.1	21.8	<28.3	25.4	●
	>65 years	17.0	20.2	<18.5	21.2	●
AT&R patients have improved physical functionality on discharge	<65 years	25.2	26.1	>24.2	24.3	●
	>65 years	18.8	18.3	>16.9	19.7	●

Specialist Mental Health Services

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

How did we perform?

Access to specialist mental health services, particularly for young people, is significantly above target levels. Equally, adult services continue to perform well and maintain access levels close to the target, with access for Māori well above target levels. However for young people (younger than 19 years) the timeliness of this service is still challenging with non-urgent wait times progressively lengthening. Although predominantly being held at less than eight weeks, performance is below target levels with nearly 20 per cent of young people not being seen within eight weeks of referral. The number, acuity and complexity of referrals received impact on the responsiveness of services.

Inpatient occupancy averaged 87 per cent across the year but all inpatient areas have found it hard to meet demand at times, often flexing up to close to or over 100 per cent. Average length of stay and readmission rates both sit below the national average.

Difficulties continue with completion of transition plans, and as a consequence we are part of the national HQSC project Connecting Care – Improving Service Transitions to improve our transition planning and move services to best practice. Significant improvement occurred in the last quarter of the year.

Work towards Zero Seclusion has resulted in a slow but steady improvement with use of seclusion reducing over the year.

Retention and recruitment of a specialist workforce has continued to challenge the service.

Following the national Mental Health and Addictions Inquiry, He Ara Oranga signals improving access for people experiencing mild to moderate mental health concerns and improving wellbeing in our community as a priority. In line with this, Southern DHB has also refreshed its strategy, Raise Hope – Hāpai te Tūmanako.

2018/19 Performance Results for Specialist Mental Health Services

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Percentage of young people (0-19 years) accessing specialist mental health services	Total	3.85%	4.30%	>3.75%	4.40%	●
	Māori	3.96%	4.90%	>3.75%	4.90%	●
Percentage of adults (20-64 years) accessing specialist mental health services	Total	3.60%	3.80%	>3.75%	3.70%	●
	Māori	6.93%	7.70%	>5.22%	7.50%	●
The percentage people who have a current transition (discharge) plan (PP7)	Total	85%	30%[9]	>95%	29%	●
Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	<3 weeks	74%	67%	>80%	58%	●
	<8 weeks	88%	84%	>95%	81%	●

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

Output Class: Rehabilitation and Support

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

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

Needs Assessment & Service Coordination

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

How did we perform?

The foundation of our Restorative Model of long term Home & Community Support Services (HCSS) for older people is now well-established with all of those clients receiving either an interRAI Contract Assessment from their HCSS provider if they are non-complex, or an interRAI Home Care Assessment from a DHB or Rural Hospital Clinical Needs Assessor if they are complex.

These assessments identify the older person's needs and 99 per cent of our clients have care plans based on those needs and the client's goals. Services are provided in a flexible manner to meet the clients' needs and goals.

2018/19 Performance Results for Needs Assessment & Service Coordination (NASC)

Measure		2016/17	2017/18	2018/19		
		Actual	Actual	Target	Actual	
Percentage of people ≥ 65 years receiving long-term home support who have a Comprehensive Clinical Assessment and an Individual Care Plan (PP23)	Total	99%	99%	95%	99%	●

Home and Community Support Services

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

How did we perform?

Given our ageing population, it is expected that increasing numbers of older people are requiring supports to maintain their independence in the community. Southern DHB is working to reduce the number of people and the amount of time older people spend in residential care, contributing to higher numbers requiring support in the community.

It is reassuring to know that we now have 82 per cent of our HCSS Support Workers with a Level 2 or greater qualification. Pay Equity legislation has supported this education. Our clients benefit from a well-trained workforce, especially our older people in their homes who have increasing frailty and chronic health conditions.

We have seen an increasing number of older people are seeking support earlier, while they are still classified as non-complex. This gives us an opportunity to prevent or slow down further decline.

2018/19 Performance Results for Home and Community Support Services

Measure		2016/17 Actual	2017/18 Actual	2018/19 Target	2018/19 Actual	
Total number of eligible people aged over 65 years supported by home and community support services (HCSS)	Total	4,287	4,464	>4,400	4,565	●
The percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Total	80%	76%	>80%	82%	●
Percentage of clients receiving home support who are classified as complex	Total	52%	50%	>55%	49%	●

Rehabilitation Services

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

How did we perform?

The WellSouth (Primary Health Network) repurposing of CarePlus funding to CLIC (Client Led Integrated Services) is now implemented in almost half of practices, giving them the opportunity to identify clients who would benefit from a Falls Assessment.

The growth in assessments is an expected result of this rollout. The assessments will have positive benefits as these clients take up measures such as medication reviews and strength and balance programmes to reduce their future falls risk.

2018/19 Performance Results for Age-Related Residential Care

Measure		2016/17 Actual	2017/18 Actual	2018/19 Target	2018/19 Actual	
Number of people assessed by the GP (primary care procedure) for fracture risk using the portal	Total	170[10]	849	>300	2,108	●

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

Age-Related Residential Care

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

How did we perform?

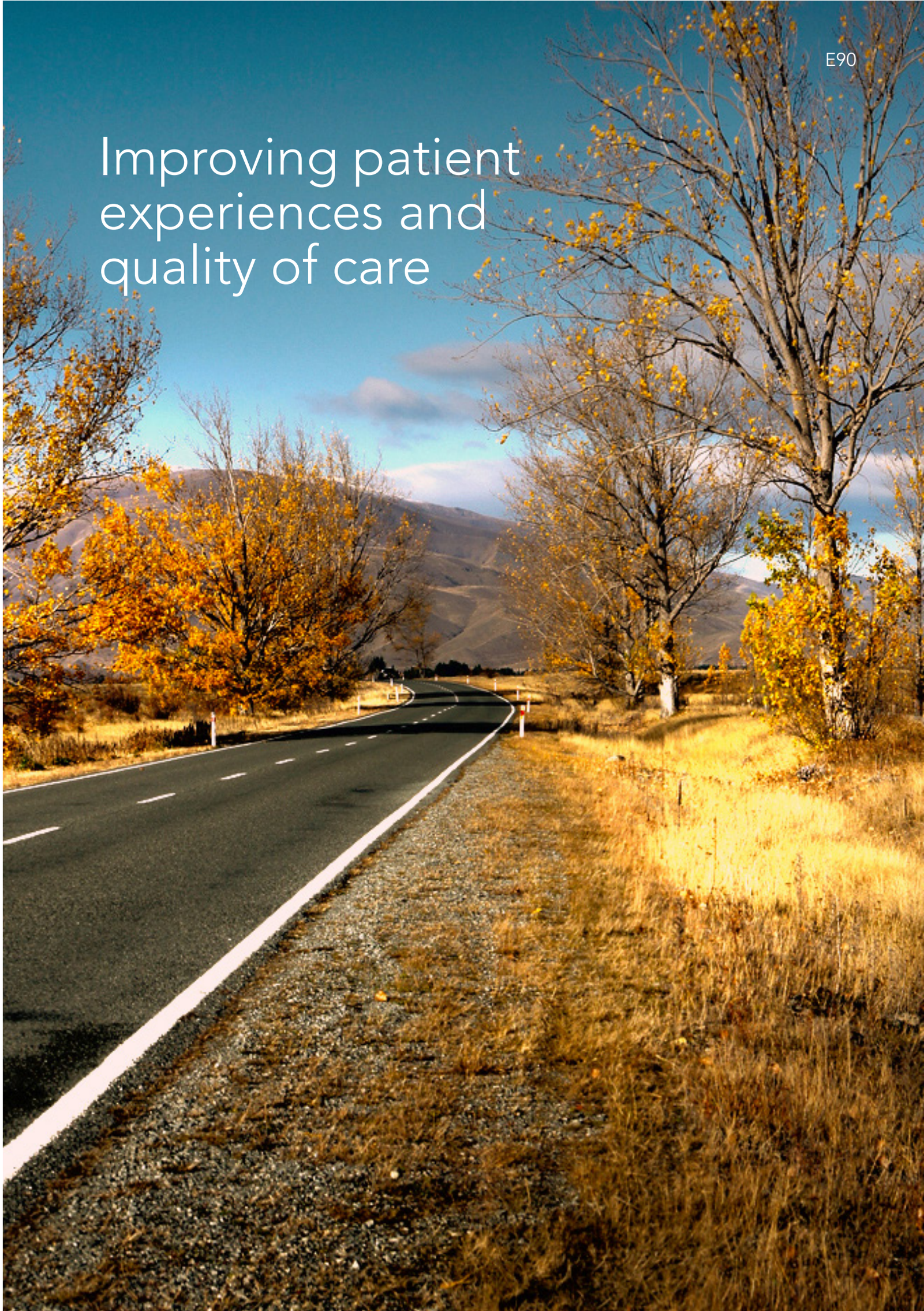
The continued decrease in the rate of rest home level residential care is a success story for the community services at Southern DHB, including our Home and Community Support Services, HOME Team and specialist nursing services. Mostly, however, it is a success story for our older people who are able to Age in Place.

Southern DHB continues to meet or exceed national averages for the percentage of aged care residents who have had an interRAI assessment within six months of admission. This assures us that older people require residential services, and gives those aged residential care services good information for the transition to their care. The residents who are entering care without an interRAI assessment are usually transferring from other services that use different assessments.

Table 17: 2018/19 Performance Results for Age-Related Residential Care

Measure		2016/17 Actual	2017/18 Actual	2018/19 Target	2018/19 Actual	
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	6.94	6.70	<7.0	6.11	●
Percentage of aged care residents who have had an InterRAI assessment within 6 months of admission	Total	New measure	97%	>95%	93%	●

Improving patient experiences and quality of care



Creating an Environment for Good Health

Creating the conditions that support wellness is a core foundation of the Southern health system.

This effort is significantly led by our public health unit, Public Health South, with the aim to improve, promote and protect the health and wellbeing of populations and to reduce inequities. An important aspect of ensuring we are effective in this effort is working within a 'Health in All Policies (HiAP)' approach. A focus this year has been on developing our capacity to influence this context, and exploring ways of working that will maximise our impact to effect change.

Further work is also underway within our hospital network, with a goal of creating a greener health care system. This effort is part of fulfilling our responsibility to support an environment that sustains good health through more sustainable operations within the DHB.

Housing

Warm dry housing is a well-recognised determinant of good health and has been a focal area for the DHB. Research was undertaken on housing in Central Otago District Council (CODC). The findings have been analysed and the draft report is currently being written and will be released in the next reporting period.

We have also worked with numerous community groups and key stakeholders invested in housing to support events and develop resources and information on the health effects from poor quality housing. This has included a Health Pathways housing page to provide General Practitioners with up to date information on what support is available for patients affected by poor quality housing; information on the Southern Health website for consumers and general public to access information on how to maintain a healthy warm and dry home; and communications and media activity including active social media messaging, supporting a wider winter wellness campaign.

Public Health South participated in the Dunedin Mayoral Housing Taskforce through a process led by Community Housing Aotearoa. We participated as part of a forum that included representatives from Government Departments, NGOs, a mental health service provider, the real estate industry, as well as Council's own social housing department. The outcome of this process was the Dunedin Housing Action Plan. Housing issues were looked at on a variety of fronts including homelessness, capability and capacity for increasing housing, affordability, and warmer homes etc. At the time of preparation of this report this plan was supported by Council and funding to implement it was being secured though the 2019-20 Annual Plan process.

Air Quality

Air quality is a significant concern, both for environmental reasons and its negative effects on respiratory health, and Public Health South has participated in numerous projects to address this issue. These include Environment Southland's Breathe Easy project, focusing on high emissions from domestic heating, industry, traffic and outdoor burning that pollute the atmosphere and are noticeably higher in the winter months. The Alexandra Air Fest was a NIWA partnership with Alexandra Primary School aimed at measuring air pollution in Alexandra while also educating the students on air pollution and clean burning. We have also been working with a range of community partners to improve the consistency is messaging about mould removal. In addition, through collaboration with Environment Southland, a health lens was applied to their communications plan on air quality.

To better understand the health impacts relating to air quality, Public Health South is working with WellSouth to obtain GP data for cardiorespiratory visits for the last five years in Alexandra, Cromwell, Clyde, Arrowtown, Milton and Invercargill, while air pollution data has been obtained from Otago Regional Council and Environment Southland, and meteorological data from NIWA research. A report will be prepared in the next reporting period and will include input from councils and NIWA and we are looking at how to facilitate future data exchange.

Submissions

Formal public health advocacy forms a significant part of Public Health South's scope of work. One hundred and twenty proposals that were looking for public input were assessed in 2018-19. Higher profile submissions were lodged on housing, parks and reserves management and transport policy, alcohol restrictions, gambling policy, and smokefree policy. An appraisal of the effectiveness of submissions lodged in 2018-19 indicated that in 49 per cent of opportunities where Public Health South had input, the matters advocated in our submissions were consistent with the decision that was made, with the balance of these opportunities relating to decisions that have yet to be made.

Healthy Food and Drink Policy

This year Southern DHB adopted a Healthy Food and Drink Policy, which was implemented across all food retail sites in the DHB. Artificially sweetened beverages are no longer sold, despite this being permitted in the national policy. Food retailers have been proactive in identifying healthier options for sale and the response to changes has been generally positive. Public Health South will help assess progress with the policy using the National Monitoring Tool.

Becoming Smokefree

Further outcomes towards becoming smokefree are reported in section one of this report (pages 15-47).

Becoming smokefree is a priority aspiration and core preventive health area for Southern DHB, which we are tackling from a number of directions. This year Public Health South collaborated with the Cancer Society to introduce the Fresh Air Project, a five month pilot in 20 hospitality venues across Dunedin, Queenstown and Invercargill. There are now 45 smokefree hospitality venues across the district and surveys showed a high level of support from customers for smokefree outdoor dining.

Smokefree enforcement officers continue their retailer education and compliance checks of 136 tobacco retailers. Five Controlled Purchase Operations were conducted in 72 premises and three sales were made to an underage volunteer. The majority of the premises were located in high deprivation areas.

Public Health South facilitated Dr Mark Wallace-Bell to deliver five presentations to staff from mental health services in Invercargill and Dunedin. The aim was to provide professional development so that staff could improve asking patients about their smoking, the most effective ways to support their quit attempts, and on the use of Nicotine Replacement Therapy. Feedback was very positive with everyone acknowledging that their clinical knowledge had increased and understanding of why it is particularly difficult for mental health service users to stop smoking. There was great interest in the information on vaping and how this harm reduction tool could see mental health service users switch to a less harmful product and reduce smoking on hospital grounds.

Public Health South staff continue to promote the Southern Stop Smoking Service in any promotional work. Clinical areas receive updates on the service on a regular basis via staff training, information to smokefree champions and at staff meetings. The number of referrals to the Southern Stop Smoking Service have increased over the last year. During this time we have encouraged staff to make referrals to the service for smokers unless patients opt off, as opposed to where previously they needed to opt in to be referred.

Period	Number of referrals received from Hospital facilities
01/06/2017-30/06/2018	206
01/07/2018-30/06/2019	373

(This represents Southland, Dunedin, Lakes and rural hospital facilities).

Mental health

Public Health South are contributing to youth resilience building projects through partnering with University of Otago and secondary schools to trial resiliency measurement tools. The application of these tools is being piloted in two Dunedin secondary schools early in July 2019.

An ongoing partnership with Grow, Southern Suicide Prevention and Youthline brought an international expert in Youth Suicide Prevention to Dunedin to deliver a 'Lives Worth Living' training seminar. We are exploring with Grow and other local stakeholders the potential for lived-experience training opportunities in Dunedin.

Public Health South worked with Ministry for Primary Industries (MPI) and Southern Rural Support Trust stakeholders to support and inform the M. Bovis response. This included orientation of new MPI staff on the mental health risks associated with a M. Bovis outbreak on a dairy property. Other supporting work included a contribution to media and print resources and ongoing linkages with community services and contractors. We are now comfortable the resources being applied to a M. Bovis response effectively take into account the mental health risks posed to affected dairy farmers in Southland.

The WorkWell workplace wellbeing programme is well-established across the country and has recently started in the Southern district.

- SDHB currently has two trained WorkWell advisors.
- Bronze accredited workplaces include Sport Southland and Sanford Bluff.
- Enrolled workplaces include Fulton Hogan and Dunedin Casino.
- Two more Otago workplaces are involved in the engage stage and more workplaces across Otago and Southland are regularly being approached.

Breastfeeding

The first 1,000 days of a baby's life is a priority and one aspect is breastfeeding promotion. Due to its importance, we focus on breastfeeding as a specific quality indicator to support children achieve their health and wellbeing potential. Initiatives and outcomes are reported in section one of this report (pages 15-47).

Alcohol Harm Reduction

Several projects are underway, aimed at reducing youth alcohol consumption. Public Health South and Mirror HQ (local youth alcohol and other drugs treatment service) collaborate to facilitate annual workshops for secondary education providers. These encourage and support providers to implement whole school approaches to reducing harm from alcohol and other drugs.

The Good One Party Register also aims to reduce alcohol related trauma. This project, funded by the Health Promotion Agency, is being implemented in Dunedin by a partnership between Otago University Students' Association, NZ Police, the Otago University's Proctor, Red Frogs and PHS. This is a programme in Dunedin where young people having a party can register it on a website. By registering the people having a party are automatically forwarded advice about being a responsible host and what to do should things get out of hand.

The after ball guidelines continue to be used to guide organisers on ways of reducing harm to those attending and this is delivered in partnership with our local police. Since being introduced in Southern most events have implemented restrictions regarding the amount of alcohol available and the opportunities for young people to access alcohol from other sources. Of the 21 known after ball events, 15 engaged with PHS and 14 implemented the recommended drink limit. The 15th has been reducing its drinks limit over time.

Game On! is a programme designed to help support our rugby clubs to stay healthy, reduce alcohol-related harm and continue to attract young people into sport by focusing on performance. Six workshops were delivered this season; four in Dunedin on injury prevention, recovery and concussion and the detrimental effect of alcohol, and two in Waitaki on club legislative requirements, including the development of an alcohol policy. This season has seen one club develop an alcohol policy, bringing our total to 9 out of 11 Dunedin clubs having developed a policy while two policies have been developed in Central Otago. Another Dunedin club that is yet to be reassessed for its accreditation level has no alcohol related sponsorship at their club - a positive step demonstrating that clubs don't need to be reliant on alcohol sponsorship.

Disease outbreak responses

Overall notified disease rates were less in 2018/19 (with 1,382 probable or confirmed cases investigated compared to 1,802 in 2017/18. The burden of enteric disease in our district continues to be predominantly caused by Campylobacter, Cryptosporidium and Salmonella where disease rates per 100,000 p.a. is generally double that of the NZ average rate. While not able to be proven, the rural agricultural nature of the Southern district is the likely to contribute to these high rates.

Pertussis and mumps cases in 2018/19 were significantly reduced from 2017/18 numbers with 60 cases (204 in 2017/18) and three cases (92 in 2017/18) respectively.

There was an outbreak of Neisseria meningitidis declared in August 2018 following a series of cases of Group B meningococcal disease with links to the University of Otago, including four students from residential halls.

Measles outbreak management over the past year has involved prompt contact tracing and isolation precautions helping to reduce or prevent secondary transmission of the illness in the community. Confirmed cases in November included an unvaccinated tourism worker in Milford Sound (likely exposed to an overseas infectious traveller) with secondary spread to another confirmed case and a probable case. A total of 50 contacts were followed up. In February and March two confirmed cases arose in Dunedin that were linked to the Christchurch outbreak – cases included a university student (65 known contacts traced) and a travelling visitor (53 contacts traced). No secondary spread occurred in the community.

Border Health Control Activities

Activities to protect border health involved health protection staff trapping mosquitos throughout the year, and no exotics were encountered. Through the mosquito surveillance, our technical officer found the first specimen of Culiseta novaezealandiae (a rare endemic mosquito) in over 13 years in a ditch outside of Port Otago.

Drinking Water

The annual survey of drinking water suppliers and associated compliance reports for all supplies >100 was completed. Supplies which were non-compliant were notified and discussed with designated officers, management and Drinking Water Assessors. PHS is developing a process of supporting and advising the identified non-compliant supplies to achieve compliance. We are currently refining our PHS Non-Compliant Drinking Water Supply policy and protocol to ensure we have consistent responses to these supplies.

This area continues to be a challenging space as our district has many small supplies that struggle to achieve compliance with the NZ drinking water standards and we have limited capacity to provide the level of advice and support needed.

These challenges have led to the creation of the Southern Joint Working Group for Drinking Water (including eight Territorial Authorities, two regional councils and PHS), which meets to discuss and develop specific actions. These include enhancing communication and information-sharing on issues such as data capture for small supplies, water policy development and disease surveillance reporting. A quality improvement activity undertaken by the drinking water team is to use a risk assessment tool on all networked supplies to enhance our collective knowledge of the profile of drinking water supplies in the Southern district.

There were no identified waterborne disease outbreaks in the Southern district notified to the Ministry of Health.

Recreational Water

Progress was made on developing a system for the management of recreational water across the Southern district. A stakeholders workshop was held in Cromwell, with participation from all Southern local authorities, both regional councils and runaka representatives. A work plan was developed, and will be reviewed in time for a pre-2019/20 bathing season workshop in August 2019.

Health Protection Officer Renee Cubitt with an example of predictive signage that was in use in Southland last summer

A collaborative project has been in place for some years in Southland on the management of recreational water. The group reviewed its signage so as to be predictive and more informative as well as minimising a need for public health action on a situation that could be predicted through rainfall, water flows, bird life or other environmental externality

Sustainability

As Southern DHB looks to transform the way healthcare is delivered throughout the region, a strong focus on environmental sustainability is key to this transformation. The Green Healthcare Steering Group has been integral in sharpening this focus and delivering actions for positive change. One of the most important pieces of work to be developed by the group in the past 12 months was the New Dunedin Hospital Environmentally Sustainable Design Technical Brief.

This brief outlined a vision and direction for a new hospital that will be "energy efficient, with a zero greenhouse gas emission energy supply, linked into low carbon transport, adaptable to cope with impacts of climate change and provide a physical environment that enhances staff productivity and work satisfaction as well as patient wellbeing and safety."

The New Dunedin Hospital project certainly provides an exciting opportunity to provide the Southern district with a carefully considered, environmentally responsible, fit-for-purpose facility. However, work is also being done in the Southern DHB's current workplaces to ensure we continue to make positive changes regularly. Some of these highlights have been:

- A submission by Southern DHB to the Government on the Zero Carbon Bill
- The establishment of a Green Healthcare Sharepoint page as a central staff site for communicating green initiatives
- A network of volunteers known as 'Green Champions' to encourage positive change across all departments, and look for opportunities to minimise waste, reduce, and recycle
- A single-use metal instrument recycling programme – in the first six months of the trialled programme over 110kg of instruments were recycled
- PVC recycling continues to be collected and recycled from multiple locations at Dunedin Hospital.
- Anaesthetists have changed their practice to reduce greenhouse gas emissions associated with the use of anaesthetic gases equivalent to a reduction of 590,000 km driven in a Toyota Corolla in a year. This has also saved over $30,000.

All of these initiatives are worthy of celebration and collectively work toward Southern DHB's goal of an overall three per cent increase in recycling and three per cent reduction in waste.

Primary and Community Care

Since being launched in early 2018, the Southern DHB-WellSouth Primary and Community Strategy and Action Plan has continued to provide a roadmap for the future of services in the Southern district.

Significant progress has been made implementing this programme of work, drawing upon engagement and partnership with health care providers across the district.

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

The roll-out of the Health Care Home model for general practice exceeded expectations from day one, with more practices than expected expressing their interest to join the programme. Since then practices have joined the programme in tranches; in the 2018/19 year a total of nine practices began implementing the programme, covering a wide geographic area (including Dunedin, Invercargill, Gore, Wanaka, Queenstown and Cromwell) a collectively reaching total of around 64,000 patients in the district.

A further tranche, representing six more practices and 56,000 further patients from Oamaru, Dunedin, Balclutha, Invercargill and Alexandra, joined the programme at the beginning of the 2019/20 year. This means that approximately 40 per cent of our population is enrolled in a practice on a journey to becoming a health care home.

The Health Care Home approach to integrated care management is a critical aspect to increasing capacity and primary care to become more flexible and accessible for patients. Initiatives include phone triage (where GPs call scheduled patients, enabling some issues to be resolved in ways that do not involve a face to face consultation), same-day appointments for triaged patients, extended hours, patient portals and proactive care planning for patients with long-term conditions.

In June 2019:

32,899 patients had access to their consultation notes

5,758 patients booked an appointment via a portal

2,058 prescriptions were ordered via a portal

GP phone triage means 40% patients could avoid a face to face visit (Data: February to May 2019).

Community Health Hubs

Along with Health Care Homes, Community Health Hubs are envisaged as a key aspect of a reshaped primary care sector, better enabling case to be delivered in a community setting, closer to a patient's home. The facilities are expected to bring together a mix of general practice and hospital-based healthcare along with some community services, to deliver better-integrated and more accessible health care for the local population. The range of services will vary depending on the needs of the local population but will include a Health Care Home general practice as well as services such as diagnostics - labs or radiology, for example - some outpatient clinics, district nursing services or allied health such as physiotherapy and pharmacy.

This year, a request for information (RFI) was published to the Government Electronic Tendering System

(GETS) calling for information from investors and developers. This generated a good level of interest, with 26 respondents, providing valuable feedback to inform further development of this initiative.

Further work is ongoing to develop principles for models of care, to help determine primary and secondary services that could be successfully delivered from a community based facility.

Locality Network

To ensure that health services are informed by community needs, the Primary and Community Care Strategy includes the formation of Locality Networks across the district. This concept was further developed across the past year, the establishment of a framework and a call for expressions of interest for the first of these networks – the Central Lakes Locality Network (CLLN). The CLLN will provide strategic advice on critical local issues including placement of a primary maternity unit and responses to the area's growing and diverse populations.

Supporting people with long-term conditions (CLIC – Client-led Integrated Care)

A revised approach to supporting patients with long-term conditions is being implemented with the CLIC – Client-led Integrated Care programme. This allows for more flexible, proactive management of high users of the health system, with individualised packages of care. All Care plans are accessible via Health One and planning training has been delivered across the district this calendar year to support the ongoing requirements of the CLIC programme.

Over 3600 patients were registered to the CLIC programme across 46 practices, across the different support categories.

- Level 3 = 19%
- Level 2 =37%
- Level 1 = 42%
- Level 0 = 2%

New whole of system brand and website – southernhealth.nz

The new Southern Health brand and website were launched in June. Southern Health is a new all-in-one website for services in the Southern district, combining information from more than 500 health providers.

Developed in partnership by Southern DHB, WellSouth PHO and the Community Health Council, it will make it easier for people to understand our health system, and find the health services they need.

A new logo was designed as an umbrella brand for everyone providing care in the Southern district, to more clearly identify them as part of a network of quality health providers across the district.

Southern Health
He hauora, he kuru pounamu

The logo represents the golden landscapes of Otago, the greens of Southland, and the Clutha Mata-Au river that – like the health services in our district – reaches from from mountains to the coast. It is underscored by a kiwaha gifted through our kaumatua: He hauora, he kuru pounamu – good health is a great treasure.

Better sharing of data

Better use of technology and sharing of information is key to a safer and more efficient health system.

Work has progressed in this area, including a project to develop ConnectMed as a single district-wide primary and secondary patient portal. A Health Care Homes dashboard is in place, providing a view of core national measures, matching primary and secondary data.

An Outcomes Framework dashboard has also been developed, allowing analysis of a number of key system measures, including outcomes for Māori.

District wide projects are also underway to enable e-prescribing in primary care, and community e-ordering of laboratory requests.

There were 869 virtual health consultations during 2018/19.

Southern HealthPathways

At the end of the 2018/19 year, 628 Pathways were live in Southern DHB, with an average of 29,027 page views per month on the HealthPathways site (compared with 21,967 in 2017/18). With the localisation programme well underway, work was started on the three-yearly review of pathways with 157 of these being completed across a number of specialities. A renewed focus on collaboration saw workgroups established across a range of specialities including rheumatology, podiatry, general surgery, shared care, child health, palliative care, respiratory, public health, laboratories and haematology.

As well as providing greater clarity in the delivery of clinical care, these efforts have supported wider health system priorities. For example, the development and progression of pathways in the areas of Advanced Care Plans, Client-Led Integrated Care (CLIC) and Primary Options for Care (POC) have supported the implementation of new models of care, resulting in care being delivered closer to home for our patients.

Primary maternity

A significant area of focus this year has been the implementation of the Integrated Primary Maternity System of Care. It had long been recognised that the existing system of care was no longer fit for purpose. It was an example of a system that had been configured not as the result of a coordinated plan, but rather the legacy of historic and piecemeal decisions. LMCs were leaving the profession, and the care women received was not equitable across the district; in Southland there were three primary birthing units within around 40 minutes of each other in Gore, Winton and Lumsden, with low volumes of births particularly in Winton and Lumsden, (with Lumsden staffed 24/7 for less than one birth per week); while other areas such as Wanaka and Te Anau had significant population bases, but no formal maternity infrastructure.

The System of Care followed two years of consultation with the community and health care providers, establishing principles for a reformed configuration of services:

- Critical mass – understand population across the district and birthing numbers; meet Ministry of Health birthing population standards; ensure there are sufficient numbers for a viable service and sustainable workforce, supported by a transfer/ transport system
- Equity for disadvantaged communities
- Acceptable travel distances to a facility – in the context of improved support for home birthing, and acknowledging the preference for travel towards secondary care locations.

The Integrated Primary Maternity System of Care aimed to take a holistic view to direct resources differently, and increase the reach of services across the whole district. Maternal and child hubs were created as an additional layer of support in Wanaka, Te Anau and Lumsden to support midwives in those communities, and improve integration with primary care services. Additional 'sustainability' payments were introduced for remote rural midwives, with 21 LMCs across the district taking up this additional remuneration, and around $250,000 in payments made across the year. Midwives' costs were further alleviated, as the DHB invested in paying for room rental, equipment and consumables through the maternal and child hubs, and provided LMCs paid time off, with a roster of back up midwives. Overall, the system of care led to a greater investment in primary maternity services in rural areas than previously.

These changes have gone some way to balancing of a maternity system that continues to be under strain nationally. Five additional midwives commenced or re-entered practice in the Central-Lakes area since making these changes. New initiatives such as 'telehealth' clinics for women who require specialist care, to avoid making the long trip to Dunedin, proved popular, around 45 consultations taking place in Wanaka, quickly exceeding capacity at the clinic.

However, the system of care was strongly opposed in Lumsden, and the transition of the birthing unit to a maternal and child hub in that location was challenging. At approximately one year into our two year implementation timeframe, we commissioned an independent mid-point implementation review, to evaluate our progress and learn from the challenges we faced.

The pressures within primary maternity care are not unique to Southern, and involve many participants, including self-employed LMCs, the Ministry of Health as their funder, as well as the rural trust hospitals, primary care providers and emergency services that support this essential service. The collaboration between these groups that has arisen as we have worked to address the concerns that were expressed represents an important pathway to ensure a sustainable service for our rural communities.

Clinical service design – Valuing Patients' Time

Patients' time is valuable, and over the past year through the Valuing Patients' Time programme we have continued to work on initiatives looking at how we can improve our patients' experience through our hospitals and beyond.

Supported by Francis Health consultants, and underpinned by a clinical governance framework and newly formed Clinical Practice Committee, the programme aims to ensure care is more streamlined with an emphasis on quality and safety.

Sitting alongside the programme are actions in the Primary and Community Strategy that look to provide more timely care through better integration between the primary and secondary care sectors.

The programme is an important priority for the coming years. This is not just about healthcare now, but about healthcare in the future and effectively managing the increasing demands on health services in the most effective and responsible way.

Improving waiting times for elective surgeries

Achieving elective surgery targets and reducing the time patients are waiting for care have been a priority for Southern DHB. Over the past year, a range of initiatives have been implemented aimed at increasing capacity through more efficient theatre utilisation, outplacing surgical work with Southern DHB teams working in private facilities, and outsourcing some operations entirely to the private sector. We also engaged with the Francis Group to further understand how capacity may be increased, and improvements can be made across the wider patient flow challenges in our hospitals.

We are pleased to report that as a result of all these efforts, Southern DHB achieved its target for elective surgery. This occurred despite serious challenges, including the significant disruption faced as we experienced five consecutive strikes from NZRDA members.

The average length of stay on ward 6ATR has **decreased by 8 days** (37%) compared to the same period last year

36 ED bed hours were saved over three days during the Clinical Decision Unit trial

During the Fit2Sit trial 10% more patients left ED within the **6 hour target**

11% more patients were **discharged before midday** during the discharge lounge trial

OPAL unit improves the patient journey

Older patients often require a short admission to the hospital before being medically stable enough to return home. However, after they are admitted they are often transferred between wards and services, and are therefore seen by different doctors, nurses and allied health professionals during their stay. This can lead to adverse outcomes and affect their length of stay.

To address this, a multi-disciplinary team on Ward 6ATR at Dunedin Hospital have successfully trialled and opened an Older Person's Assessment and Liaison Unit (OPAL unit).

In the Emergency Department, patients suitable for the unit are identified (medically stable older people over 75), and as soon as they are admitted to the OPAL Unit they receive a comprehensive geriatric assessment (CGA) by the team caring for them. The team then decides what support and treatment the patient needs, and the best place for them to receive it.

From the Unit, patients are either: discharged home with their existing or an increased support package; discharged home with support from the Home Team, or transferred to a rehabilitation bed if they need continued inpatient care.

"We've improved the patient journey and experience and results show patients are receiving more timely assessments, specialist acute geriatric care and spending less time in hospital."

Emma Grant, Charge Nurse Manager

Following the opening of the OPAL Unit the team are continuing to refine processes to improve the patient experience even further.

Red2Green saves patients' time

One of the ways of making sure our patients' time in hospital is not wasted and they get home sooner is by using the Red2Green approach. This highlights days where progress in a patient's care or towards their discharge – such as diagnostic tests being carried out – is recorded as 'green'. Days where no progress is made are tagged as 'red', with the reasons for this. Red2Green uses a simple visual management system which helps staff to identify wasted time in a patient's journey, and find solutions to resolve any delays and turn those 'red' days 'green.'

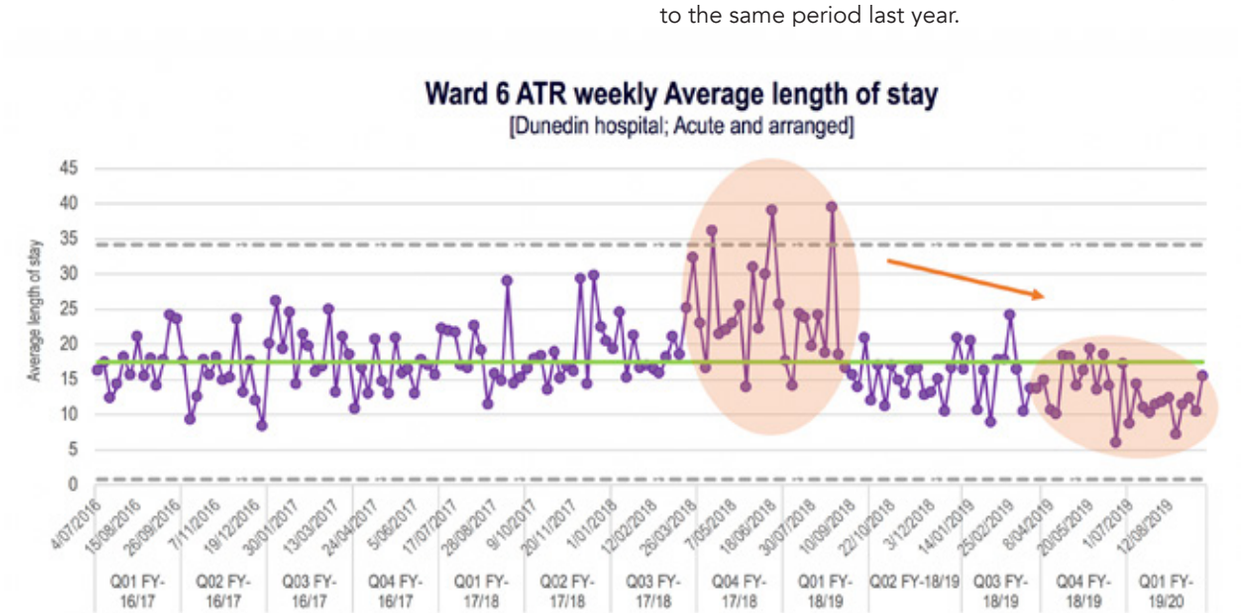
Red2Green has already been successfully rolled out in ward 6ATR, and more recently in 8 Med at Dunedin Hospital. It is planned to roll it out across Dunedin and Southland Hospital wards in the coming months.

Weekend plans keep 6ATR patients motivated

The Red2Green approach has enabled Ward 6ATR to clearly identify causes of delays in their patients' journeys. This included patients not undergoing rehabilitation over the weekends and holidays, which could result in spending more time in hospital.

The 6ATR rehabilitation team have found a way to keep patients motivated and moving over the weekend periods, making weekends and holidays value-added days for our patients. Weekend activity plans are given to patients setting out a list of personalised, patient-identified goals and expectations over the weekend that nursing staff, health-care assistants and family can assist the patient to achieve. They sit at the patient's bedside and are a motivator for the patient to follow in order to assist in achieving their goals and continue rehabilitation over the weekend.

Along with other initiatives by the 6ATR team to value patients' time, the average length of stay of patients on the ward has decreased by 8 days (37%) compared to the same period last year.



Getting Dunedin Hospital Emergency Departments patients home sooner

The Emergency Department team at Dunedin Hospital are putting an end to patients lying in beds or on trolleys when they are well enough to be safely assessed and treated while sitting in a chair.

In early 2019 one bed space in ED was converted into two chair spaces for patients who don't need to be in a bed for treatment for a 'Fit2Sit trial.'

During the trial 94% of Fit2Sit Patients left ED within the 6 Hour Target compared to 84% of non- Fit2Sit patients.

Following this successful trial the number of chair spaces is being increased to eight chairs by late 2019/ early 2020.

"By encouraging patients to sit and remain dressed for the duration of their treatment, it will improve the throughput of patients through ED and release capacity in the acute area."

Janet Andrews, Charge Nurse Manager

Clinical Decision Unit trial saves bed hours

Analysis of Southland Hospital data identified that the assessment of medical patients in the Emergency Department (ED) was a significant contributor to bed blockage in ED during periods of peak demand.

The team wanted to find a more effective way of managing acute patients and unblock the flow of patients through ED while also providing a better patient experience.

In April 2019, a four bedded area in the medical ward was made into a Clinical Decision Unit (CDU) from 10am until 10pm with a dedicated team of nurses and physicians.

By trialling a small scale, short-term model of a CDU, the team were able to identify the potential benefits and understand the additional requirements they would need to be put in place to enable successful implementation of a permanent CDU in the future.

"The trial ran over three days and saved a total of 36 ED bed hours. 75% of patients that were seen in the CDU only spent 15 minutes or less in ED. 100% of patients rated their overall experience in the CDU excellent and the staff found it was a less disruptive environment,"

Dr Prosen Ghosh, Clinical Director – General Medicine

A further trial is planned to run concurrently with the next discharge lounge trial (see below).

Discharge lounge aims to improve patient experience

While a Clinical Decision Unit improves patient experience when they arrive at hospital, Southland Hospital data also showed that the late discharge of medical patients from the ward was a significant contributor to bed blockage in the hospital during periods of peak demand. This in turn can cause long wait times for patients in the Emergency Department (ED).

A small scale trial of a discharge lounge on the Medical Ward helped to identify the likely benefits and potential issues for implementing a permanent discharge lounge concept.

During the trial medical patients ready for discharge, but waiting for transport or discharge summaries, were able to wait in the Discharge Lounge where refreshments, TV and Wi-Fi was available. More patients were discharged before midday than on the ward, and a total of 39 bed hours were freed up in the ward during the trial.

Of the **12 patients** who used the discharge lounge, **75%** were moved to the lounge before midday

The average discharge time from the Medical Ward is 2pm. By discharging **9 patients** before midday, a total of **39 bed hours** were freed up in the ward during the trial.

28% of patients were discharged from the **Medical Ward** before midday during the trial compared to a baseline of **17%**

A further trial is planned to run concurrently with the next Clinical Decision Unit trial (see above).

Less waiting for orthopaedic patients

Patients who previously waited on the ward for surgery are now able to go home to wait for their operation thanks to a new Acute@Home Pathway.

The new pathway values patient time by allowing acute orthopaedic patients who meet a set criteria to stay at home until their operation is scheduled. Eligible patients are given clear instructions about when they should come into hospital for their surgery, and what they need to do to prepare for it.

The Acute@Home Pathway was successfully trialled in conjunction with the trial of a Peri-operative Patient Flow Coordinator role to help to facilitate communication between the patients, wards and theatres. The pathway has now been successfully implemented and the role of Peri-operative Patient Flow Coordinator is being formalised. The team are also looking to see how they can develop a similar pathway for other specialties.

Hospital passport hopes to open the door to better hospital discharge

A 'Hospital Passport' for Southland Hospital medical ward patients is being trialled to help improve discharge communication with patients, and increase the number of before midday discharges.

A Hospital Passport is a guide through a patient's hospital admission, helping them understand the processes, which leads to a stress free, successful discharge. A well-planned return home is important and can decrease chances of readmission and help with recovery.

The passport runs through questions and check boxes such as, 'I know what my medications are for,' and 'Are you able to prepare your meals?'

Patients lead the process and fill in the Passport to the best of their ability with the help and support of nursing, medical and allied health staff.

Following positive feedback a further trial is planned with the aim roll out the Passport in the next few months.

The Home team brings care closer to home

The launch of the Home Team service in Dunedin and Invercargill means more patients are able to be cared for at home rather than in hospital, and those already in hospital who are medically well enough to leave, are be able to continue their recovery at home with ongoing support.

Comprised of nurses, physiotherapists, occupational therapists, social workers and rehabilitation assistants – the Home Team provides appropriate and coordinated support. This enables patients to leave hospital sooner – or not be admitted at all – and to recuperate and recover at home.

The team works with other hospital and community-based healthcare services to ensure the appropriate level of care and therapy is provided, whether in the short or longer-term.

"The Home Team enables patients to go home and still receive the care they need, once they no longer need to be in a hospital. Hospital staff can then be freed up to look after people who are acutely unwell and need more intensive, specialised level of care."

Sally O'Connor, Southern DHB Nursing Director, Strategy, Primary and Community

National bowel screening programme celebrates anniversary at Southern

The Southern DHB's National Bowel Screening Programme marked its first anniversary in April 2019, and is already making a positive difference in the communities we serve.

By the end of June 2019, the programme had detected 100 bowel cancers and identified a further 683 patients with polyps, which can turn into cancer over time. These results show the programme has a significant role to play in reducing the burden of bowel cancer in the Southern district – now and into the future.

The programme has reported consistently high participation rates and levels of community engagement. As at the end of June 2019, overall participation in the Southern DHB programme was at 72 per cent, compared with 63 per cent nationally. Notably, Māori participation sat even higher at 73 per cent, compared with 57 per cent nationally.

It is pleasing to note that Māori participation has equalled or exceeded overall participation every month since the programme began. In fact, we believe the Southern programme has the highest indigenous participation of any national bowel screening programme in the world.

Hearing from our patients

Our Patient Priorities – how are we tracking?

In 2016, Southern DHB undertook an extensive engagement with the community to better understand the priorities of our communities in relation to their experience of care. This generated over 750 pages of feedback from 3500 patients, whānau and colleagues, and led to the seven priorities for patients and whānau outlined below. This process led to a number of programmes of work, aimed at making a difference in these areas, ranging from the Releasing Time to Care initiatives within our wards, to the vision of more integrated care captured in the Primary and Community Care Strategy.

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

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

Results from Patient Survey - 2018

Patient Priorities	Average
1. To listen, communicate more and work in partnership with them	75.6%
2. To be more consistently kind, helpful and positive	60%
3. To protect our patients' dignity and humanity at all times	86.5%
4. To value our patients', whanau and community time	83%
5. To create a calmer, more compassionate experience	60.5%
6. To keep improving the food we provide (Compass Group Survey)	Dunedin: 99.4% Southland: 99% Wakari: 100%
7. To keep listening to and learning from patients and whānau	86.5%

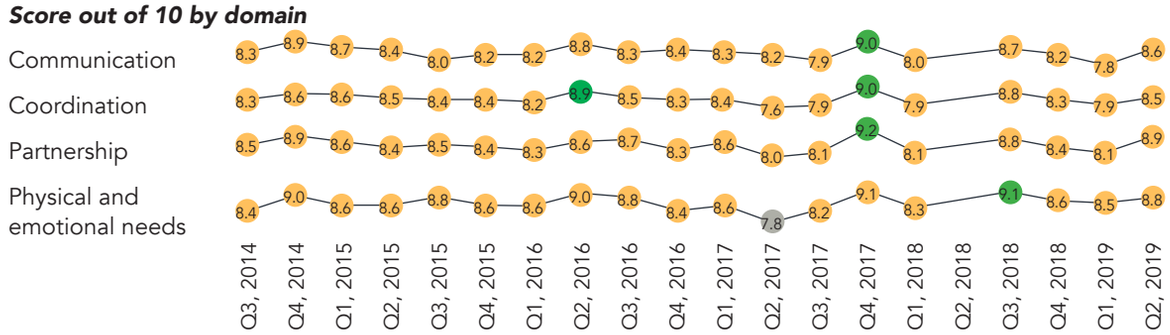
District Patient Survey: Dunedin, Southland, Lakes
May, August 2018
Answered: 1,106

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

Patientexperiencesurvey

Compared with NZ Average

Score out of 10 by domain



About the same as other DHBs
Higher than other DHBs
Lower than other DHBs
No comparison due to low response

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

Community Health Council

Empowering community, whānau and patients

The Community Health Council (CHC) was established as an advisory council for Southern DHB and WellSouth Primary Health Network. The Council brings together people from diverse backgrounds, ages, health and social experiences to give communities, whānau and patients across the Southern district a stronger voice into decision-making.

The CHC now comprises of ten community members from a range of backgrounds and experiences, and a new Chair, Mrs Karen Browne, was appointed in February 2019.

During the 2018/18 period the CHC spent a significant amount of time developing and consulting on the principles of the CHC Community, Whānau and Patient Engagement Framework, founded on three key principles (partnership, participation and protection) from the Treaty of Waitangi. To implement the CHC Framework the CHC established a register to maintain a record of CHC advisors. There are no pre-requisites to become a CHC advisor and members of the public who have experience using the health system and are interested in helping to improve it can complete an expressions of interest form. As of July 2019, there were 70 registered CHC advisors and this continues to grow as more people find out about this work.

The CHC Roadmap outlines the process of how engagement between staff and communities, whānau and patients will occur and is focussed on encouraging stronger engagement at the upper end of the engagement spectrum (collaborating and empowering patients, whānau and communities).

As part of this engagement Framework and Roadmap the CHC has developed resources for staff (Staff Information Pack) and for CHC advisors (CHC Advisor Welcome Pack). All CHC advisors are supported by a CHC member that is connected to them when they are appointed to a project and additionally feedback is collected from advisors and staff throughout the engagement process.

Lessons learnt from this work:

- There is an active willingness from staff to engage and ensure the patient/ whānau voice is included in decision-making.
- There are a lot of people across the Southern district that are willing and knowledgeable about where improvements can be made in the Southern health system.
- Collecting feedback from both staff and CHC advisors is essential to continually improve and make changes with this engagement process.

As well as engagement happening with projects within the health system in February 2019, there was confirmation from the Southern Partnership Group and the SDHB that they would connect onto this process with the new build of the hospital as a way of ensuring the community, whānau and patient voice could be incorporated into the design stages. This is a large project and the CHC will be collecting feedback from CHC advisors and staff throughout this process.

Future Plans

In October 2019, the CHC will host a symposium for all registered CHC advisors in which we will have project teams and advisors sharing their experiences and learnings of working together.

Read more about the Community Health Council in their full annual report which can be found at:

www.southernhealth.nz/community-health-council

Quality Account

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

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

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

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

This section of the report – Improving Patient Experiences and Quality of Care – includes the Serious Adverse Events reported at Southern DHB during 2018/19. It also outlines processes for gaining feedback from our patients and communities, and quality improvement initiatives.

Our performance against the national health targets and other outcome measures identified in our Annual Plan is detailed in the first section of this report: Improving Health Outcomes for our Population (pages 15-47).

Further information about our work to improve quality and patient experiences were outlined in the section of Valuing Patients' Time (page 57). In addition, initiatives to develop an organisational culture based on collaboration and safety – with the goal of continually improving our services to patients – are outlined in the following section of this report: Enabling Success: Organisational Resilience and Sustainability.

Leadership for Quality

The importance of leadership to effective quality systems was identified in the reshaping of the Executive Leadership Team in 2017, with the creation of a new role of Executive Director Quality and Clinical Governance Solutions. In 2018, Gail Thomson was appointed to this position, to work with the Clinical Council and the Executive Leadership Team to drive clinical quality and innovation within our Southern Health system.

Under her leadership, a new Quality and Clinical Governance directorate has been formed, pulling together many roles collectively focussed on learning from and improving patient safety, patient experience and outcomes. Key functions support consumer engagement, improving quality, reducing clinical risk and helping to foster an environment in which clinical care can flourish.

The team works with the services across primary, community and secondary to improve systems and processes that reduce waste such as delays. We look at feedback from patients to understand what matters to our community and make changes for the better. We embed changes through initiatives such health pathways, procedures and policies so that they become the new ways of working.

A focus for the new directorate is to review and redevelop a quality framework for the DHB, emphasising clinical governance and clarifying accountabilities and relationships at all levels of the organisation – from those involved in the 'care encounter' through to board governance. Immediate priorities have included reviewing the role and function of the Clinical Council, and establishing a new Clinical Practice Committee.

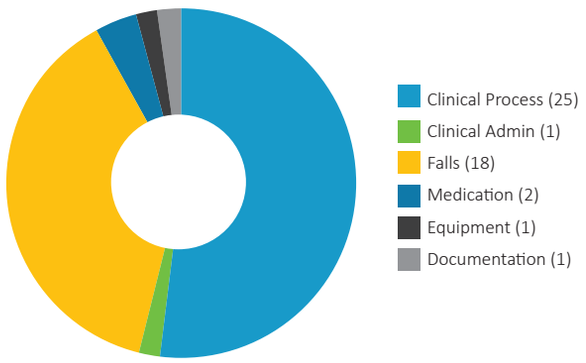
What have we learned from our adverse events - Severity Assessment Code (SAC) level 1 and 2?

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

In the 2018/19 year, there were 66 events that were classified SAC 1 and 2 at Southern DHB. As in previous years, these are subject to a national annual release, with an annual report titled Making our health and disability services safer, which is to be released in December.

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

What were the main groups of Adverse Events in 2018/19?



As indicated by the graph, the largest group of serious adverse events classified as SAC levels 1 and 2 relates to clinical processes at 52 per cent (assessment, diagnosis, treatment, general care), followed by falls at 38 per cent (serious harm from falls, for example a broken hip), medication error at four per cent (dispensing, prescribing or administration of medications) and clinical administration at two per cent (handover, referral, discharge, resources/ organisation). This year we have seen a decrease in Adverse Events SAC 1 and 2 reported in Southern DHB.

We have provided a summary of the main harms within these categories, as well as the work that is underway or planned to prevent similar events in occurring in the future.

In addition, further programmes are underway to support quality areas that may not have resulted in adverse events, but are nonetheless important as part of our ongoing efforts to improve quality and safety. In particular, these relate to improving processes to avoid errors during medical imaging; and reducing health-care acquired infections, such as surgical-site infections.

Clinical Processes

Pressure Injury Prevention Programme

With the support of ACC, Southern DHB has been leading a whole of sector work programme across the southern district which aims to reduce pressure injury harm and promote a pressure injury culture.

A Pressure Injury Prevention Coordinator role was established at the end of October 2018 to guide the programme and a sector wide Pressure Injury Prevention Governance Group including consumer representation is providing programme leadership and oversight.

There has been wide engagement across the sector to establish important baseline pressure injury prevention information—including the development of a detailed pressure reporting dashboard of key indictors to monitor the effectiveness of improvement initiatives.

A comprehensive Project Charter (Project Plan) documents 37 Improvement Actions to be implemented over the next 18 months. The current focus of the Pressure Injury Prevention Programme is to expand the availability and utilisation of information/resources specifically designed for people at risk of and those caring for people at risk of developing pressure injuries and develop and implement a pressure injury prevention module across SDHB provided services by the end of 2019. This module will also be tailored to the needs of the wider sector and rolled out to age residential care and community services. Planning is also underway for pressure injury prevention to be incorporated as part of the SDHB mandatory staff training programme commencing January 2020.

Recognition and Response – Deteriorating Patients

Whilst monitoring our Adverse Events we identified a significant patient safety concern with three Adverse Events at the SAC 1 and 2 level that highlight a delay in the recognition and response to a patient's condition deteriorating. Early in the 18/19 year, the work we had commenced the previous year continued, revitalising the existing Early Warning Scoring (EWS) and Response systems. This transitioned into the Health Quality & Safety Commission (HQSC) National improvement programme where all hospitals are required to implement improvements to their recognition and response systems for adult patients. Key focus areas for this work have been:

- adopting the national vital signs chart
- agreeing on localised escalation of concern pathways.

As part of implementing the Recognition and Response programme, significant consultation has occurred on both the Otago and Southland sites. During this consultation staff told us there was a particular need for improvement in our systems relating to out of hours staffing/expertise. As a consequence, the Clinical Team Coordinator (CTC) model has been implemented. The CTCs are senior registered nurses available to support and guide clinical teams to manage their acutely unwell and deteriorating patients. The role is part of the new mandatory escalation pathway and assists ward nurses to initiate and implement appropriate escalation of care. CTC nurses attend medical emergencies and play a pivotal role in embedding the improvements in response as part of the implementation of the new national observation charts.

Dunedin Hospital "went live" with the new chart and system on 17 June 2019 with Southland "go-live" 30 September 2019. This has included the implementation of the National EWS observation chart and the improved DHB response systems. The programme of work will continue with the Wakari site due to transition later in 2019/early 2020. Some

rural sites have also commenced or completed work in this area. We will review this in 2020 to ensure good alignment with how deteriorating patients are managed during transition from rural facilities to secondary/tertiary Hospitals. Maternity is participating in the national programme underway for a standardised maternity vital signs chart.

Falls

Our rate of serious falls has risen in the last two years. It is known that our hospital patients are generally increasing in their acuity and therefore their vulnerability to falls. Due to the complex needs of the patients in our care we are working on preventative analyses. This includes identifying the high risk patients early, as well as assessing trends in time of day and associated activities when falls occur. Findings from these analyses have led to changes such as the piloting of additional resource to undertake more frequent checking of our at-risk patients (for example, those awake and disoriented in the early hours of the morning).

We continue to aim for zero falls. There is a detailed programme of work underway in the 19/20 financial year, with a focus on patient assessment and care planning in a more streamlined way.

Medication

Southern DHB reports two medication events at the SAC 1 and 2 level this year. Further reporting of SAC 3 and 4 (moderate/minor/minimal harm) highlights the fact that medication errors continue to be a problem particularly in the administration of medication. It is recognised that this is an international and national challenge and we are working with the medication safety staff of Health Quality and Safety Commission (HQSC) and Accident Compensation Commission (ACC) to identify any further improvements we could put in place. This includes:

- A programme of work with ACC linked with HQSC to look at a cluster review of medication incidents to see if we can identify common themes which we can use as further opportunities for improvement. ACC are carrying out a comprehensive literature review to identify the most current best-practice medication safety evidence specifically in relation to medication administration.
- Our Medication and Administration Policy procedures and guidelines are in line with national medication safety best practice. However we are further reviewing these to ensure that the best possible education and training is in place.

Enabling success: Organisational resilience and sustainability

Enabling People and Systems

Enabling our people

Workforce strategy

A focal area this year has been the development of a Workforce Strategy, to meet the needs of a transforming health system. The goal of the strategy is to create a sustainable and contemporary workforce by developing workforce capacity and capabilities, as well as improving workplace culture. Importantly, the Workforce Strategy and Action Plan have been written for the Southern health system, not for Southern DHB. It recognises that in a changing health environment, long-term planning for the health workforce needs to outlive any changes in organisational structure, service delivery or delivery location and encompass both primary and secondary care. The action plan reflects the need to take clear steps forward while managing current funding limitations and changes in care delivery models by identifying resources required, and prioritising actions.

The strategy is based around four focus areas:

- Workforce planning including priority workforce and clinical leadership
- Workforce diversity and inclusion
- Workforce enablers
- Workforce data and intelligence.

These have led to the following strategic goals that are supported by a range of actions and integrated into other strategic documents including the Primary and Community Care Strategy and the Digital Strategy.

Workforce Strategic Goals

WS G1	Interprofessional/Integrated Agency Care
WS G2	People Planning
WS G3	Making Changes Stick/Accountability
WS G4	Leadership and Change
WS G5	High Valued Staff
WS G6	People Partnership

Southern Future

Strengthening our culture

The Southern Future programme has gone from strength-to-strength over the past year, with significant momentum gained in supporting our staff to feel safe to speak up in the workplace. While we continue to build a strong and positive internal culture, the programme has also been focusing on listening, acknowledging and celebrating our incredible staff.

Speak Up Supporters

The Speak Up Supporters programme has been successfully running for over a year, with 50 trained individuals available across the organisation to support staff with any workplace concerns.

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

This work continues to be supported by the Speak Up Programme – building a culture that supports high trust, professional behaviour and accountability, and where staff are empowered to speak up. Over 2500 of our staff have completed this programme to date!

Staff Engagement Survey

Providing a positive and supportive workplace is the foundation of Southern Future and fundamental to strengthening our organisational culture. One of the many ways we engage with our staff is through the annual Staff Engagement Survey – a safe and anonymous platform for staff to provide feedback about their workplace experiences.

The 2018 Staff Engagement Survey had a 50% participation rate (2234 staff), with feedback confirming our four organisational priorities have improved significantly since the 2017 survey.

Four organisational priorities

1. **Leaders communicate well, so I always know what's going on**
   2017: 37% positive **2018:** 45.6% positive
2. **In the last twelve months I have been subjected to bullying behaviour in my workplace**
   2017: 55% positive **2018:** 50.5% positive
3. **Staff performance problems are identified**
   2017: 42% positive **2018:** 53% positive
4. **I have the equipment and supplies I need to do my job properly**
   2017: 56% positive **2018:** 67.6% positive

There has been some excellent progress over the past year, and Southern DHB is committed to continuing this.

Celebrating our staff

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

Southern DHB awards celebrate outstanding staff

From breaking medical boundaries to the unsung heroes behind the scenes – Southern DHB celebrated some of its remarkable staff from across the district at the first ever Southern Excellence Awards in October 2018.

Held simultaneously in the Otago Polytechnic Hub in Dunedin and Bill Richardson Transport Museum in Southland, the Awards evening was established to recognise the diverse ways in which excellence is reflected across Southern DHB.

"With over 4000 staff, we know there's incredible innovations and achievements, acts of kindness and staff constantly going above and beyond the call of duty," says Southern DHB Chief Executive, Chris Fleming.

"The Awards are about acknowledging staff and the very important roles they play in providing care and support across the southern health system."

Nine categories have been established to represent the diversity in healthcare delivery and services including the Unsung Hero (Behind the Scenes) Award, which recognised Southland Hospital Mortuary Technician, Bill Little, for his dedication to the role.

Southern DHB will host the Southern Excellence Awards annually to "continue recognising our staff's accomplishments", says Mr. Fleming. "From the small wins to the big triumphs - it's important to celebrate them all."

Southland Hospital Mortuary Technician Bill Little with Deputy Commissioner Richard Thomson

Living our values

Photo competition brings values to life

An internal photo competition calling for photos representing our values (Kind, Open, Positive and Community) and celebrating Southern proved to be a great success.

Budding staff photographers sent through some beautiful images ranging from landscapes of the Southern region to special moments capturing our staff and patients.

The competition was a wonderful example of what our values mean to our staff and how they are positively interpreted throughout the organisation.

Photo by Rosemary Diehl, Registered Nurse

Photo by Aisling Halliday, GP Registrar

Staff innovation celebrated

Southern DHB's Innovation Challenge continues to support ideas brought forward by staff, with 33 entries in 2018.

First place was awarded to Healthcare New Zealand Community Health for their proposal of a feasibility study into the prospect of establishing community care cottages for people living with dementia in Central Otago.

Other successful entries include:

- **Chief Executive Officer Award: Virtual Health Clinics in Dunedin's Antidote Pharmacies**
  This pilot programme involves the installation of virtual health assessment booths in all six Antidote pharmacies across Dunedin, linking directly to Maihealth, a cloud-based health service run by Dr Lance O'Sullivan.
- **Patient Priority Award: Dunedin Hospital Clinical Skills Lab**
  A fit-for-purpose remodel of seminar rooms will establish a realistic single ward bed environment to facilitate simulation teaching.
- **Staff Priority Award: Strengthening partnerships in a clinical setting**
  A range of resources will be developed and delivered to support productive and collaborative working relationships between healthcare staff within the wider Southern DHB and its partners.
- **Community Priority Award: Video tools informing patients of invasive examinations**
  The Southland Radiology Department will produce a series of videos about common diagnostic procedures, including scans by ultrasound, CT and MRI, for patients to watch ahead of their scheduled appointments.

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

The Southern Innovation Challenge winners back row from left: Chin Nan loh, Sam Shaw, Jane Craig-Pearson. Front row from left: Virginia McCall, Vanessa Pullan

Good Employer Obligations Report

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

Southern DHB aims to uphold the highest level of integrity and ethical standards in everything we do. We are committed to the principles of natural justice, value all employees and treat them with respect.

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

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

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

Our values

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

EEO

Our Equal Employment Opportunities Policy was updated in 2018 and is due for review in 2021.

Leadership, accountability and culture

Investing in leadership has continued to be a significant priority for Southern DHB over the past year with the aim of strengthening our emphasis on strategic priorities, organisational culture, quality and decision-making. The ongoing investment in the Southern Future programme of work reflects the importance placed on leadership development, including the Leadership Exploration and Development programme – designed to empower leaders that champion health and positive workplace culture and have great potential for sustainable leadership.

Southern DHB takes its accountability to the community seriously, and has been developing stronger processes for understanding community needs and reporting back to them on our performance. These include the ongoing work of the Community Health Council and the appointment of Community, Whānau and Patient Advisors, who have been working with healthcare teams and managers to help shape our health services. Other actions include public forums, community consultation processes and inviting members of the public to ask questions directly to the Commissioner team at public sessions of their meetings. Further initiatives are outlined in the previous section of this report, Improving Patient Experiences and Quality of Care (page 49).

Recruitment, selection and induction

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

The Southern DHB Recruitment team also partner with managers to identify suitable and potential candidates for all key areas. Managers are offered training on best practice recruitment and selection practices as part of Southern DHB's wider Learning and Development Strategic Framework and Mandatory training programmes .Various targeted recruitment drives have been undertaken to ensure profession gaps are minimal and to lessen the impact on services.

Our orientation process for onboarding new staff members was reviewed and changed at the beginning of 2017. We welcome new employees with a Mihi, meet and greet and morning tea with members of the Executive, Senior Leadership Team and the employee's line manager, followed by a presentation by the CEO. Service inductions to the area the new employee is employed is carried out with a checklist of jobs to complete within the first six weeks of employment, including online learning modules.

Employee development, promotion and exit

Performance and development processes are in place for a multitude of professional groups. Processes are currently being reviewed to ensure strategic alignment across Southern DHB and ensure that all employees have annual performance and development discussions. Leadership is developed through initiatives such as the Leadership Exploration and Development @ Southern programme (LEADS).

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

Remuneration, recognition and conditions

A market-based model of job evaluation is in place for all staff on Independent Employee Agreements i.e. staff who do not fall under the ambit of a Collective Agreement. This approach provides market information against which Southern DHB can benchmark its market competitiveness and supports the attraction and retention of experienced employees. A long-service recognition programme acknowledges employees whose continuous service to Southern DHB is greater than 10 years.

Southern DHB also launched the 'Southern Excellence Awards' in 2018 (see page 69). These Awards recognise the outstanding contribution of our staff in nine different categories of leadership and improvement. The winners are announced at an awards evening, held annually.

Harassment and bullying prevention programme

Our harassment and bullying policy aims to promote and support behaviour that reflects our organisational values, and addressing issues effectively and quickly at the lowest possible level. It is supported by the 'Speak Up' Campaign, aimed at creating a culture where it is safe to highlight concerns, and through investing in training managers and HR professionals in both bullying prevention, management and investigation. Following on from this programme of work, the Speak Up Supporters initiative has been successfully running for over a year, with 50 trained individuals available across the organisation to support staff with any workplace concerns (see page 69).

Safe and healthy environment

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

Current practices include:

- more than 160 elected health and safety representatives in place across Southern DHB's operation
- critical risks are identified and risk reviews are underway to identify the efficacy of current controls and potential improvements
- Safety1st is established as South Island-wide incident and near-miss reporting mechanism
- tertiary accreditation and an active ACC partnership programme is in place

Health, Safety and Welfare Governance structure in place to ensure compliance with relevant legislation.

- a 24/7 employee assistance programme is available to all staff for both personal counselling and critical incident debriefing.

Employee demographics*

The Southern DHB currently employs 4,858 employees across Otago, Southland and Central Otago. 21.7 per cent of our employee base is male; 78.3 per cent are female.

There is 51.0 per cent male and 49.0 per cent female junior medical staff, and at a senior medical level female representation is 37.6 per cent of the workforce.

The nursing profession comprises 12.9 per cent male employees, whilst midwifery remains 100 per cent female. Service support staff, such as drivers, trades, security staff, are predominantly male (91.8 per cent).

Of the 4,617 employees who detailed their ethnicity, 217 (4.7 per cent) identify as Māori or Pacific.

New Zealand European/Pakeha employees represent 63.9 per cent of our employee population, which includes a total of 44 different ethnicities. Southern DHB is committed to ensuring equal employment opportunities and is continuing to look at ways to improve diversity across all levels of the organisation.

Employees with disabilities

Historically, Southern DHB has not recorded details of staff with disabilities. To address this area, in 2016 the Employee Contact Details Form was revised and now asks new employees if they identify as having a disability. As this data set develops we will gain more information to aid in ensuring Southern DHB is an equal opportunity employer. Currently 11 employees have identified themselves as having a disability.

Future workforce

We value our relationships with education providers, in particular the University of Otago, Otago Polytechnic and Southland Institute of Technology, and every year welcome students on placements. We are now reporting this in recognition of the importance of developing our future workforce.

Profession	Student placements
Registered nursing	479
Enrolled nursing	57
Midwifery	48
Medicine undergraduate	210
Medicine postgraduate (includes registrars in training)	304
Physiotherapy	183
Occupational therapy	32
Dietetics	35
Social work	7
Speech language therapy	2
Medical physics	2
Public health	2
Audiology	2
Clinical psychology	10
Oral health	5
Medical imaging	47
Radiation therapy	8
Physiology	3
Anaesthetic technicians	8
Paramedics	4
Pharmacy	14
Grand total students	**1,462**

Southern DHB employee demographics

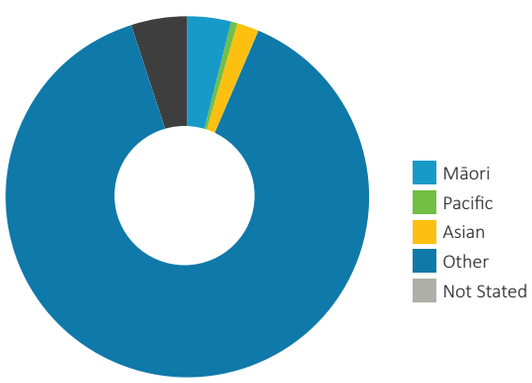
Age of Employees	Male	Female	% of Employees identified as Māori/Pacific
0-19	0.04%	0.16%	0.46%
20-29	3.25%	12.06%	20.28%
30-39	5.60%	17.15%	20.28%
40-49	4.63%	16.41%	25.35%
50-59	4.41%	19.49%	23.04%
60-69	3.29%	12.47%	9.68%
70-79	0.41%	0.60%	0.92%
80+	0.02%	0.00%	0.00%
Grand Total	21.66%	78.34%	4.47%
Total employees			**4858**

*Data correct as at 30 June 2019

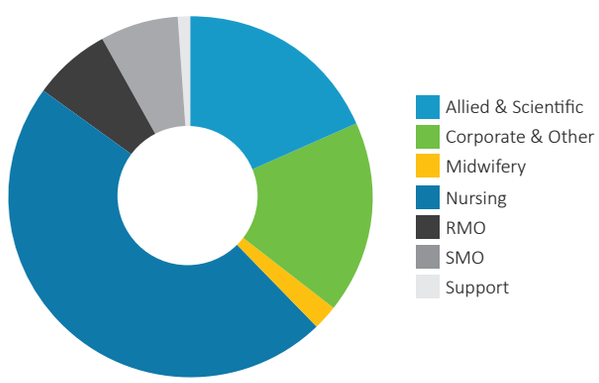
Southern DHB employee demographics

Occupational Group	Sex	Grand Total	Māori	Pacific	Asian	Other	Not Stated
Allied & Scientific	F	737	33		9	667	28
	M	163	10	1	4	136	12
Corporate & other	F	685	23	1	10	609	42
	M	151	9	1	1	136	4
Midwifery	F	108	5			97	6
	M	0					
Nursing	F	1980	93	7	22	1764	94
	M	310	12	3	3	275	17
RMO	F	164	3	3	19	134	5
	M	171	1	3	20	139	8
SMO	F	128	1		2	118	7
	M	212	4	2	10	179	17
Support	F	4				4	
	M	45	1	1		42	1
Grand Total		4858	195	22	100	4300	241

Ethnicity



Occupational Group



Systems that enable our people

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

Over the past year, this work has taken a step further, with the development of digital and workforce strategies finalised this year.

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

They build on the initiatives and priorities already underway.

Digital strategy

Extending, enabling, and supporting our people remains central to the Southern DHB's actions and strategies. Robust, future-facing business and IT systems are an important element to this – indeed one of the highest priorities identified in the Staff Engagement Survey was staff feeling they had the tools they needed to do their jobs.

Over the past year the development of the Southern Health Digital Strategy has laid a pathway to sustainable solutions that will transform the way we deliver healthcare for our community. This is a plan that describes our vision and goals to improve our digital capabilities, and provides long-term planning for our digital health system. This strategy sits within a broader suite of strategic documents: in particular the Primary and Community Care Strategy and Action Plan that envisages a more technology-enabled future, the new Dunedin Hospital project and our aspirations to develop a 'digital hospital'. Collectively, these strategies provide a comprehensive overview of our direction of travel over the next 5-10 years as a health system, and the digital strategy serves to enable this. At its core is the goal of enabling the people of Southern Health to achieve better health, better lives, and whānau ora through digital solutions.

The strategy is underpinned by four key goals:

- Enable people via new technologies
- Improve the way we share data and information
- Modernise and strengthen systems that run our applications
- Keep it simple, remove duplication.

The establishment of an Information Technology Governance group, a plan for enhancing analytics for digital insights, and further technology workshops are some of the action points to be enacted in the first phase of the Southern Health Digital Strategy in the coming months.

IT projects

Over the past 12 months a number of significant Information Technology developments enhanced the way we are able to provide care for our community. These ranged from centralising our phone systems across all Southern DHB sites, through to an improved video conference service, which has allowed for better integration with primary care providers.

This year the successful pilot of the Tap 2 Go system has meant that with a simple tap of their security card, clinical staff are able to transfer patient data between devices quickly and easily. Some key benefits of the Tap 2 Go system are the protection of patient data and safety, and also improved efficiency, with the removal of manual logins and the ability for staff to bring up patient notes securely from anywhere in the hospital. The positive feedback from the trial in Ward 8C will now see in a phase of rolling out the system across the organisation.

Improving the patient experience is at the heart of many of our IT initiatives, and this year's delivery of free Wifi services for all patients inside our hospitals was an example of this. Alongside this, Wifi services and security were strengthened greatly, with planning underway for further upgrading of Wifi capability.

An improvement for communication with staff and patients was reached with the implementation of a new digital signage system. Nine new screens were added across Southern DHB sites to share messages efficiently and raise the visibility of important events, notices, and alerts. The new screens were repurposed from the University of Otago, supporting sustainability and efficiency.

A further example of this ideal in action was the new Security Information and Emergency Management service, which was added at zero cost this year. This allows our IT service staff to monitor all the data that traverses across our entire network. From here they can closely analyse the traffic for potentially concerning security patterns, to enhance the security and efficiency of all staff working across the Southern district.

Central to all our IT initiatives and improvements the core value of Enabling People, and this value was embodied in the completion of the IT services Mentorship Programme. This has seen four new Service Desk staff inducted, as well as junior staff brought alongside senior roles who have provided on-the-job training and rich opportunities to accelerate learning and experience.

This value has also been seen in action with the establishment of an IT Manager for the ICU, Surgery and ED services, specifically set up to gain a better understanding of the challenges and needs clinical staff face every day.

This model of enablement and improved communication extends right across the Southern district: this year IT Services have also significantly strengthened relationships with rural hospitals, with Memoranda of Understanding in development with Dunstan and Oamaru hospitals.

Facilities for the Future

Ensuring we have the right facilities to deliver our health services continues to a matter of great public and staff importance, impacting both our day to day work environment and patient care, as well as informing discussions about models of care and how the Southern health system may be configured in the future.

New Dunedin Hospital

Progress on the New Dunedin Hospital project has accelerated rapidly over the last 12 months. The site masterplan was released, and it has been confirmed that the hospital will be split across two joined buildings; the Acute Services Building and the Ambulatory Services Centre.

The site masterplan marked an important step in the project, which laid out a vision for how the buildings can become a significant landmark for Dunedin that supports the city's long-standing relationship with health and health education.

It was also announced that the fast–tracking of the Ambulatory Services Centre would be going ahead, with an expected first stage opening in November 2023. One of the key decisions behind accelerating this part of the project is so that Dunedin Hospital can function more safely and effectively for patients and staff as soon as practicable. By speeding up the process and building this part first, day surgery can be moved to this new building. This will both improve services for these patients and free up capacity across the existing hospital.

Engagement with staff and the wider community has continued to ensure the new facility meets the health needs of the Southern district and adapts to new models of care. Approximately 45 Facilities in Transformation (FiT) Groups have been established to represent the wide scope of the project and give voice to Southern DHB staff, and community experts. These have included participation from around 400 staff and 30 community members.

By the end of the 2018/19 year, the New Dunedin Hospital project was moving towards signing off the Concept Design phase for the Ambulatory Services Centre. This phase focuses on showing how physical spaces and clinical departments will interact, and how staff and patients will flow within the allocated space.

The Concept Design phase for the Acute Services Building is expected to be completed by November 2019. Dialogue, collaboration, and opportunities to shape the project will continue to grow after the Concept Design is signed off and the project moves further towards more detailed design.

Initial estimates are that over 1000 workers will be needed on-site at the peak of construction. International market sounding meetings were held in July to proactively engage with the construction sector. The project was positively received by a number of large, well-established, and experienced construction firms, including international companies. Many expressed great interest in partnering with New Zealand companies to deliver on the many and varied contracts that will be needed throughout the build.

We have sought heritage advice on the existing site buildings. It has been announced that the existing Dairy Building will be retained to acknowledge the site's history, and options are being considered for how it might be adapted and used within the New Dunedin Hospital Project.

In the meantime, geotechnical investigations of the site continue, architects will be engaged, and a strategy will be created for the large and complex demolition of the Cadbury and Wilson sites, which is set to begin in early 2020.

Where are we now?

01 Indicative Business Case

Revealed poor state of current hospital buildings, confirmed need to build a new hospital, sought approval to develop a detailed business case for a new hospital.

02 Detailed Business Case

Key activities: Appointing consultant team, developing hospital specifications and project plan.

03 Implementation Business Case

Key activities: Confirming strategic and economic cases, agreeing architects, engineers and other specialists, detailing management arrangements.

04 Design

Key activities: Concept design, preliminary design, developed design, detailed design.

05 Construction

Key activities: Site preparation, progressing the build, monitoring and quality evaluation, staff training.

06 Fitout

Key activities: Buying and installing equipment, furniture and fixtures.

07 Handover

Key activities: Completion, commissioning new hospital.

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Southland Study Hub

The development of the University of Otago's new $1.5 million study hub at Southland Hospital was carried out across 2018/19, with the new facility officially opened in August 2019. The 443 square metre Division of Health Sciences study hub developed by the University of Otago to support the many students and teaching staff at the hospital, enable more local research, and enhance relationships with the community.

The study hub is a tremendous addition to Southern DHB's $2.5 million Clinical Education and Skills Centre.

The development of the study hub will encourage more collaboration between the University and the Southern DHB in training and research, and help to continue building strong connections between medical students and the medical professionals of the Southland Hospital. This will have far reaching benefits for the improvement of education in the region, and ultimately for achieving the best possible outcomes for patients.

Lakes Hospital Redevelopment

Significant progress was made this year in the upgrade of Lakes District Hospital to focus on its role in providing emergency care, diagnostic and transfers as part of a wider health system. The first stage of the Emergency Department expansion opened in May, with increased bed numbers, a negative-pressure isolation room, an additional resuscitation room, and two state-of-the-art resuscitation areas with the latest medical equipment and monitoring technology. Staff and patients are enjoying the benefits of this lighter, more open, purpose-built facility.

There is also dedicated heliport access and new St John ambulance entrance for much easier access and patient flow.

Stage 2 of the ED project will continue the trajectory towards better experiences for patients and advanced models of care. Its scope will include a 10th bed, a waiting area, an emergency shower, a triage office,

and offices for the charge nurse and student doctors. Altogether the expanded Emergency Department will more than double the capacity of the previous department.

Lakes District Hospital's brand new CT scanner was installed adjacent to the new Emergency Department, and was quickly put to good, and frequent, use.

The state-of-the-art CT scanner is only the second of its kind in New Zealand, and the first in a public hospital. It was generously funded by a Central Lakes Trust grant to the Lakes District Hospital Foundation, and the staff using it are seeing its benefits. Fractures requiring a CT are now being imaged at Lakes District Hospital prior to surgery, which is helpful for surgery planning and avoiding delays in Southland.

Te Puna Wai Ora – Critical Care Unit

The first stage of the Te Puna Wai Ora Critical Care Unit was completed in March, and has transformed the experience for patients and staff. With 12 intensive care bed spaces, open lines of sight, state-of-the-art staff facilities, improved lighting, the first stage opening has been a huge success.

The principle of putting patients first has been embedded throughout the refurbishment, with more bedside space for whānau being allocated, and a much quieter environment for critical care patients' comfort.

Stage two of the refurbishment is well under way, and is set to include staff meeting rooms and education spaces, as well as a fit-for-purpose simulation suite. Whānau waiting areas and a reception area are also in scope for this second stage of redevelopment. Stage two will include high dependency beds, achieving the goal of an integrated ICU/HDU Critical Care Unit, offering greater flexibility for managing patient care.

Asset Performance Indicators

Improving Asset Management

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

Asset Portfolio	Asset Classes within Portfolios	Asset Purpose	2017/18 Net Book Value ($000)	2018/19 Net Book Value ($000)
Property	Land, buildings, furniture and fittings, motor vehicles	To provide a base for the provision of health services	258,647	271,119
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	48,300	43,543
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of core health service by aiding decision making at the point of care	4,342	8,387

Property Portfolio Performance

Asset Performance Indicators	Indicator Class	2017/18 Result	2018/19 Standard	2018/19 Result
Percentage of buildings within the DHB's property portfolio with a current Building Warrant of Fitness[1]	Condition	93%	100%	96%

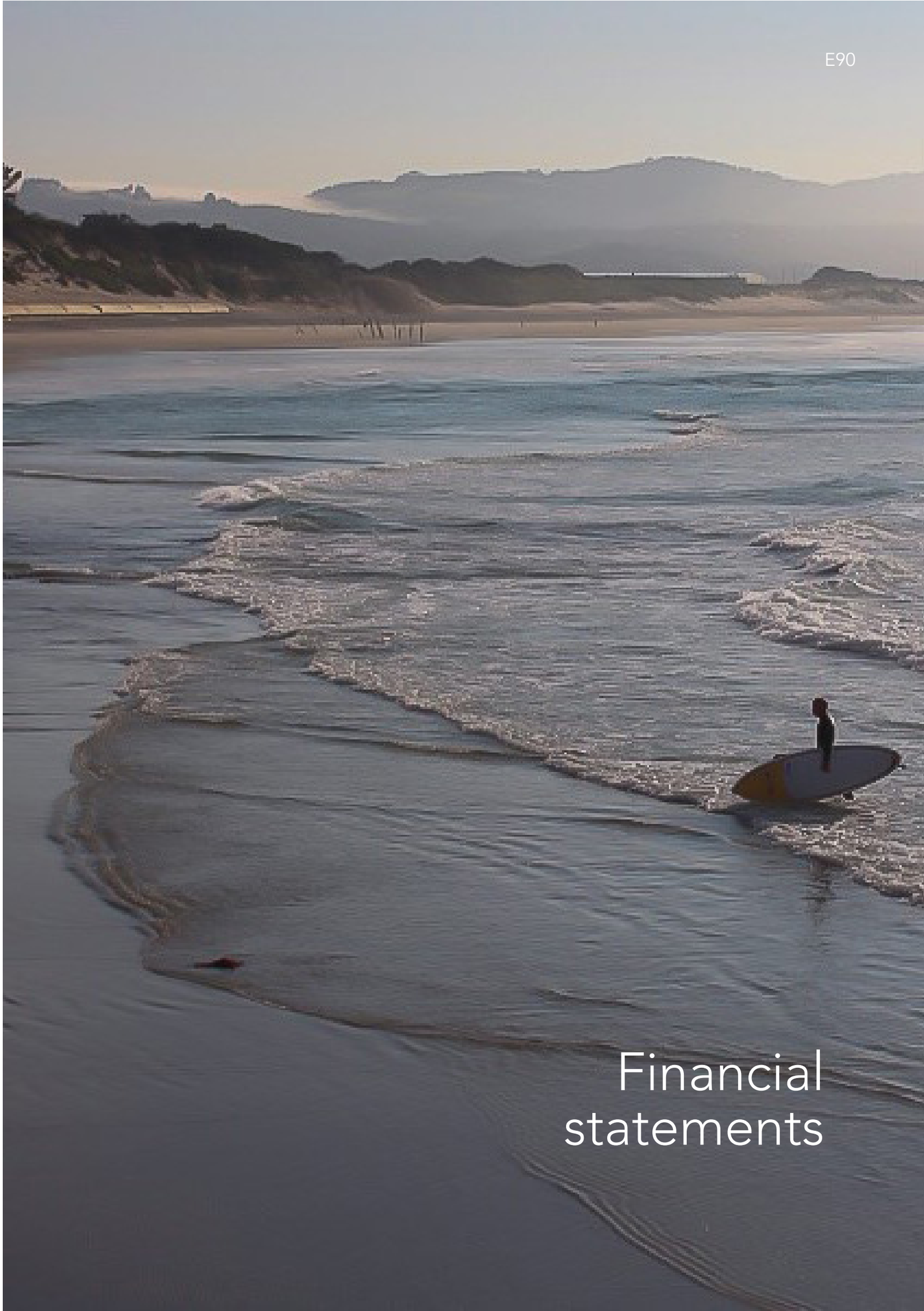
[1] Two occupied buildings within the SDHB do not have building warrant of fitness certification due to ongoing asbestos issues (Clinical Services Building, Ward Block Building) but this is expected within 12 months once inspections and 12A certification requirements are met.

Clinical Equipment Portfolio Performance

Asset Performance Indicators	Indicator Class	2017/18 Result	2018/19 Standard	2018/19 Result
Percentage of MRIs compliant with manufacturer specification standards	Condition	100%	100%	100%
Percentage of CTs and Linacs compliant with the requirements of the Radiation Protection Act	Condition	100%	100%	100%
Percentage of MRI uptime vs. operational hours	Utilisation	100%	>98%	99%
Percentage of CT uptime vs. operational hours	Utilisation	100%	>98%	98%
Percentage of Linac uptime vs. operational hours	Utilisation	new Linac being installed	>98%	Linac installation delays

Information Communication and Technology (ICT) Portfolio Performance

Asset Performance Indicators	Indicator Class	2017/18 Result	2018/19 Standard	2018/19 Result
Percentage of available capacity for storage	Condition	20%	20%	20%
Percentage uptime for critical applications	Utilisation	99%	99%	99%
Customer satisfaction level with service desk	Functionality	95%	85%	97%
Annual network penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational)	Functionality	2	2	1



Financial statements

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2019

	Note	2019 Actual $000	2019 Budget $000	2018 Actual $000
Patient revenue	2	1,023,476	1,006,681	970,662
Other revenue	2	8,407	7,017	9,007
Interest revenue		157	183	319
Total revenue		**1,032,040**	**1,013,881**	**979,988**
Personnel costs	3	442,010	386,655	369,628
Depreciation, amortisation and impairment expense	10,11	28,567	26,570	21,593
Outsourced services		49,437	42,404	45,237
Clinical supplies		96,111	83,931	84,500
Infrastructure and non-clinical expenses		51,827	49,800	48,225
Other district health boards		44,046	43,496	42,507
Non-health board provider expenses		394,874	389,900	377,050
Other expenses	6	3,370	3,519	3,369
Finance costs	5	126	146	135
Capital charge	4	11,017	9,850	9,122
Total expenses		**1,121,385**	**1,036,271**	**1,001,366**
Surplus/(deficit) for the year	17	**(89,345)**	**(22,390)**	**(21,378)**
Other comprehensive revenue				
Items that will not be reclassified to surplus/(deficit)				
Revaluation of land and buildings	17	-	-	34,570
Total other comprehensive revenue/(expense)		-	-	34,570
Total comprehensive revenue/(expense)		**(89,345)**	**(22,390)**	**13,192**

Statement of Changes in Equity
For the year ended 30 June 2019

	Note	2019 Actual $000	2019 Budget $000	2018 Actual $000
Balance at 1 July		**192,584**	**192,584**	**159,394**
Total comprehensive revenue and expense		(89,345)	(22,390)	13,192
Owner transactions				
Capital contributions from the Crown (deficit support and project equity funding)		69,878	63,994	20,705
Return of capital		(707)	(707)	(707)
Balance at 30 June		**172,410**	**233,481**	**192,584**

Explanations of major variances against budget are provided in note 24
The accompanying notes form part of these financial statements.

Statement of Financial Position
As at 30 June 2019

	Note	2019 Actual $000	2019 Budget $000	2018 Actual $000
Current assets				
Cash and cash equivalents	7	7	8	8
Trade and other receivables	8	47,353	43,731	43,731
Inventories	9	5,762	5,032	5,032
Total current assets		**53,122**	**48,771**	**48,771**
Non-current assets				
Property, plant and equipment	10	323,050	361,387	311,965
Intangible assets	11	4,505	12,222	10,884
Total non-current assets		**327,555**	**373,609**	**322,849**
Total assets		**380,677**	**422,380**	**371,620**
Liabilities				
Current liabilities				
Cash and cash equivalents	7	9,895	36,186	30,385
Payables and deferred revenue	12	63,845	50,717	49,929
Borrowings	13	922	1,226	1,226
Employee entitlements	14	112,595	79,541	76,428
Provisions	15	80	-	464
Total current liabilities		**187,337**	**167,670**	**158,432**
Non-current liabilities				
Borrowings	13	1,568	2,455	2,455
Employee entitlements	14	19,362	18,774	18,149
Total non-current liabilities		**20,930**	**21,229**	**20,604**
Total liabilities		**208,267**	**188,899**	**179,036**
Net assets		**172,410**	**233,481**	**192,584**
Equity				
Contributed capital	17	300,969	295,084	231,798
Property revaluation reserves	17	108,502	108,502	108,502
Accumulated surplus/(deficit)	17	(237,061)	(170,105)	(147,716)
Total equity		**172,410**	**233,481**	**192,584**

Explanations of major variances against budget are provided in note 24
The accompanying notes form part of these financial statements.

Statement of Cash Flows
For the year ended 30 June 2019

	2019 Actual $000	2019 Budget $000	2018 Actual $000
Cash flows from operating activities			
Cash receipts from Ministry of Health and patients	1,029,740	1,005,252	971,515
Payments to suppliers	(628,610)	(604,741)	(598,849)
Payments to employees	(404,428)	(383,381)	(362,774)
Interest received	157	183	319
Interest paid	(20)	(10)	(10)
Goods and services tax (net)	(14)	788	159
Capital charge	(11,017)	(9,850)	(9,122)
Net cash flow from operating activities	**(14,192)**	**8,241**	**1,238**
Cash flows from investing activities			
Proceeds from sale of property, plant and equipment	24	-	7
Purchase of property, plant and equipment	(32,630)	(77,329)	(27,415)
Purchase of intangibles	(658)	-	-
Net cash flow from investing activities	**(33,264)**	**(77,329)**	**(27,408)**
Cash flows from financing activities			
Capital contributions from the Crown	69,878	63,994	19,998
Drawdown/(repayment) of borrowings	(1,933)	(707)	(1,365)
Net cash flow from financing activities	**67,945**	**63,287**	**18,633**
Net increase/(decrease) in cash and cash equivalents	**20,489**	**(5,801)**	**(7,537)**
Cash and cash equivalents at beginning of year	(30,377)	(30,377)	(22,840)
Cash and cash equivalents at the end of the year	**(9,888)**	**(36,178)**	**(30,377)**

Explanations of major variances against budget are provided in note 24
The accompanying notes form part of these financial statements.

Statement of Cash Flows
For the year ended 30 June 2019 (continued)

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

	2019 Actual $000	2018 Actual $000
Net surplus/(deficit) for the period	**(89,345)**	**(21,378)**
Add/(less) non-cash items:		
Depreciation and assets written off	28,567	21,593
Increase/(decrease) in financial liability fair value	34	15
Increase/(decrease) in provision for doubtful debts	-	360
Total non-cash items	**28,601**	**21,968**
Add/(less) items classified as investing or financing activity:		
Net loss/(gains) on disposal of property, plant and equipment	(8)	37
Total items classified as investing or financing activites	**(8)**	**37**
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(3,621)	(1,759)
(Increase)/decrease in inventories	(730)	(110)
Increase/(decrease) in trade and other payables	17,189	(3,843)
Increase/(decrease) in employee benefits	33,722	6,323
Net movements in working capital	**46,560**	**611**
Net cash inflow/(outflow) from operating activities	**(14,192)**	**1,238**

The accompanying notes form part of these financial statements

Notes to the Financial Statements

1. Statement of accounting policies for the year ended 30 June 2019

REPORTING ENTITY

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

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

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

The financial statements for Southern DHB are for the year ended 30 June 2019 and were approved for issue by the Commissioner on 29 October 2019.

BASIS OF PREPARATION

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

Going concern

Southern DHB's Commissioner received a letter of support from the Ministers of Health and Finance that the Government is committed to working with them over the medium term to maintain its financial viability. It acknowledges that equity support may be required and the Crown will provide such support should it be necessary to maintain viability. The letter of support is considered critical to the going concern assumption underlying the preparation of the financial statements, as the 2019/20 Annual Plan has yet to receive approval from the Ministry of Health.

Statement of compliance

The financial statements of Southern DHB have been prepared in accordance with the requirements of the 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 (GAAP).

The financial statements have been prepared in accordance with and comply with Tier 1 Public Sector PBE standards.

Presentation currency and rounding

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

Measurement base

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

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

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

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

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

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

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

The Crown has resolved to early adopt PBE IFRS 9 Financial Instruments for financial statements prepared for periods beginning on or after 1 January 2018.

Southern DHB has applied PBE IFRS 9 and has accordingly changed its measurement of accounts receivable impairment (provisioning for doubtful debts) for the year ended 30 June 2019.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

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

Foreign currency transactions

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

Goods and services tax

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

Income tax

Southern DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax under section CW38 of the Income Tax Act 2007.

Budget figures

The budget figures are derived from the 2018/2019 statement of performance expectations. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Commissioner in preparing these financial statements.

Cost allocation

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

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

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

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

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with International Public Sector Accounting Standards (IPSAS) requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates

and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances. These results form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

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

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

- Asbestos Impairment, note 10
- Fixed assets revaluations, note 10
- Deferred maintenance, note 10
- Remaining useful lives, note 10
- Intangible assets impairment, note 11
- Employee entitlements, note 14

Comparative data

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

2. REVENUE

ACCOUNTING POLICY

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

MoH revenue

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

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

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

ACC contract revenue

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

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Southern DHB region is domiciled outside of Southern. The MoH credits Southern DHB with a monthly amount based on

estimated patient treatment for non-Southern residents within Southern. An annual wash-up occurs at year end to reflect the actual number of non-Southern patients treated at Southern DHB.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of services

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

Donations and bequests

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

Research revenue

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

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

Breakdown of Patient revenue

	2019 Actual $000	2018 Actual $000
Health and disability services (MoH contracted revenue)	982,799	930,763
ACC contract revenue	10,506	10,517
Inter-district patient inflows	21,324	21,696
Other revenue	8,847	7,686
Total Patient care revenue	**1,023,476**	**970,662**

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

Breakdown of other revenue

	2019 Actual $000	2018 Actual $000
Gain on sale of property, plant and equipment	24	8
Donations and bequests received	1,359	429
Rental revenue	2,936	2,559
Other revenue	4,088	6,011
Total other revenue	**8,407**	**9,007**

3. PERSONNEL COSTS

ACCOUNTING POLICY

Salaries and wages

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

Superannuation schemes

Defined Contribution Plans

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

Breakdown of personnel costs

	2019 Actual $000	2018 Actual $000
Salaries and wages	395,013	354,498
Defined contribution plans employer contributions	9,810	8,517
Increase/(decrease) in employee entitlements	37,187	6,613
Total personnel costs	**442,010**	**369,628**

EMPLOYEE REMUNERATION

There were 866 employees who received remuneration and other benefits of $100,000 or more for the year ending 30 June 2019 (2018: 681). The year on year increase primarily reflects the impact of one off payments (back pay and lump sum), to clinical employees for MECA settlements made during the year.

Total Remuneration and Other Benefits $000	Number of Employees	
	2019	2018
100 - 110	214	144
110 - 120	121	93
120 - 130	84	62
130 - 140	55	33
140 - 150	42	30
150 - 160	23	29
160 - 170	20	19
170 - 180	26	24
180 - 190	18	12
190 - 200	16	11
200 - 210	18	22
210 - 220	26	18
220 - 230	13	20
230 - 240	9	16
240 - 250	14	13
250 - 260	16	14
260 - 270	10	10
270 - 280	12	11
280 - 290	14	9
290 - 300	14	15

300 - 310	14	7
310 - 320	8	12
320 - 330	10	9
330 - 340	8	5
340 - 350	6	8
350 - 360	6	6
360 - 370	6	5
370 - 380	6	5
380 - 390	5	1
390 - 400	5	1
400 - 410	4	2
410 - 420	2	6
420 - 430	4	2
430 - 440	2	-
440 - 450	3	-
450 - 460	2	1
460 - 470	-	1
470 - 480	3	1
480 - 490	1	-
490 - 500	1	-
500 - 510	-	1
520 - 530	-	1
530 - 540	1	-
540 - 550	1	1
550 - 560	1	-
560 - 570	1	-
570 - 580	1	-
710 - 720	-	1
	866	**681**

Each year, as required by the Crown Entities Act, our annual report shows numbers of employees receiving total remuneration over $100,000 per year, in bands of $10,000.

Of the 866 employees in this category, 696 were regulated health professionals (2018: 549 employees were regulated health professionals).

The Chief Executive's remuneration and other benefits either paid or accrued, are in the band 540-550.

EMPLOYEE TERMINATION PAYMENTS

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

The total payments were $444,803 (2018: 25 employees totalling $656,005).

COMMISSIONER TEAM REMUNERATION

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

	2019 Actual $000	2018 Actual $000
Kathy Grant	168	170
Graham Crombie	32	55
Richard Thomson	40	43
David Perez	10	-
Jean O'Callaghan	12	-
Total Commissioner team remuneration	**262**	**268**

There were payments made to the independent Chairperson of the Finance, Audit and Risk Committee, appointed by the Commissioner since September 2015. Payments totalled $29,100 (2018: $26,400).

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

	2019 Actual $000	2018 Actual $000
Hospital Advisory Committee		
Odele Stehlin	1	-
Total Remuneration	1	-
Community and Public Health Advisory Committee/ Disability Support Advisory Committee		
Donna Matahaere-Atariki	-	1
Justine Camp	1	-
Total Remuneration	1	1
Iwi Governance Committee		
Taare Hikurangi Bradshaw	-	1
Sumaria Beaton	2	-
Justine Camp	1	2
Ann Wakefield	1	1
Donna Matahaere-Atariki	1	1
Odele Stehlin	2	2
Total Remuneration	**7**	**7**

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

4. CAPITAL CHARGE

ACCOUNTING POLICY

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

FURTHER INFORMATION ON THE CAPITAL CHARGE

Southern DHB pays capital charge to the Crown twice yearly. This is based on closing equity balance of the entity at 30 June and 31 December respectively. The capital charge rate for the periods 1 July to 31 December 2018 and 1 January to 30 June 2019 was 6%. The amount charged during the period was $11.0 million (2018: 6 %, $9.1 million).

5. FINANCE COSTS

ACCOUNTING POLICY

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

Breakdown of finance costs

	2019 Actual $000
Interest on secured loans	20
Interest on finance leases	106
Total finance costs	**126**

6. OTHER EXPENSES

ACCOUNTING POLICY

Breakdown of other expenses

	Note	2019 Actual $000	2018 Actual $000
Impairment of trade receivables		-	360
Bad debts written off		228	8
Loss on disposal of property, plant and equipment		17	45
Audit fees (for the audit of financial statements 2019)		209	202
Audit fees (for the audit of financial statements 2018)		30	-
Fees paid to other auditors for assurance and related services including internal audit		84	84
Commissioners fees	3	262	268
Operating lease expenses		2,531	2,401
Koha		9	1
Total other expenses		**3,370**	**3,369**

Operating Leases

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

The operating lease payments are made up of vehicle leases (52%), premises rental (31%), with the balance being clinical equipment and other equipment rental (18%).

Operating leases as lessee

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

	2019 Actual $000	2018 Actual $000
Non-cancellable operating lease rentals are payable as follows:		
Less than one year	890	1,296
Between one and five years	820	1,399
More than five years	119	138
Total non-cancellable operating leases	**1,829**	**2,833**

The majority of the non-cancellable operating lease expense relates to 282 fleet car leases. These leases have terms of 3.8 to 6 years, the last ones expiring April 2025.

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

7. CASH AND CASH EQUIVALENTS

ACCOUNTING POLICY

Cash and cash equivalents 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.

While cash and cash equivalents at 30 June 2019 are subject to the expected credit loss requirements of PBE IFRS9, no loss allowance has been recognised because the estimated loss allowance for credit loss is minimal.

Breakdown of cash and cash equivalents and further information

	2019 Actual $000	2018 Actual $000
Cash at bank and on hand	7	8
Demand funds with New Zealand Health Partnerships Limited	(9,895)	(30,385)
Cash and cash equivalents in the Statement of Cash Flows	**(9,888)**	**(30,377)**

WORKING CAPITAL FACILITY

At 30 June 2019, the Southern DHB held no bank overdraft facilities.

Southern DHB is a party to the 'DHB Treasury Services Agreement' between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to 'sweep' DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of a month's Provider Arm funding plus GST. For Southern DHB, that equates to $49.4m.

8. TRADE AND OTHER RECEIVABLES

ACCOUNTING POLICY

Trade and other receivables are recorded at their face value, less an allowance for expected losses.

In measuring expected credit losses, short term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due.

Short term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor in default by way of liquidation. At this point the debt is no longer subject to active enforcement.

Previous accounting policy for impairment of receivables

In the previous year, the allowance for credit losses was based on the incurred credit loss model. An allowance for credit losses was recognised only when there was objective evidence that the amount due would not be fully collected.

Breakdown of receivables and further information

	2019 Actual $000	2018 Actual $000
Receivables (gross)	51,047	47,425
Less: provision for uncollectability	(3,694)	(3,694)
Total receivables	**47,353**	**43,731**
Total receivables comprise:		
Receivables (non-exchange transactions)	27,268	25,740
Other accrued income (exchange transactions)	20,085	17,991
	47,353	**43,731**

The expected credit loss rates for receivables at 30 June 2019 and 1 July 2018 are based on the payment profile of revenue on credit over the prior 2 years at the measurement date and the corresponding historical credit losses experienced for that period.

The historical loss rates are adjusted for current and forward-looking macroeconomic factors that might affect the recoverability of receivables. Given the short period of credit risk exposure, the impact of macroeconomic factors is not considered significant.

The movement in the allowance for credit losses is as follows:

	2019 Actual $000	2018 Actual $000
Allowance for credit losses as at 1 July calculated under PBE IPSAS 29	3,694	3,334
PBE IFRS 9 expected credit loss adjustment - through opening accumulated surplus/deficit	-	N/A
Opening allowance for credit losses as at 1 July	3,694	3,334
Increase in loss allowance made during the year	228	368
Receivables written off during the year	(228)	(8)
Balance as at 30 June	**3,694**	**3,694**

Trade receivables ageing profile

	2019				2018			
	Gross Receivable $000	Estimate of losses %	Impaired Credit loss $000	Expected Credit loss $000	Gross Receivable $000	Estimate of losses %	Impaired Credit loss $000	Expected Credit loss $000
Current	9,580	0%	-	-	3,847	0%	1	-
Less than six months past due	2,149	25%	248	-	3,246	9%	294	-
Between six months and one year past due	653	75%	212	-	1,542	31%	485	-
Between one and two years past due	464	75%	349	-	850	70%	595	-
Greater than two years past due	1,685	75%	944	-	1,305	99%	1,290	-
Specific Debtors	1,951	95%	-	1,702	-	95%	-	-
Specific Debtors	80	100%	-	239	1,537	100%	-	1,029
Total	**16,562**		**1,753**	**1,941**	**12,327**		**2,665**	**1,029**

Note: Trade receivables of $16.6 million are included in Receivables (gross) figure, $51.0 million (pg. 78).

The provision for uncollectability of receivables is calculated by looking at the individual receivable balances and making a provision (loss allowance) at an amount equal to lifetime expected credit losses.

9. INVENTORIES

ACCOUNTING POLICY

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

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

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

Breakdown of inventories

	2019 Actual $000	2018 Actual $000
Pharmaceuticals	2,367	2,502
Surgical & medical supplies	3,395	2,530
Total inventories	**5,762**	**5,032**

10. PROPERTY, PLANT AND EQUIPMENT

ACCOUNTING POLICY

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

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

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

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

Revaluations

Land and buildings are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount

is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in other comprehensive revenue. Any decreases in value

relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense.

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

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

Additions

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

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

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

Disposal of property, plant and equipment

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

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

Subsequent costs

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

Depreciation

Depreciation is provided on a straight-line basis on all fixed assets other than land, at rates which will

write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

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

Buildings	5 to 79 years
Plant and Equipment	3 to 40 years
Motor Vehicles	5 to 12 years

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

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

Impairment

Property, plant and equipment and intangible assets that have a finite useful life are reviewed for indicators of impairment at each balance date and whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. If any such indications exist, the recoverable amount of the asset is estimated. The recoverable amount is the higher

of an asset's fair value less cost to sell and value in use. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

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

If an asset's carrying amount exceeds its recoverable amount, the assets are impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expenses to

the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that result is a debit in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

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

Breakdown of property, plant and equipment and further information

	Freehold land (at valuation)	Freehold buildings (at valuation)	Plant and equipment	Vehicles	Work in progress	Total
Cost	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Balance at 1 July 2017	27,487	220,640	157,070	2,310	5,680	413,187
Additions	-	-	-	-	24,913	24,913
Transfers from Work in Progress	-	3,651	7,544	-	(11,195)	-
Revaluation increase	10,510	24,060	-	-	-	34,570
Depreciation write back on Revaluation	-	(33,149)	-	-	-	(33,149)
Disposals	-	-	(1,250)	-	-	(1,250)
Balance at 30 June 2018	**37,997**	**215,202**	**163,364**	**2,310**	**19,398**	**438,271**
Balance at 1 July 2018	37,997	215,202	163,364	2,310	19,398	438,271
Additions	-	-	-	-	32,523	32,523
Transfers from Work in Progress	-	15,599	20,384	44	(36,027)	-
Disposals	-	-	(6,441)	-	-	(6,441)
Balance at 30 June 2019	**37,997**	**230,801**	**177,307**	**2,354**	**15,894**	**464,353**
Depreciation and impairment losses						
Balance at 1 July 2017	-	24,640	117,001	1,676	-	143,317
Depreciation charge for the year	-	8,509	10,858	264	-	19,631
Disposals	-	-	(3,492)	(1)		(3,493)
Elimination on Revaluation	-	(33,149)	-	-	-	(33,149)
Balance at 30 June 2018	**-**	**-**	**124,367**	**1,939**	**-**	**126,306**
Balance at 1 July 2018	-	-	124,367	1,939	-	126,306
Depreciation charge for the year	-	10,152	11,053	205	-	21,410
Disposals	-	-	(6,413)	-	-	(6,413)
Elimination on Revaluation	-	-	-	-	-	-
Balance at 30 June 2019	**-**	**10,152**	**129,007**	**2,144**	**-**	**141,303**
Carrying amounts						
At 1 July 2017	27,487	196,000	40,069	634	5,680	269,870
At 30 June 2018	**37,997**	**215,202**	**38,997**	**371**	**19,398**	**311,965**
At 1 July 2018	37,997	215,202	38,997	371	19,398	311,965
At 30 June 2019	**37,997**	**220,649**	**48,300**	**210**	**15,894**	**323,050**

Capital Commitments

	2019 Actual $000	2018 Actual $000
Buildings	16,071	15,474
Clinical equipment	11,637	2,604
Computer equipment	2,757	1,278
Non-clinical equipment	90	224
Intangibles	6	-
Total capital commitments	**30,561**	**19,580**

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

Revaluation

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

The revaluation of land and buildings of Southern DHB was carried out as at 30 June 2018 by Tony Chapman, an independent registered valuer with Colliers International and a member of the New Zealand Institute of Valuers. That valuation conformed to International Valuation Standards and was based on an optimised depreciation replacement cost methodology. The valuer was contracted as an independent valuer. Additions to land and buildings between 1 July 2018 and 30 June 2019 have been included at cost.

The value of Southern DHB's land and buildings has been reduced by $19.2 million due to the impairment of land and buildings. This has reduced the carrying amount as at 30 June 2019.

Restriction

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

IMPAIRMENT

Southern DHB impaired Land and Buildings by the value of $20.1 million in the 2016/2017 year due to the impact on fair values due to asbestos contamination identified throughout the DHB. The impairment remaining at 30 June 2019 is $19.2 million.

This contamination has been located across a number of buildings.

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

11. INTANGIBLE ASSETS

ACCOUNTING POLICY

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

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

The Health Finance, Procurement and Information Management System (FPIM), previously known as Finance, Procurement and Supply Chain (FPSC) is a national initiative and is managed on behalf of DHBs by NZ Health Partnerships Limited (NZHPL). During the year to 30 June 2019, Southern DHB capitalised payments in respect of FPIM totalling $0.7m (2018: $nil). The total value of payments capitalised by Southern DHB since the inception of FPIM to 30 June 2019 was $5.1m (2018: $4.5m).

In return for these payments, Southern DHB gained rights to access the FPIM asset. In the event of liquidation or dissolution of NZHPL, Southern DHB shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total FPIM rights that have been issued.

The FPIM rights have been tested for impairment at 30 June 2019, by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to Southern DHB's share of the DRC of the underlying FPIM assets. An impairment charge of $5.1m has been recognised in the Statement of Comprehensive Revenue and Expense in 2019 (2018: Nil).

Amortisation

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

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

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

The estimated useful lives are as follows:

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

Breakdown of intangible assets

	FSPC	Software & development costs	Total
Cost	**$000**	**$000**	**$000**
Balance 1 July 2017	4,469	24,553	29,022
Additions	-	215	215
Disposals	-	-	-
Balance at 30 June 2018	**4,469**	**24,768**	**29,237**
Balance 1 July 2018	4,469	24,768	29,237
Additions	658	120	778
Disposals	-	-	-
Balance at 30 June 2019	**5,127**	**24,888**	**30,015**
Amortisation and impairment losses			-
Balance 1 July 2017	-	16,391	16,391
Amortisation charge for the year	-	1,962	1,962
Disposals	-	-	-
Balance at 30 June 2018	**-**	**18,353**	**18,353**
Balance 1 July 2018	-	18,353	18,353
Amortisation charge for the year	-	2,030	2,030
Impairment	5,127	-	5,127
Disposals	**-**	**-**	**-**
Balance at 30 June 2019	5,127	20,383	25,510
Carrying amounts			
At 1 July 2017	4,469	8,162	12,631
At 30 June 2018	**4,469**	**6,415**	**10,884**
At 1 July 2018	4,469	6,415	10,884
At 30 June 2019	**-**	**4,505**	**4,505**

The above balance includes $0.8 million of work in progress, the major contributing item being $0.7 million relating to the South Island Patient Management System. (2018: $0.7 million relating to the South Island Patient Management System).

12. PAYABLES & DEFERRED REVENUE

ACCOUNTING POLICY

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

Breakdown of payables & deferred revenue

	2019 Actual $000	2018 Actual $000
Trade payables to non-related parties	15,045	10,201
GST payable	5,564	5,578
Revenue in advance relating to contracts with specific performance obligations	2,441	158
Other non-trade payables and accrued expenses	40,795	33,992
Total payables and deferred revenue	**63,845**	**49,929**

	2019 Actual $000	2018 Actual $000
Total payables comprise:		
Exchange transactions	55,840	44,192
Non-exchange transactions	8,005	5,737
	63,845	**49,929**

13. INTEREST-BEARING LOANS & BORROWINGS

ACCOUNTING POLICY

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

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

FINANCE LEASES

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

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

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

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

Breakdown of interest bearing loans & borrowings

	2019 Actual $000	2018 Actual $000
Current		
Current portion of secured loans	600	600
Current portion of unsecured loans	53	116
Current portion of finance lease liabilities	269	510
Total current portion	**922**	**1,226**
Non-current		
Secured loans	516	1,083
Unsecured loans	-	51
Finance lease liabilities	1,052	1,321
Total non-current portion	**1,568**	**2,455**
Total borrowings	**2,490**	**3,681**

Secured loans

Southern DHB has loans with the NZ Debt Management Office which is part of the Treasury and with the Energy Efficiency & Conservation Authority (EECA) which is a Crown Entity.

SECURITY AND TERMS

The Southern DHB cannot perform the following actions without the Ministry of Health's prior written consent:

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

The Ministry of Health retains the right to reinstate any historical covenants at any time.

Breakdown of Crown loans

	2019 Actual $000	2018 Actual $000
Interest rate summary		
Crown loans - fixed interest	-	-
Repayable as follows:		
Within one year	653	716
One to two years	516	589
Two to three years	-	548
Three to four years	-	-
Four to five years	-	-
Later than five years	-	-
	1,169	**1,853**
Term loan facility limits		
Secured loans	-	-

Breakdown of finance leases

	2019 Actual $000	2018 Actual $000
Within one year	269	510
One to two years	93	269
Two to three years	103	93
Three to four years	112	103
Four to five years	122	112
Later than five years	622	744
	1,321	**1,831**

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

14. EMPLOYEE ENTITLEMENTS

ACCOUNTING POLICY

Short-term employee entitlements

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

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

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as

long service leave and retirement gratuities, have been calculated on an actuarial basis by AON New Zealand Ltd using accepted accounting principles. The calculations are based on:

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

Presentation of employee entitlements

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

Breakdown of employee entitlements

	2019 Actual $000	2018 Actual $000
Current portion		
Long-service leave	3,856	3,616
Sabbatical leave	181	179
Retirement gratuities	3,516	2,889
Annual leave	83,270	43,864
Sick leave	317	343
Continuing medical education	5,905	5,913
Salary and wages accrual	15,550	19,624
Total current portion	**112,595**	**76,428**
Non-current portion		
Long-service leave	4,967	4,016
Sabbatical leave	2,160	1,680
Retirement gratuities	12,235	12,453
Total non-current portion	**19,362**	**18,149**
Total employee entitlements	**131,957**	**94,577**

HOLIDAYS ACT 2003

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, the Southern DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

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

The present value of sabbatical leave, long-service leave, and retirement gratuities obligations depend on a number of factors that are determined on

an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

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

The salary inflation factor has been determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. A discount rate of 1.26 % (2018: 1.78 %)

and an inflation factor of 3.42 % (2018: 3.40 %) were used.

15. PROVISIONS

ACCOUNTING POLICY

General

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

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

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

Restructuring

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

Breakdown of provisions

	2019 Actual $000	2018 Actual $000
Restructuring	80	464
Total current portion	80	464
Non-current portion		
Restructuring	-	-
Total non-current portion	-	-
Total Provisions	**80**	**464**

Restructuring provision

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

Movements in each class of provision are as follows:

	Restructuring $000
Balance at 1 July 2017	2,000
Additional provisions made	-
Amounts used	(736)
Unused amounts reversed	(800)
Balance at 30 June / 1 July 2018	**464**
Additional provisions made	-
Amounts used	(384)
Unused amounts reversed	-
Balance at 30 June 2019	**80**

16. CONTINGENCIES

ACCOUNTING POLICY

Contingent Liabilities

A contingent liability is a possible or present obligation

arising from past events that cannot be recognised in the financial statements because:

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

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

As the remediation option is determined on a case by case basis, the impairment provision recognised on the DHB's buildings may not cover all the associated impact or costs.

The DHB is currently subject to potential litigation arising from complaints filed with the Human Rights Review Tribunal.

There were no other contingent liabilities at year end.

Contingent Assets

Southern DHB has no contingent assets.

17. EQUITY

ACCOUNTING POLICY

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

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

Property revaluation reserve

These reserves relate to the revaluation of property, plant and equipment to fair value. There have been no movements in the reserve this year.

Capital management

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

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

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

Breakdown of equity

	Crown equity $000	Property revaluation reserve $000	Retained earnings $000	Total equity $000
Balance at 1 July 2017	211,800	73,932	(126,338)	159,394
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	20,705	-	-	20,705
Equity repayment to the crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	34,570	-	34,570
Deficit for the period	-	-	(21,378)	(21,378)
Balance at 30 June 2018	**231,798**	**108,502**	**(147,716)**	**192,584**
Balance at 1 July 2018	231,798	108,502	(147,716)	192,584
Capital contributions from the Crown (Deficit Support and Project Equity Funding)	69,878	-	-	69,878
Equity repayment to the crown	(707)	-	-	(707)
Movement in revaluation of land and buildings	-	-	-	-
Deficit for the period	-	-	(89,345)	(89,345)
Balance at 30 June 2019	**300,969**	**108,502**	**(237,061)**	**172,410**

Equity is made up of:

	2019 Actual $000	2018 Actual $000
Equity	167,948	187,807
Restricted equity*	4,462	4,777
Total equity	**172,410**	**192,584**

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

18. ASSOCIATED ENTITIES

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

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

The functions of SISSAL are being conducted by South Island DHB's under an agency arrangement.

19. RELATED PARTIES

TRANSACTIONS WITH RELATED PARTIES

Southern DHB is a wholly owned entity of the Crown in terms of the Crown Entities Act 2004.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management team remuneration

The key management remuneration is as follows:

	2019 Actual $000	2018 Actual $000
Commissioner Team		
Remuneration	262	268
Full time equivalent members	1.3 FTE	0.9 FTE
Total Commissioner team remuneration	**262**	**268**
Total Commissioner team full time equivalent	**1.3 FTE**	**0.9 FTE**
Executive Management		
Remuneration	2,848	2,216
Termination payments	48	210
Full time equivalent members	11.3 FTE	10.2 FTE
Total Executive Management remuneration	**2,896**	**2,426**
Total Executive Management full time equivalent	**11.3 FTE**	**10.2 FTE**
Total remuneration	**3,158**	**2,693**
Total full time equivalent	**12.6 FTE**	**11.1 FTE**

The full time equivalent (FTE) for the Commissioner team has been determined on the frequency and length of meetings and the estimated time to prepare for meetings.

An analysis of Commissioner team remuneration is provided in Note 3.

20. FINANCIAL INSTRUMENTS

ACCOUNTING POLICY

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

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

CREDIT RISK

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 15.1 % of total receivables). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

LIQUIDITY RISK

Liquidity risk represents Southern DHB's ability to meet its contractual obligations. Southern DHB evaluates its liquidity requirements on an ongoing basis and has credit lines in place to cover potential shortfalls.

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

	Balance sheet $000	Contractual cash flow $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
2019							
Secured loans	1,116	1,116	300	300	516	-	-
Unsecured loans	53	53	53	-	-	-	-
Finance lease liabilities	1,321	1,321	226	43	93	337	622
Payables and deferred revenue	63,845	63,845	63,845	-	-	-	-
Total	**66,335**	**66,335**	**64,424**	**343**	**609**	**337**	**622**
Inflow	-	-	-	-	-	-	-
Outflow	66,335	66,335	64,424	343	609	337	622
2018							
Secured loans	1,683	1,804	300	300	600	604	-
Unsecured loans	167	170	58	58	49	5	-
Finance lease liabilities	1,830	1,830	257	253	269	308	743
Payables and deferred revenue	49,929	49,929	49,929	-	-	-	-
Total	**53,609**	**53,733**	**50,544**	**611**	**918**	**917**	**743**
Inflow	-	-	-	-	-	-	-
Outflow	53,609	53,733	50,544	611	918	917	743

INTEREST RATE RISK

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

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

EFFECTIVE INTEREST RATES AND REPRICING ANALYSIS

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

2019

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office	-	1,116	300	300	516	-	-
Unsecured Bank Loans	-	53	53	-	-	-	-
Finance lease liabilities*	8.78% - 18.34%	1,321	226	43	93	337	622

* These assets/liabilities bear interest at fixed rates

2018

	Effective interest rate (%)	Total $000	6 mths or less $000	6-12 mths $000	1-2 years $000	2-5 years $000	More than 5 years $000
Secured bank loans:							
NZD fixed rate loan *							
NZ Debt Management Office	-	1,683	300	300	533	550	-
Unsecured Bank Loans	-	167	58	58	49	2	-
Finance lease liabilities*	8.78% - 18.34%	1,830	256	253	269	308	744

* These assets/liabilities bear interest at fixed rates

	Note	2019 Actual $000	2018 Actual $000
Opening Balance – Crown Loans	13	1,683	2,270
Increase Crown Loans		-	-
Repayment of Crown Loans		(567)	(587)
Conversion of loans to equity		-	-
Closing Balance – Crown Loans		**1,116**	**1,683**
Opening Balance – Contributed Capital	17	97,400	97,400
Capital contribution from/(repayment to) the Crown		-	-
Conversion of Crown loans to Crown equity		-	-
Closing Balance – Contributed Capital		**97,400**	**97,400**

FOREIGN CURRENCY RISK

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

Southern DHB is exposed to foreign currency risk on sales and purchases that are denominated in a currency other than NZD. The currencies giving rise

to this risk are primarily United States and Australian dollars.

SENSITIVITY ANALYSIS

In managing interest rate and currency risks, Southern DHB aims to reduce the impact of short-term fluctuations on Southern DHB's earnings. Over the longer term, however, permanent changes in foreign exchange and interest rates would have an impact on earnings. At 30 June 2019, it is estimated that a general change of one percentage point in interest rates would increase or decrease Southern DHB's operating result by approximately $0.01 million (2018: $0.02 million).

CLASSIFICATION AND FAIR VALUES

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

ESTIMATION OF FAIR VALUES ANALYSIS

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

	Note	Loans and receivables $000	Other amortised costs $000	Carrying amount Actual $000	Fair value Actual $000
2019					
Trade and other receivables	8	-	-	47,353	47,353
Cash and cash equivalents	7	-	-	(9,888)	(9,888)
Secured loans	13	-	-	1,116	1,116
Finance lease liabilities	13	-	-	1,321	1,321
Unsecured liabilities	13	-	-	53	53
Payables and deferred revenue	12	-	-	63,845	63,845
2018					
Trade and other receivables	8	43,731	-	-	43,731
Cash and cash equivalents	7	(30,377)	-	-	(30,377)
Secured loans	13	-	1,683	-	1,683
Finance lease liabilities	13	-	-	-	1,830
Unsecured liabilities	13	-	167	-	167
Payables and deferred revenue	12	-	49,929	-	49,929

The measurement categories and carrying amounts for financial liabilities have not changed between the closing 30 June 2018 and opening 1 July 2018 dates as a result of the transition to PBE IFRS 9. Under PBE IFRS 9, all financial instruments are measured at amortised cost on the basis of the DHB's business model for managing the financial instruments, and the contractual cash flow characteristics of the financial instruments.

FAIR VALUE HIERARCHY

The only financial instruments measured at fair value in the statement of financial position are Finance Leases. The fair value of finance leases as represented by their carrying amount in the statement of financial position, is determined using a valuation technique that uses observable market inputs (level 2).

FINANCE LEASE LIABILITIES

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

TRADE AND OTHER RECEIVABLES/PAYABLES

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

21. ADOPTION OF PBE IFRS 9 FINANCIAL INSTRUMENTS

In accordance with the transitional provisions of PBE IFRS 9, Southern DHB has elected not to restate the information for previous years to comply with PBE IFRS 9. Adjustments arising from the adoption of PBE IFRS 9 are recognised in opening equity at 1 July 2018.

Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

- Note 8 Receivables: this policy has been updated to reflect that the impairment of short-term receivables is now determined by applying an expected credit loss model.

22. MENTAL HEALTH RING-FENCE

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

During the 2011/12 year there was a change in the ring-fence calculation to include community dispensed anti-psychotic drugs, and primary mental health initiatives. Also, the mental health specific demographic rate is now used in calculating the demographic component of the ring-fence, rather than the District Health Boards' (DHBs) average demographic rate.

The year ended 30 June 2019 has resulted in a deficit of $4.6 million (2018: $1.9 million) for Mental Health services. Additionally Southern DHB has a brought-forward overspend of $7.7 million; meaning that the carry-forward overspend is $12.3 million (2018: $7.7 million).

23. EVENTS AFTER BALANCE DATE

There were no events after 30 June 2019, which could have a material impact on the information in Southern DHB's financial statements.

24. EXPLANATION OF FINANCIAL VARIANCES FROM BUDGET

Explanations for major variances from Southern DHB's budgeted figures are as follows:

Statement of Comprehensive Revenue and Expense

The unfavourable variance in total comprehensive revenue and expenses against budget for the year ended 30 June 2019 was $66.9 million.

Revenue

Total Revenue was $18.1 million higher than budget. Government and Crown contracted revenue accounted for $16.8 million of this, largely due to additional funding for the NZNO MECA and PSA MECAs, Community Services Cards, and Safe Staffing for Nursing and Pay Equity. The Non-Government revenue was higher than budget due to an uplift in healthcare delivery to non-residents and donations.

Personnel costs and outsourcing

Personnel costs were unfavourable to budget by $55.4 million.

During the year, industrial action, in particular NZNO and NZRDA, impacted on workforce costs. As a result of industrial action, additional payments of $2.2 million were made to Senior Medical Officers providing cover during NZRDA industrial action.

The MECA settlements gave effect to increases in remuneration and staffing levels across the clinical workforce contributing to the $16.2 million variance to budget.

Additional recognition of the estimated historical liability to identify, rectify and remediate any Holidays Act 2003 non-compliances added $34.1 million to personnel costs.

The actuarial calculation of the liability for non-vested employee entitlements at 30 June 2019 was $2.5 million higher than budget reflecting the significant drop in discount rates and CPI rates announced by Treasury at that time.

Outsourced Services (Includes Outsourced Personnel)

Outsourced Clinical Services were $7.0 million over budget, reflecting the outsourcing of services (including outsourced personnel working in our facilities) to meet the demand for delivery of acute and elective services beyond the current capacity within the hospitals and to recover under delivery resulting from industrial action. Similarly the services from other DHBs were $0.5 million more than expected.

Total caseweights were 8% or 4,378 higher than budgeted. In addition, despite the industrial action the elective delivery was 5% higher than the previous year.

Clinical Supplies

Clinical supplies were $12.1 million over budget due to a range of factors. These include the increasing use of high cost pharmaceutical products and the higher than expected demand for blood products, implants and prostheses. In addition, ambulance transportation costs continues to increase, particularly air ambulance with the National Ambulance Sector Office (NASO) contract substantially increasing rates reflecting the investments being made by suppliers.

Statement of Financial Position

Property, Plant and Equipment

Property Plant and Equipment was $4.6 million lower than budget reflecting the timing of purchasing and completion of capital work programmes. The capital expenditure on the new ICU facility, linear accelerator replacements, various items of clinical and infrastructural equipment and deferred maintenance programmes continue into the new financial year.

Intangible Assets

Intangible assets were $7.7 million lower than budget with the impairment of the Health Finance, Procurement and Information Management System (FPIM) being $5.1 million and the balance being underspend.

Trade and Other Receivables

Trade and Other Receivables were $3.6 million higher than budget reflecting the timing of invoicing.

Contributed Capital

Contributed Capital is $5.9 million more than budget. This is a result of the timing of equity funding from the Ministry of Health.

Employee Entitlements

Employee Entitlements are $33.6 million higher than budget primarily the increase in the estimated liability for identifying, rectifying and remediating any non-compliance with the Holidays Act 2003.

Statement of Cash Flows

Net Cash Flow from Operating Activities is $22.4 million lower than budget. While Cash Receipts from the Ministry of Health were $24.4 million higher than budget that was more than offset by Payments to Suppliers, Payments to Employees and Capital Charge all being well above budget.

Cash Flows from Investing Activities are $44.0 million favourable to budget due to the timing of capital expenditure.

Net Cash Flow from Financing Activities is $4.7 million more than budget due to the increased capital contributions.

Information on Ministerial Directions

Directions issued by a Minister during the 2017/18 financial year, or those that remain current, are as follows:

- Direction to support a whole of government approach as to implementation of a New Zealand Business Number, issued in May-16 under section 107 of the Crown Entities Act. http://www.mbie.govt.nz/info-services/business/better-for-business/nzbn
- Health and Disability Services Eligibility Direction 2011, issued under section 32 of the New Zealand Public Health and Disability Act 2000. https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf
- Directions to support a whole of government approach, issued in Apr-14 under section 107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. http://www.ssc.govt.nz/whole-of-govt-directions-dec2013
- The direction on use of authentication services, issued in Jul-08, continues to apply to all Crown agents apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction. www.ssc.govt.nz/sites/all/files/AoG-direction-shared-authentication-services-july08.PDF

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Southern District Health Board's financial statements and performance information for the year ended 30 June 2019

The Auditor-General is the auditor of Southern District Health Board (the Health Board). The Auditor-General has appointed me, John Mackey, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 82 to 110, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 15 to 32 and 34 to 47.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the "Basis for our qualified opinion" section of our report:

- the financial statements of the Health Board on pages 82 to 110:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 15 to 32 and 34 to 47:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, including:
    - for each class of reportable outputs:

- its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 23 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we outline the responsibilities of the Commissioner and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 14 on page 102, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $37.1 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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

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

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

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw attention to the disclosures made in note 1 on page 86 that outline the financial difficulties being experienced by the Health Board.

The Health Board has determined that it is a going concern, because it has obtained a letter of comfort from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, where necessary, to maintain viability. We consider these disclosures to be adequate.

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

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

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

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

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

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

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

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

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Commissioner.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Commissioner and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Commissioner is responsible for the other information. The other information comprises the information included on pages 1 to 14, 33, and 48 to 80 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

John Mackey
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand


Southern District
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Piki Te Ora
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